

Insurance Issues for LGBTQ+ Individuals: A Collection of Essays

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Insurance Issues for LGBTQ+ Individuals

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Introduction and Acknowledgments

INTRODUCTION

In late 2022, the Society of Actuaries (SOA) Research Institute and its Diversity, Equity, and Inclusion Strategic Research Program issued a call for essays to explore insurance issues pertaining to LGBTQ+ individuals. The intent of the call for essays was to gather perspectives, opinions and data on both the short-term and long-term impacts of applicable insurance issues for a variety of stakeholders and how these impacts may be experienced both directly and indirectly. Stakeholders include LGBTQ+ individuals, partners, family members, employers, insurance or financial advisors, insurance companies, and others.

A project oversight group (POG) reviewed blinded versions of the essays, and judged them for publication and awards. Judging criteria included originality, relevance, applicability, validity of any analysis or conclusions, and the extent to which an idea could contribute to the conversation on these issues. The POG selected four essays for publication and awarded each a prize.

The essays offer insights to how LGBTQ+ individuals and their families experience insurance-related issues, and to broaden understanding of these issues beyond the LGBTQ+ community. The SOA Research Institute seeks to enhance understanding of these issues and how it may lead to innovations within or related to the actuarial and insurance industries. The SOA Research Institute also seeks to illuminate opportunities for future research on these topics.

As noted on the SOA [Diversity Inclusion and Equity \(DEI\) pages](#), the SOA’s DEI statement “is for all members and candidates to feel fully included and have equitable opportunities to enter, develop, grow and succeed in our chosen profession. We seek, welcome and nurture individuals with diverse backgrounds and perspectives that represent the diversity of the workforce and thereby maximize the influence of the actuarial profession.” For more information and materials, visit the [SOA DEI resources page](#).

| | |
|--------------------|---|
| First Prize | <p>Beyond the Binary—How Insurance Companies Can Adapt to Meet the Needs of Transgender, Non-binary, and Intersex Individuals Jonah von der Embse, FSA, CERA, MAAA</p> |
| Second Prize (Tie) | <p>Looking Back to Move Forward: How the Cultural History of LGBTQ+ People Relates to the Contexts of Health, Insurance, and Marriage Edward Chamberlain, PhD</p> <p>Mental Health Services and Supports for At-Risk LGBTQ+ Youth Ellyn M. Russo, MS; Ali LaRocco; Danielle Rubin, ASA, MAAA; Donna Wix, ASA, MAAA; and Andrew Gaffner, FSA, MAAA</p> |
| Third Prize | <p>Systemic Barriers to Gender-Affirming Care for Transgender and Gender Diverse Youth Benjamin Parchem, PhD, and G. Nic Rider, PhD</p> |

THE CALL FOR ESSAYS

At the Society of Actuaries Research Institute, calls for essays are substantively different from calls for short research papers. Research Institute research papers are required to be fact-based and objective and to avoid advocacy, especially with respect to public policy. Research papers published by the Research Institute may inform readers about public policy topics but must refrain from taking a position on or advocating for a public policy issue.

Essays that the Research Institute published may be fact-based, short research papers. Alternatively, they may be more experiential in nature as a means of highlighting issues or calling for change, although they must refrain from advocating for or taking a position on a specific legislative or regulatory initiative. Both types of essays were invited in this call for essays, and both types of essays are included in this collection.

For context, the two sections of the call for essays that outline the subject matter request are replicated below.

BACKGROUND AND OVERVIEW

The Society of Actuaries Research Institute, as a component of its Diversity, Equity and Inclusion Strategic Research Program, would like to broadly explore issues pertaining to LGBTQ+ individuals that relate to a variety of types of insurance. Relevant types of insurance include risk-transfer products such as life insurance (including employer-provided life insurance benefits and individually purchased life insurance), annuities, health insurance (including health insurance benefits accessed through an employer, individually purchased health insurance, and government insurance), auto insurance, and homeowners or renters insurance. Public, social, or governmental insurance is also relevant. The intent is to gather perspectives, opinions and data on the short- and long-term impacts of applicable insurance issues for a variety of stakeholders and how these impacts may be experienced both directly and indirectly. Relevant stakeholders include LGBTQ+ individuals, partners, family members, employers, insurance or financial advisors, insurance companies, and others.

Of particular interest are the diversity of experiences within the LGBTQ+ community and opportunities to enhance understanding of the underlying issues surrounding different experiences. Both of these objectives will help inform or spark ideas for potential solutions and improvements. Our primary interest is in countries with SOA members, but we welcome essays relevant to any country.

ESSAY CONTENTS

The following questions are examples of ideas or issues to consider when choosing a topic for an essay, and all types of insurance are relevant. The list below is neither exhaustive nor intended to be restrictive of other areas related to insurance; authors may address these issues or other relevant issues:

- How do LGBTQ+ individuals and households experience insurance differently from people in other demographic groups? How does it vary, if at all, by type of insurance, for example, renters, homeowners, auto, health care, life, disability, etc.?
- How does access to insurance coverage, or lack thereof, affect LGBTQ+ individuals and households in particular? What about situations where there is access, but facilities are unwelcoming?
- Are there insurance products and innovations that could be tailored for LGBTQ+ individuals, couples or families to provide better solutions for managing financial risks?
- How do differences between state/provincial and federal laws on LGBTQ+ marriages impact decisions with respect to private and social insurance? Does common law marriage have any specific effect here?
- What challenges do financial advisors face when serving LGBTQ+ individuals, couples or families?

- Have LGBTQ+ individuals and households experienced any past issues accessing a covered insurance benefit due to restrictions by the insurance provider or due to restrictions from state/provincial and federal laws?
- How can government climate, social and infrastructure policies for LGBTQ+ individuals and households as at-risk populations enable improved financial outcomes?
- How do LGBTQ+ individuals structure financial arrangements in multiple-person households, and does this affect their access to, experiences with and use of insurance? Are there differences between households with shared financial resources and joint ownership of property and households without shared resources?
- Are there situations where LGBTQ+ individuals and households experience challenges in health or disability at claim time?
- What are the challenges with insurance specific to transgender persons?
- What challenges exist in insurance regarding gender expression or gender identity?
- What challenges exist for insurance companies when engaging with non-cisgender or non-binary individuals?
- What challenges do insurance companies face when gathering data to inform insurance practices (for example, claims, underwriting, product development) for LGBTQ+ individuals and households?
- Are changes in policy development or implementation needed, and if so, what?

ACKNOWLEDGMENTS

The SOA Research Institute Diversity, Equity, and Inclusion Strategic Research Program thanks the Project Oversight Group (POG) for their careful review and judging of the submitted essays. Any views and ideas expressed in the essays are the authors' alone may not reflect the POG's views and ideas nor those of their employers, the authors' employers, the Society of Actuaries, the Society of Actuaries Research Institute, nor Society of Actuaries members.

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First Prize Winner

Beyond the Binary—How Insurance Companies Can Adapt to Meet the Needs of Transgender, Non-binary, and Intersex Individuals

Jonah von der Embse, FSA, CERA, MAAA

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Male or female? The simple, seemingly innocuous question we all likely encounter throughout our lifetimes, right after asking for one's name. Life insurance applications are no different – in the U.S., companies currently ask individuals to select one of these two options. Although underwriting and risk classification can differentiate an individual's risk, and thus the price of the insurance product, the underlying cost structure and cash value is significantly influenced by this male/female classification. If only it was so clean-cut.

Transgender, non-binary, and intersex individuals have long been a part of society, and as they and younger generations challenge traditional ways of thinking about sex and gender, insurance companies will need to learn to adapt to a changing world. The use of sex, gender, or both is a good place to start, especially how it uniquely impacts the LGBTQ+ population and their ability to access fair and affordable insurance.

This essay is limited in scope to only a few of the myriad of issues faced by a segment of the LGBTQ+ population. However, it will give readers a brief education of the LGBTQ+ population, the importance of clarifying sex vs. gender, and how a binary classification system indirectly adds additional barriers to an already marginalized population. Finally, it will discuss what actuaries should consider for future research and discussion.

For the purposes of this essay, sex is biologically defined characteristics, while gender is a social construct, as defined by the Human Rights Campaign (HRC).¹ The HRC defines transgender as an umbrella term for individuals whose gender identity differs from the sex assigned to them at birth. Some (but not all) transgender individuals undergo gender affirming surgery to align their sex with their gender identity. Non-binary is an identity used by individuals who do not identify as male or female. Although many non-binary individuals identify as transgender, not all do. Intersex people are born with a variety of differences in their

¹ Human Rights Campaign, Glossary of Terms, accessed June 14, 2022, <https://www.hrc.org/resources/glossary-of-terms>.

sex traits and reproductive anatomy, and can identify as intersex, non-binary, male, female or a different gender.

