

After the revocation, some written information about prescription drugs was produced by a patchwork of organizations, including the AMA, the U.S. Pharmacopeia, and the American Association of Retired Persons.³ When the FDA began in 1985 to allow drug companies to advertise in mass-market magazines and newspapers so long as they included a “fair balance of information,” as required for ads in medical journals, companies began developing their own “patient information sheets,” which often simply reprinted the text of the package insert written for physicians and pharmacists. This information provision had little to do with educating consumers and much to do with expanding marketing opportunities. The medical terminology, dense verbiage, and tiny fonts of these inserts have made them inscrutable to the average consumer and virtually useless as information sources.⁴

The FDA’s Medication Guide program, proposed in 1995 and launched in 1999, aimed to mitigate this problem for some outpatient prescription products, with user-friendly information to be distributed at the point of sale. The most effective of these guides might serve as templates for risk

communication in DTCA. Moreover, in 2015, companies could harness the power of communications technologies such as smartphone-scannable QR codes to link such information to print ads or online materials for interested consumers.

Yet the primary risk-communication challenges the FDA has faced are not technological but social. In the case of the Pill, the PPI’s opponents were able to dilute and delay efforts to provide patients with clear, comprehensive risk information. The U.S. medical consumer’s voice has grown stronger since the 1970s, and the FDA increasingly relies on social scientific research in its decisions. Nonetheless, the success or failure of the current proposal depends on the agency’s ability to capture the interests of all stakeholders.

For all its capacity to encourage overdiagnosis and overmedication, DTCA’s virtue is that it treats consumers as people who deserve to know something about the compounds they take into their bodies. After 30 years of DTCA, it’s not clear that advertising is the best medium for communicating risk information,⁵ but marketers should at least be required to try to communicate risk

information as effectively as they do their promotional messages.

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Caring for Our Transgender Troops — The Negligible Cost of Transition-Related Care

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On July 13, 2015, U.S. Defense Secretary Ashton Carter announced that the military anticipates lifting its ban on service by transgender persons, those whose gender identity does not match the sex that they were assigned at birth. Although an es-

timated 12,800 transgender personnel currently serve in the U.S. armed forces (see table for explanations of estimates), they must conceal their gender identity because military policy bans them from serving and prohibits military doctors from providing tran-

sition-related care. Although some transgender people do not change their bodies to match their gender identities, government agencies, courts, and scientists agree that for many, transition-related care (gender-affirming surgery, cross-sex hormone therapy, or

Estimating the Cost to the U.S. Military of Providing Transition-Related Care for Transgender Personnel.*			
Variable	Estimate for U.S. Military	Calculation	Australian Military (accuracy check)
No. of transgender troops	12,800	$2,136,799$ (2015 force size) \div $2,581,000$ (2012 force size) \times $15,500$ (estimated no. of transgender troops in 2012) = $12,832$	
Overrepresentation of transgender persons in the military	$\times 2$	$12,800 \div 2,136,799 = 0.6\%$; among U.S. civilian adults, $700,000$, or 0.3% of the population, are transgender; $0.6 \div 0.3 = 2$	
No. expected to utilize transition-related care per yr	188	0.000044 (employee utilization rate for transition-related care at large civilian employers) \times $2,136,799 \times 2$ (overrepresentation of transgender persons in the military)	13 (persons receiving transition-related care) over 30 mo = 5.2 persons per yr; $5.2 \div 58,000$ (total force size) = 1 person per 11,154 troops; $2,136,779 \div 11,154 = 192$
Cost			
Per person receiving transition-related care	\$29,929	Cost per University of California claimant receiving transition-related care	
Total	\$5.6 million per yr	$\$29,929 \times 188$	$\$287,710$ (cost over 30 mo) \div $30 \times 12 = \$115,084$; $2,136,779$ (U.S. troops) \div $58,000$ (Australian troops) \times $\$115,084 = \4.2 million per year
Per transgender service member	\$438 per yr	$\$5.6 \text{ million} \div 12,800$	
Per member of the military	\$2.62 per yr (22 cents per mo)	$\$5.6 \text{ million} \div 2,136,779$	

* Data are from the Defense Manpower Data Center; Gates and Herman¹; Herman²; 9News³; and State of California Department of Insurance.⁴

both) is medically necessary, and state regulators have found medical exclusions to be indefensible and in some cases unlawfully discriminatory. Yet in response to Carter's announcement, opponents in the Pentagon and beyond expressed concerns about the costs of providing such care.

