FACT SHEET

Medicare & Transgender Older Adults: What Advocates Need to Know

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Transgender older adults are navigating health systems that can be complex. This resource explains what to expect from Medicare coverage for transgender older adults.

Gender Identification

Your client's gender does not appear on their Medicare card. Your client's Medicare records, however, include a gender marker based on their Social Security record. Your client's sex, gender, and gender identity should not affect their Medicare eligibility or coverage.

Until January 2025, individuals could change their sex markers with the Social Security Administration. In February 2025, the Social Security Administration changed their Program Operations Manual System to say that the agency would no longer process requests for sex marker changes.[1] For now, sex marker changes that occurred prior to this time remain. Advocates who are working with older adults where prior sex marker changes are no longer being honored can contact Justice in Aging.

Your client's Medicare records and medical records are required to be private under federal law. They may only be shared under limited circumstances.

Eligibility for Medicare

A person's gender does not affect their eligibility for Medicare.[2] This includes cases where a person is eligible for Medicare through marriage-related Social Security benefits.

Choosing Medicare Coverage

Transgender older adults have unique health needs, so it is particularly important for them to carefully choose among their Medicare coverage options.[3] There are an array of coverage options in Medicare. The plan an individual chooses can impact whether they have access to the providers they need and trust and who will provide culturally competent care.

Affordability of prescription drugs also depends on plan choices. Individuals can assess their Medicare Advantage, Prescription Drug coverage, and Medigap options through the Medicare Plan Finder. The Medicare Plan Finder offers many details about plan options, including:

- The plan's premiums, deductibles, cost-sharing, and out-of-pocket maximum;
- Whether a medication is currently on the plan's formulary, and whether it is subject to prior authorization or other utilization management restrictions; and
- For supplemental benefits (e.g., vision, dental, in-home care), what limits and cost-sharing apply. Please note that some supplemental benefits are limited to a subset of enrollees; these eligibility limits may not appear on Medicare Plan Finder.

Provider directories can be found on plan websites, and may also appear on Medicare Plan Finder. Directories can be quite inaccurate; if there is a particular provider your client wants to see, it is a good idea to contact that plan and ask if that provider will be in-network.

Organizations are available to help individuals assess their options for Medicare coverage. State Health Insurance Assistance Programs (SHIPs) are local programs, funded by the federal government, which offer assistance to all Medicare enrollees.

Local SHIP counselors can help an individual decide what coverage will best ensure access to the health care providers and the prescription medications they need, at no cost to them. The national SHIP website, shiphelp.org, includes a locator to help find a local SHIP. Individuals can also call 877-839-2675 or email info@shiphelp.org.

Though Medicare Advantage plans may offer supplemental benefits, enrollees face narrow networks and more prior authorizations. If a person remains in Traditional Medicare, they can retain a wider provider network and experience fewer instances of prior authorizations. No one is required to enroll in a Medicare Advantage plan.

Discrimination in Health Care

Regardless of how one elects to receive their Medicare coverage, federal law protects individuals from discrimination based on sex by health entities or care providers who receive federal funds.[4] There may also be additional protections in state and local law.[5]

If your older adult client has experienced discrimination in health care, please contact Justice in Aging for technical assistance.

Access to Health Care through Medicare

Medicare enrollees are eligible for a wide range of health care services, outlined in the annual Medicare & You handbook and Medicare.gov.

Health Care Typically Provided to People of a Specific Gender

Medicare should not deny coverage for health care just because the care is typically provided to persons of a specific gender.[6] A gender identifier in Medicare's records showing your client as male, for example, cannot be the basis for denying coverage of a pelvic examination if it is medically appropriate for them.

Medicare has created a special billing code, condition code 45, for procedures that may be flagged as typically performed for individuals with a different sex marker. Your client's Medicare Advantage plan may require a different billing code in these circumstances. If your

client's provider uses this code in connection with these procedures, it can help avoid improper denials of coverage.[7]

Transition-Related Medications

Medically necessary hormones to address gender dysphoria can be covered under Medicare Part D.[8] These medications typically need prior authorization before coverage will be approved. When choosing a Medicare Advantage or standalone Prescription Drug Plan, your client can use the Medicare Plan Finder. If your client's plan does not cover a particular medication, there is an exceptions process available.[9]

Please note that many hormones to address gender dysphoria are prescribed "off-label," which means that the specific use has not been approved by the Food and Drug Administration. Medicare covers off-label uses only in limited circumstances.