THE U.S. LGBTQ+ POPULATION

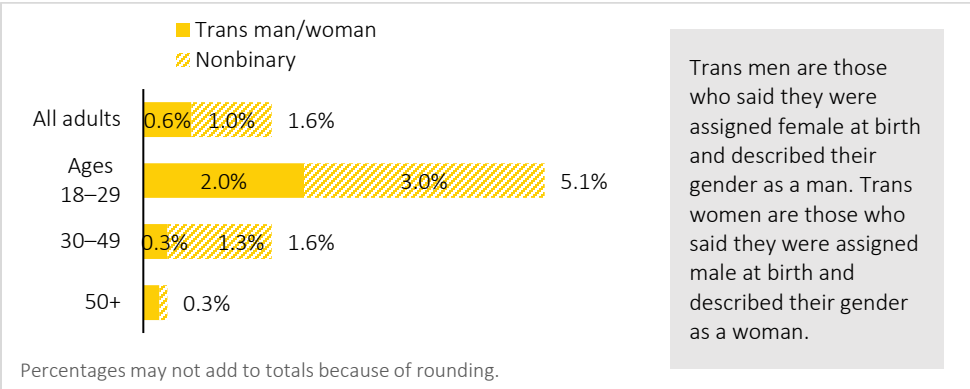
A 2022 poll by Gallup (Table 1) estimated the LGBTQ+ population in the U.S. is 7.1%, doubling in the last decade.² Broken down by generation, more than one in five members of the youngest cohort (Generation Z) identify as LGBT, likely signaling future growth. A Pew research study in June 2022 (Figure 1) further highlighted the gap based on age and generation, finding slightly more than 5% of adults aged 18–29 say their gender is different from their sex assigned at birth.³

TABLE 1 AMERICANS’ SELF-IDENTIFICATION AS LGBT, BY GENERATION

| | LGBT % | Straight/Heterosexual % | No Response % |
|------------------------------------|--------|-------------------------|---------------|
| Generation Z (born 1997–2003) | 20.8 | 75.7 | 3.5 |
| Millennials (born 1981–1996) | 10.5 | 82.5 | 7.1 |
| Generation X (born 1965–1980) | 4.2 | 89.3 | 6.5 |
| Baby Boomers (born 1946–1964) | 2.6 | 90.7 | 6.8 |
| Traditionalists (born before 1946) | 0.8 | 92.2 | 7.1 |

Source: Gallup, 2021

Figure 1
PERCENT OF U.S. ADULTS WHO SAY THEIR GENDER DIFFERS FROM THEIR SEX ASSIGNED AT BIRTH



Source: Pew Research Center, Survey of U.S. adults conducted May 16–22, 2022.

The intersex population can be difficult to quantify due to many individuals going through medical procedures early in life. However, the Center of American Progress estimates up to 1.7% of the population has an intersex trait, and approximately 0.5% of people have clinically identifiable sexual or reproductive variations (an estimated 5.6 million and 1.6 million Americans, respectively).⁴

² Jones, Jeffrey M. LGBT Identification in U.S. Ticks Up to 7.1%. <https://news.gallup.com>, Feb 17, 2022, <https://news.gallup.com/poll/389792/lgbt-identification-ticks-up.aspx>
³ Brown, Anna. About 5% of young adults in the U.S. say their gender is different from their sex assigned at birth. <https://pewresearch.org>, June 7, 2022, <https://www.pewresearch.org/fact-tank/2022/06/07/about-5-of-young-adults-in-the-u-s-say-their-gender-is-different-from-their-sex-assigned-at-birth/>
⁴ Mahowald, Lindsay and Caroline Medina. <https://americanprogress.org>, Oct 26, 2021, <https://www.americanprogress.org/article/key-issues-facing-people-intersex-traits/#:~:text=It%20is%20estimated%20that%20up,identifiable%20sexual%20or%20reproductive%20variations>

Millions of Americans do not easily fall into the buckets of “male” and “female,” and this population is only likely to grow in the future. So why do insurance companies insist on this split?

A BRIEF HISTORY OF SEX AND INSURANCE

In the late 19th century, life insurance companies commonly charged different rates based on race or geographic location, but not sex (although females were often charged more, or offered lower payouts, for annuities). In 1955, Phoenix Mutual Life Insurance company became the first company to offer females lower premiums on life insurance.⁵ However, U.S. statutory reserve mortality tables were unisex. Many companies adopted a simplification for female mortality rates through an age set back, or, in other words, using rates of a younger male.

Figure 2

A BRIEF TIMELINE OF SEX, GENDER, AND INSURANCE



Due to the uneven nature of the “mortality setback” and the rise of the feminist movement, state legislatures across the U.S. began to ban this practice. In response, the NAIC requested the Society of

⁵ Nassau Financial Group, A Legacy of Innovation and Social Commitment, accessed June 14, 2022, <https://nfg.com/insurance-company-history.html>.

Actuaries to form a task force in the mid-1970s to study whether a new mortality table should be unisex or sex distinct (Special Committee to Recommend New Mortality Tables for Valuation). In the Record of Society of Actuaries VOL. 5 NO. 4 (1979), the moderator Charles Ormsby stated, “It is highly likely that ... adopting new mortality tables today will involve stronger political crosscurrents and more controversy than heretofore.”⁶

Wilbur Bolton, a member of this committee, also recognized the complexity of the issue. He stated the difference in female vs. male mortality “cannot be rationally challenged” but admitted there were questions about the difference “outside the normal domain of actuarial investigations” and “anti-discrimination proponents claim it is morally indefensible for insurance companies to recognize differences based on past cultural influences or past patterns of employment.”

As anticipated, these sex distinct tables were challenged in the court system after their adoption. In *Norris* (1983), the Supreme Court held a state pension plan that allowed employees to choose retirement benefits from a list of companies selected by the employer, all of which paid lower benefits to women (due to sex distinct pricing), violated Title VII of the Civil Rights Act (which had previously banned race-based pricing).⁷ Although narrow in scope, the Court nonetheless explained “if it would be unlawful to use race-based actuarial tables, it must also be unlawful to use sex-based tables” because race and sex distinctions stand on the same footing under the Civil Rights Act.⁸ In response, the NAIC added a unisex version of the table.

However, for transgender and non-binary individuals, many legal questions remain. Most recently, in *Bostock* (2020), the Supreme Court analyzed several employment discrimination claims and held Title VII’s language prohibiting discrimination “on the basis of sex” included sexual orientation and “transgender status.”⁹ While the Court arguably expanded the scope of the term “sex,” it is yet to be seen if this will include gender identity and non-binary individuals and impact the insurance industry.¹⁰

CURRENT PRACTICE AND GUIDANCE

The use of sex and gender varies by company, with vague regulatory and best practice guidance. The American Academy of Actuaries Risk Classification Working Group published a public policy monograph on risk classification in the fall of 2011.¹¹ The Working Group stated desirable risk characteristics should have “objective determinability” and referenced gender as an example due to its “binary characteristic.”

In February 2021, the Society of Actuaries’ Emerging Issues in Underwriting Survey had a question about what companies ask for on their application.¹² As expected, responses showed a large variation in the use of sex or gender (Table 2).

⁶ Record of Society of Actuaries 1979 Vol. 5 No. 4 – New Valuation Mortality Tables for Individual Life Insurance.

⁷ Timeline of Major Supreme Court Decisions on Women’s Rights. <https://www.aclu.org>, <https://www.aclu.org/other/timeline-major-supreme-court-decisions-womens-rights>

⁸ Timeline of Major Supreme Court Decisions on Women’s Rights. <https://www.aclu.org>, <https://www.aclu.org/other/timeline-major-supreme-court-decisions-womens-rights>

⁹ Supreme Court of the United States Syllabus. <https://www.supremecourt.gov>, October Term 2019. https://www.supremecourt.gov/opinions/19pdf/17-1618_hfci.pdf

¹⁰ This essay focuses exclusively on the Civil Rights Act and its impact on insurance in an academic context. It is meant to give an overview of relevant laws and court cases, and not to provide legal advice of any kind.

¹¹ American Academy of Actuaries, On Risk Classification. <https://www.actuary.org>, Nov 2011, https://www.actuary.org/sites/default/files/files/publications/RCWG_RiskMonograph_Nov2011.pdf

¹² Emerging Issues in Underwriting. <https://www.soa.org>, Feb 2021, <https://www.soa.org/globalassets/assets/files/resources/research-report/2021/emerging-issues-underwriting-survey-report.pdf>

Table 2
WHAT DOES YOUR COMPANY ASK IN ITS APPLICATION?

| Response | U.S. | Canada | # of Responses |
|---------------------|-----------|-----------|----------------|
| Sex | 12 | 6 | 18 |
| Gender | 10 | 3 | 13 |
| Sex at birth | 0 | 2 | 2 |
| Both sex and gender | 0 | 0 | 0 |
| Total | 22 | 11 | 33 |

Source: Society of Actuaries, Emerging Issues in Underwriting Survey Report, February 2021.

