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“Justice is What Love Looks Like in Public”: How the Affordable Care Act Falls Short on Transgender Health Care Access

Rachel C. Kurzweil

Washington and Lee University School of Law

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“Justice is What Love Looks Like in Public”¹: How the Affordable Care Act Falls Short on Transgender Health Care Access

Rachel C. Kurzweil*

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* Candidate for J.D., Washington and Lee University School of Law, May 2015; B.A. Mount Holyoke College, May 2010. I would like to thank my faculty advisor, Professor Timothy Jost, my friends and family, and the Editorial Board of the *Washington and Lee Journal of Civil Rights and Social Justice* for all of their support during the note writing process.

1. Zack Ford, *Laverne Cox: ‘Loving Trans People Is a Revolutionary Act,’* THINK PROGRESS, <http://thinkprogress.org/lgbt/2014/01/31/3235351/laverne-cox-loving-trans-people-revolutionary-act/> (last visited Jan. 31, 2014) (detailing a speech Cox gave at the National Conference on LGBT Equality hosted by the National Gay and Lesbian Task Force quoting philosopher Cornell West).

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Introduction

“Justice is what love looks like in public” is an oft-quoted statement from Cornell West that has become a catchphrase for the transgender rights movement.² No truer words could be spoken in regards to the treatment of transgender individuals in the United States, particularly in the realm of health care access. Few groups have faced as many limitations and instances of injustice in access to health treatment and coverage. The transgender community is one of the most vulnerable and underserved

2. *See id.* (explaining the transgender movement’s use of the Cornell West quote).

populations in the American Health Care system.³ Few groups confront as many barriers to health care as transgender patients. Transgender individuals are frequently denied access to health services because of their gender identity or expression, and many frequently report feeling harassed in medical offices and hospitals.⁴ Those who are able to locate transgender-favorable care often find they cannot access services due to lack of financial resources or insurance.⁵ Some transgender individuals face additional hurdles if they wish to undergo transition-related care, because most insurance policies exclude coverage for gender-confirming interventions and surgeries.⁶ Transition-related health care includes the use of psychotherapy, hormone therapy, and/or surgical procedures for treating the psychological diagnosis of gender dysphoria.⁷ An overwhelming majority of medical authority recognizes transition-related care as an effective and medically necessary treatment for gender dysphoria.⁸ Yet many providers and insurance companies refuse to treat or recognize the necessity of transition-related care. Further, the transgender population's lack of access to care is even more striking when one considers the group's

3. AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL HEALTHCARE DISPARITIES REPORT, 229–32 (2012), *available at* <http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/2013nhdr.pdf>.

4. *See* JAMIE M. GRANT ET AL., NAT'L CTR. FOR TRANSGENDER EQUALITY & NAT'L GAY & LESBIAN TASK FORCE, INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY, EXECUTIVE SUMMARY 73–74 (2011), *available at* http://www.endtransdiscrimination.org/PDFs/NTDS_Report.pdf (reporting that 19% of a national sample of transgender individuals had been refused care by a medical provider due to their transgender or gender-nonconforming status; 28% of respondents experienced verbal harassment in a medical setting; 2% were physically attacked in a doctor's office).

5. *Id.*

6. *See id.* at 77 (noting that high costs render care inaccessible to most transgender people).

7. *See* ELI COLEMAN ET AL., WORLD PROF'L ASSOC. FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER AND GENDER NONCONFORMING PEOPLE 9–10 (7th ed. 2012), *available at* http://www.wpath.org/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf (detailing different treatment procedures used to treat gender dysphoria and the triadic approach taken by the international medical community).

8. *See id.* at 5 (describing medical treatment options for gender dysphoria as medically necessary for many transgender individuals); *see also* Am. Med. House of Delegates, Res. No. 114, *Removing Barriers to Care for Transgender Patients* (June 16, 2008), *available at* http://www.tgender.net/taw/ama_resolutions.pdf (recognizing the World Professional Association for Transgender Health (WPATH) as the leading international, interdisciplinary professional organization devoted to the understanding and treatment of gender identity disorders).

elevated risk for a number of serious health problems, such as high rates of HIV and substance abuse problems.⁹

In the past two years, LGBT Americans have witnessed improvements in their rights. The Patient Protection and Affordable Care Act (ACA)¹⁰ and the Supreme Court’s decision in *United States v. Windsor*¹¹ have both significantly changed rights of access to health care and federal benefits for the LGBT community. The ACA is the most sweeping change in the United States Health Care system since the passage of the Medicaid and Medicare statutes in 1965.¹² In restructuring the health care system, the ACA creates a platform to improve access to medical care for the LGBT community and importantly, transgender individuals. Specifically, the ACA creates a means to secure explicit protections for gender confirming care and gender-confirming procedures. The ACA also puts an end to years of discriminatory insurance practices that have isolated and harmed LGBT individuals. But the ACA falls short in two areas: coverage and access for same-sex partners and transgender discrimination. This is not to say that health care access for the LGBT community has not been improved, but the American health care system has a long way to go, particularly in regards to healthcare access for transgender individuals.

This Note examines the current landscape of transgender health care, the changes sparked by the implementation of the ACA and the effect of *Windsor*, as well as the shortcomings in the ACA’s treatment of transgender healthcare access. Part I provides a background on Transgender and LGB health care issues. It will examine the type of medical care needed by the transgender community as well as barriers to access. Part II will address how the ACA and the Supreme Court’s decision on DOMA in *Windsor* affected LGBT healthcare access and delivery. This section will examine the improvements as well as the issues that still remain. Finally, Part III will address proposals that have been made to improve health care access for

9. See GRANT ET AL., *supra* note 4, at 80–83 (finding that 41% of transgender individuals have attempted suicide at one point in their life and that individuals experienced high rates of physical violence, sexual assault and HIV as well as above average rates of drug and alcohol abuse).

10. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

11. *United States v. Windsor*, 133 S.Ct. 2675 (2013).

12. See David Leonhardt, *In Health Bill, Obama Attacks Wealth Inequality*, N.Y. TIMES, Mar. 24, 2010, available at http://www.nytimes.com/2010/03/24/business/24leonhardt.html?_r=0 (asserting that the bill is the federal government’s biggest attack on economic inequality since inequality began rising more than three decades ago).

transgender individuals. These proposals include ending employment discrimination, clarifying medical necessity review standards, and reforming state Medicaid programs. This section will focus on the Employment Non-Discrimination Act and different insurance and health care related non-discrimination directives passed by the states. The section will also examine recent state department of health and state department of insurance notices that effectively eliminate transition-related health care coverage discrimination. This Note concludes by arguing that, overall, the ACA gives judges and policymakers a rare opportunity to redirect the way transgender health care is treated. This Note advocates that policy-makers should address transgender health care disparities by issuing further guidance on the ACA's nondiscrimination provisions, which will turn give advocates and judges the ability to enable and enforce positive changes to the health care system. How effective the ACA can be in expanding transgender-related health care access and addressing transgender specific health needs is dependent on the passage of further non-discrimination provisions.

I. Background on Transgender Health Care Issues

A. Definitions

“Transgender” is generally considered an umbrella term for people whose “gender identity, expression, or behavior is different from those typically associated with their assigned sex at birth.”¹³ The term includes but is not limited to transsexuals, cross-dressers, androgynous people, and gender non-conforming individuals.¹⁴ It is also important to distinguish transgender from the LGB community. Gender identity is one’s own, internal, personal sense of being a man or woman while sexual orientation describes a person’s enduring physical, romantic, and emotional attraction

13. See *Transgender 101*, GLAAD, <http://www.glaad.org/transgender/trans101> (last visited Feb. 6, 2013) (stating that “transgender is an umbrella term”) [hereinafter *Transgender 101*]; see also JOAN M. BURDA, GAY, LESBIAN, AND TRANSGENDER CLIENTS: A LAWYER’S GUIDE 156 (2008) (detailing a basic overview of transgender issues); see also NATIONAL CENTER FOR TRANSGENDER EQUALITY, TRANSGENDER TERMINOLOGY (2014), available at http://transequality.org/Resources/NCTE_TransTerminology.pdf (defining the term “transgender” and clarifying it as an umbrella term).

14. See NAT’L CTR. FOR TRANSGENDER EQUALITY, *supra* note 13 (defining terms transgender and transsexual).

to another person.¹⁵ Transgender people may be straight, lesbian, gay or bisexual.¹⁶

“Transsexual” is a specific classification that falls under the “transgender” umbrella that is used to describe individuals who have an internal gender identity that does not “match the sex assigned at birth.”¹⁷ Some transsexuals seek to rectify this condition through psychological help and many use hormone therapy or sex reassignment surgery (SRS) to correct their biological sex.¹⁸ In the United States, transsexuals must be diagnosed with some type of gender identity disorder in order to pursue medical treatment.¹⁹ The period during which a person begins living as the gender with which they identify rather than the gender they were assigned at birth is generally known as “transition.”²⁰ The transition period may or may not include medical and legal aspects such as taking hormones, having surgery, or changing identity documents.²¹ Not all transsexual individuals undergo transition-related surgery or other procedures; some transsexuals have no desire to do so and can successfully transition without it.²²

15. See *Transgender 101*, *supra* note 13 (stating that transgender is an identity not a sexual orientation).

16. *Id.*

17. *Id.*

18. See BURDA, *supra* note 13, at 156 (detailing a basic overview of transgender issues); see also NAT’L CTR. FOR TRANSGENDER EQUALITY, *supra* note 13 (defining the term “transgender” and explaining that transition may include medical and legal aspects such as changing one’s name on a driver’s license).

19. See *Transgender Rights Toolkit: Transition-Related Health Care*, LAMBDA LEGAL, http://www.lambdalegal.org/sites/default/files/publications/downloads/trt_transition-related-health-care_3.pdf (last visited Feb. 23, 2014) (detailing how individuals obtain transition-related care and that any form of hormone treatment or surgery requires a medical diagnosis; see also AM. PSYCHIATRIC ASSOC., *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (5th ed. 2013); see also AM. PSYCHIATRIC ASS’N., *Gender Dysphoria Fact Sheet* (2013), available at <http://www.dsm5.org/Documents/Gender%20Dysphoria%20Fact%20Sheet.pdf> [hereinafter *DSM-V Fact Sheet*] (stating that part of the motivation for changing the diagnostic term from gender identity disorder to gender dysphoria was to create a term that is less discriminatory while still providing a diagnostic term that is necessary for treatment and insurance coverage).

20. See NAT’L CTR. FOR TRANSGENDER EQUALITY, *supra* note 13 (defining “transition” as the time when a person begins living as the gender with which they identify rather than the gender they were assigned at birth, which often includes changing one’s first name and dressing and grooming differently).

21. *Id.*

22. See *Transgender Equality*, HUMAN RIGHTS CAMPAIGN, <http://www.hrc.org/resources/entry/transgender-faq> (last visited Feb. 23, 2014) (stating that

Additionally, there are a variety of terms used to address transgender individuals post transition. According to the National Center for Transgender Equality, “transgender man,” is generally adopted a term for a transgender person who currently identifies as a man; while “transgender woman” describes a transgender person who currently identifies as a woman.²³

Gender Identity Disorder (GID) is the previous diagnostic term used for transsexuals seeking medical remedies to their discontent with their assigned sex.²⁴ GID was defined in the American Psychiatric Diagnostic Manual of Mental Disorders IV (DSM-IV).²⁵ The DSM-IV focused on two components that must present to make a GID diagnosis: there must be evidence of a strong and persistent cross-gender identification and there must be evidence of persistent discomfort about one’s assigned sex or a sense of inappropriateness in the gender role of that sex.²⁶ The DSM-IV also lists specific diagnostic criteria for GID: (1) a strong and persistent cross-gender identification, (2) persistent discomfort with his or her sex, (3) the disturbance is not concurrent with a physical intersex condition, (4) the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.²⁷

The GID diagnosis was generally disliked by the transgender community because it made being transgender seem like a mental disorder, which included a stigma and represented a lack of understanding about the condition.²⁸ Beginning in 2010, there was a move by transgender advocates

many people can successfully transition without surgery—some have no desire to pursue surgeries or medical intervention); see also *LGBT Resources: Definition of Terms*, UC BERKELEY GENDER EQUITY RESOURCE CTR., http://geneq.berkeley.edu/lgbt_resources_definition_of_terms#transman (last visited Feb. 23, 2014) (stating that not all individuals choose to transition).

23. See NAT’L CTR. FOR TRANSGENDER EQUALITY, *supra* note 13 (defining transgender man).

24. See AM. PSYCHIATRIC ASSOC., *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 576–82 (4th ed. 2000), available at https://www.aclu.org/files/images/asset_upload_file155_30369.pdf. [hereinafter DSM-IV] (providing standard criteria for the classification of mental disorders).

25. *Id.* at 576.

26. *Id.* at 576–77.

27. *Id.*

28. See Wynne Parry, *Gender Dysphoria: DSM-5 Reflects Shift in Perspective On Gender Identity*, HUFFINGTON POST (June 4, 2013), http://www.huffingtonpost.com/2013/06/04/gender-dysphoria-dsm-5_n_3385287.html (noting that transgender advocates have pointed out that distress is not an inherent part of

to change the definition in the DSM.²⁹ Jack Drescher, a member of the American Psychological Association (APA) committee tasked with changing the definition of GID, told advocates that his subcommittee’s recommendation came from a desire to stop “pathologiz[ing] all expressions of gender variance just because they were not common or made someone uncomfortable.”³⁰ Drescher also acknowledged that “all psychiatric diagnoses occur within a cultural context . . . [W]e know there is a whole community of people who are not seeking medical attention and live between the two binary categories.”³¹ In changing the diagnosis for transgender individuals the APA was taking a needed step for providing a means for treatment for transgender individuals who wish to undergo transition-related care, while also removing the stigma that often comes with calling something a disorder.

The new edition of the DSM released in 2013, the DSM-V, changed the diagnostic term for GID to “Gender Dysphoria.”³² Gender dysphoria (“GD”) is now used to describe a person whose gender at birth is contrary to the one they identify with.³³ For a person to be diagnosed with gender dysphoria there must be a marked difference between the individual’s expressed or experienced gender and the gender others would assign him or her and it must continue for at least six-months.³⁴ The DSM-V states that this condition/state can manifest in a variety of ways; including strong

being transgender, setting it apart from many other disorders in the DSM); *see also* J. Bryan Lowder, *Being Transgender is No Longer a Disorder*, SLATE (Dec. 3, 2012), http://www.slate.com/articles/health_and_science/medical_examiner/2012/12/dsm_revision_and_sexual_identity_gender_identity_disorder_replaced_by_gender.html (discussing the transgender community’s response to reports that the APA approved changes to the DSM).

29. *See* Lowder, *supra* note 28 (explaining how advocates moved to get a change to the DSM-IV).

30. *See id.* (discussing the APAs move to change the DSM GID definition to “gender dysphoria” and removing the term “disorder” as a crucial step in ending the belief that transgenderism is a disorder).

31. *Id.*

32. *See DSM-V Fact Sheet, supra* note 19 (explaining that the DSM determines how mental disorders are defined and diagnosed and how the new diagnostic terms are meant to avoid stigma and ensure clinical care for individuals who feel themselves to be a different gender than their assigned gender).

33. *See DSM-V Fact Sheet, supra* note 19 (explaining that gender dysphoria replaces “gender identity disorder” to describe individuals who see themselves to be a different gender than their assigned gender).

34. *See DSM-V Fact Sheet, supra* note 19 (emphasizing that the individual must suffer distress with their current assigned gender for at least six-months).

desires to be treated as the other gender or to be rid of one's sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender.³⁵ The DSM-V also adds a post-transition "specifier"³⁶ for people who are living full-time in their specified gender.³⁷

The new definition is crucial because, as emphasized by many advocates, transgender identity is not a mental illness.³⁸ The change resembles the elimination of homosexuality from the DSM forty years ago, when the psychological community recognized that one can be homosexual and psychologically healthy or vice versa, homosexuality itself was not the diagnosed condition.³⁹ The GID definition focused on the "identity" issue and the incongruity between someone's birth gender and the gender with which he or she identifies.⁴⁰ Though the incongruity element is still crucial to the definition of gender dysphoria, the DSM-V now emphasizes the importance of *distress* about the incongruity for diagnosis.⁴¹ Changing the definition was crucial for persons requiring diagnostic treatment of gender

35. See *DSM-V Fact Sheet*, *supra* note 19 (stating that gender dysphoria manifests in different ways and the diagnosis is fact based and patient specific).

36. "Specifier" is a medical term of art used in the DSM-V. The post-transition specifier has been added because after gender transition many people no longer meet criteria for gender dysphoria, but still remain in need of treatments to improve life in the desired gender and this specifier recognizes that need. AM. PSYCHIATRIC ASS'N, HIGHLIGHTS OF CHANGES FROM DSM-IV-TR TO DSM-5 (2013), available at <http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf>.

37. See *id.* (stating that the specifier is meant to ensure treatment access for individuals to undergo hormone therapy, related surgery, and psychotherapy or counseling to support their gender transition).

38. See Parry, *supra* note 28 (emphasizing that gender dysphoria and being transgender is not a mental illness, but realizing that the need for some form of diagnosable condition is required for treatment and care); see also Lowder, *supra* note 28 (discussing how the transgender community felt that gender identity disorder created a stigma against transgender individuals).

39. See *id.*, at 576–77 (quoting Robin Rosenberg, a clinical psychologist and author).

40. See *id.* (explaining how the shift in diagnosis is crucial to understanding the difference between being transgender and having gender dysphoria). The new definition reflects recognition that the disagreement between birth gender and identity may not be pathological if it does not cause the individual distress. *Id.* Many transgender people are not distressed by their cross-gender identification and should not be diagnosed with gender dysphoria. *Id.* This new diagnosis is important because transgender people have often pointed out that distress in gender dysphoria is not an inherent part of being transgender—which is unique from many other disorder in the DSM because much of the distress that accompanies gender dysphoria arises as a result of a culture that stigmatizes people who do not conform to gender norms. *Id.*

41. *Id.*, at 576–77.

dysphoria because it simplified the standards that must be met in order for an individual to receive medical treatment.⁴² These individuals needed a term that protects their access to care and that will not be used against them in social, occupational, or legal areas.⁴³

B. Transgender Health Care Needs

Transgender individuals have various health care needs that must be met. Transgender individuals require basic health care check-ups and screenings such as Pap smears and prostate cancer screenings, which are generally based on a person’s gender marker on their insurance contract.⁴⁴ Apart from general health requirements such as check-ups and disease treatment, individuals with gender dysphoria require specific treatment for their diagnosis.⁴⁵ Treatment for transsexual individuals diagnosed with gender dysphoria includes counseling, cross-sex hormones, gender reassignment surgery, and social and legal transition to the desired gender.⁴⁶

The DSM-V definition outlines the common treatments for gender dysphoria.⁴⁷ Generally, gender dysphoria treatment involves a combination of “triadic” therapy, hormone therapy, sex reassignment surgery, and/or “real life experience.”⁴⁸ Real life experience is an extended period of time during which a patient must live in his or her preferred gender role.⁴⁹ Real

42. *Id.*; see also *DSM-V Factsheet*, *supra* note 19 (explaining how changing the diagnostic definition was crucial for acceptance and treatment of transgender individuals with gender dysphoria).

43. Parry, *supra* note 28, at 576–77.

44. See *Health Insurance Discrimination for Transgender People*, HUMAN RIGHTS CAMPAIGN, <http://www.hrc.org/resources/entry/health-insurance-discrimination-for-transgender-people> (last visited Feb. 23, 2014) (describing how transgender individuals are discriminated against in the health care market, most health insurance contracts are written in a way that can deny transgender people coverage irrespective of whether those needs are related to transitioning).

45. See *id.* (stating that not all transgender people have the same medical needs—they may have already transitioned or choose not to transition at all).

46. See *DSM-V Fact Sheet*, *supra* note 19 (explaining treatment for gender dysphoria that is endorsed by the APA).

47. See *id.* (detailing triadic care system used to treat gender dysphoria).

48. See *id.*; see also RACHEL ANN HEATH, *THE PRAEGER HANDBOOK OF TRANSSEXUALITY: CHANGING GENDER TO MATCH MINDSET* 80 (Judy Kuriansky ed., 2006) (stating that the real-life experience is often for a minimum of twelve months but can be extended up to two years).

49. See RACHEL ANN HEATH, *THE PRAEGER HANDBOOK OF TRANSSEXUALITY:*

life experience is used to test whether there is further consolidation of gender identity in the patient.⁵⁰ This practice is coupled with psychotherapy, which helps to further the goal of a stable lifestyle for the patient.⁵¹ The goal of combining the triadic therapies is to illuminate the patient's history and his or her current expectations, ensure that the patient actually wants to undergo reassignment, and to ensure that the patient is psychologically prepared change genders.⁵²

Each patient must be evaluated on a case-by-case basis with expert medical judgment required for both reaching a diagnosis and determining a course of treatment.⁵³ After the patient has begun the real-life experience and undergone a period of psychotherapy, a physician may prescribe hormone treatment.⁵⁴ Hormones are administered over a period of time before, during, and after sexual reassignment surgery.⁵⁵ Hormone therapy, though a necessary part of treatment for gender dysphoria, poses numerous medical risks and should always be supervised by a physician.⁵⁶ Estrogen can increase blood pressure, blood sugar, and cause blood clotting.⁵⁷ Anti-androgens can lower blood pressure, disturb electrolytes, and dehydrate the body.⁵⁸ Hormone therapy can also have adverse effects on

CHANGING GENDER TO MATCH MINDSET 80 (Judy Kuriansky ed., 2006) (stating that the real-life experience is often for a minimum of twelve months but can be extended up to two years).