Having analyzed the cost that the military will incur by providing transition-related care, I am convinced that it is too low to warrant consideration in the current policy debate. Specifically, I estimate that the provision of transition-related care will cost the military \$5.6 million annually, or 22 cents per member per month. Of course, the cost will depend on how many transgender personnel serve and utilize care, and estimates are sensitive to certain assumptions, such as the expectation that the military will not become a "magnet" employer

for transgender people seeking health care benefits. Though my utilization and cost estimates are quite close to actual data provided by an allied military force, it seems clear that under any plausible estimation method, the cost amounts to little more than a rounding error in the military's \$47.8 billion annual health care budget.

My calculations are as follows. In 2014, scholars estimated that 15,500 transgender personnel served in the military out of a total force of 2,581,000, but they included troops who were ineligible for health benefits.¹ Moreover, the military has become smaller in recent years: as of May 31, 2015, a total of 2,136,779 troops served in the Active and Selected Reserve components and were thus eligible for health benefits. Assuming that the number of transgender personnel

has declined along with the overall force size, and excluding those serving in Reserve components whose members are ineligible for medical benefits, I estimate that 12,800 transgender troops serve currently and are eligible for health care.

As for the expected utilization of transition-related care, the latest research suggests that among large civilian employers whose insurance plans offer transition-related care including surgery and hormones, an average of 0.044 per thousand employees (one of every 22,727) file claims for such care annually.² On the basis of this utilization rate, the military could expect that 94 transgender service members will require transition-related care annually. However, transgender persons are overrepresented in the military by a factor of two — possibly in part because, before attaining self-

acceptance, many transgender women (people born biologically male who identify as female) seek to prove to themselves that they are not transgender by joining the military and trying to fit into its hypermasculine culture.⁵

If transgender people are twice as likely to serve in the military as to work for the civilian firms from which the 0.044 figure was derived, then an estimated 188 transgender service members would be expected to require some type of transition-related care annually. It is not possible, on the basis of the available data, to estimate how many will require hormones only, surgery only, or hormones plus surgery.

As an accuracy check, consider the Australian military, which covers the cost of transition-related care: over a 30-month period, 13 Australian troops out of a full-time force of 58,000 underwent gender transition — an average of 1 service member out of 11,154 per year.³ If the Australian rate were applicable to the U.S. military, the Pentagon could expect 192 service members to undergo gender transition annually.

To estimate the cost of care, note that under insurance plans offered to University of California employees and their dependents, the average cost of transition-related care (surgery, hormones, or both) per person needing treatment was \$29,929 over 6.5 years.⁴ This estimate was derived from 690,316 total person-years of coverage, a sample arguably large enough to justify extrapolation to other settings.⁴ By comparison, over a 30-month period, the Australian military paid U.S. \$287,710 for transition-related care for 13 service members, or \$22,132 per person requiring care.³

Under these utilization-rate and cost-per-claimant estimates, pro-

viding transition-related care to the 188 military personnel expected to require it annually would cost an estimated \$5.6 million per year, or \$438 per transgender service member per year, or 22 cents per member per month. If the Australian military's annual cost of transition-related care were applied to the U.S. armed forces, the Pentagon could expect to pay \$4.2 million per year to provide such care.

Actual costs could be lower than expected, because transition-related care has been proven to mitigate serious conditions including suicidality that, left untreated, impose costs on the military, and addressing symptoms might conceivably improve job performance as well. There are costs, in other words, of *not* providing transition-related care, due to potential medical and psychological consequences of its denial, paired with the requirement to live a closeted life. In addition, the \$29,929 cost-per-claimant estimate was derived from private-sector care, but the military provides care more efficiently than civilian systems do. Although the military might outsource some transition surgeries to private providers, many transition surgeries are well within the skill set of its reconstructive surgeons. Finally, transgender service members may be less likely than civilians to seek transition-related care, owing to hostile command climates or an unwillingness to interrupt military service.