Several states have limited the use of sex and gender in other insurance products. Eight states mandated auto insurance become gender neutral,¹³ and in 2022, New York began requiring auto insurers to offer a gender X option.¹⁴ Meanwhile, Montana, which previously was the only state to be gender neutral since 1983, repealed its unisex mandate in 2021.¹⁵ Although all states allow for an individual to officially change one’s gender and the U.S. issues gender X passports, only 16 states allow for a gender X birth certificate,¹⁶ which can make it difficult for some individuals to obtain what could be considered appropriate documentation before applying for life insurance.

Due to the varied guidance and regulations, LGBTQ+ consumers are left to bear the burden. Quotacy aggregated a list of companies on how they would rate a transgender individual and received answers ranging from “gender they identify as” to “birth sex,” with varying requirements on sex reassignment surgery.¹⁷ Non-binary individuals also face an uphill battle – as of today, no insurance companies offer a gender-neutral life insurance policy.¹⁸ These additional barriers are potentially preventing millions of individuals from receiving the financial stability and security provided by life insurance.

ARE THERE OTHER MODELS?

In 2012, the European Union, one of the largest insurance marketplaces in the world, went through a significant change due to a lawsuit over auto insurance rates. The entire insurance industry was mandated to become gender neutral.

The E.U. justices referenced the U.S. Supreme Court’s decision to make Social Security gender-neutral on the basis of equal rights as a foundation to their decision.¹⁹ The advocate general stated the following in their arguments to the justices:

“There is a sweeping assumption that the different life expectancies of male and female insured persons... which merely come to light statistically – are essentially due to their sex... it is especially easy to implement distinctions on the basis of sex... correct recording and

¹³ Manning, Susan. How your gender affects auto insurance rates. <https://www.insure.com>, Aug 8, 2021, <https://www.insure.com/car-insurance/gender-auto-insurance-rates/>

¹⁴ Insurance Circular Letter No. 7 (2022). <https://www.dfs.ny.gov>, April 22, 2022, https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2022_07

¹⁵ Downing, Troy. Comments to CSI Regarding HB 379 Memo. <https://leg.mt.gov>, Feb 18, 2021, <https://leg.mt.gov/bills/2021/Minutes/House/Exhibits/buh34a05.pdf>

¹⁶ Identity Document Laws and Policies. <https://www.lgbtmap.org>, https://www.lgbtmap.org/equality-maps/identity_document_laws

¹⁷ Cornelius, Natasha. Does Being Transgender Affect Life Insurance Rates. <https://www.quotacy.com>, June 2, 2022, <https://www.quotacy.com/does-being-transgender-affect-life-insurance-rates/>

¹⁸ Fontinelle, Amy. How Being Nonbinary Affects Getting Life Insurance. <https://www.investopedia.com>, Sep 1, 2022, <https://www.investopedia.com/how-being-nonbinary-affects-getting-life-insurance-4869749>

¹⁹ End to Gender Discrimination. <https://www.hfw.com>, <https://www.hfw.com/End-to-gender-discrimination>

evaluation of economic and social conditions and of habits of insured persons is much more complicated... [use of sex] as a kind of substitution criterion for other distinguishing features is incompatible with the principle of equal treatment for men and women.”

After the ruling, the industry was given eighteen months to transition to gender neutral pricing. Hato Schmeiser and his coauthors put together a survey in the summer of 2012 to measure consumer attitudes in Europe about the use of risk factors and possible market implications.²⁰ First, they referenced a study that found a positive correlation between consumers’ willingness to buy insurance and their perception of the fairness of premiums and benefits. Next, they designed a study to measure consumers’ perception of what is fair and justified. The study found consumers perceived gender as either neutral or unagreeable to be used as a risk differentiation criterion, and the differences in price due to gender to be higher than “acceptable.”

The researchers then considered the market implications from the gender-neutral mandate. They estimated adverse selection effects and cross subsidization could increase, and in markets with low price elasticity and non-compulsory purchasing, this could cause the subsidizing policyholders to lapse, raise prices for remaining policyholders, and reduce demand. The decrease in demand could lead to future limitations on product offerings and a withdrawal of companies from different markets. Consumers might switch to alternative products or self-insurance solutions. The overall market could decrease in size along with the quality of insurance benefits, with the strongest impact likely to occur in life and annuity marketplaces due to the voluntary nature (compared to compulsory auto insurance).

However, the article also stated gender neutral insurance could spur positive consumer reactions. As their research showed, consumers were more inclined to buy policies they perceived as fair, and consumers currently view the use of gender as disagreeable (unfair). In the decade since the switch to gender neutral, the E.U. insurance marketplace has performed similarly to the U.S. market,²¹ showing the worst fears of the authors had not come to pass.

Something to consider is gender neutral insurance does not mean all females and males pay the same rate, or even the average female pays the same as the average male.

Five years after gender-neutral auto insurance went into effect, an analysis by The Guardian confirmed two identical profiles that only varied by male and female received the same quote from several auto insurance companies in the U.K.²² However, when aggregating data, the researcher found the difference in premium paid by the average male vs. the average female tripled compared to what it was prior to gender neutral pricing.

A common thought is making life insurance gender neutral would raise female rates and lower male rates (and the opposite for annuities) until the premiums paid between the two are the same. Although this would happen for policyholders with identical risk profiles, this may not necessarily be the case across a large population because a large difference in premium paid is attributable due to other risk attributes

²⁰ Schmeiser, Hato, Tina Stormer and Joel Wagner. Unisex Insurance Pricing: Consumers’ Perception and Market Implications. <https://link.springer.com>, Dec 4, 2013, <https://link.springer.com/article/10.1057/gpp.2013.24>

²¹ Life Insurance and Annuities in the US. <https://www.ibisworld.com>, Aug 30, 2022, <https://www.ibisworld.com/industry-statistics/market-size/life-insurance-annuities-united-states/>. Insurance Europe, Statistics, accessed June 14, 2022, <https://www.insuranceeurope.eu/statistics>.

²² Collinson, Patrick. How an EU Gender equality ruling widened inequality. <https://www.theguardian.com>, Jun 14, 2017, <https://www.theguardian.com/money/blog/2017/jan/14/eu-gender-ruling-car-insurance-inequality-worse>.

(smoking, medical history, etc.). In other words, although rates may not explicitly vary by male vs. female, they may implicitly vary through other pricing variables with a non-zero correlation to sex.

WHAT CAN ACTUARIES DO?

In a rapidly evolving world, it is worth pausing and viewing things comprehensively and fundamentally. Actuaries are essential in developing and managing risk classification systems that underpin the insurance industry to provide affordable and fair products. However, how to determine what is “fair” is hardly a straightforward process.

Gender and sex are far from “binary, objectively determinable” characteristics, and there will never be a clean-cut way to sort them into two buckets. Thus, actuaries should critically examine whether using sex or gender is a fair and accurate way to assess risk. Without even considering how difficult it is to sort transgender, non-binary, and intersex individuals into these pre-determined categories, we must consider whether this is the right way to assess risk fairly. The E.U. demonstrates a mature and developed marketplace could work effectively under a gender-neutral framework, but it’s not the only option.

If actuaries (and regulators) decide to continue using sex or gender to assess risk, the next step would be to settle on consistent use – should actuaries use sex, gender, or sex assigned at birth?


Gender expression would appear to be the most client friendly option, especially for transgender individuals. However, in a “male/female” world, this option would not work for non-binary individuals. Sex assigned at birth is another logical option, but this may be a challenging data point to collect from a privacy standpoint, and it may be hard to justify, for example, the use of male rates for a fully transitioned transgender female. Asking for a birth certificate may also not be a viable solution as most states allow for them to be amended for transgender individuals, in addition to more than a dozen states now allowing for gender X (both as an amendment and for newborns).

Yet another option could be the approach New York has taken with auto insurance: allowing for sex distinct rates, but also mandating a third, gender neutral option be available for all residents of the state. However, how companies create the assumptions and prices for a third, gender neutral option could be a complex process, and there is a risk consumers could anti select against companies. Yet another ethical quandary could occur if emerging experience warrants higher prices for the third option vs. male/female.

As confusing and difficult as this may seem for actuaries, it can be even more so for all the consumers on the other side of the equation. Every additional requirement placed on underinsured communities further hinders their ability to achieve financial stability and security. The Academy’s monograph on risk classification states classification systems should be acceptable to the public, recognize the values of society, and respect personal privacy. As societal values evolve, actuaries and insurance companies should evolve as well. Millions of individuals may depend on how actuaries and regulators approach and handle this in the years to come.