Gender-Affirming Surgeries

Over ten years ago, the Department of Health and Human Services changed its policy and started covering medically necessary gender-affirming surgery.[10] Medicare approves coverage of medically necessary gender-affirming surgeries to address gender dysphoria on a case-by-case basis. The medical necessity standard is the same whether your client gets their Medicare coverage through Traditional Medicare (also referred to as Original Medicare) or through a Medicare Advantage plan.

Although determinations are on a case-by-case basis, Medicare looks to the guidelines contained in the World Professional Association for Transgender Health (WPATH) Standards of Care.[11] When supporting your client's request for Medicare coverage, their provider should address how their case meets WPATH standards. Your client must use providers who take Medicare. If your client is in a Medicare Advantage plan, they usually need to use providers who are in their plan's network or get permission to go outside of the network.

Appeals

If your client is denied coverage for any surgery, procedures, or drugs and believes the denial was incorrect, your client can file an appeal. Appeal processes are available whether your client is in Traditional Medicare or a Medicare Advantage plan, and whether the denial occurred after the care was provided or in a prior authorization decision before care was provided.

For more information on appeals, see CMS's Filing an Appeal and Medicare Rights Center's Appeal Basics. Getting the cooperation and support of your client's medical provider is important to a successful appeal. Individuals concerned with how they are being treated by a provider or a plan can also file a complaint.

Medicaid and Other Coverage

Individuals can be enrolled in Medicare and other coverage at the same time, including Medicaid, employer-sponsored insurance, and retiree coverage. These additional sources of coverage may also be a source of coverage for gender-affirming care and possibly offer additional non-discrimination protections. For example, currently over half of state Medicaid programs explicitly cover transgender care. The policies of most other states are silent, with a few explicitly banning coverage. A state's Medicaid policies do not affect an individual's right to any coverage under Medicare. For example, if a state bans transgender coverage

under Medicaid, Medicare enrollees in that state still have access to services through Medicare.

Endnotes

1. SSA Emergency Message 25014, Enumeration: Updated Instructions for Requests to Change Sex Field Data on the NUMIDENT (1/31/2025); see also SSA POMS RM 10212.200 Changing NUMIDENT Data for Reasons Other than Name Change (updated February 7, 2025); Advocates for Transgender Equity, Know Your Rights: Social Security; Chris Geidner, "Exclusive: Social Security "immediately" stopped making sex identification changes on Friday" (Feb. 1, 2025). ↑

2. See, e.g., SSA POMS RM 10212.200 Changing NUMIDENT Data for Reasons Other than Name Change (updated February 7, 2025) ("The sex field on the NUMIDENT should not be used to make any determination about initial or continuing benefit eligibility."). ↑

3. Generally speaking, a person can choose between (1) Traditional Medicare, with a standalone Prescription Drug Plan. Individuals on Traditional Medicare may want to enroll in a Medigap plan to cover cost-sharing; and (2) Medicare Advantage, a managed care option for Medicare. ↑

4. 42 U.S.C. § 18116. ↑

5. Movement Advancement Project, Healthcare Laws and Policies. ↑

6. The administration has moved to significantly reduce access to gender-affirming care for youth. On December 18, 2025, Secretary Kennedy signed a declaration finding that gender-affirming care for children and adolescents does not meet professionally recognized standards of health care. One day later on December 19, 2025, the Centers for Medicare & Medicaid Services (CMS) issued two notices of proposed rulemaking pertaining to gender-affirming care for children. The first would bar hospitals from performing such care on children as a condition of participation in Medicare and Medicaid, and the second would prohibit federal Medicaid funding for such care on children. The proposals are not finalized, and comments are due on February 27, 2026. While these actions do not prohibit the provision of gender-affirming care to older adults, they may indirectly limit access. ↑

7. Section 240 of Chapter 32 of the Medicare Claims Processing Manual. ↑

8. Sometimes, a medication is covered by Part B instead, including in some cases where the medication is injected by a medical profession, coverage for the medication may come through Medicare Part B. See CMS, Prescription Drugs (Outpatient). ↑

9. CMS, Exceptions Process. ↑

10. Prior to 2014, gender-affirming surgery was excluded because it was considered experimental. In 2014, this exclusion was eliminated. HHS DAB NCD 140.3, Transsexual Surgery (May 30, 2014). Though there is no national coverage determination for gender-affirming surgeries, coverage for surgeries is considered according to rules governing "reasonable and necessary" coverage on a case-by-case

basis. For more in-depth discussion, see Trans Maryland, Medicare Coverage of Gender-Affirming Surgery (May 2023). ↑

11. See Medicare Appeals Council Decision M-15-1069, finding WPATH to be a reasonable guideline in the absence of a national coverage determination or local coverage determination. ↑