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Taking it to the Bank: Actualizing Health Care Equality for San Francisco’s Transgender City and County Employees

J. Denise Diskin

We are the city that has taught and insisted to the rest of the world that there should be equal benefits for equal work - we require that of private businesses that work with us - but we, the city, have not been living up to our own standard... Now, we're going to correct that.

I. Introduction

In February of 2007, news broke across the nation that Steve Stanton, City Manager of Largo, Florida, had been fired by a 5-2 vote of the city commissioners after his announcement that he planned to transition from male to female. Stanton had been employed as city manager for fourteen years, but city officials felt that after Stanton announced his plans to change genders, they had “lost confidence in his ability to lead.” In the majority of cities around the country, such a firing might only be cause for righteous indignation. In Largo, however, the vote was blatantly against the law as Largo is one of a growing number of cities in the United States that has a non-discrimination policy covering gender identity.

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Like Largo, San Francisco protects its city employees from discrimination based on their gender identity. Written into San Francisco’s city laws are broad prohibitions against discrimination based upon several factors, including race, creed, religion, age, sex, sexual orientation, gender identity, domestic partner status, marital status, disability, AIDS or HIV status, weight, and height.\(^5\)

However, those extensive protections have not come without the efforts of countless community activists and city residents who have worked to make the case for anti-discrimination measures, and who have held the city accountable for creating policies that are anti-discriminatory in both word and action.\(^6\) In this note, I chart the decisions made by San Francisco’s Health Service System Board (“HSSB”) and the San Francisco City Board of Supervisors to provide transition-related health care coverage to its transgender city and county employees. In taking this action, San Francisco became the first city to fully actuate its anti-discrimination measure by funding transition-related medical costs for its city employees. Such medical costs are typically not covered for patients who are undergoing procedures as part of a gender transition, though they are covered for non-transgender (also called cisgendered) patients, creating a significant financial barrier to health care for transgender discrimination based on gender identity” hyperlink; then follow “Go” hyperlink next to “City and County Governments”) (last visited Oct. 18, 2007) [hereinafter Human Rights Campaign Database].

6. See infra Part V.
7. “Transgender,” as used here, refers broadly to people whose gender expression is nontraditional and/or whose gender identity is different than their birth gender. This term may include female or male cross dressers, drag queens or kings, masculine females, feminine males, or those who identify as genderqueer or who identify as neither male nor female. “Transgender” also encompasses the term “transsexual,” which I use to refer to those who transition from one gender to the other with some degree of medical intervention. While many transsexuals consider themselves to be transgender, far fewer of those who identify as transgender identify specifically as transsexual. Individuals born biologically male who transition to become female may refer to themselves as male-to-female, or transgender women. Individuals born biologically female who transition to become male may refer to themselves as female-to-male, or transgender men. See generally SAN FRANCISCO HUMAN RIGHTS COMM’N, Compliance Guidelines to Prohibit Gender Identity Discrimination (2003), http://www.sfgov.org/site/sfhumanrights_page.asp?id=6274; HUMAN RIGHTS CAMPAIGN, TRANSGENDER AMERICANS: A HANDBOOK FOR UNDERSTANDING 7-9 (Human Rights Campaign Fund 2007).
employees. While this decision has cost the city relatively little money and impacted a nearly statistically insignificant number of people, its greater implications for considering deprivation of health care a discriminatory issue are enormous.

In this note, I first use San Francisco’s health care coverage to discuss the intersectional marginalization of transgender communities, communities of color, and poor communities. Next, I analyze these communities’ access to legal rights in connection with their access to medical care, using a great deal of the research on the needs and experiences of the San Francisco transgender community done by the Transgender Law Center and the National Center for Lesbian Rights. Finally, I discuss the organizing strategies employed by activists, so that this note may serve not only as an analysis of the impact of their efforts, but also a guide for activists wishing to replicate these movements in their own communities. In order to give the credit deserved to the work of the members of the Transgender Community Task Force, who worked on this issue for such a long time, it is imperative for me to note that because this movement to convince a public entity to negotiate with its insurance provider to obtain transition-related medical coverage was entirely the first of its kind, much of the reporting of the events at the time was obtained through personal interviews and journalistic accounting. A substantive history of this period of activism has not been recorded, and as a law student with limited resources, I was unable to perform all of the interviews that deserved to be included in this account. Many of the activists in this particular moment of San Francisco history have continued to work for the rights of marginalized communities, and have inspired the work of many up and coming transgender and ally activists as well so that San

8. Some of the medical procedures commonly undergone as a part of gender transition include hormone therapy (wherein patients take the hormones testosterone, estrogen, or progesterone in order to acquire some of the secondary sex characteristics of their desired sex), hysterectomy (removal of the uterus), oophorectomy (removal of the ovaries), mastectomy (removal of breast tissue), chest reconstruction (most often performed on transgender men; surgical reconstruction of skin and nipples to create a masculine-appearing upper torso), vaginoplasty (surgical creation of a vagina and female genitals), metoidioplasty or clitoral release (surgical creation of a phallus and sometimes testicles from pre-existing female genitalia and/or testicular implants), and phalloplasty (construction of a penis using grafts from other parts of the body and/or testicular implants).

