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“A Policy Approach to Transphobia”

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Mandating the Coverage of Gender-Affirming Care

Introduction

Transgender people face systemic discrimination in accessing healthcare. Economic analysis can help policy makers frame the issue in a way that can lead to more trans-inclusive healthcare policies within federally funded institutions. I investigate policy solutions to the "societal and medical barriers" preventing trans people from accessing the health care they need (Stroumsa 31). I explore how political forces and individual behavior both perpetuate and combat systemic transphobia through a probability model and game theory model, respectively. Finally, I model the policy design process in proposing a policy mandating all federally funded healthcare programs explicitly cover gender-affirming healthcare.

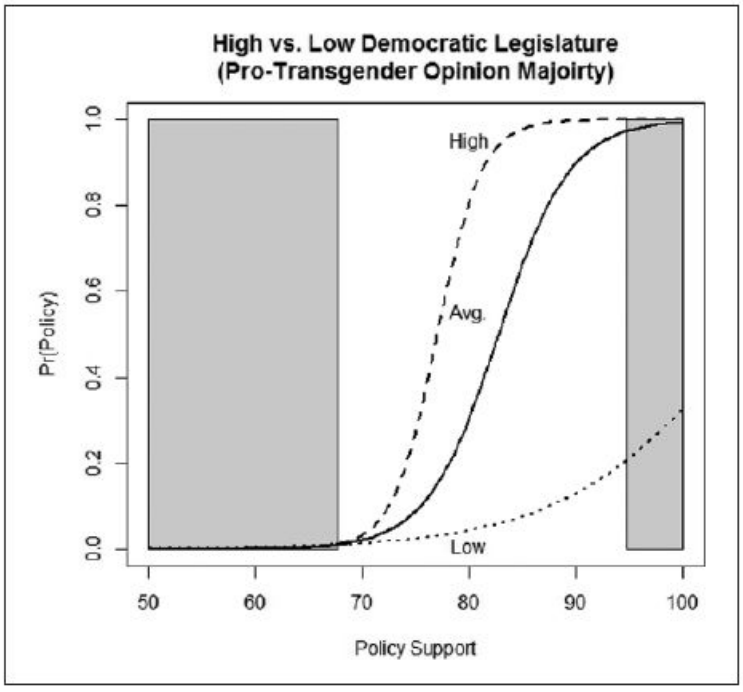
A Probability Model

This model investigates the dynamics between public opinion, composition of the legislature, and the probability that a trans-inclusive anti-discrimination policy will pass. Actors involved in this model include: trans people, the legislature, and voters. Actors' incentives in either supporting or opposing the policy vary; trans people are motivated by safety, economic well-being, mental well-being, and the struggle against political powerlessness and systemic transphobia. Legislature members likely face such incentives as political power, the chance of re-election, their base's political stance, and other political forces. Voters' incentives could include the effects of a discriminatory policy on local and state economies, adherence to moral or religious convictions, and whether one personally knows a trans person.

The social goal of a trans-inclusive anti-discrimination law is to establish trans people as a protected class, and to mitigate the negative health, workplace, social, educational, and economic effects of discrimination. However, though trans-advocacy groups hold concentrated, rather than diffuse, interests, and thus should have sufficient political power to pass desired policies, they face several obstacles. This model identifies and explains how the composition of the legislature affects the probability a trans-inclusive anti-discrimination policy will be passed, given a particular degree of public support.

Key Characteristics

This model focuses on the effects of the proportion of Democrats in the legislature because the Democratic party holds the pro-transgender opinion majority (Flores et al. 6). These three lines predict the probability of a trans-inclusive policy being passed given a proportion of Democrats in the legislature and the degree of public support for a trans-inclusive anti-discrimination policy. The solid line reflects the probability the legislature composed of the average proportion of Democrats will pass a trans-inclusive policy given a degree of public support. The dotted lines predict the probability the policy will pass if the legislature were one standard deviation below and above the average. For example, if the legislature is composed of an average amount of Democrats, and 80% of the public supports the policy, the probability of the policy passing is slightly above 40%. The likelihood of the legislature with a low proportion of Democrats passing the policy with the same degree of public support rests at about 5%. Thus, a plausible obstacle to passing a trans-inclusive anti-discrimination law is the responsiveness of the legislature to public opinion, as well as the degree of public support itself (Flores et al. 6)



A Game Theory Model

This model is adapted from “Economics and Identity” (Akerlof and Kranton). Akerlof and Kranton explore how individual behavior and identity can be expressed in economic terms, applying a game theory model to interactions between individuals of different identities. The model below applies game theory to individual behavior and transphobia, investigating the payoffs, externalities, and responses associated with interactions between a cisgender person and a transgender person.