* * * * *

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Second Prize Winner

Looking Back to Move Forward: How the Cultural History of LGBTQ+ People Relates to the Contexts of Health, Insurance, and Marriage

Edward Chamberlain, PhD

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During recent decades, a growing number of professions have been reflecting on the roles that gender and sexual identity have played in the daily processes of business and employment. As a part of this reflection, a sizable number of intellectuals and leaders have contemplated the considerable diversity of employment experiences. In particular, there is a growing interest in considering the varied experiences of people who are lesbian, gay, bisexual, transgender, and queer. To address this diverse community, people have come to embrace the term “LGBTQ+” as a way of representing their lives. Moreover, LGBTQ+ people are diverse in a variety of ways because their experiences of gender and sexuality intersect with a wide range of social dynamics including that of class status, ethnicity, gender, health, physical abilities, race, and religion, among the many. Nevertheless, LGBTQ+ people at times can feel somewhat uncomfortable talking about their experiences of gender and sexuality, especially in the contexts of professional situations such as insurance and finances because it often requires a “coming out” process.

The idea of “coming out” involves the divulging of intimate details such as the personal information of one’s sexual orientation and one’s relationship to their partner. In looking back, LGBTQ+ people were seen as coming out of the closet when they identified themselves in terms of their sexual orientation. There is a broad understanding that the closet was the place where they once hid their true selves for the sake of safety and protection from harassment or violent responses. Such forms of hiding occurred because there is concern about how heterosexuals and the state will perceive their so-called difference. To the dismay of many, LGBTQ+ people have been placed in some rather difficult and dangerous situations due to anti-gay attitudes, cisgender viewpoints, homophobia, and transphobia. Such coming out experiences also can have physical effects on people. Having to come out to people repeatedly is stressful because there is potential for blowback or ongoing negativities that arise from having to face bigotry and homophobia.

Such stress can exacerbate the health of LGBTQ+ people, many of whom already are already living with ailments and conditions such as anxiety, depression, or similar kinds of psychological conditions. It is believed that such stress likewise has shortened the lifespans of some LGBTQ+ people. In certain cases, this kind of unrelenting stress can have effects on the human heart and other vital systems of the body. These unfortunate circumstances play out in a broad array of places including the social environments of workplaces, thus affecting how people perform on the job and elsewhere. Moreover, these stresses often go unnoticed by businesses, governments, and state agencies, which fail to take into account how their

practices and policies shape the health and well-being of LGBTQ+ lives. Among these groups, there are financial enterprises, insurance companies, and actuaries that sadly have remained uninformed about the realities, stress, and illness that some LGBTQ+ people are facing. Such stress and illness are not only sources of momentary discomfort. Despite the creation of various medicines, many illnesses such as HIV/AIDS are stigmatized by varying people, which brings about feelings of shame.

To address some of these experiences, this essay draws from both research and personal experiences for the sake of giving a well-rounded perspective on the ways that LGBTQ+ people have faced a range of challenges and struggles, which shape their interaction with professionals, insurance companies, and financial groups. For this essay, my approach is shaped by my own personal experience as a queer person as well as relevant occurrences, whereby the intimate lives of real LGBTQ+ people can be understood as evidence that attests to the social complexities that LGBTQ+ people face. While this evidence certainly cannot cover every person's life, many fields of research utilize the study of personal experience as a way of understanding a number of intricate and silenced problems that frequently go unnoticed. The intimate nature of one's love life and family life frequently are said to be "off limits," yet these experiences affect us and drive us to act in a multitude of ways. Hence, there is a common belief that we must take stock of these intimate social dynamics for the sake of understanding the true diversity of people's lives. As researchers observe, our intimate life such as whom we love or marry indeed has a multifaceted set of connections to the larger nation-state including its laws, policies, and processes.

As a case in point, the multilayered experience of marriage merits consideration. Before same-sex marriage was legalized by the U.S. Supreme Court decision of *Obergefell v. Hodges* (2015), my partner and I decided to enter into a domestic partnership, which granted us certain benefits in Washington state. The formalizing of our partnership felt tangible and real when we had our forms notarized, and we subsequently received laminated cards with our names on them. The state's government granted us these cards, and they served as proof that our partnership was a real and valid arrangement—if anyone or any group should question it. Nevertheless, while the government in the state of Washington had solemnized our relationship, the United States federal government would not recognize our relationship in the contexts of taxation and insurance. As a result, we were required to pay additional taxes on our insurance plan. That is to say, we were taxed more than our heterosexual counterparts in similar situations because our household was regarded as legally different from that of heterosexual couples. In effect, my partner and I had to pay money to be our true selves and protect ourselves. This situation was reminiscent of the way that some ethnic and racial groups have been treated differently and unfairly by the state in past decades. While these struggles are distinctive and by no means the same, there is a long history of various minority groups being forced to do undesirable things that the U.S. majority is not required to do. Understanding this history allows us to see how some states have attempted to discipline certain intimacies that depart from the norms embraced by the heterosexual majority.

Although this inequality has been addressed by the decision of *Obergefell v. Hodges*, there is a continued interest in challenging and overturning this court decision, which would create an unstable and unpredictable situation for thousands of LGBTQ+ people including their most vulnerable family members: their children. To address these uncertainties, the U.S. House of Representatives voted to approve the Respect for Marriage Act in July of 2022, and the U.S. Senate likewise voted to approve this legislation in November of 2022. After being signed by President Joe Biden in December of 2022, this legislation became law, guaranteeing that the marriages of same-sex couple and interracial couples would be recognized as valid by the U.S. federal government, state governments, and territories. Along with ensuring the recognition of these marriages, the new law has repealed the Defense of Marriage Act of 1996, which earlier had limited the institution of marriage to heterosexuals only. Consequently, the historic Respect for Marriage Act has been viewed as a major step forward in protecting LGBTQ+ lives. Yet, some concerns

about this matter remain because there are many members of Congress, court judges, and presidential candidates who continue to vocalize their disapproval of same-sex marriages. As a result, thousands of LGBTQ+ couples are saving their money in the event that their lives are thrown upside down by a change in law. If this set of laws and court decisions were repealed, LGBTQ+ people could face new legal challenges as well as further struggle.

Such possibilities are inspiring many LGBTQ+ people to put away money for safekeeping in arrangements such as an I.R.A., which similarly can involve taxation. In my own case, I decided to establish an I.R.A. with the help of a major financial company, only to face a set of questions that were largely geared towards heterosexual people. When I called to finalize the I.R.A., one of the financial advisers began the conversation by assuming I had been married to a wife—when I actually married my husband. This adviser asked questions about “your wife,” which caused a feeling of tightness and tension all over my body. I wondered: “Should I correct them? Do I need to be honest for the sake of keeping things legal?” My silence on the phone caused the financial adviser to pause, and he seemed to sense my hesitation. He stated, “Let me start again – Do you have a partner?” This question made me feel more comfortable, although I admit that afterwards I felt like I would not want to go through that situation again. In the days that have followed, I have not felt comfortable with the idea of calling them back to engage in another conversation, where both sides might end up feeling disconcerted. Hence, creating a more informed and inclusive set of communication processes is crucial for companies, financial advisors, insurers, and other experts so they can be successful in their assessments and studies.

Communication between LGBTQ+ people and their places of work is becoming more complicated in certain areas of employment such as education, where there is debate about what kinds of language and books can be used in schools. In light of these events, there is a need for more dialogue, reflection, and review of existing policies in multiple arenas such as those of governmental offices, corporations, state agencies, and the offices of actuaries. While each state will develop its own response, there is a need for professionals such as actuaries and insurance companies to reflect on the best ways to move forward. While a range of questions are likely to arise, professionals in the field can begin to reflect on the ways that their offices or the larger company may be operating on systems or thought processes that are largely unprepared for the experiences of LGBTQ+ lives. As a part of this review, existing policies and processes can be revised so that they are honoring the citizenship and daily life of LGBTQ+ communities.

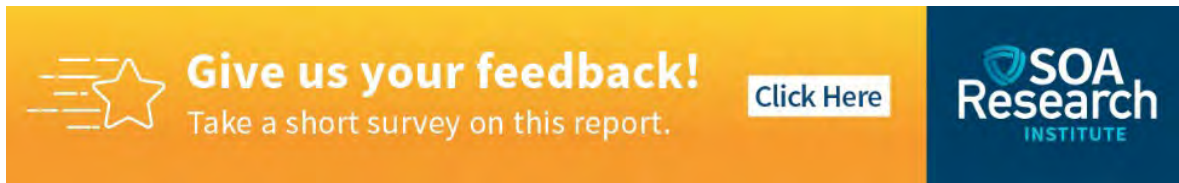
Along with the review of process, there is a need to consider the matter of equity and inclusion such as how people are treated in professional interactions. People who work in the contexts of insurance can be trained to show respect and being inclusive, but there may need to be a way of creating “buy-in” that makes this learning worthwhile. Organizers of such training should consider whether this training should take place during the onboarding process or every few years due to the fact that the concerns circulating in LGBTQ+ communities are evolving, and such concerns can vary from region to region. Creating new incentives for workers to learn about these social issues also can be a means of encouraging them to complete such trainings and put them into practice effectively. Even so, such incentives are unlikely to create a guarantee that all workers will actually put the trainings into action uniformly. A broader set of efforts are likely to be needed for the sake of creating a more inclusive and supportive atmosphere.