50. See WORLD PROF'L ASSOC. FOR TRANSGENDER HEALTH, *supra* note 7.

51. See *id.*, at 12 (noting that the goal of treatment is not to cure GID but to provide a stable lifestyle with realistic chances for relationships and other gender identity expression).

52. See WORLD PROF'L ASSOC. FOR TRANSGENDER HEALTH, *supra* note 7, (outlining the process of psychotherapy and the goals of combining this treatment with real life experience).

53. See *DSM-V Fact Sheet*, *supra* note 19 (stating that diagnosis and treatment considerations and decisions are dependent on fact-specific issues concerning the patient in question such as physician health and psychological history).

54. See HEATH, *supra* note 48, at 113 (noting the different hormones available for men and women who wish to change sex).

55. See *id.* (outlining the SRS procedure and that hormone therapy is not only a crucial part but is an ongoing form of treatment).

56. See *Key Transgender Health Concerns, LGBTI Health*, VAND. U. MED. CTR., <https://medschool.vanderbilt.edu/lgbti/health/transgender> (last visited Dec. 5, 2014) (explaining the medical problems that can arise from hormone use and noting that persons who wish to use hormones should only do so under the supervision of a doctor who can prescribe appropriate doses and monitor its effects).

57. See *id.* (stating the possible negative side effects of transition-related hormone therapy).

58. See *id.* (detailing different effects of SRS).

liver functions and cause hyperprolactinemia—a disorder of the pituitary gland that results in an excess secretion of prolactin.⁵⁹ If left untreated, many of the adverse side effects cause further medical problems for patients undergoing transition and require additional medications.⁶⁰ Thus, the treating physician plays a crucial role for individuals who wish to undergo transition-related procedures. Physicians are necessary to monitor different treatments, to ensure that individuals remain healthy throughout treatment, and to make sure that adverse side effects of hormone treatment and surgery are well monitored.

In addition to hormone therapy, the final part of triadic therapy is sex reassignment surgery (SRS).⁶¹ SRS can include a number of different procedures.⁶² For transgender women,⁶³ one possible procedure is a vaginoplasty, which involves the creation of a vagina using both penile skin and a urethral flap.⁶⁴ For transgender men,⁶⁵ phalloplasty is often performed—a procedure that is done to create a penis.⁶⁶ Transsexual men can also receive a hysterectomy, vaginectomy, and mastectomy.⁶⁷ Transsexual individuals can also receive treatment in the form of speech therapy, voice box surgery, and facial feminization therapy.⁶⁸

Like any extensive medical procedure, the entire transition process is costly. In 2001 the average cost for male to female SRS was over \$10,000—with prices of well-known surgeons ranging from \$4,500–

59. See HEATH, *supra* note 48, at 116 (providing examples of different adverse effects hormones can have); see also *Hyperprolactinemia*, JOHNS HOPKINS MED. http://www.hopkinsmedicine.org/neurology_neurosurgery/specialty_areas/pituitary_center/conditions/hyperprolactinemia.html (last visited Feb. 23, 2014) (defining the different symptoms of hyperprolactinemia which can include tumors, loss of libido, impotency, and infertility—and outlining that treatment is based on factors such as age and medical history sometimes it is treated through drug therapy while other times surgical intervention is required).

60. *Id.*

61. See *id.* at 116 (stating that not all transsexuals engage in surgery).

62. *Id.* at 124.

63. Man who identifies and transitions into being a woman.

64. See HEATH, *supra* note 48, at 124–29 (detailing surgical procedure of a vaginoplasty).

65. Woman who identifies and transitions into being a man.

66. See HEATH, *supra* note 48, at 116 (describing methods for a phalloplasty).

67. See *id.* at 134–37 (describing the different surgery options for transsexual men).

68. See *id.* at 141–54 (outlining additional procedures available to transsexual patients).

\$26,000 for male to female surgeries.⁶⁹ Conversely, female to male surgeries generally range from \$4,000–\$60,000 and averaged \$18,000 in 2001.⁷⁰ Recent statistics show that costs have not changed much. Hormones cost approximately \$100 per month and therapy is about \$100 per session.⁷¹ Surgeries typically cost between \$7,000 and \$50,000, and some phalloplasties can cost upward of \$100,000.⁷² Most health insurance—both public and private—will cover basic health care needs, but generally do not cover transition procedures.⁷³

C. Consequences of Inability to Obtain Health Care

Inability to obtain proper treatment for gender dysphoria can have many negative consequences for transsexual individuals, but they are not the only ones who suffer from exclusions.⁷⁴ Transgender individuals are also excluded from basic health care access because of lack of insurance or refusal of providers to render services.⁷⁵ Instances of transgender discrimination in health care have ranged from degradation to outright to

69. See Chad Ayers, *The Need for Change: Evaluating the Medical Necessity of Gender Reassignment Through International Standards*, 18 WASH. & LEE J. CIVIL RTS. & SOC. JUST. 351, 358–59 (2012) (citing Mary Ann Horton, *The Cost of Transgender Health Benefits*, OUT & EQUAL WORKPLACE SUMMIT (Sept. 2008), <http://www.tgender.net/taw/thb/THBCost-OE2008.pdf> (citations omitted)) (surveying prices for transition surgeries among different physicians).

70. See *id.* (explaining a survey sent to surgeons in order to estimate costs).

71. See Blake Ellis, *Transgender and Struggling to Pay Medical Costs*, CNN MONEY (Aug. 22, 2013), <http://money.cnn.com/2013/08/22/pf/transgender-medical-costs/> (stating that transition procedures such as hormones and therapy are a continuous cost); see also *Recommendations for Transgender Health Care*, TRANSGENDER L. CTR., <http://www.transgenderlaw.org/resources/tlchealth.htm> (last visited Feb. 25, 2014) (stating that transition-related procedures are costs and as a result many transgender people cannot obtain medically necessary treatments because they cannot afford to pay them).

72. *Id.*

73. See *Resources: Health Insurance Discrimination for Transgender People*, HUMAN RIGHTS CAMPAIGN, <http://www.hrc.org/resources/entry/health-insurance-discrimination-for-transgender-people> (last visited Jan. 1, 2013) (stating that health care covers general needs like check-ups but will not cover procedures if they are designated for transition-related procedures).

74. See Am. Med. House of Delegates, *supra* note 8, at 1 (explaining the effects of not providing access to procedures for transsexual individuals with GID).

75. See GRANT ET AL., *supra* note 4, at 72–84 (detailing how health care providers discriminate against transgender individuals by refusing to treat them, whether or not they have undergone a transition).

refusals to provide care that results in poor health outcomes for transgender people.⁷⁶ Rather than endure abuse and poor treatment, transgender people often go without health care.⁷⁷

Similar to everyone else, transgender individuals need acute care when they are sick and preventative care to keep from getting sick, including gender-specific services such as Pap-smears and prostate exams.⁷⁸ Transgender people may even need a mix of different preventative health screening procedures.⁷⁹ For example, a transgender woman may require a mammogram and a prostate exam, depending on what stage of the transition process she is in.⁸⁰ Access to basic health care such as physician services impacts overall physical, social, and mental health status, the prevention of diseases and disability, quality of life, preventable death, life expectancy, and the detection and treatment of health conditions.⁸¹ Thus, disparities in access to health services impact transgender individuals’ ability to reach their full potential while also affecting their quality of life.⁸² Further, many treatable medical conditions become emergency medical conditions, which strains the health care system when individuals are uninsured and require treatment they cannot afford.⁸³

Though there are no transgender specific diseases, there are numerous health disparities that directly affect the transgender and LGB population. Sexually transmitted infections, including HIV, are major concerns among

76. *See id.* at 6 (summarizing refusal or care rates and poor health outcomes).

77. LAMBDA LEGAL, CREATING EQUAL ACCESS TO QUALITY HEALTH CARE FOR TRANSGENDER PATIENTS: TRANSGENDER-AFFIRMING HOSPITAL POLICIES 2, *available at* http://www.lambdalegal.org/sites/default/files/publications/downloads/fs_transgender-affirming-hospital-policies.pdf (last visited Dec. 5, 2014) (on file with the Washington & Lee Journal of Civil Rights and Social Justice).

78. Kellan Baker & Andrew Cray, *Why Gender-Identity Nondiscrimination in Insurance Makes Sense*, CTR. FOR AM. PROGRESS, 2 (May 2, 2013), *available at* <http://www.americanprogress.org/wp-content/uploads/2013/05/BakerNondiscriminationInsurance-6.pdf>.

79. *Id.*

80. *See id.* (examining different health disparities faced by transgender individuals).

81. *See Access to Health Services*, HEALTHY PEOPLE, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1> (last visited Feb. 26, 2014) (describing new federal program created to address health access issues and limit disparities in access).

82. *See id.* (elaborating on the effects that limited access to health care has on individuals in general while also noting that the LGBT community has some of the most limited access).

83. *See* LAMBDA LEGAL, *supra* note 77, at 2.

some LGBT groups, particularly male-to-female transgender persons.⁸⁴ Data on HIV rates in transgender persons is sparse, but a recent systematic review estimated a HIV prevalence of 28% in male-to-female transgender persons.⁸⁵ Transgender individuals are also susceptible to the same health disparities as other LGB individuals such as high rates of substance abuse and mental disorders.⁸⁶ Members of the LGBT population are approximately twice as likely to smoke as the general population and more susceptible to drug abuse—though studies have been conflicting.⁸⁷

Not only are there psychological ramifications that result from feeling as if one is the wrong gender, many transsexuals who are unable to undergo any form of transition therapy often turn to negative coping mechanisms.⁸⁸ The American Medical Association (AMA), the American Psychiatric Association, and the World Health Organization have all recognized gender dysphoria as a serious medical condition.⁸⁹ The AMA specifically states that GID—now gender dysphoria—if left untreated, “can result in clinically significant psychological distress, dysfunction, debilitating depression, and, for some people without access to appropriate medical care and treatment, suicidality and death.”⁹⁰ The National Center for Transgender Equality and the National Gay and Lesbian Task Force conducted a survey in 2010 and found that participants used drugs and alcohol as a coping mechanism for dealing with discrimination and depression; while 41% of respondents said

84. KEVIN L. ARD & HARVEY J. MAKADON, THE FENWAY INST., IMPROVING THE HEALTH CARE OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER PEOPLE: UNDERSTANDING AND ELIMINATING HEALTH DISPARITIES 3 (2012), available at http://www.lgbthealtheducation.org/wp-content/uploads/12-054_LGBHealtharticle_v3_07-09-12.pdf.

85. See *id.* at 4 (referencing Jeffrey H. Herbst et al., *Estimating HIV Prevalence and Risk Behaviors of Transgender Persons in the United States: A Systematic Review*, 12 AIDS BEHAV. 1–17 (2008)).

86. *Id.* at 4.

87. See *id.* (referencing Y. Song et al., *Substance Use and Abuse*, in HARVEY J. MAKADON ET AL., THE FENWAY GUIDE TO LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH 209–47 (2008)).

88. NCTE, *infra* note 110, at 6.

89. See Baker & Cray, *supra* note 78, at 5 (referencing publications by the AMA, APA, and WHO which suggest the removal of barriers to transition-related health care and these organizations’ acceptance that gender identity disorder requires treatment).

90. Am. Med. House of Delegates, *supra* note 8, at 2 (citing AM. PSYCHIATRIC ASSOC., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 576–82 (4th ed. 2000)).

they had attempted suicide.⁹¹ Thus, there is a significant need for improved transgender health care access.

D. Barriers to Care

Access and discrimination go hand-in-hand as discrimination has historically led to limited access and inadequate care for the LGB and Transgender community. The main barriers to care are employment discrimination against transgender individuals, lack of employment insurance coverage for transition-related care, insurance discrimination based on transgender status, and lack of insurance coverage for transition-related care. These barriers to care are found in both private and government provided health insurance programs.

1. Employment and Workplace Discrimination Limit Transgender Access to Care

Workplace and employment discrimination limits health care access for transgender individuals because most Americans who are insured are covered through employment based insurance.⁹² Twenty-nine states do not have sexual orientation nondiscrimination laws and thirty-four do not have gender nondiscrimination laws.⁹³ Some state sexual orientation and gender nondiscrimination laws outlaw employment discrimination, but not public

91. See GRANT ET AL., *supra* note 4, at 64–65 (detailing different and dangerous coping mechanisms used by transsexuals).

92. *Id.*

93. See Andrew Cray & Kellan Baker, *The Affordable Care Act: Progress Toward Eliminating Insurance Discrimination Against Transgender People*, CTR. FOR AM. PROGRESS (May 30, 2013), <http://www.americanprogress.org/wp-content/uploads/2013/05/CrayNonDiscrimIns-facts.pdf> (stating which states do and not have gender non-discrimination laws); see also Assistant Secretary for Health, *Recommended Actions to Improve the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Communities*, U.S. DEPT. OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/lgbt/health.html> (last updated January 2012); see also Sean Cahill, *Fenway Comments On HHS's Rulemaking for the Nondiscrimination Requirements in Section 1557 of the Affordable Care Act*, THE FENWAY INST. (Oct. 15, 2013), <http://fenwayfocus.org/2013/10/fenway-comments-on-hhss-rulemaking-for-the-nondiscrimination-requirements-in-section-1557-of-the-affordable-care-act/>.

accommodation discrimination, leaving LGBT, particularly transgender, individuals vulnerable to discrimination.⁹⁴

Lack of employment opportunity not only impedes transgender and transsexual individuals' ability to obtain care through insurance, but also inhibits individuals' ability to pay for general health care and transition-related care.⁹⁵ A 2011 national survey of transgender individuals conducted by the National Center for Transgender Equality and the National Gay and Lesbian Task Force found that respondents experienced unemployment at twice the rate of the general population and 47% said they had experienced an adverse job outcome such as being fired, not hired, or denied a promotion for being transgender or gender non-conforming.⁹⁶ Further, many transgender individuals drop out of school before finishing high school due to lack of uniform anti-discrimination policies.⁹⁷ The study also found that respondents who had lost a job due to bias also experienced ruinous consequences such as four times the rate of homelessness, 85% more incarceration, and more than double the HIV infection rate compared to those who did not lose a job due to bias.⁹⁸ These statistics show not only continued transgender discrimination in the employment landscape but also that this discrimination has adverse effects on transgender health.

Prior to the ACA, transgender individuals could be denied coverage irrespective of whether their health needs were related to transitioning.⁹⁹

94. *See id.* (There is a general ban on discrimination on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases, or operates a place of public. 42 U.S.C. § 12182 (1990). All persons are also entitled to equal enjoyment of goods, services, facilities, privileges, advantages, and accommodations of any place of public accommodation, without discrimination or segregation on the ground of race, color, religion, or national origin. 42 U.S.C. § 2000(a). Though there are prohibitions based on grounds of disability or race or religion, there is no accommodation law for LGBT status, which still allows for employer discrimination).

95. *See id.* (detailing the effects of a lack of ability to obtain employment); *see also* Jeffrey Young, *Transgender Americans Struggle for Coverage as U.S. Lags 'Far Behind' Even Iran*, THE HUFFINGTON POST, (Aug. 22, 2012) http://www.huffingtonpost.com/2013/08/22/transgender-coverage_n_3797843.html.

96. GRANT ET AL., *supra* note 4, at 2.

97. *See* DEAN SPADE, COMPLIANCE IS GENDERED: STRUGGLING FOR GENDER SELF-DETERMINATION IN A HOSTILE ECONOMY 217, 218–19 (Paisley Currah et al., eds., 2006), *available at* http://www.deanspade.net/wp-content/uploads/2010/07/compliance_iscgendered1.pdf [hereinafter COMPLIANCE IS GENDERED] (stating that much of the economic and educational discrimination against transgender individuals remains legal).

98. GRANT ET AL., *supra* note 4, at 3.

99. *Resources: Health Insurance Discrimination for Transgender People*, *supra* note

The ACA has now established non-discrimination provisions that HHS specified prohibits denial of coverage for transgender individuals based on their health status or preexisting conditions.¹⁰⁰ Though this is a step in the right direction, discrimination against LGB and transgender individuals remains prominent in the health insurance industry. The vast majority of commercial health insurance plans in the U.S. exclude all or most coverage for treatment related to gender transition.¹⁰¹ This “transgender exclusion” denies coverage for treatments such as psychological counseling for initial diagnosis and ongoing transition assistance, hormone replacement therapy, and surgeries related to sex reassignment.¹⁰² The exclusion generally exists unless an employer, or the state in the case of public health programs, specifies that they will cover procedures used in transition-related care or specifically cover gender transition procedures.¹⁰³

Many employers do not want to cover transition-related care out of fear that doing so will raise the cost of insurance premiums.¹⁰⁴ Recent data

73.

100. See U.S. DEPT. OF HEALTH & HUMAN SERVS., *Section 1557 of the Patient Protection and Affordable Care Act*, HHS.GOV, <http://www.hhs.gov/ocr/civilrights/understanding/Section%201557/index.html> (last visited Nov. 19, 2013) (explaining the non-discrimination provision of the ACA); see also *An Overview of Section 1557, Nondiscrimination Standards, and the Affordable Care Act: A Tool for Stakeholders*, NAT'L. WOMEN'S LAW CTR. (2013), available at http://www.nwlc.org/sites/default/files/pdfs/final_nwlc_aca_nondiscrimination_guide.pdf [hereinafter *An Overview of Section 1557*]; see also 42 C.F.R. §155.120(c)(2014) (“In carrying out the requirements of this part, the State and the exchange must: (1) Comply with applicable non-discrimination statutes; and (2) Not discriminate based on race color, national origin, disability, age, sex, gender identity or sexual orientation.”).

101. See *Resources: Health Insurance Discrimination for Transgender People*, *supra* note 73 (explaining that a majority of health insurance plans exclude transition related treatment).

102. *Id.*; see also Shannon Minter, *Representing Transsexual Clients: Selected Legal Issues*, NAT'L CTR. FOR LESBIAN RIGHTS (2003), [http://www.transgenderlaw.org/resources/translaw.htm#_ftnref49&__utma=149406063.1289414064.1380831485.1388605885.1388611341.11&__utmb=149406063.0.10.1388612339&__utmc=149406063&__utmz=149406063.1388359941.9.8.utmcsr=google|utmccn=\(organic\)|utmcmd=organic|utmctr=\(not%20provided\)&__utmv=-&__utm=191722922](http://www.transgenderlaw.org/resources/translaw.htm#_ftnref49&__utma=149406063.1289414064.1380831485.1388605885.1388611341.11&__utmb=149406063.0.10.1388612339&__utmc=149406063&__utmz=149406063.1388359941.9.8.utmcsr=google|utmccn=(organic)|utmcmd=organic|utmctr=(not%20provided)&__utmv=-&__utm=191722922) (last visited Oct. 22, 2014) (detailing the different treatment options for transgender individuals).

103. Minter, *supra* note 102.

104. See *FAQ About Health Provider Discrimination*, LAMBDA LEGAL, <http://www.lambdalegal.org/know-your-rights/transgender/health-provider-discrimination-faq> (last visited Oct. 31, 2013) [hereinafter *Lambda Provider Discrimination*] (explaining that insurers fear coverage for transition related care will increase insurance premiums).

has shown that this is not the case because gender dysphoria is rare.¹⁰⁵ Data from San Francisco, which was the first U.S. city to provide insurance coverage for gender dysphoria related care for public employees in 2001, found that the change would not raise costs for municipal employees.¹⁰⁶ Since San Francisco released its report, Portland and Multnomah County, Oregon, Seattle and Minneapolis have followed suit.¹⁰⁷ Additionally, according to the Human Rights Campaign, a growing number of larger and Fortune 500 Companies have started offering transition-related care for transgender employees.¹⁰⁸

2. Discrimination by Private Insurance Companies

As a result of employment discrimination and/or an inability to obtain insurance through an employer, many transsexual individuals rely on individual or personal insurance¹⁰⁹ in order to fund transition-related care.¹¹⁰ Though this is a feasible means to obtain coverage, many transgender individuals face the additional hurdle of an inability to access economic and educational opportunities due to discrimination, which limits

105. *Id.*

106. *Id.* see also *FAQ on Access to Transition Related Care*, LAMBDA LEGAL, <http://www.lambdalegal.org/know-your-rights/transgender/transition-related-care-faq> (last visited Jan 1, 2013) (explaining the survey and how the surcharge that employees had been paying to cover the policy change was reduced to zero; there was no need to take in the extra money, because the cost of covering these claims was so negligible); see also J. Denise Diskin, *Taking it to the Bank: Actualizing Health Care Equality for San Francisco's Transgender City and County Employees*, 5 HASTINGS RACE & POVERTY L.J. 129, 154 (2008).

107. *Lambda Provider Discrimination*, *supra* note 104.

108. *See id.* (identifying the Human Rights Campaign survey).

109. Private insurance is referring to insurance the individual purchases with their own funds. It is not provided through public health care programs or through employer based coverage. Private insurance is often more expensive and has more limited coverage than employer based plans.