This is a simplified model examining how individuals interact with each other’s identities and their own identities as they operate within a dominant, oppressive system of transphobia and, in the case of Person j, as they transgress the prescriptions of that transphobic system. This model involves just two actors, though in reality these actions can occur at the individual, family, community, firm, and society-wide level.

This model is applicable to societies where a binary construction of gender dominates, accompanied by the oppression and policing of those who transgress the expectations established by this understanding of gender. This construction of gender entails the following:

1. Sex is synonymous with gender, and there is only male and female.
2. Sex and gender are static and determined by external genitalia.
3. People whose existence contradicts these criteria are characterized as a “failed” man/woman, deceitful, delusional, etc.
4. Acknowledging someone as the gender they are, if that gender does not align with the sex assigned at birth, is “incorrect”, giving into delusion, etc. (ie using correct pronouns/name, referring to them as their gender)

In this model, there are two possible activities:

1. Acting/expressing gender in line with expectations prescribed to assigned sex at birth

2. Acting according to gender, not prescribed expectations/behaviors/roles/bodies associated with one’s sex assigned at birth

Note: This model operates on the understanding that gender is determined by the individual themself, not by sex assigned at birth.

Two actors participate in the game described by Figure 1. Person i is cisgender. Person j is transgender, nonbinary, or gender-nonconforming (GNC). Both are acting to optimize their utility *V*.

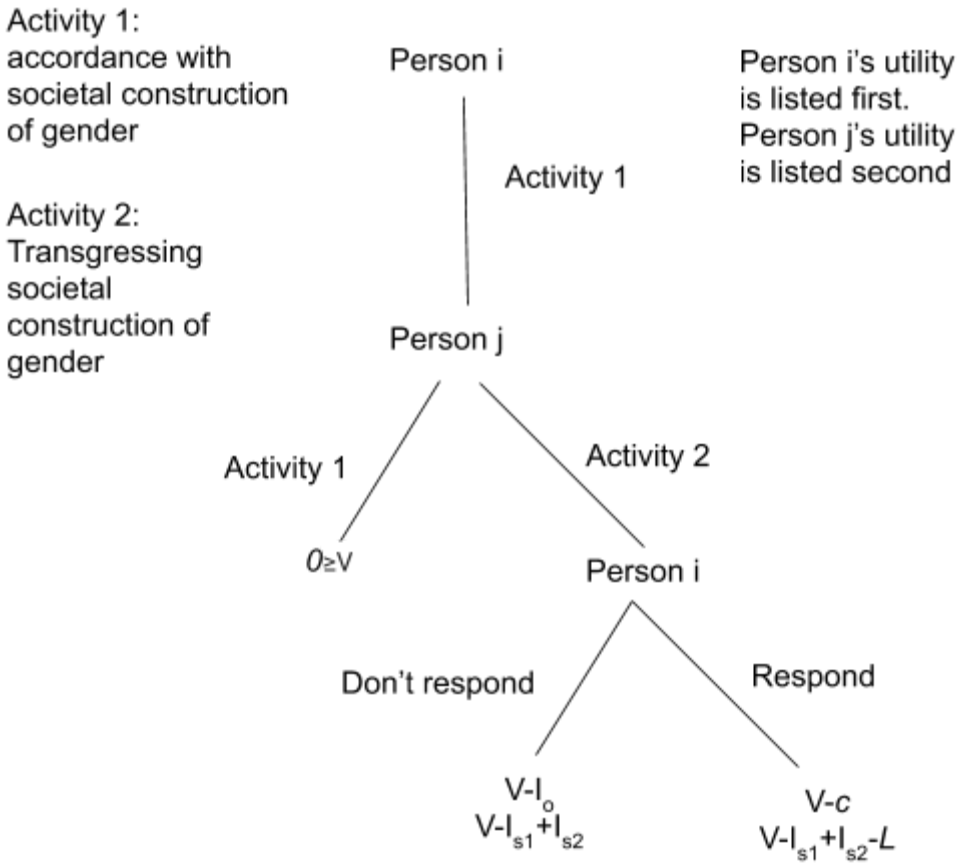
Person i, as a cisgender/non-GNC person, only has a taste for Activity 1, and has a strong preference (whether unconsciously or consciously) for all other actors also having a taste for Activity 1 . This strong preference originates from an “internalization of prescriptions,” meaning individuals have learned and embodied the prescribed expectations for gender and will experience anxiety if they themselves or others do not abide by these prescriptions (Akerlof and Kranton 716).