Workplaces such as those of government workers, insurers, and actuaries ultimately can begin to create an inclusive culture by basing their work in the goals of diversity, equity, and inclusion (or D.E.I.), which largely involves a series of principles and best practices. These practices can guide workers toward honoring the uniqueness and humanity of LGBTQ+ people. Weaving these practices into the processes of a workplace can take time, but there are myriad rewards including easier interactions and happier clients. Such revisions often will begin in the offices of Human Resources, where people review the company’s handbooks and systems that have shaped the workplace over the years. These efforts can be a way of

beginning the process, however there will need to be more discussions and leadership that can bring these initiatives to fruition. By moving toward such goals, today's workers, insurers, and actuaries can be better prepared for serving a great range of people, who hope to be treated in a way similar to their heterosexual counterparts. Through such efforts, people in various areas stand to live a life that is less stressful and healthier, where they can express themselves honestly. As state workers, insurers, and actuaries are seeking to create better processes, we all stand to benefit by exploring inclusive ways of communicating and interacting, thus honoring the experiences of all people.

* * * * *

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Second Prize Winner

Mental Health Services and Supports for At-Risk LGBTQ+ Youth

Ellyn M. Russo, MS; Ali LaRocco; Danielle Rubin, ASA, MAAA; Donna Wix, ASA, MAAA; and Andrew Gaffner, FSA, MAAA

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Youth (ages 13 to 24 years) with a sexual/gender identity¹ of lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ+) often report feelings of hopelessness and despair because of lacking community and family support and access to mental health care. Resulting mental health diagnoses like depression, anxiety, and substance problems, and potentially other health conditions, increase the risk for attempted suicide in this population relative to non-LGBTQ+ youth, particularly when left unaddressed.²

The Trevor Project, the world's largest suicide prevention and mental health organization for LGBTQ+ young people, estimates that 1.8 million LGBTQ+ youth seriously consider attempting suicide each year; this represents 45% of LGBTQ+ youth and more than half of transgender and nonbinary youth.³ Further, their survey results have found that 58% of LGBTQ+ youth report experiencing symptoms of depression, including two-thirds of transgender and nonbinary youth. Moreover, 82% of LGBTQ+ youth desired mental health care in the past year yet less than half of these individuals received it.⁴

Taken together, these statistics demonstrate the potential for LGBTQ+ youth to be experiencing depressive symptoms that may contribute to suicide, attempted suicide, or serious consideration of suicide (suicidality) at higher rates than the general youth population. The gap in mental health care that is represented by those who desired mental health care but were unable to obtain it highlights not only the complexity of the reality of accessing health care for members of the LGBTQ+ community, but also contributes to the increased risk for untreated mental illness and suicide attempts or death.

In the remainder of this essay, we seek to illuminate a comparison of the mental health status and associated costs of potentially at-risk LGBTQ+ youth to a reference commercially insured youth population. We explore the health care costs associated with a recorded diagnosis of depression as a proxy for mental health care needs and

¹ We use the term identity as our focus throughout this essay is on an individual's conception of themselves; however, this is not meant to exclude the impact of behaviors and/or orientation on an individual's mental health.

² American Foundation for Suicide Prevention, "Risk Factors, Protective Factors, and Warning Signs," accessed March 18, 2023, <https://afsp.org/risk-factors-protective-factors-and-warning-signs>.

³ A.E. Green, M. Price-Feeney & S.H. Dorison, 27 Jun 2019, *National Estimate of LGBTQ Youth Seriously Considering Suicide*, The Trevor Project, <https://www.thetrevorproject.org/research-briefs/national-estimate-of-lgbtq-youth-seriously-considering-suicide/>.

⁴ The Trevor Project, 15 Dec 2022, *2022 National Survey on LGBTQ Youth Mental Health by State*, <https://www.thetrevorproject.org/research-briefs/2022-u-s-national-survey-on-lgbtq-youth-mental-health-by-state-dec-2022/>.

one of the most common risk factors for suicidality. We then use statistics and findings from the Trevor Project’s most recent annual survey to highlight the opportunity to improve access to mental health services and supports for LGBTQ+ youth both inside and outside the medical health care system to ultimately reduce overall costs and discuss potential risk factors for LGBTQ+ youth that may result in increased overall costs.

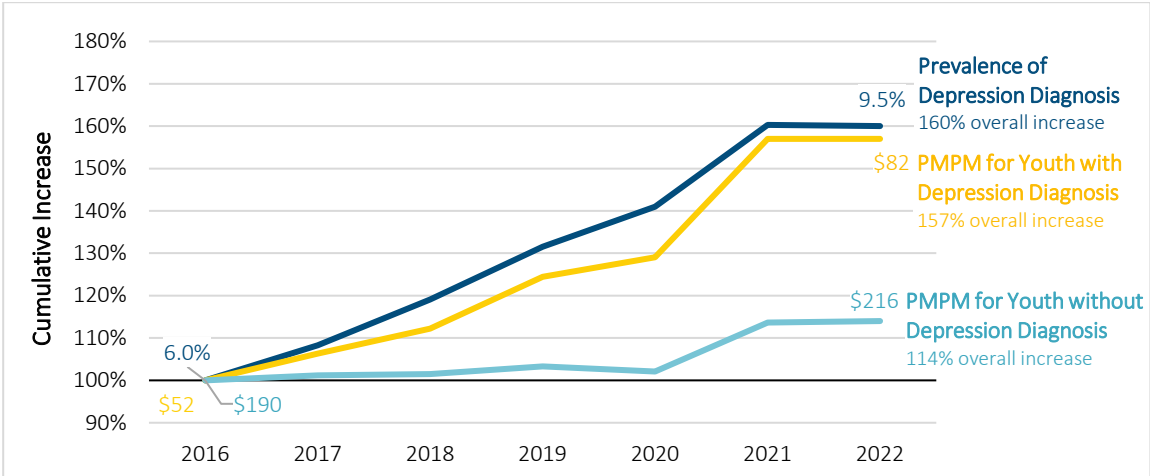
FINDINGS

Our analysis integrates findings from a comprehensive proprietary national health care administrative claims dataset with publicly available results from the Trevor Project survey to estimate the health care costs associated with increased access to mental health services for LGBTQ+ youth. We demonstrate that commercially insured LGBTQ+ youth are estimated to have an average per member per month (PMPM) cost of \$441 to \$745, a range between 48% to 150% of additional allowed costs relative to the average PMPM cost for our reference youth population.

To make this estimate, we first calculated the percentage of commercially-insured youth irrespective of sexual/gender identity with a recorded diagnosis for depression and found that this prevalence increased in recent years, from 6.0% in 2016 to 9.5% in 2021, for an average annual increase of nearly 13% (see Figure 1). The 2021 total medical and pharmacy allowed costs PMPM normalized for geographic differences for these youth was \$298. We observed that total allowed costs PMPM increased from \$52 in 2016 to \$82 in 2021, with an average annual increase of almost 12%, for those identified with a recorded diagnosis of depression but remained relatively flat (\$190 to \$216) for those without a recorded diagnosis.

We also found that youth with a recorded diagnosis of depression maintained higher average non-depression medical and pharmacy allowed costs than youth without a recorded diagnosis: across all health care services, youth identified with a depression diagnosis in 2021 had an average of \$617 additional total allowed costs compared to their peers without a depression diagnosis (see Figure 2).

Figure 1
CUMULATIVE INCREASE IN THE PERCENTAGE OF YOUTH AGED 13 TO 24 YEARS WITH A RECORDED DIAGNOSIS OF DEPRESSION (PREVALENCE) EACH YEAR AND TOTAL MEDICAL AND PHARMACY ALLOWED COSTS PER MEMBER PER MONTH (PMPM) FOR THOSE IDENTIFIED WITH AND WITHOUT A RECORDED DIAGNOSIS OF DEPRESSION, 2016 TO 2021



Depression defined by International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code of F32, F33, or F34.