110. See Jaime M. Grant et al., *Nat'l Transgender Discrimination Survey Report on Health and Health Care*, THE NAT'L CTR. FOR TRANSGENDER EQUAL. & THE NAT'L GAY AND LESBIAN TASK FORCE, at 5 (Oct. 2010), available at http://transequality.org/PDFs/NTDSReportonHealth_final.pdf [hereinafter NCTE] (stating that 19% of the transgender population sampled reported being refused medical care due to their transgender or gender non-conforming status). It is important to note that here, private insurance is differentiated from employer-based care. Here, the term is meant to represent insurance that is purchased privately by individuals, not which is provided through one's employment.

their inability to afford their health care needs.¹¹¹ As a result, a large portion of the transgender community faces financial hardships that make affording private insurance nearly impossible.¹¹² Even if an individual can afford private health insurance, or receives private health insurance through their employer, there are still additional obstacles of discrimination and exclusion procedures.¹¹³ Traditionally, insurers have relied on their ability to deny coverage for pre-existing conditions as a way to deny coverage of transition-related care.¹¹⁴ Provisions in the ACA, which bar insurance companies from denying coverage based on preexisting conditions, have generally eliminated this practice.¹¹⁵ The ACA does not prevent insurance companies from excluding certain types of medical procedures on the basis that they are not medically necessary or are cosmetic.¹¹⁶

Appealing insurance company decisions is often difficult for transgender individuals because private insurance is governed by contract law.¹¹⁷ Thus it is up to the individual to ensure that the plan he or she purchases includes gender transition care.¹¹⁸ Most insurance companies

111. See COMPLIANCE IS GENDERED, *supra* note 97, at 218–19 (stating that much of the economic and educational discrimination against transgender individuals remains legal).

112. See *id.* at 219 (stating that harassment is widespread in schools and higher education and that transgender people face severe discrimination in the job market and are routinely fired for transitioning on the job of whether the genders identities come to their supervisor’s attention).

113. See Liza Khan, *Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform*, 11 YALE J. HEALTH POL’Y, L. & ETHICS 375, 398 (2011) (detailing the different forms of discrimination that occur in the private insurance setting such as denial of claims as experimental or denial of procedures based on preexisting conditions).

114. *Id.* at 398–400.

115. See ACLU KYR, *infra* note 116 (discussing in detail how insurance companies have discriminated against transgender individuals through pre-existing conditions and medically necessary classifications).

116. Part III of this note goes into more detail on these exclusions. Patient Protection and Affordable Care Act §§ 1557, 2704 [hereinafter PP&ACA] (prohibiting exclusion of preexisting conditions and preventing discrimination in coverage); see also AM. CIVIL LIBERTIES UNION, *Know Your Rights-Transgender People and the Law*, ACLU (Nov. 19, 2009),

http://www.aclu.org/hiv-aids_lgbt-rights/know-your-rights-transgender-people-and-law [hereinafter ACLU KYR] (stating that coverage depends upon the individual contract with the individual insurance company).

117. See ACLU KYR, *supra* note 116 (detailing how contract law governs private individual insurance because such programs are based on a contracted agreement between the insurance company and the insured).

118. See *id.* (explaining how coverage is dependent on the insurance contract and how

will exclude many transition procedures, transition-related care, procedures related to transition specifically, or are unclear about whether those services are covered.¹¹⁹ Generally, insurance companies deny coverage for SRS by declaring it a cosmetic procedure, which allows them to get around the “medically necessary standard.”¹²⁰ The “medical necessity standard” is a common health coverage term that defines health care services that a physician exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease, or its symptoms.¹²¹ For example, in *Davidson v. Aetna Life & Cas. Co.*,¹²² Victoria Davidson had an insurance policy through his employer stating that cosmetic surgeries would be covered if the surgery is necessary for the repair a non-occupational injury.¹²³ Aetna argued that SRS is not necessary to repair an injury and is purely cosmetic and denied coverage of the procedure.¹²⁴ The district court found for Davidson after determining that SRS is performed in order to correct a psychological defect, not solely improve muscle tone or physical appearance—a general trait of cosmetic procedures.¹²⁵ Thus, the court determined that classifying the procedure as more than cosmetic is appropriate.¹²⁶ *Davidson*, though a victory for transgender individuals, illustrates that outcomes in other similar

many plans do not cover transition-related care and/or specifically exclude it).

119. *See id.* (describing how insurance companies generally exclude transition related care).

120. *See id.* (noting that classifying something as cosmetic gets around any claim of medical necessity); *see also* Section II(B)(3) for an explanation of the “medical necessity” standard.

121. *See* WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, *WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage for Transgender and Transsexual People Worldwide*, WPATH, available at http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1352&pk_association_webpage=3947 (last visited Nov. 9, 2014) (providing examples of how insurance companies define “medical necessity”).

122. *Davidson v. Aetna Life & Cas. Co.*, 420 N.Y.S. 2d 450 (N.Y. 1979).

123. *See id.* at 451 (finding that SRS is not merely cosmetic surgery).

124. *See id.* at 453 (stating Aetna’s Medical Director maintained that there is nothing physically wrong with a transsexual’s body; the director went further to say that the surgery was attempting to change the body to fit the transsexual’s mind).

125. *See id.* at 453 (explaining the court’s determination that the SRS procedure was more than a cosmetic because of the psychological benefits gained by the patient with GID and that it more than improving a physical aspect of their body).

126. *See id.* at 453 (stating that court is deferring the professional judgment of medical experts and does not want to interfere).

cases are heavily dependent on the court’s opinion and whether or not they want to view transition-related care as medically necessary or cosmetic.¹²⁷

3. Discrimination with Public Health Programs

The same discriminatory insurance practices that occur in private health insurance are also present in public insurance programs—namely state Medicaid programs. Medicaid statutes vary by state and though the federal Medicaid statute does not *exclude* reimbursement of treatments related to SRS, states can choose whether or not to reimburse certain medical procedures under their programs.¹²⁸ Federal regulations constrain some state Medicaid choices—for example, a state may not deny services to an otherwise eligible individual solely because of a diagnosis, illness, or condition.¹²⁹ But states are still given broad power to choose procedures to cover under state Medicaid, leading to a marked disparity in transgender care for those who qualify for Medicaid.¹³⁰

Case law is also inconsistent in regards to transgender health care access under Medicaid.¹³¹ Some regulations and case law establish that a state cannot categorically deny compensation for SRS under Medicaid but other cases uphold a state’s denial of reimbursement for SRS procedures.¹³² In *Pinneke v. Preisser*¹³³ the United States Court of Appeals for the Eighth

127. *See id.* at 450–53 (analyzing the current understanding of transsexualism as a medical diagnosis and noting that the decision to require coverage under an insurance plan depends on each individual’s case).

128. *See BURDA, supra* note 13, at 174–175 (providing examples of states that do not provide for SRS under their Medicaid programs).

129. *See* 42 C.F.R. § 440.230(c) (2011) (“The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.”).

130. *See BURDA, supra* note 13, at 174 (providing examples of states that exclude SRS).

131. *See id.* (showing how Medicaid statutes vary between states); *see also* 42 U.S.C. § 1396a(a) (outlining state plans for medical assistance and the requirements for the type of care that states must provide and who is eligible—also pointing out minimum requirements and that states can add to coverage requirements if they so choose).

132. *See* 42 U.S.C. § 1396 (a)(A)(10) (2010) (providing a list of care and services that must be provided in order for medical assistance); *see also* 42 C.F.R. § 440.230(c) (2011) (“The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.”).

133. *See Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980) (stating that there

Circuit held states cannot absolutely exclude the only known available medical treatment for a gender identity disorder because that would be considered an arbitrary denial of benefits based exclusively on a diagnosis or type of illness.¹³⁴ In *Pinneke* the court stated that the Iowa Department of Social Services could not create an irrebuttable presumption that SRS can never be medically necessary¹³⁵ and that it must take into account the applicant's diagnosed condition, the prescribed treatment, and the knowledge of the medical community.¹³⁶ In *Doe v. State*¹³⁷ the Supreme Court of Minnesota addressed an adult male transsexual's appeal from a decision of the State Welfare Department denying him medical benefits to fund his sex-transition surgery.¹³⁸ In rendering its decision that the Welfare Department's determination to deny medical assistance benefits to Doe was arbitrary and unreasonable, the court also ruled that the determination of whether SRS is medically necessary must be decided on a case-by-case basis and based on an unbiased evaluation.¹³⁹

Conversely, other courts have denied coverage for SRS under various rationales. In *Casillas v. Daines*¹⁴⁰ a Federal District Court ruled in favor of the New York State Department of Health's denial of Terri Casillas claim for Medicaid coverage for surgeries and services to treat her GID.¹⁴¹ The

cannot be an irrebuttable presumption that SRS is never medically necessary).

134. *See id.* at 547–49 (noting that Pinneke was eligible for Medicaid, diagnosed with a transsexual personality and denied funding for SRS surgery; the court found that SRS was the only treatment available to relieve her condition and the state plan was an arbitrary denial of benefits because it excluded the only known treatment).

135. *See id.*

136. *See id.* at 549–50 (emphasizing that the decision of whether a certain treatment is “medically necessary” rests with the individual's physician and not with government officials).

137. *Doe v. State*, 257 N.W.2d 816 (Minn. 1977).

138. *See id.* at 817 (providing background on Doe's case and going into detail into Doe's transition surgery request and denial).

139. *See id.* at 821 (determining that the Minnesota Welfare Department's denial of medical assistance benefits to an adult male transsexual was arbitrary and unreasonable).

140. *See Casillas v. Daines*, 580 F. Supp. 2d 235, 247 (S.D.N.Y. 2008) (finding that the state agency's rationale “provided a more than sufficient rational basis” related to the government interest of protecting the health of its citizens and the conservation of limited medical sources).

141. This case was decided in 2008, when GID was still the term used to diagnosed transgender individuals requesting transition-related care under the DSM-IV. *See id.* at 238, 247 (noting that the state agency cited serious complications from the surgeries and the administration of estrogen as evidence that providing for these procedures under Medicaid went against the state's interest in protecting the health of its citizens and the conservation of

New York State Health Department had adopted a regulation that prohibits state Medicaid reimbursement for services related to gender reassignment.¹⁴² Casillas challenged the ban with the support of her current psychologist and her prior treating psychiatrist, and argued that the treatments were medically necessary.¹⁴³ The court disagreed with Casillas’s claim that she had been denied equal protection on the basis of her diagnosis.¹⁴⁴ Instead, the court agreed with the state agency’s explanation—that it was protecting the health of state citizens and conserving limited medical resources—and the policy survived rational basis review.¹⁴⁵

Some courts have denied reimbursement for transition-related care on the grounds that SRS is “experimental” and that there is disagreement with regards to the efficacy of such procedures. For example, in *Rush v. Parham*¹⁴⁶ the United States Court of Appeals for the Fifth Circuit found that Georgia could reasonably exclude reimbursement of experimental treatments and remanded to the district court to determine if the specific procedures in question in the case could be classified as experimental.¹⁴⁷ Similarly, in *Smith v. Rasmussen*,¹⁴⁸ the Eighth Circuit upheld an Iowa law that prohibited funding of SRS.¹⁴⁹ Unlike the Fifth Circuit, the *Smith* court did not find that procedures were experimental; instead the court relied on the Department of Health’s research that demonstrated different opinions of

limited medical resources).

142. *See id.* at 237 (citing 18 N.Y.C.R.R. § 505.2(1)(2011)).

143. *See id.* at 238 (stating that the “plaintiff was examined by a medical doctor who is Professor and Chairman of Plastic and Reconstructive Surgery at Philadelphia College of Osteopathic Medicine who has opined that hormones, orchiectomy and vaginoplasty are medically necessary to treat plaintiffs [sic] GID.”).

144. *See id.* at 247 (reviewing the agency’s rationale for denying reimbursement of SRS and associated treatments).

145. *See id.* (stating that the agency’s rationale “provided a more than sufficient rational basis which was related to legitimate government interests – the health of its citizens”).

146. *See Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980) (finding that Georgia could exclude SRS procedures from Medicaid reimbursement because it is an experimental treatment).

147. *See id.* at 1156–57 (remanding the case to a lower court for determination of whether or not the procedures could reasonably be considered experimental).

148. *See Smith v. Rasmussen*, 249 F.3d 755, 762 (8th Cir. 2001) (determining that the regulation was the reasonable result of rulemaking processes that overcame the presumption in favor of the treating physician).

149. *See id.* at 760–61 (describing the regulation and the process the state used to reach its decision)

the effectiveness and value of SRS.¹⁵⁰ The different cases and variety of rulings are evidence of the ongoing disagreement in the United States courts and among the medical community¹⁵¹ over the efficacy and value of SRS and other transgender transition-related treatments.¹⁵² Also, the cases show that states continue to have great control over whether or not to include certain transition procedures.¹⁵³

Medicare is equally discriminatory towards transgender individuals, particularly regarding transition-related care for those with gender dysphoria.¹⁵⁴ Like Medicaid, Medicare has banned even the consideration of coverage for sex reassignment surgery and related care because of a fear of “serious complication[s]” resulting from “experimental surgery” since 1981.¹⁵⁵ The Medicare ban also uses the same “medical necessity” provision and requirements as Medicaid and has used that standard to ban any sort of coverage for transition-related care.¹⁵⁶ The ban created a threshold barrier to coverage for medical care for transgender people under Medicare, which prohibited all forms of gender reassignment surgeries

150. *See id.* at 761 (describing that the value of the surgery has been questioned).

151. Though the AMA has come out in favor of transition related care as a necessary treatment for gender dysphoria, not all physicians and practitioners agree with this assessment. *See Am. Med. House of Delegates, supra* note 8.

152. *See BURDA supra* note 13, at 174 (explaining how different states have varying Medicaid provisions on SRS and transgender care); *see generally*, *Doe v. State*, 257 N.W.2d 816 (Minn. 1977); *see generally* *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980); *see generally* *Casillas v. Daines*, 580 F. Supp. 2d 235, 247 (S.D.N.Y. 2008).

153. *See generally* *Doe v. State*, 257 N.W.2d 816 (Minn. 1977); *see generally* *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980); *see generally* *Casillas v. Daines*, 580 F. Supp. 2d 235, 247 (S.D.N.Y. 2008).

154. *See* 1 SEXUAL ORIENTATION AND THE LAW §10:22 (2013) (stating that Medicare, Tricare, and the Veterans Health Administration do not pay for sex reassignment surgeries)

155. *See Medicare Can Pay for Transgender Recipient’s Gender Confirmation Surgeries: Feds*, HUFFINGTON POST (May 30, 2014, 1:06 PM), http://www.huffingtonpost.com/2014/05/30/medicare-transgender-gender-surgery_n_5418899.html (explaining a recent Health and Human Services Departmental Appeals Board decision that ruled that a three-decade-old rule excluding transition related surgeries from the procedures covered by the national health program for the elderly and disabled was unjustified); *see also* Evan McMorris-Santoro, *Obama Administration Opens the Door to Medicare-Funded Sex Reassignment Surgery*, BUZZFEED (May 30, 2014, 12:02 PM), <http://www.buzzfeed.com/evanmcsan/obama-administration-opens-the-door-to-taxpayer-funded-sex-r> (stating that language banning the coverage of sex reassignment surgery was issued in 1981).

156. *See* Social Security Act, 42 U.S.C. §1395y(a)(1)(A) (2013) (stating Medicare payment for items or services “not reasonable and necessary for the diagnosis or treatment of illness or injury” are barred from coverage).

regardless of the individual patient’s diagnosis or serious medical needs.¹⁵⁷ This ban was recently questioned by LGBT rights activists and was lifted by a Department of Health and Human Services Department Appeals Board Ruling on May 30, 2014.¹⁵⁸

II. What the ACA and United States v. Windsor Mean for LGBT Health

The ACA and *U.S. v. Windsor* have been heralded as victories for the LGBT community.¹⁵⁹ As the largest-ever health insurance expansion takes place in the United States, the promise of finally getting health care will be a “boon for much of the LGBT community.”¹⁶⁰ *Windsor* represented a needed victory for the LGBT community as a whole in securing their federal rights.¹⁶¹ Though both can be considered “wins” for the LGBT community and should be considered a step in the right direction towards more acceptance and health care access, there are still problems and limitations that have yet to be addressed. Generally, representatives have found that the ACA and *Windsor* stand to benefit the LGBT community while continuing to fail to provide any real improvements for transgender

157. See *LGBT Groups Challenge Medicare’s Refusal to Provide Healthcare to Transgender Patients*, NAT’L CTR. FOR LESBIAN RIGHTS (Mar. 29, 2013), <http://www.nclrights.dreamhosters.com/press-room/press-release/lgbt-groups-challenge-med-icare-refusal-to-provide-healthcare-to-transgender-patients/> (explaining how LGBT advocacy groups challenged the decades long Medicare ban on transition related care).

158. See DEP’T OF HEALTH AND HUMAN SERVICES DEPARTMENTAL APPEALS BD., DAB No. 2576 – NCD 140.3, *Transsexual Surgery* (May 30, 2014), *available at* <http://www.scribd.com/doc/227212239/DAB-No-2576-NCD-140-3-Transsexual-Surgery> (stating that denying Medicare coverage of all transsexual surgery as a treatment for transsexualism is not valid under the “reasonableness standard”).

159. See *How Obamacare Helps the LGBT Community*, THE WHITE HOUSE BLOG (Dec. 17, 2013, 1:00 PM), <http://www.whitehouse.gov/blog/2013/12/17/how-obamacare-helps-lgbt-community> (explain that the Obama administration views the ACA as an improvement on LGBT healthcare).

160. See Scout, *Health Insurance Exchanges Might Not Be Accessible to Trans* People*, HUFFINGTON POST (Oct. 9, 2013, 1:11 PM), http://www.huffingtonpost.com/scout-phd/health-insurance-exchanges-trans-people_b_4057628.html (noting that current attempts to increase the LGBT community’s knowledge about health insurance exchanges and the publicity campaigns failed to reach transgender people because they have such a history of discrimination that they are wary of any health care promises) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

161. *Id.*

individuals.¹⁶² Part II of this note will first examine the improvements in LGBT—particularly transgender—health care that stem from the ACA and *Windsor*. Second it will address some crucial issues that still remain and hinder transgender health care access.

A. Improvements in Transgender Health Care Access

I. ACA Improvements to Access and Nondiscrimination

The Patient Protection and Affordable Care Act (ACA) was meant to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private coverage, and reduce the costs of health care through various state and federal mechanisms.¹⁶³ The ACA seeks to achieve these goals through the optional state expansion of Medicaid, the creation of insurance exchanges, and a ban on discrimination by health insurers.¹⁶⁴ LGBT individuals, like all other Americans, will benefit from more affordable insurance coverage plans that cover pre-existing conditions, access to preventative care, and small business tax credits.¹⁶⁵ More specifically, LGBT and particularly transgender individuals stand to benefit most from the nondiscrimination provisions of the ACA.¹⁶⁶ The ban on discrimination represents a progressive move by the Obama administration towards further acceptance of the LGBT community.¹⁶⁷ The ban has also created a new tool to combat LGBT health care discrimination.

162. *See id.* (noting that although the transgender community has more access through the non-discrimination provisions of the ACA and the exchanges, many are still wary of seeking care); *see also* Mitch Kellaway, *Transgender Health Insurance (Part 2) Why Coverage is Only the Beginning*, HUFFINGTON POST (Sept. 6, 2013 5:47 PM), http://www.huffingtonpost.com/mitch-kellaway/transgender-health-insurance_b_3850332.html (explaining the author's own experience with transition-related care and the limitations faced by others, particularly the inability to find insurance coverage and/or physicians to perform transition-related procedures).

163. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

164. *Summary of the Affordable Care Act*, KAISER FAMILY FOUND. (Apr. 23, 2013), <http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf>.

165. *See The Affordable Care Act Helps LGBT Americans*, WHITEHOUSE.GOV (last visited Nov. 19, 2013), http://www.whitehouse.gov/sites/default/files/docs/the_aca_helps_lgbt_americans.pdf (explaining that one of the administration's main goals under the ACA is to improve LGBT health care access).

166. *Id.*

167. *See id.* (explaining how the administration seeks to improve LGBT health care

Discrimination in the health care industry generally refers to the ways in which insurers differentiate among individuals in designing and implementing health insurance coverage.¹⁶⁸ Discrimination can occur at the point of enrollment, the way coverage is designed, and the decisions that insurers make when administering benefits and services.¹⁶⁹ The nondiscrimination provision of the ACA protects individuals from discrimination based on race, color, national origin, sex, age, or disability under any health program or activity that is receiving federal financial assistance.¹⁷⁰ The nondiscrimination provision is outlined in Section 1557 of the ACA.¹⁷¹ Section 1557 applies to public and private entities such as state health departments, hospitals, clinics, or insurance companies that receive federal funds; Medicare and Medicaid, including the health insurance marketplaces.¹⁷² As a result, any health program or activity that receives federal financial assistance, such as hospitals, clinics, employers, or insurance companies that receive federal money must abide by the rules of section 1557.¹⁷³ The provision further applies to visiting nurse programs,

access by ending discriminatory practices).

168. See Kevin Lucia et al., *New Report on State Approaches to Nondiscrimination under the Affordable Care Act*, CTR. ON HEALTH INS. REFORMS GEO. U. HEALTH POL’Y INST. (July 29, 2013), <http://chirblog.org/new-report-on-state-approaches-to-nondiscrimination-under-the-aca/> (explaining the Center’s study that found that discriminatory practices have not been deterred by the ACA or HHS regulations); see also Sara Rosenbaum, *Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Reform Opinions*, GEO. L. O’NEILL INST. FOR NAT’L AND GLOBAL HEALTH L., at 6 (2009), available at http://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1023&context=ois_papers.

169. See Rosenbaum *supra* note 168 at 6–7 (outlining enrollment based discrimination tools).

170. See *Section 1557 of the Patient Protection and Affordable Care Act*, U.S. DEPT’T OF HEALTH & HUMAN SERVS. <http://www.hhs.gov/ocr/civilrights/understanding/section1557/> (last visited Nov. 19, 2013) (stating that the nondiscrimination provision applies under any program or activity that is administered by an Executive agency or any entity established under Title I of the ACA – meaning that this provision virtually applies to all aspects of the health care system); see *An Overview of Section 1557*, *supra* note 100.