Person j, as a trans/nonbinary/GNC person, will have a taste for Activity 2. However, as a necessary condition of living in a binary-gendered society, Person j may also have a taste for Activity 1. Person j could even gain utility from Activity 1, as they may find safety, financial wellbeing, social acceptance, and an operational support system in Activity 1. However, as a trans/nonbinary/GNC person, Person j will most likely experience significant losses in utility from Activity 1, which could include heightened dysphoria, discomfort, and severely diminished mental health. Thus, if Person j chooses Activity 1, their utility *V* will either be zero, where the gains and losses in utility cancel out, or negative, where the losses in utility are larger than the gains.

If Person j “chooses” Activity 2, the game continues. When Person j chooses Activity 2, they experience both gains and losses in utility. Person j may experience a loss in utility due, again, to anxiety regarding internalized prescriptions. They may also experience social ostracization, workplace discrimination, lack of access to healthcare, violence, and lack of financial stability. This loss is denoted I_{s1}. The gains in utility may come from improved mental health, new membership to a supportive community, lessened dysphoria/increased gender euphoria, and/or a reaffirmation of a support network. These gains are denoted I_{s2}.

Person i will either choose to respond or not respond to Person j’s undertaking of Activity 2. This stage of the game occurs because of “identity externalities” (Akerlof and Kranton 728). Person j undertaking Activity 2 will incur a “cost” on Person i; for example, a cisgender man (Person i) may feel a trans woman’s existence threatens his masculinity, and will experience a loss Io (o denotes “other” here) in utility. If Person i chooses not to respond, they end the game with utility $V - I_o$. However, if Person i does choose to respond, they may enact physical, verbal, and/or sexual violence on Person j, or choose to disregard her name and pronouns. This response will restore utility at a cost *c*. As a result of Person i’s response, Person j will experience a loss L in utility. As demonstrated in the given example, the loss L can be significant.

The Model:



Data Analysis

The dataset used in this analysis was obtained from the study "Transgender Prejudice Reduction and Opinions on Transgender Rights: Results from a Mediation Analysis on Experimental Data" (Flores). The data has several limitations. First, it only assesses characteristics of trans people, meaning there are no means of comparing outcomes for trans people vs. cisgender people. Second, the dataset's assessment of racial characteristics is limited, as it only assesses whether respondents are white or non-white. Third, the characteristics assessed by the survey are limited, meaning there may be several confounding variables going unaccounted for, such as the respondent's education level.

With these limitations in mind, below are two pivot charts describing trends in the dataset. Figure 3 compares the average income of trans people according to their "outness" and their race. "Outness" describes the degree to which those in a trans person's life are aware of their trans identity. Race, in this context, denotes whether a person is white. Figure 1 indicates the following:

1. White trans people earn, on average, a higher income than non-white trans people.

2. Both white and non-white trans people who are “out” earn, on average, a lower income than people who are not “out”.
3. Non-white trans people who are “out” earn the least, on average.

These results bear important implications for the game theory model illustrating identity gains and losses for cis and trans people. Losses in income may translate to a loss of utility sustained by a trans/nonbinary/GNC person if they opt to live according to their gender, as opposed to their sex assigned at birth.

It is important to note that the income variable for the dataset listed income categories, rather than actual incomes of each respondent, and incomes were assigned to respondents based on the mean of the income class to which they belonged. Income, then, must be regarded as a rough estimate in these figures.

Figure 4 illustrates rates of voter registration among white trans people and non-white trans people. Around 93% of white trans people are registered to vote, versus 83% of non-white trans people. Rates of voter registration could reflect the amount of trust communities, especially marginalized communities, have in the voting system, as well as access to voters’ education and physical voting sites.

Rates of voting registration could be used as a proxy for political power, which influences the degree of legislative support of the trans community, especially trans Black, Indigenous, and people of color (BIPOC). Recall that the probability model illustrates how the proportion of Democrats in the legislature affect the probability of a transgender-inclusive policy being passed. To achieve a Majority-Democrat legislature, and thus increase the likelihood of an inclusive policy, the trans community needs political power, which may be lacking, according to these findings.