Figure 2
TOTAL MEDICAL AND PHARMACY ALLOWED COSTS PER MEMBER PER MONTH (PMPM) FOR DEPRESSION-RELATED AND NON-DEPRESSION-RELATED MEDICAL, AND PHARMACY, CLAIMS AMONG CONTINUOUSLY-ENROLLED COMMERCIALY-INSURED YOUTH AGED 13 TO 24 YEARS WITH AND WITHOUT A RECORDED DIAGNOSIS FOR DEPRESSION, 2021

| Youth Population Aged 13–24 Years | Members | Medical PMPM | | Pharmacy PMPM | Total PMPM |
|-----------------------------------|---------|--------------------|------------------------|---------------|------------|
| | | Depression-Related | Non-Depression-Related | | |
| Total | 7.5M | \$25 | \$229 | \$43 | \$298 |
| Diagnosis of Depression | 716k | \$265 | \$502 | \$89 | \$856 |
| No Diagnosis of Depression | 6.8M | \$0 | \$200 | \$39 | \$239 |

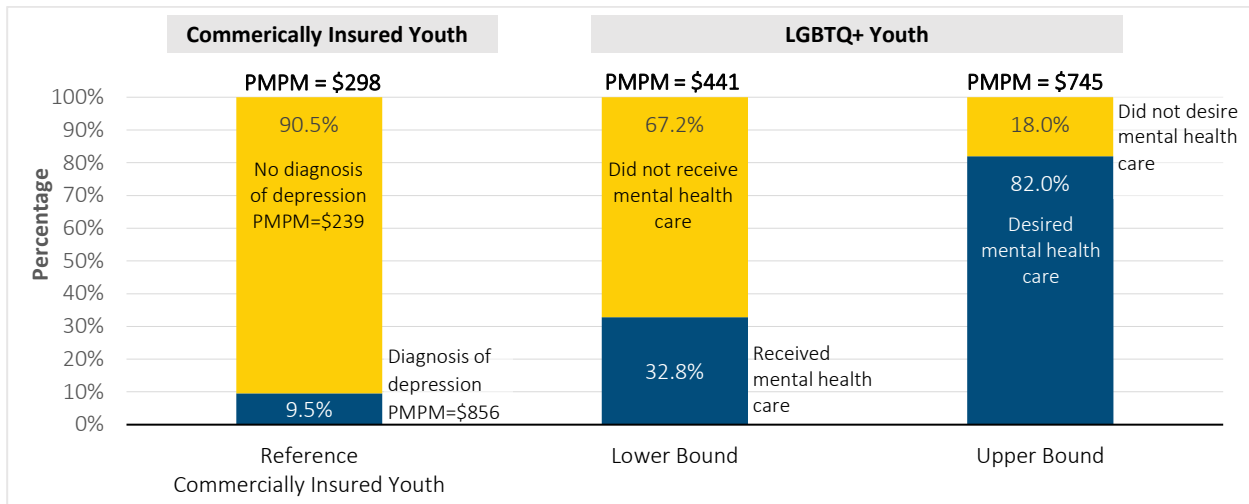
Depression defined by ICD-10-CM diagnosis code of F32, F33, or F34; Non-Depression-Related, though defined by the lack of a diagnosis code for depression, could include behavioral health services for depression and/or for other behavioral health conditions.

We then estimated the mix of youth within the LGBTQ+ population with mental health care needs by identifying relevant summary statistics from the Trevor Project survey report as follows:³

- 32.8% of LGBTQ+ youth desired and received mental health care.
- 49.2% of LGBTQ+ youth desired mental health care but did not receive it.
- 18% of LGBTQ+ youth did not desire mental health care.

Combining these Trevor Project findings for LGBTQ+ youth to indicate prevalence of depression as a proxy for mental health care needs (32.8% for lower, and 32.8% + 49.2% for upper, bounds) with the cost estimates for insured youth from the claims data analysis, we calculated a PMPM for LGBTQ+ youth as shown in Figure 3. We estimate PMPM costs for LGBTQ+ youth who receive mental health care are more than 48% higher than the reference commercially-insured youth population, and 150% higher for LGBTQ+ youth who desire mental health care.

Figure 3
PERCENTAGE OF YOUTH WITH A RECORDED DIAGNOSIS FOR DEPRESSION AND TOTAL MEDICAL AND PHARMACY ALLOWED COSTS PER MEMBER PER MONTH (PMPM) FOR CONTINUOUSLY-ENROLLED COMMERCIALY-INSURED YOUTH AGED 13 TO 24 YEARS IN 2021 (REFERENCE) AND LGBTQ+ YOUTH WHO RECEIVE (LOWER BOUND) OR DESIRE (UPPER BOUND) MENTAL HEALTHCARE



Depression defined by ICD-10-CM diagnosis code of F32, F33, or F34 for the reference commercially insured youth population, 2021; Scenarios for LGBTQ+ youth are based on desire for, and receipt of, mental health care from survey response summary data, not mix of sexual/gender identity and desire / receipt of mental health care by sexual/gender identity in the reference population; PMPM calculated as reference PMPM diagnosis of depression * received / desired mental health care + reference PMPM no diagnosis of depression * did not receive / desire mental health care, 2021.

DISCUSSION

After combining our findings with those available from the Trevor Project, we estimate that costs for LGBTQ+ youth range from 48% to 150% higher than those for the reference commercially-insured youth population. Assuming LGBTQ+ youth that received mental health care are included in the reference insured youth population, while LGBTQ+ youth that desired but did not receive mental health care are not, we can estimate an upper bound for the total PMPM by adjusting the prevalence of a recorded diagnosis of depression. This results in a potential PMPM of \$328, or a 10% increase from the reference PMPM (\$298; Figure 4).

Figure 4
ESTIMATED TOTAL MEDICAL AND PHARMACY ALLOWED COSTS PER MEMBER PER MONTH (PMPM) FOR CONTINUOUSLY-ENROLLED COMMERCIALY INSURED YOUTH AGED 13 TO 24 YEARS WITH AND WITHOUT A RECORDED DIAGNOSIS FOR DEPRESSION ACCOUNTING FOR MENTAL HEALTH CARE OF AT-RISK LGBTQ+ YOUTH

| Diagnosis of Depression | | | No Diagnosis of Depression | | Total |
|---|-------------------------|-------|---|-------|-------------------------------|
| (1) | (2) | (3) | (4) | (5) | ((1) + (2)) * (3) + (4) * (5) |
| Youth That Do and Do Not Identify as LGBTQ+ | Additional LGBTQ+ youth | PMPM | Youth That Do and Do Not Identify as LGBTQ+ | PMPM | PMPM |
| 9.5% | 10% * (82%-32.8%) = 5% | \$856 | 1 - (9.5% + 10% * (82%-32.8%)) = 85.5% | \$239 | \$328 |

Based on 2021 reference data using depression defined by ICD-10-CM diagnosis code of F32, F33, or F34 (1) and Trevor Project survey data (2).

The process of obtaining mental health services in the United States can be accompanied by many barriers. For the LGBTQ+ population, a lack of acceptance, particularly for LGBTQ+ youth and especially among close family members, can often lead to avoidance of seeking out or obtaining mental health services⁵. According to other results of the Trevor Project survey, community acceptance, and emotional support for LGBTQ+ youth provide a positive and protective significant impact on the emotional well-being of these individuals.² For example, LGBTQ+ youth with highly supportive families are half as likely to attempt suicide. Additionally, supportive school models that employ trusted adults have shown to improve perception of the school environment, and thus increase feelings of safety and understanding. Schools are identified as primary environments for fostering support and addressing discrimination and stigma among LGBTQ+ youth and their peers. Conditions in schools such as feelings of connectedness, supportive educators, anti-bullying policies and inclusive education curricula, contribute to the environment.⁵

In 2018, the American Academy of Pediatrics (AAP) released a policy statement describing its recommendations to pediatric providers looking to support and promote the health of youth who identify as transgender and gender diverse (TGD)⁶. The AAP offers relevant concepts and discusses the challenges associated with care for members of this population, including:

- A gender-affirmative care model, wherein “pediatric providers offer developmentally appropriate care that is oriented toward understanding and appreciating the youth’s gender experience”
- Inclusion of gender-affirming care and treatment options as routine discussion in pediatric visits

⁵ The top three reasons that LGBTQ+ youth reported to the Trevor Project for not seeking needed, appropriate mental healthcare are (1) fear of discussing mental health outcomes, (2) concerns with obtaining parent/caregiver permission, and (3) fear of not being taken seriously³
⁷ Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents | Pediatrics | American Academy of Pediatrics (aap.org) Jason Richard Rafferty, Oct 2018, “Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents,” Policy Statement, American Academy of Pediatrics, http://publications.aap.org/pediatrics/article-pdf/142/4/e20182162/1066566/peds_20182162.pdf.

- The importance of family acceptance, which can help to reduce fears on the part of young people and support self-esteem, social involvement, and overall health
- State level education policy and non-discrimination laws that support safe schools and communities
- Increasing culturally competent care and education among providers so that they are able to support patients and families

The opportunity to inquire about sexual and gender identity, and demonstrate affirming care, can occur at least annually for many LGBTQ+ youth in states where laws permit, as AAP recommends annual physical examination for adolescents between the ages of 13 and 21 years of age.⁷ Inquiring about identity nonjudgmentally is the first, and most vital, step towards being able to understand someone’s experience sufficiently to educate and offer interventions suitable for the individual’s situation. In addition, AAP acknowledges that all electronic medical record (EHR) systems should not only have the capacity to confidentially collect information on and respect a patient’s asserted gender identity but includes in their recommendations that duplicate charts should be avoided.