171. *Section 1557 of the Patient Protection and Affordable Care Act*, *supra* note 170.

172. See *id.*; see also 42 C.F.R. §155.120(c) (2014) (“In carrying out the requirements of this part, the State and the exchange must: (i) Comply with applicable non-discrimination statutes; and (ii) Not discriminate based on race color, national origin, disability, age, sex, gender identity or sexual orientation.”).

173. See *An Overview of Section 1557*, *supra* note 100 (detailing the filings the Center

community health education interventions, and similar programs that receive federal dollars.¹⁷⁴ Section 1557 specifically extends the discrimination prohibition to entities that receive federal assistance in the form of contracts of insurance, credits, or subsidies.¹⁷⁵ The prohibition also applies to any program or activity administered by an executive agency, or any program created under Title I of the ACA, including new state health insurance exchanges.¹⁷⁶

All public and some private insurance plans must abide by the Section 1557 discrimination prohibition.¹⁷⁷ It is not clear how Section 1557 applies to some employer and individual insurance plans. Most private insurance plans—through partnerships with public programs like Medicaid—receive federal funding or assistance,¹⁷⁸ which could subject them to the Section 1557 discrimination prohibition.¹⁷⁹ However, it is unclear whether a private insurance carrier partnering with a federal agency is considered to be receiving federal assistance to an extent that would subject the carrier to Section 1557. In January 2014, the National Women’s Law Center (“NWLC”) used this reasoning to launch complaints against Genworth Financial, John Hancock, Transamerica, and Mutual of Omaha to the HHS Office of Civil Rights.¹⁸⁰ The complaints are in response to the insurance

made against insurance companies using a gender-marker for long-term care coverage).

174. *Id.*

175. *Id.*

176. *Id.*

177. *See id.* (noting which insurance plans are must follow the ACA provision); *see also* Section 1557 of the Patient Protection and Affordable Care Act, *supra* note 170.

178. *See Long Term Care Insurance Partnership Plans*, AMERICAN ASSOCIATION FOR LONG-TERM CARE INSURANCE, <http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php> (last visited July 31, 2014), (explaining that the Long Term Care Partnership Program is a joint federal-state policy initiative to promote the purchase of private long term care insurance).

179. *See* Affordable Care Act, Pub. L. No. 111-148 § 1557 (2010) (stating that the provision applies to any program or activity that is administered by an Executive agency or any entity established under Title I of the ACA, or that receives federal funding for programs).

180. *NWLC Section 1557 Complaints: Sex Discrimination Complaints Against Four Long-Term Care Companies*, NAT’L WOMEN’S L. CTR. (Jan. 16, 2014), <http://www.nwlc.org/resource/nwlc-section-1557-complaints-sex-discrimination-complaints-against-four-long-term-care-comp>; *see also* Ann Carns, *Long-Term Care Insurance Priced by Gender*, N.Y. TIMES (Feb. 11, 2014), *available at* http://www.nytimes.com/2014/02/12/your-money/long-term-care-insurance-priced-by-gender.html?_r=0.

companies’ announced practice of “gender-rating” long-term care insurance policies, or charging women more than men for the same coverage simply because they are women.¹⁸¹

In the complaints, the NWLC asserts that the insurer’s gender-based premiums for long-term care insurance violate Section 1557.¹⁸² The complaints state that because insurers offer long-term care policies through Medicaid partnership programs in some states, they received federal assistance, rendering them subject to the provisions of section 1557.¹⁸³ For example, in the complaint filed against Transamerica, the NWLC states that CMS assists Transamerica through the Washington State’s Partnership Program,¹⁸⁴ a state program that links private long-term care insurance policies with “special Access to Medicaid.”¹⁸⁵ Through the Partnership Program, CMS, the Washington DSHS, and the Washington HCA incentivize the purchase of Transamerica’s long-term care insurance policies.¹⁸⁶ The program provides incentives for individuals to purchase Transamerica’s Partnership Program-approved long-term care insurance policies by providing special access to Medicaid if individuals buy and use benefits under a Partnership approved policy.¹⁸⁷ NWLC asserts that because the Medicaid Partnership Program with Transamerica is a joint federal-state program that provides health care coverage for low-income people and is administered by CMS and the Washington Health Care Authority, Transamerica must follow the provisions of Section 1557.¹⁸⁸ The other complaints follow a similar framework in attributing a relationship between

181. *NWLC Section 1557 Complaints*, *supra* note 180; *see also* Carrns, *supra* note 180.

182. Carrns, *supra* note 180.

183. *See id.* (detailing the content of the complaint and the relationship to section 1557).

184. Washington State’s Partnership Program is a joint effort between the federal-state Medicaid program, private long-term care insurers, and state agencies. It is administered collaboratively by the Washington State HSHS, Washington HCA, and the Washington Office of the Insurance Commissioner. WASH. REV. CODE. § 48.85.010 (2012).

185. WASH. STATE DEP’T OF SOC. & HEALTH SERVS. *Washington Long-Term Care Partnership*, available at <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCTPartnershipMainPage.shtml#182-513-1400> (last visited July 28, 2014).

186. *Administrative Complaint to the U.S. DHHS Office for Civil Rights*, NAT’L WOMEN’S L. CTR., at 4 (Jan. 16, 2014), available at http://www.nwlc.org/sites/default/files/pdfs/2014-01-16_transamerica-wa_ocr_complaint.pdf.

187. *Id.*

188. *Id.*

private insurers and state Medicare or Medicaid Programs.¹⁸⁹ HHS has yet to issue a ruling based on whether these arguments prove that private insurance companies can be bound to the provisions of Section 1557 because they receive federal assistance for some of their programs.

The nondiscrimination provision of the ACA also applies to marketing, public education, and consumer assistance programs¹⁹⁰ as well as benefit design and the ten “essential health benefits” required in all plans individual and small employer plans.¹⁹¹ Essential health benefits must include items and services within at least ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavior health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision.¹⁹² Section 1557 creates a mechanism for consistent federal and state

189. See *Administrative Complaint: Genworth Life Ins. Co. KY*, NAT'L WOMEN'S L. CTR. (Jan. 16, 2014), available at http://www.nwlc.org/sites/default/files/pdfs/2014-01-16_genworth-ky_ocr_complaint.pdf (stating that Genworth participates in the Partnership Program with CMS and Kentucky's Department of Medical Services); see also *Administrative Complaint: Genworth Life Ins. Co. WA*, NAT'L WOMEN'S L. CTR. (Jan. 16, 2014), available at http://www.nwlc.org/sites/default/files/pdfs/2014-01-16_genworth-wa_ocr_complaint.pdf (explaining the partnership between Genworth WA and CMS and the Washington State Partnership Program); *Administrative Complaint: John Hancock Life Insurance Company WA*, NAT'L WOMEN'S L. CTR. (Jan. 16, 2014), available at http://www.nwlc.org/sites/default/files/pdfs/2014-01-16_john_hancock-wa_ocr_complaint.pdf (stating John Hancock participates in the Partnership Program); *Administrative Complaint: Mutual of Omaha Insurance Company*, NAT'L WOMEN'S L. CTR. (Jan. 16, 2014), available at http://www.nwlc.org/sites/default/files/pdfs/2014-01-16_mutual_of_omaha-wa_ocr_complaint.pdf (explaining the company's participation in the Partnership Program with CMS and Medicaid, making it subject to Section 1557); *Administrative Complaint: Transamerica Life Ins. Co. MN*, NAT'L WOMEN'S L. CTR. (Jan. 16, 2014), available at http://www.nwlc.org/sites/default/files/pdfs/2014-01-16_transamerica-mn_ocr_complaint.pdf (explaining Transamerica's participation in the Partnership Program with Minnesota).

190. 45 C.F.R. § 147.104(e) (2014); see also *An Overview of Section 1557*, *supra* note 100.

191. See *An Overview of Section 1557*, *supra* note 100 (noting that the non-discrimination provision applies to more than just insurance plans).

192. See DEP'T OF HEALTH & HUMAN SERVS., *Glossary: Essential Health Benefits*, available at <https://www.healthcare.gov/glossary/essential-health-benefits/> (last visited Jan. 6, 2014); see also 42 U.S.C. § 18022(b) (detailing the ten essential health benefits that every health care plan must cover under the ACA).

enforcement of the nondiscrimination standards.¹⁹³ The provision is meant to end the pre-ACA discriminatory practices of insurers and providers.¹⁹⁴ Federally, 1557 is enforceable through the filing of an administrative complaint or by lawsuit.¹⁹⁵ The Office for Civil Rights (OCR) at the Department of Health and Human Services has been tasked with enforcing Section 1557 and will receive any administrative complaints—though other federal agencies will have responsibilities enforcing 1557.¹⁹⁶ The Department of Justice is required to include 1557 in its enforcement of civil rights laws.¹⁹⁷ States are required to engage in oversight and enforcement by enforcing existing state laws that apply to ACA-related entities.¹⁹⁸ States can accomplish this through consumer protection laws and rules regarding deceptive practices that can be used to reinforce federal nondiscrimination regulations regarding market practices.¹⁹⁹ States can also enforce these regulations through public accommodation laws that protect individuals against discrimination by or in public or private entities that are used by the public.²⁰⁰

In order to provide more clarification on nondiscrimination policies, the HHS Office of Civil Rights (OCR) issued a letter to LGBT advocacy groups in July 2012.²⁰¹ The OCR stated that Section 1557’s sex

193. *An Overview of Section 1557*, *supra* note 100, at 12.

194. *Id.*

195. *Id.*; see also Patient Protection and Affordable Care Act § 1557, codified at 42 U.S.C. § 18116 (2012).

196. *An Overview of Section 1557*, *supra* note 100, at 12.

197. *Id.*

198. *Id.*

199. See *id.* at 13 (noting that public accommodation laws protect individuals against discrimination and can be leveraged to support federal nondiscrimination provisions). Seventeen states and the District of Columbia (Minnesota, Rhode Island, New Mexico, California, Illinois, Maine, Hawaii, New Jersey, Washington, Iowa, Oregon, Vermont, Colorado, Connecticut, Nevada, Massachusetts, and Delaware) have laws banning discrimination based on sexual orientation and gender identify/expression while four states (Wisconsin, New Hampshire, Maryland, and New York) have laws banning discrimination based on sexual orientation. See also *State Nondiscrimination Laws in the U.S.* THE TASK FORCE (June 2, 2013), http://www.thetaskforce.org/downloads/reports/issue_maps/non_discrimination_6_13_color.pdf.

200. *An Overview of Section 1557*, *supra* note 100.

201. Letter from Leon Rodriguez, HHS Office of Civil Rights, to Maya Rupert, Federal Policy Director, National Center for Lesbian Rights [hereinafter Letter from Leon Rodriguez to Maya Rupert], available at <http://www.scribd.com/doc/102169872/HHS-Response-1557-7-12-12>; see also M. Dru Levasseur, *Affordable Care Act and Nondiscrimination*, LAMBDALEGAL.ORG,

discrimination prohibition, “extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity [and] also prohibits sexual harassment and discrimination regardless of actual or perceived sexual orientation or gender identity of the individuals involved.”²⁰² HHS confirmed what many LGBT advocates felt the ACA’s anti-discrimination provisions create an important new tool to combat anti-LGBT and especially anti-transgender discrimination in health care.²⁰³ The letter and clarification it provides is a significant development that builds on a series of recent rulings that have extended sex discrimination prohibitions to include discrimination based on gender identity expression.²⁰⁴ The importance of this change in federal policy cannot be overstated. The guidance is crucial and is considered by advocates to be the beginning of further reforms sought to benefit the LGBT community.

2. ACA Increases Access to Mental Health and Substance Abuse Disorder Services

In mandating essential health benefits coverage, the ACA expands mental health and substance abuse disorder coverage.²⁰⁵ Beginning in 2014, small group and individual market health plans will be required to cover mental health and substance abuse disorder services with coverage that is comparable to that for general medical and surgical care.²⁰⁶ This means that about 3.9 million people covered in the individual market will gain either mental health or substance abuse disorder coverage or both; it is also

<http://www.lambdalegal.org/blog/aca-and-nondiscrimination> (Aug. 7, 2012), (stating that the letter is a significant development in transgender rights and that it is hard to overstate the significance of the guidance).

202. Letter from Leon Rodriguez to Maya Rupert, *supra* note 201, at 1.

203. *Id.* at 2.

204. See Levasseur, *supra* note 201 (noting EEOC and HUD rulings and guidance clarifying that discrimination against LGBT persons is sex discrimination).

205. See Kirsten Beronio et. al, *ASPE Issue Brief: ACA Expands Mental Health and Substance Abuse Disorder Benefits and Federal Parity Protections for 62 Million Americans*, DEP’T OF HEALTH & HUMAN SERVS. (Feb. 20, 2013), available at http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf (emphasizing that the ACA makes mental health and substance abuse disorder coverage a required part of any health program, including state programs provided through Medicaid).

206. *Id.* at 1.

estimated that 1.2 million individuals currently in small group plans will receive mental health and substance abuse disorder benefits under the ACA.²⁰⁷ The ACA also builds on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)²⁰⁸ to extend the federal parity protections to 62 million Americans.²⁰⁹

The MHPAEA is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance abuse disorder (“MH/SUD”) benefits from imposing less favorable benefit limitations on those benefits than medical/surgical benefits.²¹⁰ The MHPAEA is an extension of the Mental Health Parity Act of 1996 (MHPA) which provided that large group health plans cannot impose lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical and surgical benefits.²¹¹ The MHPAEA preserved the MHPA and added new protections, such as extending the parity requirements to substance abuse disorders.²¹² The MHPAEA originally applied to group health plans and group health insurance coverage, but was amended by the ACA.²¹³

Under the ACA amendments, the MHPAEA now applies to individual health insurance coverage.²¹⁴ HHS has jurisdiction over public sector group health plans—referred to as “non-Federal governmental plans”—while the

207. *Id.* at 2.

208. 42 U.S.C. § 300gg-26 (2008).

209. *See* Beronio, et. al, *ASPE Issue Brief*, *supra* note 205 (explaining how the ACA expands mental health care coverage).

210. CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *The Mental Health Parity and Addiction Equity Act*, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html (last visited July 28, 2014).

211. *Id.*

212. *See id.* The key changes were that: (1) if a group health plan or health insurance coverage included medical/surgical benefits and MH/SUD benefits, the financial requirements and treatment limitations that apply the MH/SUD benefits must be no more restrictive than the limitations that apply to substantially all medical/surgical benefits; (2) MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits; (3) if a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, and the plan or coverage provides for out-of-network medical/surgical benefits it must provide the same for MH/SUD benefits; and (4) standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD must be disclosed upon request.

213. *Id.*

214. *Id.*

Department of Labor and the Treasury have jurisdiction over private group health plans.²¹⁵ Employment-related group health plans may be either “insured” (purchasing insurance from an issuer in the group market) or “self-funded.”²¹⁶ The insurance that is purchased, whether by an insured group health plan or in the individual market, is regulated by the State’s insurance department.²¹⁷ Private employment-based group health plans are regulated by the Department of Labor.²¹⁸ The final regulation that puts the ACA’s changed into effect has been effective since January 13, 2014.²¹⁹ The regulation applies to non-Federal governmental plans with more than 100 employees and to group health plans of private employers with more than 50 employees.²²⁰

The regulation also applies to health insurance coverage in the individual health insurance market but does not apply to group health plans for small employers, except as is covered by the essential health benefits requirements of the ACA.²²¹ The regulations do not require group health plans to provide MH/SUD benefits, but if plans do provide such benefits, the financial requirements and treatment limitations that apply to MH/SUD cannot be more restrictive than the limitations and requirements that apply to substantially all of the medical surgical benefits.²²² This does not apply to all plans, but does provide an expansion of protections of mental health and substance abuse disorders treatment and program assistance for many individuals.²²³ Under the new parity rules, 7.1 million Americans currently covered in the individual market will be able to count on mental health and

215. *Id.*

216. *See id.* (stating that group health plans that pay for coverage directly, without purchasing health insurance from an issuer, are called self-funded group health plans).

217. *Id.*

218. *Id.*

219. 78 C.F.R. § 68,240 (Nov. 13, 2013).

220. 78 C.F.R. § 68,240 (Nov. 13, 2013); *see also* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT *supra* note 210.

221. *Id.*

222. *Id.*

223. *Id.*; *see also* 78 C.F.R. §§ 68,240, 68,248 (Nov. 13, 2013). The MHPAEA does not apply to non-federal governmental plans that have 100 or fewer employees; small private employers that have 50 or fewer employees; group health and plans that are exempt from the MHPAEA based on their increased cost; and large, self-funded non-Federal government employers that opt-out of requirements of the MHPAEA.

substance abuse disorder coverage that is comparable to their general medical and surgical coverage.²²⁴

Increased access to mental health and substance abuse disorder services will greatly help the transgender community.²²⁵ Mental health services are an essential and costly part of transgender health care, particularly for individuals who wish to undergo hormone therapy or SRS procedures.²²⁶ Gender dysphoria must be diagnosed before an individual can begin to undergo various treatments.²²⁷ If left undiagnosed transgender persons with gender dysphoria can suffer dangerous mental ramifications.²²⁸ The American Medical Association, American Psychiatric Association and the World Health Organization have all recognized gender dysphoria as a serious medical condition that if left untreated “can result in clinically significant physiological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death.”²²⁹ Thus, the ACA’s requirements for coverage of mental health services are a step in the right direction and will provide for necessary treatment for transgender individuals.

3. *Windsor Improvements*

In *U.S. v. Windsor*, the Court overturned part of the Defense of Marriage Act of 1996 (DOMA)²³⁰ that denied federal benefits to same sex couples.²³¹ Justice Kennedy, writing for the Court, closed his majority

224. See Beronio, *supra* note 205 (explaining how though limited, the changed rules provide more coverage and protections for mental health treatments and needs than did before).

225. See CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 210 (stating that mental health and substance abuse disorder treatments must be covered by insurance plans).

226. See WORLD PROF’L ASSOC. FOR TRANSGENDER HEALTH, *supra* note 7, at 165–232 (providing flexible standards of care for Gender Identity Disorders) (on file with the Washington and Lee Journal of Civil Rights and Social Justice) (emphasizing that in order to pursue gender conforming care, transgender individuals will have to undergo a psychiatric evaluation in order to receive a diagnosis to have the procedures covered by insurance companies).

227. *DSM-V Fact Sheet*, *supra* note 19.

228. See AM. MED. HOUSE OF DELEGATES, *supra* note 8 (noting the different problems associated with Gender Identity Disorder).

229. *Id.* at 1.

230. Defense of Marriage Act, 28 U.S.C. §1738C (2013).

231. *United States v. Windsor*, 133 S.Ct. 2675 (2013).

opinion by stating that DOMA must fail because it denies same-sex couples the dignity that states that have passed same-sex marriage statutes intended them to have.²³² Importantly, Kennedy stated that DOMA sets same-sex couples apart in a way that violates the due process and equal protection principles guaranteed under the Constitution.²³³ The decision does not guarantee a right to same-sex marriage, but allows individuals who live in states that allow same-sex marriage to receive the same federal benefits as heterosexual couples legally married in these states.²³⁴

Windsor and the end to discrimination against same-sex couples on the federal level are important to transgender individuals in two ways. First, *Windsor* demonstrates openness on the part of the Court to non-traditional sexual orientation. The Court's opinion is crucial for other transgender friendly policies and laws to be developed and enforced. It also hopefully marks the beginning of more pro-LGBT rulings and legislation regarding health care access. Second, *Windsor* has a direct effect on transgender individuals' right to marry and the benefits that accompany a recognized marriage, an important means for transgender individuals to access health care.²³⁵ Transgender people face unique legal issues with marriage, which in turn affects benefits and health care access for couples.²³⁶ Transgender individuals are often able to enter into a heterosexual marriage after undergoing sex-reassignment procedures and legal gender documentation changes, but they may also be married to a person of the same sex.²³⁷ Though being transgender and being gay are different,²³⁸ some same-sex

232. *Id.* at 2696.

233. *Id.* at 2696.

234. *Id.* at 2693.

235. See *FAQ About Transgender People and Marriage Law*, LAMBDALEGAL.ORG, <http://www.lambdalegal.org/know-your-rights/transgender/trans-marriage-law-faq> (last visited Feb. 25, 2014) (describing how transgender individual's marriage rights can be limited depending on state law and policy and depending on if they are a different-sex or same sex-couple); see also *Transgender People and Marriage: The Importance of Planning*, HUMAN RIGHTS CAMPAIGN, available at <https://www.hrc.org/resources/entry/transgender-people-and-marriage-the-importance-of-legal-planning> (last visited Feb. 25, 2014).

236. See *FAQ About Transgender People and Marriage Law*, *supra* note 235.

237. See *id.* (noting that transgender individuals can transition during a marriage and if the couple stays together the result is a legal marriage in which both spouses are male or female.)