In contrast, actual costs will be higher if the military covers more procedures than the insurance plans from which the \$29,929 estimate was derived. In addition, costs will be higher if transition-related care is offered to family members and dependents. Finally, if transgender civilians join the

military in order to obtain care, costs will be higher than estimated. Military recruiters have used the promise of health care benefits to entice civilians to enlist, and if transition-related coverage motivates outstanding transgender candidates to serve, that is not necessarily problematic. That said, civilian insurance plans increasingly cover transition-related care, which reduces the incentive to join the armed forces to obtain care. And low utilization rates reported by civilian firms offering such care may suggest that few transgender persons obtain civilian employment for that purpose. If so, it would be difficult to imagine that large numbers would seek to join the military to obtain such care, given the multiyear service obligations they would incur.

Some observers may object to the concept that the military should pay for transition-related care, but doctors agree that such care is medically necessary. And though costs can be high per treated person, they are low as a percentage of total health spending, similar to the cost of many other treatments that the military provides. Even if actual costs exceed these estimates on a per-capita basis for persons requiring care, the total cost of providing transition-related care will always have a negligible effect on the military health budget because of the small number treated and the cost savings that the provision of such care will yield. The financial cost of transition-related care, in short, is too low to matter.

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Civil Rights and Health — Beyond Same-Sex Marriage

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The recent Supreme Court decision in *Obergefell v. Hodges*, which rejected as unconstitutional state bans on same-sex marriage, was a major milestone for the lesbian, gay, bisexual, and transgender (LGBT) civil rights movement. Soon after the decision, a dental hygienist, chatting with me on an airplane, mentioned that her gay niece was getting married. “How nice,” she said, “that this is now legal everywhere. In the past, gay people were so often treated very badly!” The idea that the acceptance of same-sex marriage as part of the fundamental right to marriage heralds the end of bad treatment of LGBT people and denial of their rights may be a commonly held notion, but it's most likely overly optimistic, as well as contrary to the evidence on health disparities.

The Court had found in prior decisions that there is a fundamental right to marry — for example, in *Loving v. Virginia*, which banned miscegenation laws prohibiting interracial marriages. Now, Justice Anthony Kennedy, writing for the majority in *Obergefell*, has made both a very human case for extending marriage rights to same-sex couples — “marriage . . . embodies the highest ideals of love, fidelity, devotion, sacrifice, and family” — and a constitutional case for affording such couples equal pro-

tection (under the 14th Amendment). He states clearly that “the Constitution grants them that right” — for it grants all Americans “equal dignity in the eyes of the law.”

It is less clear, however, that the decision represents a significant change in the way LGBT people will be treated in the United States. Public policies such as legalizing same-sex marriage may well have positive effects on the daily lives, health, and welfare of LGBT people. But other legal and health policy battles remain if we are to ensure that “being treated badly” becomes a thing of the past.

There is a body of literature showing that heterosexual marriage is correlated with improved health. A review by Kiecolt-Glaser and Newton showed that heterosexual marriage is associated with improved cardiovascular, endocrine, immune, and other physiological outcomes, as well as mental health, with greater protection for men than for women.¹ These apparent benefits of marriage are similar to the effects achieved by improving risk factors such as smoking, high blood pressure, high cholesterol levels, obesity, and lack of physical activity. Same-sex marriage is a relatively recent phenomenon, but some studies have already extended those findings to same-

sex couples. A recent study by Kail et al., for instance, using a well-validated five-response measure that has been successfully and repeatedly correlated with objective measures, found that same-sex couples living in states with legally sanctioned same-sex marriage reported a rating of “poor” health less frequently than couples in states without legally sanctioned same-sex marriage.² The effect for heterosexual couples has been attributed to both “selection and protections” — healthier people are more likely to marry and receive the protections described by Kail and others.

The mechanism whereby married same-sex couples achieve better health outcomes may also include other factors. One of the main theories about why LGBT people and other minority groups are affected by health disparities involves something called “minority stress,”³ which reflects the daily burdens of discrimination and societal exclusion. For example, there are hundreds of benefits that accrue to married couples, from Social Security survival benefits to inheritance-tax exemptions to hospital visitation rights. These benefits will improve the lives of same-sex couples in the states now forced to allow them to marry, presumably reducing minority stress.