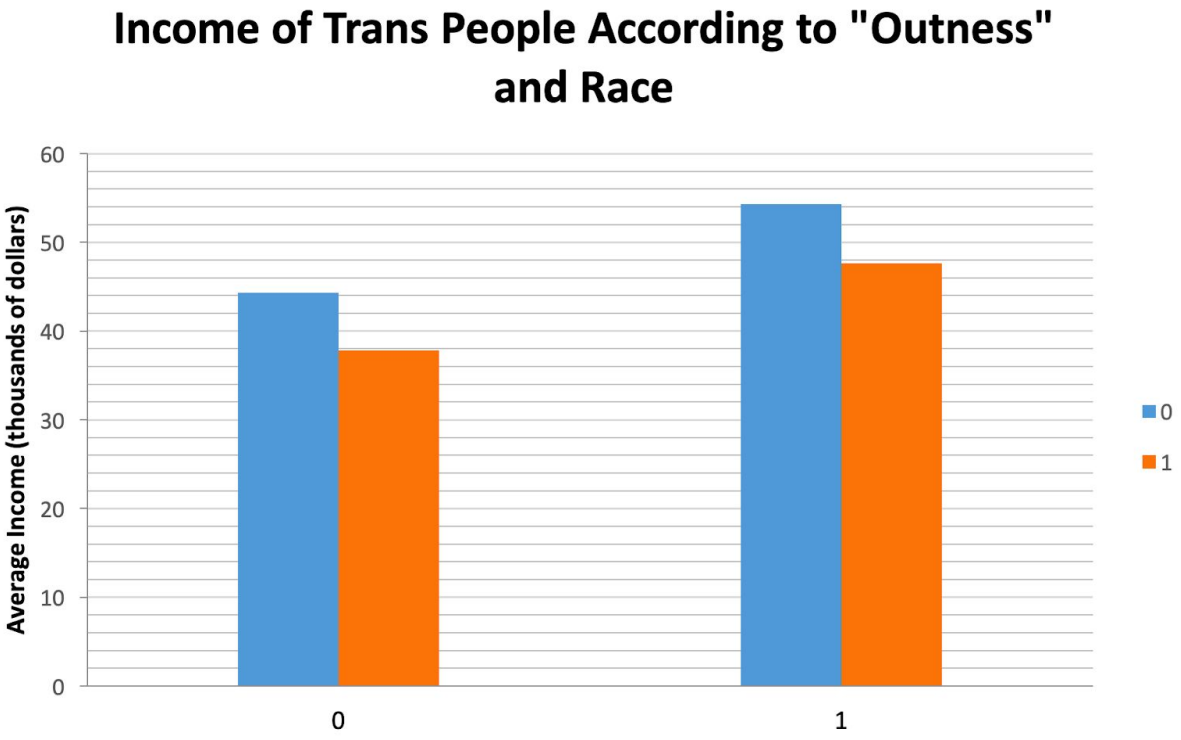

Income of Trans People According to "Outness" and Race
Average Income (thousands of dollars)
60
50
40
30
20
10
0
0
1
0
1

Fig 3

Fig 4

Cost-Benefit Analysis (CBA)

This cost-benefit analysis is investigating the costs and benefits of implementing a policy mandating all federally funded healthcare programs cover gender-affirming care. Below, preceding the CBA table, is rationale supporting each cost and benefit.

Benefits

Reduced suicide rates: This was identified as a benefit to this policy because barriers to gender-affirming care are listed among the risk factors contributing to heightened risk of suicide (Stroumsa 31). The suicide rate among the trans community is at 41%, compared to 1.6% in the general population ("Attempted Suicide Rate"). The population of trans people in America is 1.6 million (Flores). Supposing, conservatively, that this policy reduces the suicide rate by 5%, the policy would prevent the suicide of 80,000 people. Using the Statistical Value of a Life as reported by the Department of Transportation ("US Department of Transportation Memo"), which is $9.6 million, the value of saving 80,000 lives would be $768,000,000,000.