238. See *Transgender 101*, *supra* note 13 (stating that being gay is considered a sexual identity and orientation while transgender is a gender identity or expression).

marriage bans still affect transgender individuals’ ability to marry.²³⁹ If transgender individuals live in a state where same-sex couples cannot have a legally recognized marriage, their marriage may not be valid.²⁴⁰ If a transgender couple is different sex—for example, a transgender man who is married to a non-transgender woman—the validity of the marriage under state law depends on whether the government respects the gender identity of the transgender spouse.²⁴¹ Basically, if a transgender man marries a woman in a state that does not recognize his transition and also has a ban on same-sex marriage, the marriage is deemed a same-sex and is not recognized.²⁴² The Court’s ruling on DOMA helps rectify this disparity at the federal level.²⁴³ By recognizing valid same-sex marriages, the Court allows transgender couples that may be denied benefits by states that do not recognize transition or same-sex marriage, access to federal benefits if they get married in a state that does allow same-sex marriage.²⁴⁴ The ruling has also been affecting state policies by sparking rulings and legislation overturning same-sex marriage bans.

Spousal coverage is an important pathway to insurance for millions of people, thus the DOMA ruling and subsequent policy interpretations have resulted in expanded access for some LGBT families to a range of benefits including dependent health coverage.²⁴⁵ Benefit access and marriage recognition is an important means for health care access for many transgender couples.²⁴⁶ If one spouse is employed, the other generally has a greater likelihood of health care access through an employment-based plan

239. See *FAQ About Transgender People and Marriage Law*, *supra* note 235. (outlining different discriminatory policies and limitations towards transgender marriage rights); see also *Transgender 101*, *supra* note 13.

240. See *id.* (stating that some states that do not recognize gender transition will still prevent a transgender individual from marrying someone of their original sex before transition because it would be considered a same-sex marriage).

241. *FAQ About Transgender People and Marriage Law*, *supra* note 235; see also *Transgender People and Marriage: The Importance of Planning*, *supra* note 235.

242. *FAQ About Transgender People and Marriage Law*, *supra* note 235; see also *Transgender People and Marriage: The Importance of Planning*, *supra* note 235

243. *Id.*

244. *Id.*

245. See Usha Ranji et al., *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.*, KAISER FAMILY FOUND. (Jan. 08, 2014), <http://kff.org/report-section/health-and-access-to-care-and-coverage-for-lgbt-individuals-in-the-u-s-impact-of-policies-on-coverage-and-access-to-care/> (explaining that *Windsor* lead to an expansion of benefits coverage for LGBT families).

246. *Id.*

that covers the spouse in a state where the marriage is valid.²⁴⁷ Limits in the ability to marry hinder transgender access to spousal or dependent health coverage and can prevent premium tax credit benefits under the ACA because the tax credits are affected by changes in marital status and household income.²⁴⁸

In practice, the legal validity of marriage involving transgender spouses is not yet firmly established in many states, which can affect benefit and health care access.²⁴⁹ Some courts have ruled that transgender people cannot marry, which is usually justified by a reliance on statutes that refuse to acknowledge gender transition or statutes that ban same-sex marriage.²⁵⁰ For example, in *Littleton v. Prange*,²⁵¹ an appellate court in Texas invalidated a seven-year marriage between Christine Littleton, a transgender woman, and her deceased husband.²⁵² Ms. Littleton brought a wrongful death suit seeking damages for her husband's death.²⁵³ The court ruled that a person's legal sex is genetically fixed at birth and that Ms.

247. See Hubert Janicki, *Employment-Based Health Insurance: 2010, Household Economic Studies*, 3, U.S. CENSUS BUREAU (Feb. 2013), <http://www.census.gov/prod/2013pubs/p70-134.pdf> (stating that the unemployed and individuals not employed in the labor force were generally covered by a previous employer's plan or that of a spouse through dependent coverage). It is important to note that the ACA has sparked a change in this statistic, as of 2012 7% of employers did not cover spouses when other coverage was available to them and 4% of employers with 1,000 more employees reported not providing such spousal coverage. Paul Fronstin, et al., *The Cost of Spousal Health Coverage*, EMP. BENEFITS RESEARCH INST. (2014), available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_01_Jan-14_SpslCvg-RetPlns.pdf. As of late 2012–early 2013, another 8% of large employers were reporting that they planned to exclude spouses from coverage when other coverage was available. *Id.* However, this is only if other coverage options are available, which often times are not for transgender individuals. But, plans may begin to charge more for spouses; see also Carrns, *supra* note 180.

248. See Janicki, *supra* note 247, at page 2 (explaining discriminatory practices that prevent recognition of transgender marriages); see also *Questions and Answers on the Premium Tax Credit*, INTERNAL REVENUE SERV. <http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit> (last visited Mar. 4, 2014) (stating that premium tax credits for the year will differ if your family size and household income you report on your return—the more your family size income differs from the Marketplace estimates used to compute your advanced credit payments).

249. See *FAQ About Transgender People and Marriage Law*, *supra* note 235. (examining cases that have led to disagreement among the courts in regards to transgender marriages).

250. *Id.*

251. *Littleton v. Prange*, 9 S.W.3d 223 (1999).

252. *Id.*

253. *Id.*

Littleton should be deemed to be legally male, despite her female anatomy and appearance and that she has lived as a woman for most of her life.²⁵⁴ The marriage was invalidated under Texas’ ban on same-sex marriage and the rights afforded to a legal spouse were denied to Ms. Littleton.²⁵⁵ Not only was she denied the right to bring a wrongful death suit, but also the right to intestate inheritance, to obtain her deceased husband’s Social Security and retirement benefits.²⁵⁶ Other courts have made similar rulings regarding non-recognition of medical and legal transitions by transgender individuals.²⁵⁷

Evolving trends of acceptance across legislatures and state courts have led to changes in many discriminatory policies regarding transgender marriage rights as well as health care access for spouses.²⁵⁸ This move towards acceptance of transgender marriage is well illustrated in examining the Texas Legislature and state courts’ recent change in posture regarding transition and marriage.²⁵⁹ In 2009, the Texas Legislature amended the family code to add a court order related to an applicant’s “sex change” as a form of acceptable proof to establish an applicant’s eligibility to obtain a marriage license.²⁶⁰ Texas’ ban on same-sex marriage remained unaffected by the law and, until recently, continued to cause problems for transgender individuals.²⁶¹ This created confusion about whether someone who has transitioned to a gender they were not assigned at birth can marry someone of the same or opposite gender.²⁶² The Texas Appeals Court has recently

254. *Id.* at 230–32.

255. *Id.* at 232.

256. *Id.*

257. *See In re Estate of Gardiner*, 273 Kan. 191 (2002) (stating a transgender woman’s marriage was invalid by declining to recognize the gender marker change on her Wisconsin birth certificate and relying on a Kansas statute that ban same-sex marriage).

258. *FAQ About Transgender People and Marriage Law*, *supra* note 235.

259. *Id.*

260. *See* TEX. FAM. CODE ANN. § 2.005(b)(8) (2009); *see also* Zack Ford, *Texas Appeals Court: State Must Recognize Transgender Identities in Marriage*, THINK PROGRESS (Feb. 13, 2014), <http://thinkprogress.org/lgbt/2014/02/13/3289941/texas-appeals-court-state-recognize-transgender-identities-marriage/#> (describing recent court case and stating that the lower court had ruled against the transgender individual’s marriage eligibility under Texas’ same-sex marriage even though the 2009 law had been established).

261. Ford, *Texas Appeals Court: State Must Recognize Transgender Identities in Marriage*, *supra* note 261.

262. *Id.*

addressed the confusion in *In re Estate of Araguz*.²⁶³ In *Araguz* Nikki Araguz's husband died and his ex-wife and mother sued alleging that Araguz deserved no death benefits because Nikki was a transgender woman.²⁶⁴ The court determined that transgender people should not be denied the right to marry a person of the opposite gender because of the gender they were classified as at birth.²⁶⁵ The case shows the court's recognition of not only the 2009 Texas law and the growing trend of acceptance of transgender individuals' right to marry and access benefits.²⁶⁶ The court did not explicitly address the confusion about how the statute applies to transgender individuals who identify as gay or bisexual, but it established precedent to recognize their authentic identities that are legally changed.²⁶⁷ Confusion about transgender marriage rights and same-sex marriage rights in Texas may be changing soon—U.S. District Judge Orlando Garcia ruled on February 26, 2014 that Texas' ban on same-sex marriage was unconstitutional.²⁶⁸ The recent ruling is the latest in a series of similar victories for gay rights activists stemming from *Windsor*, following decisions in Utah,²⁶⁹ Kentucky,²⁷⁰ and Virginia²⁷¹ which show a continuing trend of legalizing gay marriage.²⁷² Though the ruling only issued a

263. *In re Estate of Araguz*, 2014 WL 576085 (Feb. 13, 2014).

264. *See id.* (giving background that Araguz was born a man but was diagnosed with gender dysphoria at age eighteen and transitioned into a female; also noting that Araguz legally had her name, driver's license and birth certificate changed and that at the time of her wedding, she had male sex organs but was living as a woman—she had genital reassignment surgery in 2008).

265. *Id.*

266. Ford, *supra* note 260.

267. *Id.*

268. *See* Chris Tomlinson, *Texas Gay Marriage Ban Latest to be Struck Down*, ASSOCIATED PRESS (Feb. 26, 2014), <http://bigstory.ap.org/article/federal-judge-strikes-down-texas-gay-marriage-ban>.

269. *See* *Kitchen v. Herbert*, 2013 WL 6697874 (D. Utah Dec. 20, 2013) (holding that Utah's law banning same-sex marriage denied plaintiffs right to marry, court could apply rational basis test to plaintiff's equal protection claim and the state interest in promoting responsible procreation and optimal child rearing were not furthered by the prohibition).

270. *See* *Bourke v. Beshear*, 2014 WL 556729 (W.D. Ky. Feb. 12, 2014) (stating Kentucky's refusal to recognize same-sex marriages from other jurisdictions ruled unconstitutional; implementation of decision stayed until March 20, 2014; additional plaintiffs challenge the state's denial of marriage licenses to same-sex couples).

271. *See* *Bostic v. Rainey*, 2014 WL 561978 (E.D. Va. Feb. 13, 2014) (stating that Virginia same-sex marriage ban ruled unconstitutional ruled by U.S. District court; ruling stayed pending appeal to 4th Circuit Court of Appeals).

272. Tomlinson, *supra* note 268.

preliminary injunction that will remain in effect until the conclusion of an appeal, it is a victory for LGBT Texans and shows a changing tide in LGBT rights as whole in more conservative states.²⁷³

The Court’s ruling in *Windsor* has also affected federal LGBT policies that can further benefit transgender couples and increase access to health care and benefits. As a reaction to the Court’s decision, several federal agencies have created rules that recognize the validity of same-sex marriages across state lines. The Internal Revenue Service (IRS) issued a Revenue Ruling in August 2013, which stated that it would recognize same-sex marriages for federal tax purposes, even if the couple resides in a state that does not recognize their union.²⁷⁴ The ruling may also have an important effect on transgender couples’ ability to utilize the premium tax credits of the ACA when they enter into the health exchanges.²⁷⁵

Shortly after the IRS’s ruling, the Employee Benefits Security Administration of the Department of Labor issued a technical release in September 2013 that defined “spouse” and “marriage” under the Employee Retirement Income Security Act (ERISA).²⁷⁶ The release states that the terms spouse and marriage in employee benefit plans will be interpreted to include same-sex partners if the couple was legally married in a state that recognizes same-sex marriages.²⁷⁷ The law of the state in which the couple is living in or domiciled will not be relevant.²⁷⁸ This can also apply to

273. *Id.*

274. See Rev. Rul. 2013-17, 2013-81 I.R.B. 201, available at <http://www.irs.gov/pub/irs-irbs/irb13-38.pdf>. IRS Revenue Ruling Released August 30, 2013 (clarifying Rev. Rul. 58-66, 1958-C.B. 60 and determining the status of individual of the same-sex who are lawfully marries under the law of state that recognizes such marriages for federal tax purposes); see also Timothy Jost, *Implementing Health Reform: IRS Announcement On Same-Sex Marriages and Navigator Manual*, HEALTH AFFAIRS BLOG (Sept. 25, 2013), <http://healthaffairs.org/blog/2013/08/31/implementing-health-reform-irs-announcement-on-same-sex-marriages/>;

275. I.R.S., *Answers on the Premium Tax Credit*, <http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit> (last visited Mar. 4, 2014).

276. See U.S. DEP’T OF LABOR, *Technical Release No. 2013-04: Guidance to Employee Benefit Plans on the Definition of “Spouse” and “Marriage” under ERISA and the Supreme Court’s Decision in United States v. Windsor*, (Sep. 18, 2013), available at <http://www.dol.gov/ebsa/newsroom/tr13-04.html> (explaining the changes in terminology that resulted from *Windsor*).

277. *Id.*

278. *Id.*

transgender couples if they are domiciled in a state that refuses to recognize a transition and has a ban on same-sex marriage but were married in a state that recognizes same-sex marriage.²⁷⁹

The *Windsor* judgment and ERISA guidance do not necessarily increase all same-sex couples' access to health care, though they do benefit transgender couples. Fully insured plans, where the employer pays a premium to a third party insurance company that then provides coverage for employees, are governed by state insurance regulation of the state where the owner of the plan is located.²⁸⁰ If the owner of the plan is in a state that recognizes same-sex marriage the plan must cover same sex couples., but if it is not located in such a state, then coverage for same-sex spouses will not usually be required.²⁸¹ Self-insured plans, where the employer hires an administrator to manage the plan but provides the coverage and pays claims, are governed by ERISA, which is thought to overrule state insurance regulation for such plans.²⁸² Because these plans are governed by federal law, including Title VII of the Civil Rights Act of 1964, which does not currently recognize sexual orientation as a protected class, employers can and do argue that they do not have to cover the same-sex spouses of employees.²⁸³

The possibility of ERISA provisions requiring coverage for same-sex spouses has recently been questioned. In *Roe v. Empire Blue Cross Blue Shield*,²⁸⁴ the United States District Court for the Southern District of New York found that a self-insured health plan that excludes same sex spouses does not violate ERISA.²⁸⁵ Even though New York allows same-sex marriages under the New York Marriage Equality Act, the court framed the issue as whether a private plan violates a provision of ERISA by excluding

279. *Id.*

280. *See Will Marriage Help Us Get Spousal Health Insurance?*, LAMBDA LEGAL <http://www.lambdalegal.org/publications/will-marriage-help-us-get-spousal-health-insurance> (last visited Oct. 25, 2014); *see also* Michael Shultz, *What Marriage Equality Means for Your Employee Benefits*, JD SUPRA (June 17, 2014), <http://www.jdsupra.com/legalnews/what-marriage-equality-means-for-your-em-14628/> (explaining how insurance plans where the insurer pays a third party are governed by state insurance law).

281. *Id.*

282. *Id.*

283. *Id.*

284. *Roe v. Empire Blue Cross Blue Shield*, 2014 WL 1760343 (S.D.N.Y. May 1, 2014).

285. *Id.*

same-sex couples from beneficiary status.²⁸⁶ The court ruled that ERISA gives employers “broad discretion in writing the terms of welfare benefit plans.”²⁸⁷ Further, the court held that ERISA Section 510,²⁸⁸ which prohibits any employer from discriminating against a beneficiary for exercising his or her benefit rights or the attainment of any benefit right, does not apply to the facts of the case because there was no adverse employment action.²⁸⁹ Importantly, the court made clear that it was not ruling on whether plans that exclude same-sex couples from the definition of spouse are constitutional, but nonetheless denied the claim.²⁹⁰ Representatives believe that the ruling emphasizes the need for EEOC guidance with respect to the rights of same-sex spouses under employer health insurance plans.²⁹¹ Similar standards used by employers could also have negative ramifications for transgender couples if a spouse has not completed the legal transition process and is still considered their original sex, effectively rendering the couple a same-sex couple and subject to the same limitations.

Though there are limitations, there is a growing trend among the U.S. agencies to issue guidance that provides more transgender discrimination prohibitions and rights to access to health care. The U.S. Office of Personnel Management (OPM) has issued guidance regarding transgender individuals in the federal workplace.²⁹² The OPM stated that, “[i]f employees in transition are validly married at the time of the transition, the transition does not affect the validity of that marriage, and spousal coverage should be extended or continued even though the employee in transition has a new name and gender.”²⁹³

CMS also issued guidance to state health officials as a result of the *Windsor* ruling and in light of the IRS’s revenue ruling.²⁹⁴ First, eligibility

286. *Id.*

287. *Id.*

288. ERISA, 29 U.S.C. § 1140 (2006).

289. *Roe*, 2014 WL 1760343.

290. *Id.*

291. SAUL EWING, *ERISA Self-Insured Health Plan Not Required to Cover Same Sex Spouses* (July 9, 2014), <http://www.saul.com/publications/alerts/erisa-self-insured-health-plan-not-required-cover-same-sex-spouses>; *see also* 29 U.S.C. § 1140.

292. *FAQ About Transgender People and Marriage Law*, *supra* note 235.

293. *See id.* (referencing guidance issued by the U.S. Office of Personnel Management).

294. CMS issued guidance in the form of a letter from Cindy Mann, Director of Center

rules in regards to the treatment of same-sex spouses' eligibility for premium tax credits will be treated in the same manner as opposite-sex spouses.²⁹⁵ Second, the guidance allows state officials to take a different approach towards how they treat same-sex couples for Medicaid and CHIP eligibility.²⁹⁶ CMS clarifies that a state is "permitted and encouraged, but not required," to recognize same-sex couples that are legally married under the laws of the jurisdiction in which the marriage occurred.²⁹⁷ The guidance suggests that CMS will issue additional guidance on non-Modified Adjusted Gross Income (MAGI) Medicaid eligibility after the SSA releases its forthcoming guidance interpreting the DOMA decision.²⁹⁸ The guidance further notes that CMS will require states to formally clarify whether they will adopt marriage definitions for Medicaid that differ from federal policy used by the IRS and other entities.²⁹⁹

The regulations signal not only the federal government's acceptance of *Windsor*, but also their push to make sure that it is enforced.³⁰⁰ The changes are crucial for the LGBT community because they provide more access to benefits and health care for couples.³⁰¹ The regulations also signal a move towards more acceptance and recognition of the needs for equal LGB, particularly transgender, health care access. The change in federal policy will hopefully lead to more coverage for transgender individuals as government agencies become more and more accepting. But, the regulations and *Windsor* fall short in various areas and leave open many questions regarding transgender and same-sex spousal health care.

for Medicaid and State Operations. See Letter from Cindy Mann to State Health Officials, Re: United States v. Windsor (Sept. 27, 2013), available at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-13-006.pdf>.

295. See *id.*; see also Jost, *supra* note 274 (outlining the new regulations that have been promulgated).

296. Letter from Cindy Mann, *supra* note 294.

297. *Id.*

298. *Id.*; see also CMS, *Medicaid and CHIP in 2014: Seamless Path to Affordable Coverage*, 5, available at <http://www.medicaid.gov/State-Resource-Center/Downloads/3-29-12-Eligibility-Webinar-Slides.pdf> (last visited Nov. 23, 2014) (explaining that MAGI is a methodology for how income is counted and how household composition and family size are determined and is used to determine Medicare and Medicaid eligibility).

299. Letter from Cindy Mann, *supra* note 294.

300. See *id.* (stating that states are encouraged but not forced to adopt regulations that recognize same sex couples).

301. *Id.*; see also Jost, *supra* note 274.

Particularly because states still maintain a substantial amount of control over transgender marriage and health care access.

4. *Ban Lifted on Medicare Discrimination*

In May of 2014, the Obama administration made more headway towards advancing transgender rights and transgender health care access by ending a decades-long blanket ban that prevented Medicare from covering sex reassignment surgery.³⁰² The lift on the thirty-three year ban on Medicare coverage was the result of a ruling by a Department of Health and Human Services Department Appeals Board (“DAB”) board in response to a lawsuit filed last year on behalf of Denee Mallon, a seventy-four-year-old transgender woman.³⁰³ The DAB is an internal review structure within HHS that provides independent review of disputed decisions on Department programs and provides binding decisions on HHS.³⁰⁴ The blanket Medicare ban was established in 1981, as a result of a belief that transition surgeries were purely experimental, but now most medical associations consider it a safe option for those suffering from gender dysphoria.³⁰⁵ In rendering its decision, the DAB determined that medical studies published over the past three decades showed that the grounds for the exclusion of coverage are no longer “reasonable” and lifted the ban.³⁰⁶ The DAB stated that even assuming the National Coverage Determination’s exclusion of coverage at the time were reasonable, that lack of coverage was no longer reasonable. The DAB further ruled that denying Medicare coverage of all transsexual surgery as a treatment for transsexualism is not valid under the

302. See DEP’T OF HEALTH & HUMAN SERVS., *supra* note 158 (giving the DABs ruling on lifting the Medicare ban on coverage for transition surgeries); see also McMorris-Santoro, *supra* note 155 (stating that on May 30, 2014 HHS lifted the Medicare ban on sex reassignment surgery coverage); see also Ariana Eunjung Cha, *Ban Lifted on Medicare Coverage for Sex Change Surgery*, WASH. POST (May 30, 2014), available at http://www.washingtonpost.com/national/health-science/ban-lifted-on-medicare-coverage-for-sex-change-surgery/2014/05/30/28bcd122-e818-11e3-a86b-362fd5443d19_story.html (stating that a 33-year ban on Medicare coverage for gender reassignment surgery was lifted).

303. See Cha, *supra* note 302 (detailing Denee Mallon’s case before the HHS board).

304. See DEP’T OF HEALTH & HUMAN SERVS., *Department Appeals Board (DAB)*, <http://www.hhs.gov/dab/> (last visited July 12, 2014) (explaining what the DAB’s role and the different divisions).

