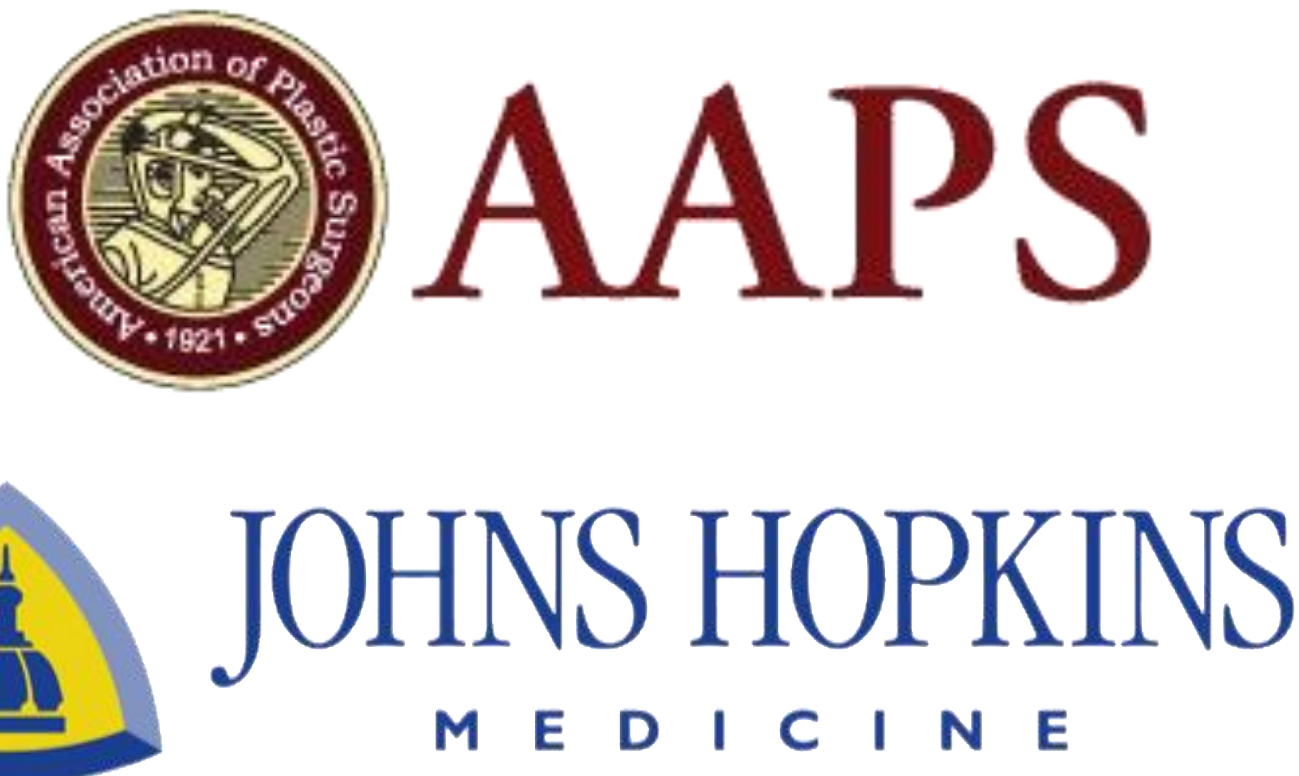


Disparities in the Coverage of Gender-Affirming Bottom Surgery and Fertility Services



Ermina Lee, BS¹, Alexandra J. Davis, BA, BS², Carson S. Hartlage, BS¹, Maria Sckaff, BS², Bashar Hassan, MD³, Ledibabari M. Ngaage, MA Cantab, MB BChir², Katie E. Cameron, MD, MBE³, Fan Liang, MD³

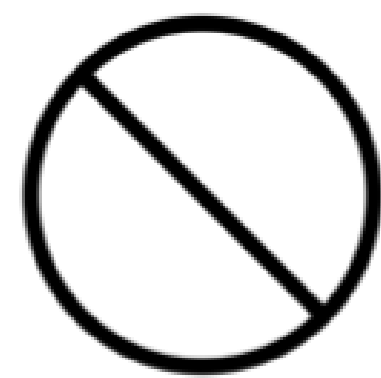
¹University of Cincinnati College of Medicine, Cincinnati, Ohio, USA
²Johns Hopkins University School of Medicine, Baltimore, Maryland, USA
³Center for Transgender and Gender Expansive Health, Baltimore, Maryland, USA

Background

Up to 51% of transgender women and 37.5% of transgender men would have seriously considered fertility preservation if offered prior to medical transition



Gender-affirming genital reconstruction (“bottom surgery”) typically involves gonadectomy



Fertility preservation utilization is **low** (<5-7%) among transgender and gender (“TGD”) individuals, barriers include:

- Hormone therapy pause for gamete procurement (1-6 months)
- Out-of-pocket costs (\$10,000-\$15,000 for oocyte or embryo, \$500-\$1,000 for sperm)
- Inability to delay transition

Objective

To examine the insurance coverage for TGD individuals seeking fertility services and bottom surgery

Methods

Cross sectional analysis: 10 largest private insurers – 60% of National Market Share
Online evidence of coverage and telephone interview:
(1) prior authorization, (2) case-by-case, (3) no coverage, or (4) state-specific