Though our findings are suggestive that health care costs on a PMPM basis are likely to be higher for LGBTQ+ youth than for a reference youth population, it is not uncommon for individuals who identify as LGBTQ+ to delay or avoid, even routine, care for the reasons, among others, mentioned above regarding mental health care. Information needed to calculate LGBTQ+ youth’s access to care is not consistently nor broadly available, making comparisons to other populations difficult to accurately measure. Further research is needed to describe the frequency of different categories of care received for LGBTQ+ youth and whether this differs from the reference youth population, including the ratio of depression to non-depression care, to understand whether there are additional needs being met—or not—for this population.

SUMMARY

Our findings and the results of the Trevor Project survey highlight the opportunity, and subsequent health care costs, to address the additional mental health challenges faced by LGBTQ+ youth. We further illustrated an increase to the prevalence of depression for the reference population over time, which should be expected to continue, and can be driven both by a rise in new cases or care in under-diagnosed / under-treated instances. Anticipating an increase to health care costs among youth is therefore warranted for insurers, as is improving access to much needed care to decrease the burden of severe outcomes among youth, especially LGBTQ+ youth.

Support for LGBTQ+ youth has been shown to be of vital importance for prevention of severe outcomes associated with mental health challenges. While work to enhance this support must encompass all aspects of an individual’s environment, including supportive families, schools, and communities at-large, efforts to similarly modify existing health care models should not be overlooked. Just as our health care system has accepted the obligation to diagnose high cholesterol levels to prevent fatal heart attacks, so, too, must we facilitate inclusive competence in order to recognize earlier a youth’s risk for a severe outcome relative to their sexual/gender identity.

Gathering usable data is difficult because members of these populations often do not feel safe in medical settings, with methods of gathering health data creating additional barriers. Thus, health care claims data are likely not representative of an insured LGBTQ+ population. Insurers should monitor surveys with self-reported information in addition to existing data sources, including EHRs, and resources on their insured population to

8 American Academy of Pediatrics, 2022, “Recommendations for Preventative Pediatric Health Care,” https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

obtain the best information available to contribute more proactively to efforts that ensure care is appropriate for LGBTQ+ youth that are at high risk for negative and all too often life-threatening outcomes.

METHODS

The study population included individuals aged 13 to 24 years continuously enrolled with a payer type of commercial—health maintenance organization (HMO), preferred provider organization (PPO), Patient Protection and Affordable Care Act (ACA), and other—for each calendar year (2016 to 2021). The presence of an ICD-10-CM diagnosis code of F32, F33, or F34 on a claim (except for claims for laboratory or imaging services) during each calendar year identified a member with a diagnosis of depression. Medical allowed costs were summarized annually for claims with an ICD-10-CM diagnosis code of F32, F33, or F34 as depression-related services and claims without one of these diagnosis codes as non-depression-related services for members identified with a diagnosis of depression and those without. Pharmacy claims were similarly summarized but without depression attribution. Findings were normalized to account for geographic differences using Milliman’s proprietary commercial area factors but were not risk- or acuity-adjusted.

LIMITATIONS

Our analysis was not designed to determine the statistical significance of the differences in health care costs observed or estimated, nor to identify contributing factors to these amounts. LGBTQ+-related diagnoses and treatment, including but not limited to a diagnosis of gender dysphoria and hormone therapy treatment, were not specifically identified nor stratified. We chose to use depression as a proxy for mental health care needs as the most common risk factor for suicide, and we recognize this is likely an oversimplification of the various needs for any given population, including LGBTQ+ youth.

We categorized all health care claims with the presence of a diagnosis for depression as depression-related costs; however, the encounter for which the costs were incurred may or may not have been for depression. Furthermore, we did not rely on utilization of mental health care services as the basis for our estimates. We did not account for the severity of depression or other mental health status, for other conditions, nor for treatment associated with depression or other mental health or other conditions that contribute to total allowed PMPM costs; instead, we assumed the distribution of depression severity, other mental health status severity, other condition severity, and treatment type, frequency, and duration of the reference population were, on average, similar to the LGBTQ+ youth population.

Members identified with a diagnosis of depression were required to have one claim with an ICD-10-CM code of interest. We did not require the presence of an additional claim nor any other indicator of treatment for depression. Conversely, it is possible that some youth with depression do not have a diagnosis recorded annually. Results from the Trevor Project used in the analysis for the receipt and/or desire of mental health care may differ for commercially insured LGBTQ+ youth as the survey is based on individuals self-reporting their status while claims data represent a diagnosis from a medical professional. Finally, our findings for commercial health insurance may not apply for other payer types, particularly government-funded options such as Medicaid or the State Children’s Health Insurance Program.

CAVEATS

This analysis has been prepared for the specific purpose of estimating allowed costs among LGBTQ+ youth compared to a reference commercially insured youth population. This information should not be used for any other purpose.

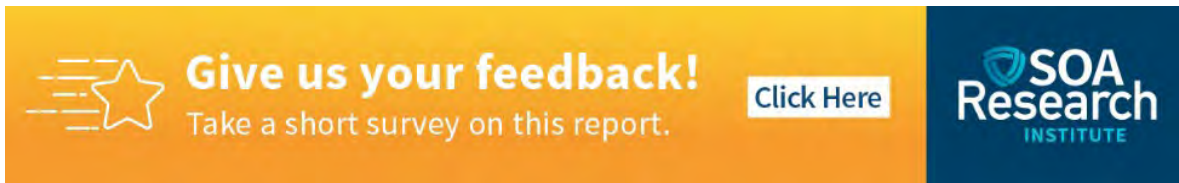
The results presented herein are estimates based on carefully constructed actuarial models. We have reviewed the models for consistency, reasonableness, and appropriateness to the intended purpose and in compliance


with generally accepted actuarial practice and relevant actuarial standards of practice. Differences between our estimates and actual amounts depend on the extent to which actual experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis.

In performing this analysis, we relied on data provided by Milliman Consolidated Health Cost Guidelines Sources Database (CHSD_2208) contributors and survey findings from the Trevor Project. We have not audited or verified this data and other information but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. Results have not been adjusted to reflect differences in services provided during the COVID-19 pandemic.

* * * * *

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Third Prize Winner

Systemic Barriers to Gender-Affirming Care for Transgender and Gender-Diverse Youth

Benjamin Parchem, PhD, and G. Nic Rider, PhD

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The healthcare industry is a complicated network of multiple systems that interconnect to provide critical services for the health and well-being of communities. It can be challenging to position health care, a vital and life-saving resource for many, in the capitalistic context of the United States, where, at times, it can feel like there is a push-pull between increasing profit margins and making services more accessible. As providers in the field of child and adolescent gender health care, we have struggled to reconcile the internal discomfort that comes with knowing the high-quality services we are providing are financially taxing or altogether unrealistic for many families. And the reality is when families are unable to obtain insurance coverage for our services, they are faced with the decision to either pay out of pocket or forgo treatment altogether, which is a hard decision to make when such a specialty service as gender-affirming care can be life-saving for their child and also be entirely disruptive to a family's finances (which may impede a family's ability to meet their child's basic needs).

Of course, providers have to be compensated for their services, and revenue has to cover the costs of operating and maintaining a clinic. From our anecdotal experience as providers of gender-affirming mental health care, we are deeply concerned about the accessibility and quality of health care services for transgender and gender diverse (TGD) youth. TGD youth have many health care considerations, and relatedly, need comprehensive health insurance coverage for evidence-based care. The motivation behind this essay is not to desecrate the health insurance industry, but to shed light on the health disparities faced by TGD youth and the role that payers¹ can play in ameliorating these disparities.

For those who want to access gender-affirming care, the disparity in health care access is a multi-faceted problem with several interconnected factors (e.g., medical mistrust, health care discrimination, help-seeking stigma, concerns around identity disclosure, cultural and religious concerns, transportation, etc.). A salient and well-documented barrier is either being uninsured or having an insurance plan that does not provide adequate coverage for necessary services (DeVoe et al., 2007; Hoffman & Paradise, 2008; Lazar & Davenport, 2018; Patel et al., 2018). From our perspective as providers, it can feel like health insurance companies serve as the gatekeepers to life-saving health care services, including gender-affirming

¹ Payers vary by specific health care coverage plan. Some examples of payers include health insurance companies, employers in the case of a self-funded health insurance plan, managed care organizations, the federal government, or state government. Insurance companies may serve as administrators for other payers such as employers or governmental plans; as plan administrators, they serve as messengers when working with individuals and health care providers.

interventions, because regardless of the payer, health insurance companies are typically the messengers of whether a service or procedure is covered. From the perspective of payers, in some cases, employers and/or families have a choice of the coverages they elect to cover and/or plan they select, and what is or is not covered by their plan is a consequence of that decision. In other cases, federal or state governments mandate, limit, or prohibit coverage of some services and procedures.