305. See Cha, *supra* note 302 (explaining the reasoning behind the DAB’s decision).

306. *Id.*

reasonableness standard nor under established standards of treatment accepted by medical experts.³⁰⁷

Many advocates believe that that this ruling is long overdue and that it is a step towards increased acceptance of transgender people. Some believe that the change to Medicare could have far reaching implications for American medicine and help drive more private insurers to offer coverage for sex reassignment surgery and related care.³⁰⁸ Though this ruling can be viewed as a victory in some respects, it is still limiting and does not truly change insurance companies or the government's ability to discriminate against transgender individuals. The ruling does not mean Medicare will automatically start covering sex reassignment surgery and transition related care, though the program will no longer be prevented from doing so when claims are made.³⁰⁹ Patients under Medicare will not be guaranteed coverage for surgeries under the decision, they will have to justify their need just as they have to for any other medical treatments.³¹⁰ Further, the ruling does not apply to Medicaid.³¹¹

Though the ruling will not fully change access to gender reassignment care, the statement is a rare on-the-record communication from an agency that has—in the past—sought to avoid controversy by keeping DAB deliberations out of the headlines.³¹² The current ruling is a marked change; particularly because the Obama administration and Health and Human Services first broached the idea of allowing Medicare to cover transgender surgery in 2013.³¹³ In 2013, HHS released that it would consider revising the Medicare policy to cover medically necessary gender transition

307. See DEP'T OF HEALTH & HUMAN SERVS., *supra* note 158 (stating that a reasonableness standard is going to be used and that a blanket ban on Medicare coverage of transition related surgeries does not meet the reasonableness standard).

308. See McMorris-Santoro, *supra* note 155 (asserting that changes in Medicare coverage determinations can effect private insurance company coverage).

309. See *id.* (explaining the limits to the DAB ruling).

310. *Id.*

311. *Id.*

312. *Id.*

313. See Sunnive Brydum, *Medicare Won't Yet Decide Whether to Cover Gender Reassignment Surgery*, THE ADVOCATE (Apr. 1, 2013), available at <http://www.advocate.com/politics/transgender/2013/04/01/medicare-wont-yet-decide-whether-cover-gender-reassignment-surgery> (explaining the backlash and rescission after HHS released that it would seek comments on a potential policy change on Medicare's long-standing ban on coverage for gender reassignment surgeries).

surgeries and sought public input on the topic.³¹⁴ However, the same day the topic was opened for comment HHS withdrew the request, stating that the ban would instead be reviewed through the independent Department Appeals Board process.³¹⁵ The move was generally viewed as positive, but some believe it was caused by vocal opposition from conservative critics to have the Medicare policy change pursued through the less public DAB.³¹⁶ Nonetheless, the ruling stands for the supposition that government, at least through Medicare, is finally accepting and executing policies consistent with the consensus of the medical and scientific community that access to gender transition-related care is medically necessary for many people with gender dysphoria. Though limited, it is a step in the direction towards more accessible care for individuals with gender dysphoria.

B. Continuing Problems/Shortcomings in Health Care Access

Though the ACA and the Court’s ruling in *Windsor* are moving the United States towards more acceptance of the LGBT community, there are still many lingering issues regarding health care access that have yet to be addressed. The ACA takes needed steps to improve LGBT health care as a whole, but it does not solve all of the existing problems, especially transgender health care issues. The elimination of pre-existing conditions and discrimination will not necessarily end discriminatory practices against transgender individuals.³¹⁷ Even if transgender exclusions are removed from plans, insurers are not prohibited from creating health plans that deny coverage for services that are not medically necessary, that are experimental, or that are comparatively more expensive than other treatments.³¹⁸ Finally, there are issues concerning care exclusions for

314. *See id.* (detailing the public comment announcement on the HHS website); *see also* McMorris-Santoro, *supra* note 155 (stating that HHS sought to reconsider the coverage through a public process).

315. Brydum, *supra* note 313.

316. *See id.* (stating that the National Center for Transgender Equality viewed the HHS move as positive even though it was reneged and believed that HHS did not stop considering changing the policy, just through a different administrative process); *see also* McMorris-Santoro, *supra* note 155 (stating that the public process primed conservative critics to launch a vocal opposition campaign that caused HHS to step back and pursue the change through the DAB).

317. Lucia, *supra* note 168.

318. Andrew Cray, *FAQ: Health Insurance Needs for Transgender Americans*, CTR. FOR AM. PROGRESS (Oct. 3, 2012), <http://www.american>

transgender individuals' post-transition needs that fall under transition-related bans.³¹⁹ These problems may still occur under the ACA, particularly with the lack of federal guidance and regulator of non-discriminate and continued unclear standards for transgender individuals.

1. Non-Discrimination Provisions Not as Strong as Many Believe

Recent findings by the Georgetown University Health Policy Institute (the Institute) suggest that the nondiscrimination standards have *not* significantly changed the way that state regulators or insurers approach benefit design and that regulators face practical limitations in trying to implement the mandated requirements.³²⁰ The Institute found that some regulators are not willing to assume a broader role in defining discriminatory benefit design without clearer federal standards.³²¹ Particularly, the lack of clear guidance leaves questions of how nondiscrimination requirements relate to the essential health benefits benchmark plans.³²²

The non-discrimination provision and the end to pre-existing condition exclusions provide more opportunities for transgender individuals and persons with gender dysphoria to access health care. Though insurers may no longer limit coverage based on an individual's gender identity, the ACA does not require insurers—public or private—to cover gender reassignment surgeries, hormone therapy, or other treatment needs.³²³ The Institute's study found that stakeholders struggled to articulate an ideal standard for identifying discriminatory benefit design and that there are still questions as to how nondiscrimination requirements relate to essential health benefits plans.³²⁴ The study also determined that some regulators may not be willing to assume a broader role in defining discriminatory benefit design without

progress.org/issues/lgbt/report/2012/10/03/40334/faq-health-insurance-needs-for-transgender-americans/.

319. *Id.*

320. *Id.*

321. *Id.*

322. *See id.*; *see also Glossary: Essential Health Benefits*, *supra* note 192 (defining health benefits certain health plans are required to cover).

323. *See Lucia*, *supra* note 168.

324. *Id.*

clearer federal standards.³²⁵ In support of the Institute’s assertions, a recent survey conducted by the HHS Office of Inspector General found that five of the six states surveyed did not monitor Medicaid Managed Care Entities compliance with the federal provider nondiscrimination contract provisions and that Centers for Medicare and Medicaid Services (CMS) oversight to ensure compliance of state contracts was inconsistent.³²⁶ The limitations to state and federal compliance monitoring and gaps in the statute may leave the transgender population open to continued discrimination. This is particularly true in considering coverage options available to transgender individuals.

2. Discrimination Through Defining Transition Surgery as Cosmetic

The ACA has eliminated discrimination for pre-existing conditions, but insurers can still limit treatment options for gender dysphoric patients requiring transition through cosmetic and experimental exclusions.³²⁷ Insurers often classify gender-confirming care as either cosmetic or experimental and use that classification to deny coverage.³²⁸ Insurers use this strategy to draw a line that limits the number of nonessential procedures covered, which is part of an overall strategy to control health care costs.³²⁹ Cosmetic procedures are generally considered optional or elective in nature, while experimental interventions are usually believed to have questionable medical value.³³⁰ Some insurers explicitly restrict

325. *See id.* (noting the different challenges raised by state officials in regards to nondiscrimination under the ACA). The study found that states and insurers have not changed their approach to nondiscrimination but are using new tools, such as attestations, outlier analysis, and internal tracking databases, to monitor for compliance. *Id.* States raised questions about how nondiscrimination requirements relate to the essential health benefits benchmark plan and identified challenges in enforcement because of a lack of clinical expertise and the inability of fully see benefits in the filing process. *Id.*

326. Daniel R. Levinson, *State and CMS Oversight of the Medicaid Managed Care Credentialing Process*, DEP’T OF HEALTH & HUMAN SERVS. 2 (Nov. 2013), available at <http://oig.hhs.gov/oei/reports/oei-09-10-00270.pdf>.

327. *See* Noa Ben-Asher, *The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties*, 29 HARV. J.L. & GENDER 51, 58 (2006) (explaining how insurance companies avoid covering transition related procedures by claiming the procedures are merely cosmetic and not medically necessary).

328. *Id.*

329. *See* Cray, *supra* note 318 (noting that insurers use a variety of measures to lower premiums costs by denying certain procedures that they deem cosmetic or unnecessary).

330. *See* Cristine Nardi, Comment, *When Health Insurers Deny Coverage for Breast*

coverage for transition-related treatments by classifying them as cosmetic or experimental while others rely on contract interpretation to reject claims for gender-confirming care under these categories.³³¹

Transition-related surgeries are generally believed to be more than cosmetic, though they have some cosmetic features.³³² There is a significant body of medical evidence and behavioral science research documenting the efficacy for transition-related interventions, which casts doubt on insurers' classification of gender-confirming care as experimental.³³³ Medical professionals have been providing transitional treatments to transgender patients for over thirty years and procedures have been continuously improving parallel to medical advancements.³³⁴ Even some state Medicaid agencies have found that such interventions can be "appropriate and medically necessary for some people and [should not be] considered experimental."³³⁵ Gender transition procedures can be considered more akin to reconstructive surgery, which is a procedure performed on abnormal structures of the body, "caused by congenital defects, developmental abnormalities, trauma, infections, tumors or disease,"³³⁶ rather than

Reconstructive Surgery: Gender Meets Disability, 1997 WIS. L. REV. 777, 784 (1997) (defining cosmetic procedure as a procedure intended to enhance a normal structure); see also Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1638 (1992) ("The 'experimental' exclusion common in health insurance policies responds to a growing concern that most current medical procedures were adopted without ever having been tested rigorously and that at least some of the procedures commonly used today have limited or no medical value.").

331. See *Health Insurance Discrimination for Transgender People*, *supra* note 44 (providing examples of transgender insurance exclusions and how insurance companies argue exclusions based on vague provisions of insurance contracts that can be interpreted as prohibiting procedures necessary for transition-related care).

332. See Khan, *supra* note 113, at 396 (describing how transition-related procedures have some cosmetic qualities, but that in the case of patients with GID, they are more than cosmetic).

333. For discussion about the general acceptance of hormonal therapy and surgical reassignment surgery as appropriate treatments for gender dysphoria, see P.T. Cohen-Kettenis & Louis J. G. Gooren, *Transsexualism: A Review of Etiology, Diagnosis and Treatment*, 46 J. PSYCHOSOMATIC RES. 315, 326 (1999); see also David A. Gilbert et al., *Transsexual Surgery in the Genetic Female*, 15 CLINICS PLASTIC SURGERY 471, 486 (1988); see also Donald R. Laub et al., *Vaginoplasty for Gender Confirmation*, 15 CLINICS PLASTIC SURGERY 463, 470 (1988).

334. See Eric B. Gordon, *Transsexual Healing: Medicaid Funding of Sex Reassignment Surgery*, 20 ARCHIVES SEXUAL BEHAV. 61, 72 (1991).

335. *Id.*; *Smith v. Rasmussen*, 249 F.3d 755, 760 (8th Cir. 2001).

336. Khan, *supra* note 113, at 396 (2011) (quoting Nardi, *supra* note 330, at 783–84).

cosmetic surgery, which is performed to reshape normal structures “of the body in order to improve the patient’s appearance and self-esteem.”³³⁷ Though psychological and environmental factors can influence gender identity, genetic, hormonal, and psychological factors appear to play a significant role, which further distinguishes gender variance from cosmetic conditions.³³⁸

Another important factor that differentiates transition-related care from cosmetic procedures is the fact that the decision to pursue gender-confirming care is not exclusively at the discretion of the patient; doctors impose stringent requirements on transgender patients.³³⁹ To qualify for sex reassignment surgery, a gender dysphoric patient wishing to transition must show: (1) a recommendation in writing by two behavioral scientists, one whom has known the patient in a therapeutic relationship for 6 months; (2) a successful cross-living test over a one-year period; and (3) legal, social, psychological, sexual and endocrine success during cross living.³⁴⁰ Overall, it is difficult to find any real medical support for the “cosmetic” argument proffered by insurance agencies in refusing to cover gender transition surgeries.³⁴¹ Hormone therapy and sex reassignment surgery do not simply enhance ordinary biological features, they radically change the anatomy and biological function of a patient’s body.³⁴² Transitioning can also put family relationships, friendships, and employment at risk; few undergo the procedure just to improve their appearance or their self-esteem.³⁴³ Insurers also attempt to support their “cosmetic” claim by asserting that transition-related interventions only alter “normal” features that are fully functional.³⁴⁴ This claim has little merit as insurers regularly cover procedures that do not result in any new functional

337. *Id.*

338. *Id.*

339. See Hazel Glenn Beh, *Sex, Sexual Pleasure, and Reproduction: Health Insurers Don’t Want You To Do Those Nasty Things*, 13 WIS. WOMEN’S L.J. 119, 153, 154 (1998).

340. *Id.* at 152.

341. *Id.*

342. See Stan H. Monstrey et al., *Sex Reassignment Surgery in the Female-to-Male Transsexual*, 25 SEMINARS IN PLASTIC SURG. 229–44 (2011) (detailing transition operative procedures and how they are performed in stages to alter the gender of an individual).

343. See Beh, *supra* note 339, at 154 (explaining the strain transition places on an transgender individual).

344. See *id.* (describing a case where “[t]he insurer argued that gender dysphoria was cosmetic surgery not necessitated by a non-occupational injury”).

capacity, such as breast reconstruction following a mastectomy; insurers also cover procedures such as prosthetic eyes.³⁴⁵ Biologically, the procedures have no functional outcome, but they are generally viewed as improving quality of life that is distinguishable from cosmetic surgery.³⁴⁶

3. Discrimination Through “Medically Necessary Standard”

Public and private insurers also attempt to refuse transition-related coverage by deeming procedures “medically unnecessary,” which is arguably the least well-defined exclusion clause in most insurance plans.³⁴⁷ Despite endorsement of transition-related interventions in the medical community, insurers and courts remain skeptical of their medical necessity for several reasons.³⁴⁸ First, insurers and courts argue that coverage of transition-related health benefit is justified because the gender-confirming care is expensive, with costs as high as \$75,000 per person.³⁴⁹ However, the experience of insurers who cover transition-related care suggests that expenses are not as high as many imagine.³⁵⁰ For example, when San Francisco’s coverage of transition-related procedures for city employees began, actuaries estimated that thirty-five of the city’s thirty-seven thousand employees would use the new benefits in the first year at a cost of \$1.75 million to the city.³⁵¹ Data showed that in 2005 the city paid out only *eleven*

345. See Nardi, *supra* note 330, at 783 (1997) (noting that insurers generally pay for prosthetic eyes which serve no functional purpose).

346. See *id.* (describing that some view breast reconstruction as taking an abnormal structure and “returning it to its normal appearance”).

347. See *id.* (noting that there is no standard definition for what is “medically necessary”); see also Khan, *supra* note 113, at 399 (stating that “[m]edical necessity” does not mean life-or-death necessity; it refers to medically appropriate or medically beneficial treatment. The intent of the standard is to exclude coverage for care that is harmful, of no benefit, or nonstandard”); see *Dallis v. Aetna Life Ins. Co.*, 574 F. Supp. 547, 551 (N.D. Ga. 1983) (discussing the meaning of the term “necessary”), *aff’d*, 768 F.2d 1303 (11th Cir. 1985).

348. See Khan, *supra* note 113, at 400.

349. See *id.* (explaining that the possibility of high cost for transition related care are used to justify excluding coverage for transition procedures).

350. See *id.* at 401 (describing an insurer’s findings after they began to cover transition-related care).

351. See Diskin, *supra* note 106, at 154 (2008) (explaining the city’s coverage of transition-related procedures and care); see also *Lambda Provider Discrimination*, *supra* note 104; see also Rachel Gordon, *S.F. to Finance Staff Sex-Changes*, S.F. CHRON. (May 1, 2001), [available at](#)

gender dysphoria-related claims and the surcharge that employees had been paying to cover the policy change was reduced to zero.³⁵² Financing gender reassignment surgery for transgender city employees only cost \$182,374 over four years.³⁵³ This was less than the *thirty-five* cases estimated by actuaries when the city was debating whether to cover such care.³⁵⁴

Second, insurers and courts question the medical necessity of gender-confirming care because not all transgender individuals seek transition-related interventions.³⁵⁵ It is often difficult to justify health expenditures for a “condition” that is not always treated with medicine.³⁵⁶ Insurers seeking to deny coverage for transition procedures often rely on the fact that some transgender individuals resist the idea that medical interventions are necessary to correct non-normative gender identities.³⁵⁷ But, just because not all transgender individuals want to transition through medical means does not mean that transition-related procedures are not medically necessary for some transgender individuals. Incongruence between physical appearance and gender identity can cause severe

<http://www.sfgate.com/news/article/S-F-to-finance-staff-sex-changes-Milestone-act-2925719.php>.

352. *Lambda Provider Discrimination*, *supra* note 104.

353. Diskin, *supra* note 106, at 159.

354. *See San Francisco Transgender Benefit: Actual Cost & Utilization (2001-2006)*, HUMAN RIGHTS CAMPAIGN, <http://www.hrc.org/resources/entry/san-francisco-transgender-benefit-actual-cost-utilization-2001-2006> (last visited Mar. 4, 2014) (noting that initial actuarial costs estimated 35 claimants per year, although actuaries and advocates know this was an overestimate); *see also Corporate Equality Index*, HUMAN RIGHTS CAMPAIGN (2014), available at [http://hrc-assets.s3-website-us-east-1.amazonaws.com/files/assets/resources/CEI_2014_final_draft_7.pdf#_utma=149406063.1289414064.1380831485.1406771431.1415461948.27&__utmb=149406063.4.10.1415461948&__utmc=149406063&__utmz=149406063.1415461948.27.18.utmcsr=google|utmccn=\(organic\)|utmcmd=organic|utmctr=\(not%20provided\)&__utmv=&__utmk=23968826](http://hrc-assets.s3-website-us-east-1.amazonaws.com/files/assets/resources/CEI_2014_final_draft_7.pdf#_utma=149406063.1289414064.1380831485.1406771431.1415461948.27&__utmb=149406063.4.10.1415461948&__utmc=149406063&__utmz=149406063.1415461948.27.18.utmcsr=google|utmccn=(organic)|utmcmd=organic|utmctr=(not%20provided)&__utmv=&__utmk=23968826) (noting how other cities and companies have followed suit based on San Francisco’s experience).

355. *See Khan*, *supra* note 113, at 402 (noting that some transgender individuals are opposed to the idea that “medical interventions are necessary to correct non-normative gender identities”).

356. *See id.* (noting the difficulty that courts and insurers face in determining the medical necessity of gender-confirming care).

357. *See Jerry L. Dasti, Advocating a Broader Understanding of the Necessity of Sex Reassignment Surgery Under Medicaid*, 77 N.Y.U. L. REV. 1738, 1743 (2002) (noting that people are able to choose their gender rather than being bound by their anatomical configuration).

psychological distress and limit some transgender individuals' "ability to function and survive in society, given current biases and beliefs."³⁵⁸

Medical necessity review is particularly prevalent in Medicaid determinations and has played a significant role in determining whether Medicaid recipients receive access to transition-related care.³⁵⁹ Because Medicaid is a state-run program funded with federal and state dollars, states have significant discretion in determining which services they will provide under the Medicaid Act.³⁶⁰ As long as states follow a "formal" rulemaking process, they are free to exclude certain interventions by classifying them as medically unnecessary, which results in different decisions about which procedures are eligible for Medicaid coverage as rulemaking procedures are not necessarily consistent across states.³⁶¹ Most states have restricted Medicaid coverage for some transition-related intervention on medical-necessity grounds.³⁶² A survey by the Iowa Department of Human Services found that forty states do not fund sex reassignment surgery through Medicaid.³⁶³

Similarly, state courts have been inconsistent in their determinations of whether or not transition-related care must be funded through state benefit programs. In *Smith v. Rasmussen*,³⁶⁴ the Eighth Circuit upheld Iowa's refusal to fund sex reassignment surgery.³⁶⁵ The court notes that though the surgery may be medically necessary in some cases, the "availability of other treatment options" for gender identity disorder and "lack of consensus" in the medical community about the efficacy of surgery permits

358. See Susan Etta Keller, *Crisis of Authority: Medical Rhetoric and Transsexual Identity*, 11 *YALE J.L. & FEMINISM* 51, 72 (1999) (noting the social consequences that an individual might face when he or she does not receive treatment).

359. See Khan, *supra* note 113, at 399 (describing that insurers often attempt to control healthcare costs by limiting coverage to what they deem is "medically necessary").

360. See 42 U.S.C. § 1396 (2006) (stating that the standards adopted for determining what type of medical assistance is covered be "reasonable" and "consistent with the objections" of the Act).

361. See *Smith v. Rasmussen*, 249 F.3d 755, 760 (8th Cir. 2001) (comparing rules promulgated in different states which led to different outcomes).

362. See Keller, *supra* note 358, at 72 (explaining how states have restricted Medicaid coverage for transition-related procedures).

363. *Rasmussen*, 249 F.3d at 761 n.5; see also Khan, *supra* note 113, at 399.

364. *Rasmussen*, 249 F.3d at 760.