Results

Most insurers excluded TGD individuals from fertility services entirely, limiting access to expert fertility counseling before bottom surgery

- Every insurer (n=10) had prior authorization for bottom surgery
- Four offered **no coverage** for fertility preservation, one had prior authorization, and one offered case-by-case
- The remaining four insurers offered coverage in accordance with **state-specific** iatrogenic infertility mandates
- Of these eleven state-specific plans, eight covered TGD individuals (n=8 covered sperm and oocyte cryopreservation, n=4 embryo, n=3 storage costs)

Conclusion

Without active inclusion of TGD individuals, expanding access to fertility preservation will continue to leave marginalized patients behind

- Who should qualify for care under iatrogenic infertility?
- Fertility must not be used as a criterion to restrict access to transition-related care

Contact: Ermina Lee, lee3ej@mail.uc.edu
Selected References
1. Sauerbrun-Cutler MT et al. The Status of Fertility Preservation (FP) Insurance Mandates and Their Impact on Utilization and Access to Care. *J Clin Med.* (2024).
2. Stolk THR et al. Desire for children and fertility preservation in transgender and gender-diverse people: A systematic review. *Best Pract Res Clin Obstet Gynaecol.* (2023).

Figure 1: Flowchart Demonstrating Online Policy Assessment of Insurance Coverage

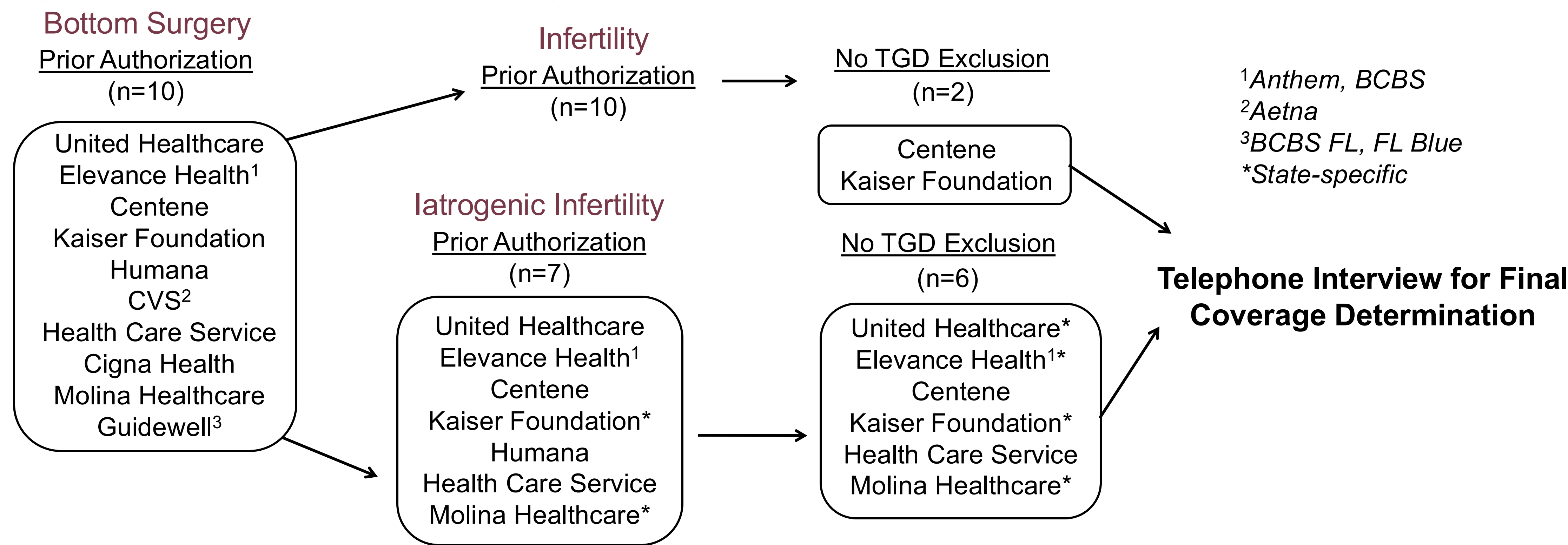


Table 1: Coverage of Fertility Services for TGD individuals Undergoing Bottom Surgery

Insurer (% Market Share)	Storage and Preservation	Assisted Reproduction
United Healthcare (15.35)	state-specific ¹	no coverage
Elevance Health (7.17)	state-specific ²	no coverage
Centene (6.68)	prior authorization	prior authorization
Kaiser Foundation (6.19)	state-specific ³	no coverage
Humana (6.03)	no coverage	no coverage
CVS (5.82)	no coverage	no coverage
Health Care Service (3.54)	case-by-case	no coverage
Cigna Health (2.36)	no coverage	no coverage
Molina Healthcare (2.00)	state-specific ⁴	no coverage
Guidewell (1.84)	no coverage	no coverage

¹CA, WA
²CA, CO, CT, ME, NH
³CA, MD, DC
⁴CA

2005 ----- Advent
Oncofertility – the integration of fertility care for patients undergoing sterilizing cancer treatment

2017 ----- State mandated-coverage
Iatrogenic Infertility – relatively novel qualifying condition for fertility preservation* resulting from oncofertility advocacy

*Standard of care: sperm, oocyte, and embryo cryopreservation (American Society of Reproductive Medicine, American Society of Clinical Oncology)