For various reasons, payers often base their coverage of services on standards of care. There have been established standards of care for the health of transgender and gender diverse people since 1979, with the most recent update published in 2022 (Coleman et al., 2022). Knowing this, it is unclear to us as providers why there are still “transgender exclusions” in many health insurance plans and denial of coverage of gender-affirming interventions (Bakko & Kattari, 2020; Nahata et al., 2017). Aside from state-required exclusions, if the argument is that the problem is what plans an employer selects for its employees, or what plan a family selects for themselves, and not about what is actually included in these plans, then why are medically necessary gender-affirming interventions not included in every basic plan offered to consumers? When there is no coverage or inadequate coverage, families we work with have shared with us that they feel like they are being sent the message: “you are not worth it.” This leaves these youth in a very challenging position, which can include having to manage their gender dysphoria, deal with a plethora of minority stressors, and process suicidal thoughts without adequate support. Now, TGD youth are incredibly resilient and have found ways to leverage their strengths in the face of adversity, but should they have to?

Recent literature indicates that TGD youth who have access to gender-affirming care have notable improvements in mental health outcomes relative to those who do not (Kuper et al., 2020; Tordoff et al., 2022). And this goes beyond gender-affirming medical interventions, as mental health care is integral to someone’s gender-related health care. Unfortunately, health insurance plans can be limited with regard to in-network mental health professionals who specialize in gender health for children and adolescents. Interviews with families of TGD youth have revealed that when they contact their health insurance provider to request coverage for mental health services within a specialty gender clinic, they are given a referral list of generalized mental health professionals with the argument that these providers can offer the same services (Price et al., 2022). Mental health care for TGD children and adolescents is a very niche and specialized service that many mental health professionals are not adequately trained to provide (Coleman et al., 2022).

Between the two of us in our professional experiences, we have worked in a variety of settings and multiple geographic regions. We have noticed, which appears to be thematically true based on published literature, that TGD youth of color are not coming in for gender-affirming health care services nearly as often as their white counterparts (Goldenberg et al., 2019; Inwards-Breland et al., 2021). TGD youth of color exist at intersections of social and structural oppressive forces (e.g., racism, cissexism, genderism, classism, adultism, etc.), which limits and creates differential access to resources based on statuses of power and privilege. In research with TGD youth of color, barriers to accessing and engaging with health care included uncertainty over where to find care, concerns about insurance coverage of care, ingrained racism within the medical system, poor communication with providers, a sense of being judged or mistrusted, concerns about being misgendered when making appointments and sitting in the waiting room, denial of care due to racial/ethnic identity, stigma related to sexual health (e.g., HIV), and others (Goldenberg et al., 2021; Gridley et al., 2016). A noteworthy paradox is that TGD youth of color would like assistance from providers to help them navigate their insurance coverage (Goldenberg et al., 2021). With the number of barriers that TGD youth of color face in accessing and engaging with their health care, one structural factor that is more modifiable than deeply rooted systems of power and oppression is insurance coverage for health care, particularly gender-affirming health care. Of note, many families would benefit

from payers relieving the burden of having to navigate complicated health insurance policies through a gender health specific patient navigator (Gridley et al., 2016).

If payers design insurance plans that best meet the needs of historically oppressed and marginalized families, everyone's health care experience is improved. Equitable access is good for everyone, not just the disenfranchised. But it makes the most significant impact for those that exist at the intersections of multiple oppressive systems, which confer additional physical, mental, and behavioral health challenges. TGD youth, particularly TGD youth of color, face startling rates of bullying victimization, discrimination, harassment, interpersonal and community violence, sexual violence, and social rejection among others (Gordon et al., 2018; Gower et al., 2022; Kattari et al., 2021; Newcomb et al., 2020; Witcomb et al., 2019). These stressors directly and indirectly contribute to disproportionate rates of depression, suicidality, anxiety, stress-related disorders, physical health complaints, chronic health conditions, and more among TGD youth (Fulginiti et al., 2021; Goldenberg et al., 2021; McQuillan et al., 2021; Newcomb et al., 2020).

These systemic factors that contribute to poorer health and a more difficult time accessing health care among TGD youth are placed in the context of an increase in legislative restrictions placed on gender-affirming care for youth. At the time of writing this essay (April 2023), twelve states in the U.S. have passed laws to restrict critical health care services for TGD youth (ACLU, 2023), and there has been an increase in anti-trans youth bills over the past few years from 159 bills in 2021 to 376 bills in 2023, more than a 2-fold increase (Trans Formations Project, 2023). These bans will obviously be detrimental to TGD youth and will disproportionately impact TGD youth of color who already face further barriers to health care access. With these bans on gender-affirming health care for TGD youth, families may be required to travel across state lines for appropriate care, assuming that whatever insurance policy they have would cover out of network or out of state care. These health care bans are life-limiting for many TGD youth who will no longer be able to access the health care they need to feel affirmed in their identity or comfortable in their body because, for some, being dead is more appealing than having to live in an identity or body that does not reflect their sense of self and embodiment.

Health insurance companies are likely feeling somewhat stuck having to operate within state-sanctioned legal parameters, while also understanding the importance of covering health care services aligned with the standards of care for TGD youth (Coleman et al., 2022). Health insurance companies are only one piece of the puzzle regarding the systemic barriers that TGD youth face. For example, in 2022, 65% of workers who participated in an employer-sponsored health care plan are in self-funded plans (KFF, 2022), which have been shown to have more exclusions on gender-affirming care (Kirkland et al., 2021). It is fairly clear that the way things are operating currently is not working. From a cost-effectiveness perspective, we know that having greater access to quality health care services would ultimately end up saving health insurance companies money given the reduction in emergency room visits and uncompensated care costs (Dranove et al., 2016; Singer et al., 2019). TGD youth are entitled to quality gender-affirming health care services, and TGD youth of color ought to be able to access these services at a similar rate as their white counterparts, at minimum. Health care is a human right, not a privilege. The World Health Organization and the United Nations have called upon healthcare systems globally to adopt a rights-based approach to health through implementing policies and programs that prioritize the health needs of those most marginalized (United Nations Department of Economic and Social Affairs, 2015; World Health Organization, 2017).

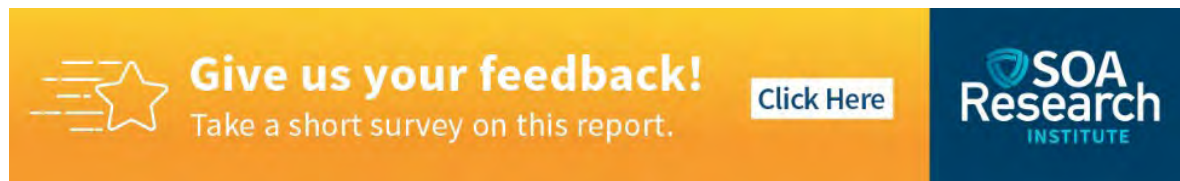
We do see the health insurance industry as playing a pivotal role in addressing the structural barriers of simply having access to gender-affirming health care services. Health insurance companies may be helpful in the following ways, which have been discussed by other clinicians and researchers in the field (Dowshen et al., 2019; Goldenberg et al., 2021; Ngaage et al., 2021; Padula & Baker, 2017): (1) increasing coverage for gender-affirming mental health and medical care, particularly through public health insurance plans that

often sponsor marginalized families, (2) reducing the ticket price of health care services designated “specialty care”, as many outpatient clinics that serve TGD youth fall within this distinction, (3) credentialing more gender health specialist providers to work in integrated primary care settings to streamline services and reduce siloing of health care services, and (4) increasing funding for transportation to and from health care visits or supplying low-resource families with adequate technology for telehealth services. Importantly, telehealth services are not a cure-all for barriers to health care access for TGD youth because many youth may not feel comfortable or safe to discuss their gender-related needs in their home or school environments (Szilagyi & Olezeski, 2021).

We see a need for greater collaboration between health care providers, health insurance companies, and consumers to devise creative solutions to the inaccessibility of gender-affirming health care services. Time is precious. Each day, month, year that TGD youth continue to experience insurmountable barriers to accessing their basic human right to gender-affirming health care, we continue to fail to instill a sense of hope, a key protective factor against TGD youth ending their lives far too early (Mora, 2019; Pacey et al., 2021). Health insurance companies are a powerful force in the healthcare industry, and it is long past due that the various stakeholders in gender health care collaboratively lead the pathway towards ameliorating these disparities in access for TGD youth. There is no better time than now to steer the future of health care services in the direction of equity – it will literally be lifesaving for TGD youth, and it is “worth it”.

* * * * *

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