365. See *id.* (upholding Iowa's refusal to fund sex reassignment surgery on the grounds that the prohibition was both reasonable and consistent with the Medicaid Act).

states to refuse coverage for transition intervention under Medicaid.³⁶⁶ Some courts have not accepted broad restrictions against transition-related interventions in Medicaid programs. For example, in *Doe v. Minnesota Department of Public Welfare*,³⁶⁷ the state supreme court found that the state’s total exclusion of transsexual surgery from eligibility for medically necessary assistance was void because the ban was “directly related to the type of treatment involved” rather than to an evaluation determining whether the intervention was in fact medically necessary.³⁶⁸

In general, it seems the courts have yet to determine the proper approach for assessing the medical necessity of transition-related care.³⁶⁹ Further, the American Medical Association, has formally announced its support for gender confirming since 2008, stating that “medical literature has established the effectiveness and medical necessity of mental health care, hormone therapy, and sex-reassignment surgery in the treatment of patients diagnosed with gender dysphoria.”³⁷⁰

4. Care problems After Transition Has Occurred

Patients may now have more access to care under the ACA, but transgender patients can still be denied coverage for conditions unrelated to transitioning when providers erroneously assume a connection.³⁷¹ Many

366. *Id.*

367. 257 N.W.2d 816, 821 (Minn. 1977).

368. *See Doe v. Minnesota Department of Public Welfare*, 257 N.W.2d 816, 820 (Minn. 1977) (finding that the prohibition of benefits for transsexual surgery violated 45 CFR § 10 which stated that “the State may not arbitrarily deny or reduce the amount, duration, or scope of, such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition”).

369. *Id.*; *see generally* Smith v. Rasmussen, 249 F.3d 755, 760 (8th Cir. 2001); *see also* Rush v. Parham, 625 F.2d 1150 (5th Cir. 1980) (stating the Georgia Department of Medical Assistance had ban on transsexual surgery because it was experimental and not medically necessary, that it had provided for transsexual surgery in an appropriate case but it determined that it was not medically appropriate in applicant’s case and the state did not have to cover such a procedure).

370. *See* Am. Med. House of Delegates, *supra* note 8; *see also* Am. Med. House of Delegates, Res. No. 122, *AMA Policies on LGBT Issues*, available at http://www.tgender.net/taw/ama_resolutions.pdf (last visited Nov. 23, 2014) (outlining AMA policies of nondiscrimination, encouraging research into the impact of transgender care and treatments, recognizing LGBT health disparities, and removing financial barriers to care for transgender patients).

371. *See* Young, *supra* note 95 (describing the difficulties that transgender people often

medical services needed by transgender people during transition and other points in their lives are part of the course of care required for other medical conditions and are routinely covered by health insurance plans.³⁷² For example, hormone therapy is often utilized by patients to treat low testosterone or estrogen levels.³⁷³ But, insurers frequently expand transgender exclusions to deny transgender people coverage for basic services unrelated to transition.³⁷⁴ For example, if a man transitions into a woman but retains her prostate, an insurer may no longer cover a necessary annual prostate exam.³⁷⁵ As another example, a transgender woman in New Jersey was denied coverage for a mammogram on the basis that it fell under the plan's exclusions for treatments "related to changing sex."³⁷⁶ It took a two-year appeal process before the insurer agreed that the exclusion unfairly prevented her from receiving medically necessary care and reimbursed her for the mammogram.³⁷⁷

III. Current Proposals and Solutions

There are many options to improve transgender health care, but the most crucial is actually providing access to care. Many companies and private insurers have begun to cover transgender transition-related care, and sponsored programs to educate physicians and practitioners about transgender specific needs.³⁷⁸ Before proficient transgender health care can occur, issues of access and discriminatory practices need to be addressed. Part III of this note will examine possible solutions advanced by advocates to address problems that continue to exist under the ACA and in America's health care system for transgender individuals.

face regarding health insurance coverage).

372. See Cray, *supra* note 318 (describing health insurance needs for transgender people).

373. Cray, *supra* note 318.

374. *Id.*

375. ACLU KYR, *supra* note 116.

376. Cray, *supra* note 318.

377. See Mary Ann Spoto, *N.J. Transgender Woman Wins Battle with Insurance Company to Have Mammogram Covered*, NJ.COM, (May 2, 2012, 5:32 PM), http://www.nj.com/news/index.ssf/2012/05/nj_transgender_woman_wins_batt.html.

378. See *Corporate Equality Index*, *supra* note 354 (listing Fortune 500 and other companies that cover transition-related care under their corporate health insurance plans and companies that have strong nondiscrimination policies).

A. Increase Health Care Access by Limiting Employment Discrimination

Most transgender individuals who lack health care do not have access to it because they are unemployed.³⁷⁹ Unemployment not only limits transgender individuals’ ability to obtain employer based coverage, but it also inhibits their ability to purchase private insurance.³⁸⁰ Currently, people can be legally fired or refused employment for being gay in twenty-nine states and individuals can also be fired because of their gender non-conforming status in thirty-three states.³⁸¹ The discrepancy in employment laws occurs because states have the ability to draft their own nondiscrimination laws and there is no federal law that consistently protects LGBT individuals from employment discrimination.³⁸² As a result LGBT, and particularly transgender individuals, face discrimination in employment including being fired, denied a promotion, and experiencing harassment.³⁸³ On November 7, 2013, the Senate Passed the Employment Nondiscrimination Act (ENDA) for the first time in the legislation’s two-decade history.³⁸⁴ Advocates believe that passing this bill through the House will lead to more protection of transgender individuals and as a result improve access to health care.³⁸⁵

379. *ENDA Passes Senate 64-32*, HRC BLOG (Nov. 7, 2013), <http://www.hrc.org/blog/entry/enda-passes-senate-64-32>.

380. *See id.* (discussing how employment discrimination poses significant problems for the LGBT community).

381. Zack Ford, *Breaking: Senate Passes LGBT Employment Non-Discrimination Act (ENDA)*, THINKPROGRESS, (Nov. 7, 2013), <http://thinkprogress.org/lgbt/2013/11/07/2910661/breaking-senate-passes-lgbt-employment-non-discrimination-act-enda/>.

382. *See Issue: Federal Advocacy, Employment Non-Discrimination Act*, HUMAN RIGHTS CAMPAIGN, <http://www.hrc.org/laws-and-legislation/federal-legislation/employment-non-discrimination-act> (last visited Jan. 11, 2013) (noting that 21 state and the District of Columbia have passed laws prohibiting employment discrimination based on sexual orientation, and 17 states and D.C. also prohibit discrimination based on gender identity).

383. *See id.* (noting the purpose of the Employment Non-Discrimination Act (ENDA) is to provide protections against workplace discrimination on the basis of sexual orientation or gender identity).

384. *See ENDA Passes Senate 64-32*, *supra* note 379; Ford, *supra* note 381; *see also* Eric Krupke, *Employment Non-Discrimination Act Passes First Senate Hurdle*, NPR (Nov. 7, 2013), <http://www.npr.org/blogs/itsallpolitics/2013/11/04/243023548/senate-poised-to-pass-employment-non-discrimination-act> (stating that the last time the ENDA faced a vote in the Senate was in 1996, when Republicans held the majority and it failed with a final vote of 49–50).

385. *See Employment Non-Discrimination Act*, HUMAN RIGHTS CAMPAIGN,

The ENDA would provide basic protections against workplace discrimination on the basis of sexual orientation or gender identity.³⁸⁶ The bill prohibits employers, employment agencies, and labor unions from using an individual's sexual orientation or gender identity as the basis for employment decisions, such as hiring, firing, promotion, or compensation.³⁸⁷ The ENDA prohibits covered entities from subjecting an individual to different standards or treatment based on the individual's actual or perceived sexual orientation or gender identity.³⁸⁸ The act also bars discrimination based on the sexual orientation or gender identity of those with whom the individual associates.³⁸⁹ The bill is closely modeled on existing civil rights laws and explicitly prohibits preferential treatment and quotas.³⁹⁰ But unlike Title VII, the ENDA does not permit disparate impact suits.³⁹¹ The limitation on disparate impact suits would require a plaintiff to prove that an employer intended to discriminate, which is a higher evidentiary threshold and provides additional protection for employers.³⁹² The provision also bars the EEOC from requiring employers to collect or provide statistics on sexual orientation and gender identity. This allows for the preservation of employee privacy by not requiring employees to disclose whether or not they identify as LGB or are transgender.

The ENDA is not without limitation. The ENDA does not cover small businesses with fewer than fifteen employees nor does it apply retroactively.³⁹³ The bill also does not apply to religious organizations—any religious entity that is exempt from Title VII's prohibition on religious discrimination will continue to be able to exclude gay, lesbian, bisexual, and transgender employees.³⁹⁴ Even with its shortcomings and though it has

<http://www.hrc.org/resources/entry/employment-non-discrimination-act> (last visited June 2, 2014) (stating that supermajorities of Republicans and Democrats support the ENDA).

386. *Issue: Federal Advocacy, Employment Non-Discrimination Act*, *supra* note 382.

387. *Id.*

388. *Id.*

389. *Id.*

390. *Id.*

391. *Id.*; see also Jody Feder & Cynthia Brougher, *Sexual Orientation and Gender Identity Discrimination in Employment: A Legal Analysis of the Employment Non-Discrimination Act (ENDA)* 5, CONG. RESEARCH SERV. (July 15, 2014) available at <https://www.fas.org/sgp/crs/misc/R40934.pdf>.

392. Feder, *supra* note 391.

393. *Issue: Federal Advocacy, Employment Non-Discrimination Act*, *supra* note 382.

394. *Id.*

yet to pass the House, the passage of the ENDA by the Senate is a crucial step in establishing rights for transgender individuals. By establishing employment rights through the ENDA transgender individuals will be given more access to necessary health care.³⁹⁵ In passing the ENDA, the legislature has sent a crucial message to transgender individuals that their plight is not ignored and that the government is interested in protecting their rights. The passage of ENDA can help build trust with the transgender community and lead to more balanced federal policies in the health care exchanges, which in turn may motivate more transgender individuals to enter the health care exchanges.³⁹⁶

Many transgender and transsexual individuals have chosen to not get health care because of the long history of discriminatory practices used by insurance companies and providers.³⁹⁷ A 2013 survey by the Center for American Progress on HHS’s LGBT health care awareness campaign found that though the campaign reached many LGB individuals, it did not spark awareness about the exchanges and other health programs that are emerging under the ACA.³⁹⁸ The same survey noted that many transgender individuals have an extreme wariness of any representative of the health care system that has resulted from years of discrimination.³⁹⁹ A similar survey conducted by a state health project in Missouri determined that transgender individuals in the state struggled to even obtain information from insurers about transgender coverage.⁴⁰⁰ These recent surveys show

395. *See Employment Non-Discrimination Act*, ACLU, https://www.aclu.org/hiv-aids_lgbt-rights/employment-non-discrimination-act (last visited Mar. 5, 2014) (stating that at current law, transgender individuals can be fired or denied employment solely based on their gender identity in 33 states).

396. *See* Scout, *supra* note 160 (stating that many transgender individuals avoid the health care system because of fear of discrimination and unfavorable treatment as well-limited access) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

397. *See id.* (stating that the Center for American Progress’ data collection found that the existing exchange message works for most LGB people, but not trans* people and that the trans* focus groups “were some of the saddest [the researcher] had ever run”).

398. *See id.* (noting that participants in the Center for American Progress focus groups had such a profound history of discrimination that they had developed an extreme wariness of any representative of the health care system).

399. *See id.* (noting that events from the most recent assessment of trans* needs showed that nearly one-fifth of respondents had not just been discriminated against by health providers, but outright turned away from care for being trans*).

400. *See id.* (explaining that when a representative of a Missouri LGBT equality group called an insurer, she was transferred 20 times and never received information about trans* health coverage).

that transgender individuals are wary of the health care system as whole and are even reluctant to call navigators.⁴⁰¹ Thus there is a grave possibility that even with increased protections, the health insurance exchanges and other insurance programs being offered under the ACA will continue to be inaccessible to transgender individuals.⁴⁰² Advocates believe the ENDA and more statutes protecting transgender individuals can help improve the bleak turnout of transgender individuals in the exchanges.⁴⁰³ Regulations and acts similar to ENDA would give the federal government footing for proving that they are concerned with the plight of transgender individuals. In doing so, more transgender people are likely to engage with the federal health care system.

B. Discriminatory Health Care Practices Need to Be Addressed

Even if transgender individuals obtain health insurance coverage, transsexual people with gender dysphoria may still be limited. As addressed in Part II, many insurance companies still discriminate against transgender and transsexual individuals, particularly with coverage of transition-related care.⁴⁰⁴ In order to address the continuing discrimination against transgender people in need of transition procedures, advocates believe HHS should promulgate further non-discrimination provisions that are more LGBT—and specifically transgender—focused. Second, advocates assert that HHS should clarify what “medically necessary” means for transgender individuals—particularly that SRS and other transition procedures are medically necessary for transsexual people with gender dysphoria.⁴⁰⁵

401. See Scout, *supra* note 160; see also *Glossary: Navigator*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/navigator/> (last visited Mar. 6, 2014) (defining a health care navigator as an individual or organization trained to help consumers, small businesses, and their employees as they look for health coverage through the Health Insurance Marketplace—a resource for learning about health care options—including completing eligibility and enrollment forms) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

402. See *id.*

403. See *id.* (emphasizing that transgender individuals needed trans*-specific questions answered).

404. See *infra* Part III (explaining how insurance companies discriminate against transgender individuals through medical-necessity reviews and classifying transition procedures as cosmetic).

405. See DSM-V Fact Sheet, *supra* note 19 (stating that SRS and other transitions procedures are necessary treatment for individuals diagnosed with gender dysphoria).

1. HHS Needs to Promulgate Further Non-Discrimination Provisions with an LGBT Focus

Many advocates believe that the current non-discrimination provision of the ACA and the clarifications that have followed are not enough to protect transgender health care access. For example, on September 30, 2013, the Fenway Institute, an LGBT health care, education, research, and advocacy organization, submitted a public comment to HHS, urging the department to issue a nondiscrimination provision to ensure LGBT Americans’ ability to access nondiscriminatory health care in all settings, regardless of sexual orientation or gender identity.⁴⁰⁶ The Fenway Institute believes that such a regulation would be consistent with other HHS-published regulations such as the 2012 federal regulation that outlaws sexual orientation and gender identity discrimination by Qualified Health Plans traded on state Marketplaces.⁴⁰⁷ This 2012 nondiscrimination regulation protects against insurance discrimination on the basis of sexual orientation and gender identity, but not against discrimination in health care.⁴⁰⁸ There is no federal civil rights statute covering sexual orientation and no federal sexual orientation health care nondiscrimination regulation—lesbian, gay, and bisexual individuals remain vulnerable to discrimination in states without nondiscrimination protections.⁴⁰⁹

An HHS nondiscrimination regulation covering sexual orientation and gender identity, as proposed by the Fenway Institute, would make it more likely that transgender people will self-disclose to health care providers.⁴¹⁰ Self-disclosure of sexual orientation and gender identity, and the tracking of such data is a critical step towards understanding and reducing LGBT health disparities.⁴¹¹ Such a regulation would also be consistent with the steps taken by non-governmental bodies to protect LGBT patients. For example,

406. Cahill, *supra* note 93; see also *About Fenway–Fenway Health*, FENWAY INST., http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_abt_about_home (last visited Nov. 1, 2013) (stating that Fenway Health is an LGBT health care, education, research, and advocacy organization) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

407. *Id.*

408. *Id.*

409. *Id.*

410. *Id.*

411. *Id.*

the Joint Commission⁴¹² now requires the hospitals it accredits to establish nondiscrimination policies that are inclusive of sexual orientation and gender identity and expression and to implement equal visitation policies.⁴¹³ A federal regulation banning discrimination on the basis of sexual orientation and gender identity in health care will help further transform the United States health care system and lead to more comprehensive care for the LGBT population.

2. HHS or Other Government Agencies Should Clarify What “Medical Necessity” is in Relation to Transition-Related Care

Many advocates believe that the government should determine and clarify, as the medical community has,⁴¹⁴ that SRS and other gender confirming procedures are medically necessary for individuals with gender dysphoria.⁴¹⁵ Since 2008, the American Medical Association (AMA) has stated that, “[A]n established body of medical research demonstrated the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID... the AMA support[s] public and private health insurance coverage for the treatment of gender identity disorder.”⁴¹⁶

412. See *About the Joint Commission*, JOINT COMM’N, http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx (last visited Sept. 10, 2014) (explaining that the Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the United States) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

413. See Cahill, *supra* note 93.

414. See *AMA Policies on LGBT Issues*, AM. MED. ASS’N, <https://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glb-adv-isory-committee/ama-policy-regarding-sexual-orientation.page> (last visited Sept. 10, 2014) (stating that—through its H-65.983 Nondiscrimination Policy—the AMA affirms it has not been its policy to discriminate with regard to sexual orientation or gender identity, and that—through its H.185-950 Removing Financial Barriers to Care for Transgender Patients—it supports treatment for patients with GID) (on file with the Washington and Lee Journal of Civil Rights and Social Justice); see also Khan, *supra* note 113, at 414 (explaining that transition-related procedures are medically necessary because of psychological benefits people with gender-identity disorder attain through the procedures and because it is often what the physician believes is the necessary mode of treatment for the condition).

415. See DSM-V Fact Sheet, *supra* note 19, 25 (explaining that SRS and hormone therapy as well as psychotherapy are necessary treatments for gender dysphoria); see also AM. MED. ASS’N, *supra* note 411.

416. See Am. Med. House of Delegates, *supra* note 8 at 1–2 (2008) (using the term

Contrary to the findings and beliefs of the medical community, insurers have and continue to use medical-necessity reviews to restrict transgender patients’ access to transition-related and gender confirming health care.⁴¹⁷ Advocates now fear that because the ACA’s nondiscrimination provisions prevent pre-existing condition discrimination, insurance companies will increase their reliance on medical necessity reviews to deny coverage of transition-related procedures.⁴¹⁸ Thus under the ACA, insurers have more incentive to narrow the kinds of services considered medically necessary, especially for a politically powerless group like transgender individuals.⁴¹⁹ Unless there is some form of intervention, insurers may continue to use medical necessity review to discriminate against transgender individuals and continue to deny necessary coverage for those with gender dysphoria.⁴²⁰ Though medical necessity review in itself is not a bad practice, the way insurers use it to make coverage determinations for transgender patients requires further regulation.

In order to achieve equal care for transgender individuals, regulators must first clarify what a “medical necessity” is. Advocates believe medical necessity should be defined as more than a specific treatment that is essential to one’s bodily or mental well-being.⁴²¹ Such a strict definition of medical necessity does not comport with how modern medicine treats medical conditions—patients with the same condition often have diverse medical needs and treatments that are necessary interventions for one patient may not be necessary for another.⁴²² For example, treatment for individuals with diabetes varies depending on the individual’s health history and other factors. Sometimes diabetes is treated through changing one’s diet and adding in exercise, while sometimes insulin injections are required. The same can be said of gender dysphoria—it is a classified

“gender identity disorder” because at the time the resolution was published in 2008, this phrase was the DSM-IV definition for gender dysphoria).

417. See Khan, *supra* note 113, at 414 (2011) (outlining different occurrences of insurance company discrimination based on the medical necessity standard).

418. *Id.*

419. *Id.*; see also Cahill, *supra* note 93.

420. *Id.*

421. See Kahn, *supra* note 113, at 414 (explaining how medical necessity is sometimes defined).

422. See DSM-V Fact Sheet, *supra* note 19 (explaining the psychological and physical strain faced by transsexual individuals with gender dysphoria and how if left untreated, it could lead to destructive behavior and even suicide).

diagnosis with steps for diagnosis and treatment that must be met before any form of transition care is started.⁴²³

Many advocates believe that the necessity of transition procedures should be left to the treating physician's judgment.⁴²⁴ This view is consistent with past medical and insurance practices for other treatments. A given treatment is generally considered necessary when a patient's physician finds that the intervention is medically appropriate for a patient's condition.⁴²⁵ In the past, insurers and courts have deferred to the physician's judgment, provided that it aligns with the medical community's recommended treatment for the condition.⁴²⁶ Under such a standard, the medical necessity for transition-related care should not even be in question, given that the American Psychosocial Association, with the DSM-V, has established a standard of treatment for gender dysphoria that is also in conjunction with international medical practices.⁴²⁷ Thus, the establishment of a standard in the form of rule promulgated by HHS or another agency would serve only to clarify an existing standard, not create a new one. Doing so would prevent private insurance companies from denying legitimately diagnosed transsexuals with gender dysphoria transition-related treatments under the guise that the procedures are medically unnecessary.

423. *See id.* (stating that to be diagnosed an individual must experience a marked difference than the individual's expressed gender and the gender others would assign him or her and it must continue for at least six months).

424. *See Khan, supra* note 113, at 414 (emphasizing that many transgender advocates and physicians believe that the medical necessity of transition-related care should be left up to the patient and their physician).

425. *See id.* (discussing how courts and medical professional review boards generally defer to the treating physician's diagnosis and treatment plan in cases of medical necessity questions).

426. *See James P. Jacobson, To Pay or Not to Pay, That Is the Question: Coverage Disputes Between Health Plans and Members*, 29 *HAMLIN J. PUB. L. & POL'Y* 445, 448–49 (2007) (discussing exclusions for cosmetic and experimental treatments).

427. *See DSM-V Fact Sheet, supra* note 19 (stating that treatment for gender dysphoria is based on a triadic care method that incorporates psychological treatment with hormone therapy and transition-related services such as SRS); *see also* WORLD PROF'L ASSOC. FOR TRANSGENDER HEALTH, *supra* note 7 (providing flexible standards of care for Gender Identity Disorders).