Increased gender euphoria/decreased gender dysphoria: Transgender people who seek gender-affirming care need this care to decrease gender dysphoria, which is the discomfort a person feels when their body does not align with their gender, or to increase gender euphoria, which is a sense of comfort and peace with one's gender. Dysphoria or decreased gender euphoria contribute to increased rates of depression. Thus, expanding access to gender-affirming care also means reducing the mental health issues facing the trans community. This benefit was quantified by creating a proportion between two ratios:

1. The ratio of the annual cost of depression to depression rates among the general population

2. The ratio of the saved cost of depression if the policy reduced depression rates among the trans community by 5% to the reduced depression rate among the trans population.

According to the American Psychiatric Association, the annual cost of depression is estimated to be $210.5 billion ("Quantifying the Cost of Depression"). This cost is likely an underestimate, as it only measures direct costs. Depression rates among the general population are at 6.7% ("Quantifying the Cost of Depression"). The depression rates among the transgender community are at 50% of the trans population (Schrieber). This CBA supposes the policy reduces the depression rate from 50% to 45%. Five percent of 1.6 million is 80,000. The unknown value in this proportion is the money saved by that 5% reduction. Using cross-multiplication, the saved cost comes to $768,164,069.63.

Decreased HIV rates: Increasing access to gender-affirming care is linked to reduced HIV rates among the transgender community (Poteat). Evidence from a study by the Transgender Law Center "supports the importance of gender-affirming medical care in promoting engagement in HIV care and suppression of viral load among transgender people" (Poteat).

Schackman et al. estimate the annual cost of HIV per patient to be $229,800. The HIV rate among trans people is estimated to be around 1.4%, five times the rate among the general population (Poteat). Supposing the policy reduced HIV rates from 1.4% to 0.9%, 14,400 less people would be living with HIV. The total value of that 14,400 reduction would be $3,309,120,000.

Total value of benefits: $772,077,284,070

Costs:

This analysis found that the only cost of policy implementation would be the cost of providing care. Estimates place the cost of providing gender-affirming care between $34,000 and $43,000 ("Covering Transgender Healthcare"). It is critical to note that policymakers typically deem a

policy cost-effective if the annual cost is below $100,000 (“Covering Transgender Healthcare”). After ten years, the annual cost falls to between $7,000 and $10,000.

Thus, for the first ten years, the cost of providing care to the entire transgender population would be $68,800,000,000. This figure is an overestimate, utilizing the highest possible cost of providing gender-affirming care, as well as the entire population of transgender people (not all transgender people want or need means of medical transition).

After the first ten years of care, the maximum total annual cost would be $16,000,000,00.

Total value of costs:

First ten years: $68,800,000

After ten years: $16,000,000,000

BENEFITS	
Reduced suicide rates among the trans community	$768,000,000,000
Increased gender euphoria/decreased gender dysphoria	$768,164,069.63
Decreased HIV rates	$3,309,120,000
Total	**$772,077,284,070**
COSTS	
Annual cost of provision of care (first 10 years)	$68,800,000,000
Annual cost after first 10 years	$16,000,000,000
Total (first 10 years)	**$68,800,000,000**
Total (after first 10 years)	**$16,000,000,000**

Policy Design

Step 1: Identifying Potential Benefits

The goal of this policy is to recognize gender affirming care as medically necessary for anyone seeking to obtain it, as well as making that care as accessible as possible. Vaguely worded goals may include “rights for trans people” or “improved access to healthcare”.

The outcome of interest would be increased numbers of trans people accessing gender-affirming care if they need or want it. Intermediate measures may include increased public acceptance of the transgender community, increased momentum for other trans-inclusive policies, and a decrease in the use of gendered language within policy and regulations.

The Trump Administration has an extensive record of anti-transgender policies, such as the military ban on transgender service members; “religious liberty” policies allowing medical providers to refuse care to patients service on the basis of religious beliefs; and the erasure of non-discrimination language in education, housing, and labor policies (“The Discrimination Administration”).

Public attitude toward the transgender community is sharply divided; Pew Research Center reports that a third of Americans believe we’ve “gone too far” in accepting trans people. Fifty-four percent of all adults believe gender is determined by sex at birth, while 44% believe gender can be different from sex at birth. Political party membership is closely related to a person’s beliefs about gender and sex; eighty percent of Republicans believe gender is determined by sex at birth, while only 34% of Democrats share that belief (Brown).