C. Require Coverage of Transition-Related Care in Public and Private Insurance Plans

The federal government should consider requiring coverage for transition procedures under all health insurance plans, including public health programs. Some states and cities have already taken it upon themselves to do so and it has resulted in more comprehensive care for transgender individuals with no increase in cost.⁴²⁸ As discussed in Part III of this note, public and private insurance programs alike discriminate against transgender individuals on a multitude of fronts.⁴²⁹ But most importantly, both forms of health care often fail to realize or cover transgender- and transsexual-specific health care needs.⁴³⁰ Plans will not cover certain types of treatments for transgender people, namely SRS and hormone therapy,⁴³¹ and at times will change coverage options after an individual has transitioned.⁴³² Many plans, even under the ACA, continue to discriminate through the medical-necessity standard and some public programs do not even afford transgender patients medical-necessity review with the state’s department of insurance.⁴³³

428. See *Corporate Equality Index*, *supra* note 354 (noting that numerous public employers offer inclusive coverage including the University of California and the University of Michigan, as well as the cities of Minneapolis, New York, and San Francisco).

429. *Id.*

430. *Id.*

431. SRS and hormone therapy are generally referred to as “transition related procedures” or “gender confirming care.”

432. See Kate Walsham, *De-Gendering Health Insurance: A Case for a Federal Insurance Gender Nondiscrimination Act*, 24 HASTINGS WOMEN’S L.J. 197, 206–07 (2012) (explaining that many plans will not cover transition-related procedures, often referred to as “gender incongruent procedures,” but will cover the same procedures for a nontransgender patient providing examples of denials for Pap smears for a transgender male).

433. See Shannon Minter et al., *A New Approach to Healthcare Equality for Transgender People: California’s Insurance Gender Non-Discrimination Act*, 2 LGBT POL’Y J. HARV. KENNEDY SCH. 35, 39 (2012) (detailing how medical necessity review is not given for denial of transition-related care that is classified a cosmetic); Walsham, *supra* note 432, at 215 (2012) (explaining how states can dictate what procedures Medicaid must cover based on medical necessity, and how some states deny medical-necessity review when these denials are contested); see also TRANSGENDER LAW CTR., TRANSGENDER HEALTH AND THE LAW: IDENTIFYING AND FIGHTING HEALTH CARE DISCRIMINATION (2004), available at <http://translaw.wpengine.com/wp-content/uploads/2012/07/99737410-Health-Law-Fact.pdf> (last visited Sept. 12, 2014) (discussing denial of medically necessary procedures based on a patient’s gender marker).

In failing to provide care within public programs, the United States is far behind a surprising array of countries—including Iran, Brazil, Argentina, and the United Kingdom—that cover procedures like hormone therapy and SRS either free of charge or at a low cost.⁴³⁴ For example, though Iran has some of the strictest laws on sexuality and same-sex relations in the world, Iran also has an extremely liberal sex-change operations industry.⁴³⁵ According to a 2012 report by the BBC, the Iranian regime made sexual reassignment surgery more accessible by announcing that health insurance companies must cover the full cost of sex-change operations.⁴³⁶ Similarly, in 2012 Argentina passed a law that not only gives people the right to specify how their gender is listed at the civil registry, but that also covers sex-change surgery or hormone therapy for adults as part of their public or private health care plans.⁴³⁷ It is crucial that the United States

434. See Jillian Berman & Jeffrey Young, *Transgender Americans Struggle for Coverage as U.S. Lags 'Far Behind' Even Iran*, HUFFINGTON POST (Aug. 22, 2013), http://www.huffingtonpost.com/2013/08/22/transgender-coverage_n_3797843.html (detailing transgender health care coverage in other countries and, based on the United States' National Transgender Discrimination Survey, how these foreign nations cover more procedures than American insurance programs).

435. See Sasha von Oldershausen, *Iran's Sex-Change Operations Provided Nearly Free-of-Cost*, HUFFINGTON POST (June 4, 2012), http://www.huffingtonpost.com/2012/06/04/iran-sex-change-operation_n_1568604.html (stating that Iran has a reputation for an extremely liberal sex-change operations industry).

436. *Id.*; see also *Iran's Health Insurers to Pay for Sex Change Operations*, BBC (May 29, 2012), <http://www.bbc.com/news/world-middle-east-18258276> (last visited Sept. 12, 2014) (interviewing and reporting on how health insurance companies in Iran are obliged to cover the costs of sex reassignment surgery); see also Ali Hamedani, *The Gay People Pushed to Change Their Gender*, BBC PERSIAN (Nov. 4, 2014) <http://www.bbc.com/news/magazine-29832690> (stating that Ayatollah Khomeini passed a fatwa in the 1980's allowing sex-change operations in the country); see also Mehrnaz Samimim, *Fatwa Allows Sex Changes in Iran, but Stigma Remains*, AL MONITOR (Oct. 7, 2013) <http://www.al-monitor.com/pulse/originals/2013/10/iran-subsidizes-sex-change-surgery.html> # (detailing how the Iranian government subsidizes sex reassignment surgeries and treatment). It is important to note that while this is in stark contrast to United States policy, Iran is still a country where same-sex relationships are punishable by execution, making sex-change surgeries often the only difference between life and death. See von Oldershausen, *supra* note 435 (noting that although the freedom to change sex might be a relief to some Iranians, there is also a pressure felt by gay men and women in Iran to have sex reassignment surgeries as a means of legitimizing their sexual orientation because as gay individuals, they are committing a crime, while as transsexuals, they can exist under Iranian law).

437. Michael Warren, *Argentina Approves Transgender Rights Legislation, Makes Sex-Change Surgery a Legal Right*, HUFFINGTON POST (May 10, 2012), http://www.huffingtonpost.com/2012/05/10/gender-identity-law-argentina_n_1505093.html

follows suit given that transgender Americans are disproportionately poorer than the rest of the population with more than one-quarter living off \$20,000 per year or less.⁴³⁸ Many transgender individuals cannot afford health care in general let alone transition-related care. Thus, it is crucial that public programs expand their coverage, as doing so would not increase health care costs.⁴³⁹ A study of San Francisco’s experience with offering coverage of transition procedures to city employees found that costs and claims fell well under the figures estimated by actuaries and in the end did not cost the city or its employees more to cover transition procedures.⁴⁴⁰ Advocates believe that based on the statistics from San Francisco, there is no monetary justification for not covering gender confirming care for transsexual individuals with gender dysphoria because it will likely not increase insurance costs and premiums.⁴⁴¹ Requiring coverage for transition-related care within public programs can help shape the standard for how private insurance companies determine coverage, thus leading to more transition-related care available to transgender individuals.

Some states have already reformed their insurance regulations and many advocates believe the federal government should follow suit and take similar action.⁴⁴² The different state statutes and bulletins can serve as a framework within which a federal policy can be developed. The insurance and managed care departments of Vermont, the District of Columbia, California, Colorado, Massachusetts, and Oregon have issued regulations and bulletins in 2012, 2013, and 2014 that have banned transgender discrimination in state health care programs and required coverage of some

(on file with the Washington and Lee Journal of Civil Rights and Social Justice).

438. See Berman, *supra* note 434 (citing the United States’ National Transgender Discrimination Survey).

439. See *Corporate Equality Index*, *supra* note 354; see also *Transgender-Inclusive Health Care Coverage*, HUMAN RIGHTS CAMPAIGN, <http://www.hrc.org/resources/entry/transgender-inclusive-benefits-medical-treatment-cost-and-utilization> (last visited Nov. 8, 2014) (noting that numerous public employers offer inclusive coverage: University of California, University of Michigan, the city of Minneapolis, City of the New York, and San Francisco).

440. See *Transgender-Inclusive Health Care Coverage*, *supra* note 439 (noting that actuaries estimated that 35 people per year would access \$50,000 in services and the actual utilization over a five year span from 2001–2006 was a total of 37 claims and a total expenditure of \$383,000, which was far less than expected).

441. *Id.*

442. See Baker, *supra* note 78 (summarizing how state insurance departments in California, the District of Columbia, Vermont, Oregon, and Colorado have released bulletins that further limit transgender discrimination in insurance coverage).

transition-related procedures.⁴⁴³ The District of Columbia has passed the Unfair Insurance Trade Practices Act that prohibits any treatment procedure designed to alter an individual's physician characteristics to those of the opposite sex.⁴⁴⁴ In Vermont, the state Insurance Department has released a bulletin clarifying that insurance companies shall not exclude coverage for medically necessary treatments including gender reassignment surgery for gender dysphoria and related health conditions.⁴⁴⁵

Prior to the publication of the HHS regulation clarifying that plans may not discriminate based on gender identity or sexual preference, California, in 2005, passed the Insurance Gender Nondiscrimination Act (IGNA).⁴⁴⁶ The IGNA established a state insurance framework wherein an insurer that covers a procedure for a non-transgender patient, must cover that procedure for a transgender patient.⁴⁴⁷ The IGNA was passed to recognize and address problems transgender individuals face accessing care even when they have insurance.⁴⁴⁸ The IGNA emphasizes that many transgender insureds still need medical services typically given to members

443. *What Coloradans Need to Know About the Division of Insurance Recent Bulletin on Health Insurance*, ONE COLORADO, <http://www.one-colorado.org/what-coloradans-need-to-know-about-the-division-of-insurance-recent-bulletin-on-health-insurance/> (last visited Feb. 12, 2014) (explaining that discrimination based health coverage is prohibited, in Colorado and that equal procedures must be given to all insureds) (on file with the Washington and Lee Journal of Civil Rights and Social Justice); *see also FAQ: California's Ban on Transgender Exclusions in Health Insurance*, TRANSGENDER LAW CTR., <http://transgenderlawcenter.org/archives/4273> (last visited Feb. 12, 2014) (describing the California Department of Managed Health Care's removal of blanket exclusions of coverage based on gender identity or expression) (on file with the Washington and Lee Journal of Civil Rights and Social Justice); *see also* Dave Blanchard, *Oregon Bans Transgender Health Care Discrimination*, OREGON PUB. BROADCASTING, (Jan. 11, 2013), <http://www.opb.org/radio/programs/thinkoutloud/segment/oregon-bans-transgender-health-care-discrimination/> (stating that the Oregon Insurance Division ruled that insurance companies cannot discriminate against transgender individuals) (on file with the Washington and Lee Journal of Civil Rights and Social Justice); Jeremy C. Fox, *Mass. to Cover Range of Transgender Medical Care*, BOSTON GLOBE (June 20, 2014), *available at* <http://www.bostonglobe.com/metro/2014/06/20/state-cover-gender-reassignment-surgery-and-hormone-treatment-for-transgender-patients/a9OPrvqdUPmRoiAQugVwEO/story.html>.

444. *See* Baker, *supra* note 78 (describing Washington, D.C.'s Unfair Insurance Trade Practices Act).

445. *See id.* at 4 (explaining the Vermont Insurance Department's bulletin).

446. *See* Insurance Gender Nondiscrimination Act, 2005 CAL. LEGIS. SERV. 421 (West).

447. *See* Minter, *supra* note 433, at 39 (explaining how the IGNA requires equal coverage among all patients in regards to procedures); *see also* Walsham, *supra* note 432,

448. *Id.*

of the opposite sex and that health plans that deny such procedures because of transgender status are contrary to effective public health practices.⁴⁴⁹

The California Department of Managed Health Care (DMHC) has built on the IGNA and the HHS non-discrimination clarification and ordered that California’s health plans remove exclusions of coverage based on gender identity and expression.⁴⁵⁰ The guidance from the DMHC was issued in 2013 and states that the IGNA guarantees all people the right to access coverage for medically necessary care regardless of their gender identity or gender expression.⁴⁵¹ This effectively removes the medical necessity limitation used by insurance companies to deny coverage of transition procedures for patients with gender dysphoria.⁴⁵² The directive applies to HMOs and PPOs regulated by the DMHC and builds on a parallel nondiscrimination regulation issued by the Department of Insurance in 2012 that covers health insurance under their regulation.⁴⁵³ As a result, all California health plans and insurers cannot arbitrarily deny medically necessary services provided to policy-holders simply because they are transgender.⁴⁵⁴ The DMHC letter also instructs health plans to revise current plan documents to remove exclusions and limitations related to

449. See CAL. HEALTH & SAFETY CODE § 1365.5(a) (2005); CAL. INS. CODE § 10140(a) (2005). California’s health insurance regulation statutes are bifurcated into the Health and Safety code and the Insurance code. The IGNA appears in both section 1365.5 of the California Health and Safety code and section 10140 of the California Insurance code--these provisions are identical; see also *CA Bans Insurance Discrimination Against Transgender Patients*, TRANSGENDER LAW CTR. (Apr. 9, 2013), <http://transgenderlawcenter.org/archives/3920> (stating “insureds may identify themselves as a certain sex, they may still need medical services typically given to members of the opposite sex ... A health plan that automatically denies coverage of gynecological services for men as inappropriate could then deny appropriate medically necessary services for transgender enrollees.”).

450. See *CA Bans Insurance Discrimination Against Transgender Patients*, *supra* note 449 (clarifying that California’s health plans under the IGNA must give all people the right to access coverage for medically necessary care regardless of the patient’s gender identity or expression).

451. *CA Bans Insurance Discrimination Against Transgender Patients*, *supra* note 449; see also *FAQ: California’s Ban on Transgender Exclusions in Health Insurance*, *supra* note 443.

452. See *CA Bans Insurance Discrimination Against Transgender Patients*, *supra* note 449 (detailing how California law removes the medical necessity limitation that insurance companies use to justify transition related health care exclusions).

453. *Id.*

454. *Id.*

gender transition.⁴⁵⁵ The Letter also directs that transgender individuals be given access to DMHC's Independent Medical Review (IMR) process if a health plan denies a specific medical service or treatment.⁴⁵⁶ The letter impacts 22.5 million Californians who are enrolled in health plans regulated by the DMHC and an additional 3.7 million people who are enrolled in health plans regulated by the DIO.⁴⁵⁷ Because insurance companies must comply with the DMHC and DOI Director's letters in order to sell insurance in the state, the letters carry the force of the law in California.⁴⁵⁸ The letters are not without limitation, the DMHC and DOI Letter's do not impact self-insured plans—generally used by larger businesses—because they are regulated under ERISA⁴⁵⁹ and by the Department of Labor.⁴⁶⁰

Similarly, Colorado's Division of Insurance has released a bulletin that bans health insurance discrimination against transgender Coloradans.⁴⁶¹ The bulletin mandates that transgender citizens of the state be afforded the same care and treatment as all other Coloradans under their health insurance plans.⁴⁶² Further, it bars the practice of excluding medically necessary care prescribed for the treatment of gender dysphoria and requires private health insurance companies to cover medically necessary care for transgender Coloradans on the same terms they cover all care.⁴⁶³ The Oregon Insurance Division has also ruled that insurance companies cannot discriminate

455. *Id.*

456. *See FAQ: California's Ban on Transgender Exclusions in Health Insurance*, *supra* note 443.

457. *See id.* (highlighting that, Kaiser Permanente, one of the largest insurers in California, is regulated by and subject to DMHC guidance).

458. *Id.*

459. 29 U.S.C. §§ 1021–1453. ERISA is a federal insurance law that preempts state nondiscrimination protections.

460. *FAQ: California's Ban on Transgender Exclusions in Health Insurance*, *supra* note 443.

461. *See CAHP Issues Statement—Health Insurance Coverage for Transgender Individual*, COLORADO ASS'N OF HEALTH PLANS (Dec. 16, 2013) <http://www.colohealthplans.org/2/post/2013/12/cahp-statement-health-insurance-coverage-for-transgender-individuals.html> (detailing Colorado's insurance bulletin); *see also TLDEF Applauds Colorado Decision Banning Transgender Health Care Discrimination*, TRANSGENDER LEGAL DEFENSE & EDUCATION FUND [.http://www.transgenderlegal.org/headline_show.php?id=405](http://www.transgenderlegal.org/headline_show.php?id=405) (last visited February 26, 2014).

462. *Id.*

463. *Id.*

against transgender individuals.⁴⁶⁴ The regulations are similar to Colorado and California in that they mandate that any procedure or treatment that would be provided to a non-transgender person, such as counseling, hormone treatment, or genital surgery, cannot be denied to a transgender individual.⁴⁶⁵ For example, an insurance company that offers genital surgery for someone who was maimed or intersex will now also have to cover the same procedure for transgender individuals.⁴⁶⁶

The states adopting these policies are not requiring coverage for specific medical treatments; instead they are simply guaranteeing transgender individuals the same rights to coverage as all other individuals seeking identical procedures. In doing so these states are taking a major step forward in providing better and more comprehensive care for transgender people and removing tools used by insurance companies to deny coverage of transition-related care. The regulations are making crucial strides in expanding transgender health care access, but they do not cover people eligible for Medicare and/or Medicaid programs.⁴⁶⁷ Though California Medicaid, Medi-Cal, covers some transition procedures such as hormone replacement therapy and some forms of SRS.⁴⁶⁸

Proponents of transgender rights believe HHS should promulgate an additional nondiscrimination provision that builds on 1557’s clarification and parallels what California, Oregon, and Colorado have done.⁴⁶⁹ These regulations are crucial because they create a fair system, by guaranteeing the same coverage to all insureds and effectively end the denial of transition-related care coverage.⁴⁷⁰ Advocates believe that promulgating

464. See Blanchard, *supra* note 443 (explaining Oregon Insurance Division determination prohibiting transgender discrimination); see also Jonathan J. Cooper, *California & Oregon Direct Insurance Companies to Provide It*, HUFFINGTON POST (Nov. 11, 2013), http://www.huffingtonpost.com/2013/01/12/transgender-health-coverage-california-oregon-insurance_n_2463615.html.

465. *Id.*

466. *Id.*

467. *Id.*

468. *What Transgender Californians Need to Know About Health Care Reform*, TRANSGENDER LAW CTR., <http://transgenderlawcenter.org/archives/9145> (last visited Feb. 25, 2014).

469. *Id.*; see COLORADO ASS’N OF HEALTH PLANS, *supra* note 461; see also Cooper, *supra* note 464.

470. See *What Transgender Californians Need to Know About Health Care Reform*, *supra* note 468 (quoting Ray Crider, a 28-year-old transgender man, “I just never felt that I was anybody else. I see everybody else being taken care of without having to fight the

such a rule or issuing a regulation at the federal level will give transgender individuals the equal standing they deserve and provide them with the needed confidence to pursue treatment options they desire.⁴⁷¹ The state directives have been met with much support by LGBT advocates, and after seeing the success of expanding city-based health insurance for employees in Portland and San Francisco many believe these state regulations will have nothing but a positive effect on statewide health care access.⁴⁷² Thus, advocates believe that these successes at the state level could serve as a framework for expanding federal non-discrimination laws for transgender health care access.⁴⁷³ These changes will not only effect private insurers, but also serve to improve state Medicaid coverage for transition related care, as it has in California.⁴⁷⁴

IV. Conclusion

In examining the history of transgender health care discrimination, it is clear that the situation for transgender individuals in the U.S. is beginning to improve. More and more corporations and public employers cover transition-related care for transsexual employees and culturally competent care for transgender employees.⁴⁷⁵ HHS has taken some steps to improve access for transgender individuals with gender dysphoria by lifting Medicare's blanket ban on covering transition related care.⁴⁷⁶

But discrimination in the workplace and health care market still exists. The first step to eliminate discrimination should be to pass the ENDA through the House. The ENDA will, by limiting employment discrimination, address crucial health care access issues.⁴⁷⁷ More employment opportunities will either provide transgender individuals with

system.”).

471. *See id.* (emphasizing the importance for transgender individuals to have a rule or regulation to base advocacy and rights on).

472. *Id.*

473. *Id.*

474. *Id.*

475. *See Corporate Equality Index, supra* note 354 (listing corporations that provide health care coverage for transition related procedures).

476. NCD 140.3, *Transsexual Surgery*, DEP'T OF HEALTH & HUMAN SERVS., DEP'T APPEALS BD., APP. DIV., Docket No. 14 A-13-87, Decision No. 2575 (May 30, 2014).

477. *See Ford, supra* note 381.

employer-based health insurance or provide them with the funds to enter the Health Exchanges or examine a broader array of private health plans that may cover transition-related care. The passage of the ENDA will also be a crucial signal to the transgender community that the government not only recognizes their struggle, but that they are seeking to remedy it through the legislative process.

The second step is for the federal government to build on the 2012 HHS nondiscrimination clarification and promulgate additional nondiscrimination provisions specific to transgender health care access issues. These provisions should mirror those already established by California, Oregon, and Colorado state insurance departments.⁴⁷⁸ One such provision should clarify that the treating and diagnosing physician, not the insurance company, should determine the medical necessity of transition-related procedures. Other provisions should clarify that health plans and insurers, both public and private, cannot arbitrarily deny medically necessary services provided to policyholders because they are transgender. Further, there should be a rule requiring insurance companies to cover medically necessary care for transgender individuals on the same terms as all other care provide to plan members.

The fact that the ACA has yet to improve care, still allowing for medical necessity and cosmetic discrimination in transition-related care, is telling of the state of the health care system in the U.S. Clearly, we still have a long way to go towards improving transgender health care disparities. The ACA has launched a new era in American health care and refocused government interest on social legislation. It presents an opportunity for transgender individuals and advocates to legislate federal protection for access to health care and should be capitalized on by advocates. An end to discriminatory practices is not likely to come without further forms of federal protection and it is up to the government to seize this pivotal moment for change in the treatment of transgender individuals in the health care system.

478. *What Coloradans Need to Know About the Division of Insurance Recent Bulletin on Health Insurance*, ONE COLORADO, <http://www.one-colorado.org/what-coloradans-need-to-know-about-the-division-of-insurance-recent-bulletin-on-health-insurance/> (last visited Feb. 12, 2014); see also *FAQ: California’s Ban on Transgender Exclusions in Health Insurance*, *supra* note 443; see also Blanchard, *supra* note 443.