The political and public barriers to the public are formidable. However, grassroots and community-level organizations continue to push for trans-inclusive policies at the school, city, state, and federal level. For example, Gender Justice LA, a small organization in California, has advocated for and achieved anti-transphobia policies within policing, which mandate officers are not to assume trans people are sex workers, and that they cannot misgender trans people they encounter (Lehtinen). Outfront MN, an LGBT advocacy organization in Minnesota, leads trans-centered training programs for schools, police departments, and workplaces. Just as the marriage equality movement targeted public opinion through education, community-building, and framing (ie “Love is Love”), the movement for trans liberation could also utilize the grassroots approach. The grassroots approach could also garner political pressure to enact change at the state and federal level. The political momentum to realize the “whole loaf” policy is there.

Step 2: Identifying Market Failures

As an institution necessarily influenced by systemic oppression, the healthcare market is limited by transphobia masked by economic reasoning. The rationale for excluding gender-affirming care cited by insurance providers have been proven outdated, scientifically unsound, or incorrect; for example, Wong found that insurers use systemic transphobia to exclude gender-affirming care, knowing that there will be little to no public backlash against such policies (476-477). Specifically, insurers argue gender-affirming care is a cosmetic or superficial undertaking, and incorrectly assume all trans people will pursue the most expensive gender-affirming treatment (Wong 475). Further, because the transgender population is small relative to the general

population, insurers are able to exclude trans people from coverage without running the risk of losing a large customer base (Wong 476). In short, the market does not deliver a trans-inclusive outcome because profit-motivated insurers leverage systemic transphobia to maintain a status quo long debunked by medical professionals.

Step 3: Identifying Relevant Institutions

Changes would occur at the state and federal level. At the federal level, this change could entail a bill requiring all federally funded healthcare programs and private insurers to explicitly cover gender-affirming care. State healthcare programs would be required to comply with these regulations.

These changes would occur both at the legislative level and within the U.S. Department of Health & Human Services.

The recent passage of the Equality Act in the House of Representatives indicates there is a measure of political support at the federal level. Political support may be less in states with explicit policies banning coverage of gender affirming care.

Step 4: Evaluating Policy Options

Policy Options:

1. Mandating all federally funded healthcare programs and private insurance companies cover gender-affirming care.
2. Mandating just all Medicare and Medicaid programs cover gender-affirming care
3. Mandating private insurance companies cover gender-affirming care
4. Mandating all federally funded healthcare programs and institutions cover and provide gender-affirming care

Step 5: Assessing the Political Landscape

Votes for this policy would come from the legislature. Public officials need to be presented with up-to-date medical evidence, empirical analysis of costs and benefits of this policy, and appeals by individuals and advocacy organizations. The central argument for this policy would be that covering gender-affirming care is economically feasible, just, and medically appropriate.

The grassroots approach and the gatekeepers approach would work well together. Grassroots organizations will build momentum at the community level, working to provide education about gender and the challenges faced by the trans community, while medical professionals, economists, and supportive public officials can work at the legislative level to pass such a policy.

Framing would be important in garnering support for this policy. Positioning the tax burden on the wealthy to pay for this program would be important— taxpayers may be hesitant about supporting this policy if they believe their taxes are going toward unnecessary healthcare. Education and advocacy, then, would be critical in gaining public support.

It may be difficult to achieve widespread understanding of the fluidity of gender and the narrowness of our current conceptualization of the gender binary. However, it may not be necessary to immediately achieve this understanding if people can be convinced of the importance of this care, regardless of whether they understand how gender works. Thus, evoking positive emotional responses with the stories of trans people who have been able to access gender-affirming care could be one method of building support for this policy.

Step 6: Making a Policy Option

The best option would be to mandate all federally and privately funded healthcare programs cover gender-affirming care. The most feasible option, however, may be to first mandate that all federally funded healthcare programs cover gender affirming care.

Step 7: Building a Coalition

Intersectional advocacy groups are important resources for queer and trans advocacy. For example, Black Lives Matter, in working for racial justice, centers women and trans and queer people. Racial, economic, and gender justice advocates are valuable in coalition-building, as trans women of color are the most impacted by systemic transphobia.

Additionally, increasing numbers of young, progressives of color and transgender people are being elected to public office; this indicates there may be more politicians willing to advocate for this policy and join this coalition.

Step 8: Expansion

The policy could grow to include measures to address the violence enacted against trans women, especially black trans women, as well as the housing and economic inequities faced by trans people. If the policy addressed issues salient to the most marginalized among the trans community, it could garner more community-level support, as well as maximize its impact among the most affected by transphobia and racism.

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