9. See infra note 127.
II. The Problem of Obtaining Health Care in Transgender Communities

A. Intersecting Health, Race, Class, and Gender in San Francisco

It is tempting to view transgender people as members of a monolithic community, with common needs and oppression because of their gender identities; however this is in fact not the case. The U.S. and California Censuses do not collect data on whether people identify as transgender. Even if they did, the diversity of transgender identifications and communities, as well as a lack of social visibility and legitimacy would make it very difficult to obtain reliable data about gender, let alone other factors such as race or household income. It is reasonable to assume, however, that transgender people come from communities and backgrounds as varied as cisgendered people. That diversity of background and experience also means that the priorities and experiences of discrimination are very diverse, and layered with the myriad ways in which transgender people experience both oppression and privilege. For example, in the Trans Realities survey conducted by the Transgender Law Center and National Center for Lesbian Rights in 2003, 31 percent of those surveyed reported discrimination in health care, and ranked discrimination in health care second in importance to them, with employment discrimination being most important. However, health care decreased in importance to groups that had less access to it. For example, health care was second most important to survey respondents who identified

10. I am particularly indebted to writer, activist, and educator Jamison Green, Marcus Arana of the San Francisco City and County Human Rights Commission, Zak Szymanski, Assemblymember Mark Leno, Chris Daley of the Transgender Law Center, and Donna Ryu of the University of California Hastings College of the Law Civil Justice Clinic for the incredible gift of their time, energy, patience, information, and editing.

themselves as Asian American/Pacific Islander and European American, who reported having "some form of health insurance" at rates of 67 percent and 58 percent, respectively.\textsuperscript{12} African-American/Black respondents felt health care was less important than employment, housing, and police harassment, with only 50 percent of respondents reporting having access to health insurance.\textsuperscript{13} Latina/Latino/Hispanic respondents ranked health care fifth in importance, behind employment, police harassment, immigration, and housing discrimination, with only 33 percent of respondents having access to health insurance.\textsuperscript{14}

Other socio-economic barriers also affect the access people have to health care. Nearly one half of survey respondents lacked any kind of health insurance, which is more than two times the percentage of people in California who lacked health insurance in the 2000 California census.\textsuperscript{15} However, the survey also indicates that some groups within the transgender community have a more difficult time obtaining basic health care coverage: Latina/Latino/Hispanic respondents were one and a half times more likely to be uninsured than the surveyed pool, and people earning less than $25,000 a year were one and a quarter times more likely to be uninsured than the pool. Of the 50 percent of those surveyed, anecdotal evidence shows that very few can use that coverage to pay for transition-related procedures.\textsuperscript{16}

There are clear race, class, and gender-based reasons for the need for insurers and employers to stop excluding transgender people from health care coverage: transgender people, regardless of their race or class, often end up being marginalized in both employment and health care because of gender identity discrimination. If they are also poor people or people of color, they are doubly or triply marginalized by racism, classism, and often homophobia. This results in lower-paying jobs with fewer benefits, coinciding with the national downward trend in employer-provided health care and exacerbated by systematic underemployment.

\textsuperscript{12} Id. at Appendix C, fig. 1, 3.
\textsuperscript{13} Id.
\textsuperscript{14} Id.
\textsuperscript{15} Id. at II.C.
\textsuperscript{16} Id. at II.C.2.
While the City of San Francisco and an increasing number of private employers have removed the transgender exclusion and cover most procedures sought for medical transition, removing the exclusion does not necessarily mean that transgender people will be able to access a doctor who is willing to treat them respectfully, or who knows anything about transgender-specific health care. Some transgender people have experienced such discrimination when they attempt to access health care services that they have been barred from receiving health care at all. In an interview conducted in 2001, one female to male (“FTM”) transperson reported that he was denied coverage for uterine cancer by his insurance company because it “did not cover uteruses in men.” In another example, Robert Eads, a FTM transperson who developed ovarian cancer, was denied treatment by over twenty doctors and died, untreated.

To non-transgender people, the issue of health care coverage for the statistically very small number of people who are transgender employees of San Francisco City and County may seem academic. But equal rights under the law are not denied because of the size of one’s community. In 2003, the National Center for Lesbian Rights and the Transgender Law Center published “Trans Realities: a Legal Needs Assessment of San Francisco’s Transgender Communities” (“Trans Realities”) in order to quantify and identify the gender identity-related legal problems and to determine the extent to which the needs of transgender communities in San Francisco are being met by the city’s anti-discrimination laws. The report was compiled through a combination of survey data and anecdotal reporting, with the intention of providing community organizations with the “actual, instead of perceived” transgender community needs in order to be most effective in their service. The report found instances of discrimination in transgender communities to be quite high: nearly one of two respondents experienced gender identity-based employment discrimination, one

18. MINTER & DALEY, supra note 11, at II.A.5.
20. For a documentary of his fight with ovarian cancer, see SOUTHERN COMFORT (New Video Group 2001).
21. MINTER & DALEY, supra note 11, at I.A.
of three suffered such discrimination in public accommodations, and over 30 percent reported discrimination in accessing health care.

Moreover, as one survey respondent noted, "[d]iscrimination is not the only reason a transgender person might need free legal help!"\(^ {22} \) In other words, the Trans Realities report suggests that while transgender people face inordinate discrimination based on their gender identity, they also have the same legal needs as non-transgender people. While gender identity discrimination may be at the core of some legal problems that transgender people face, that discrimination can also lead to poverty due to either under- or unemployment, steep medical bills, unstable housing, increased police interactions (in part related to unemployment discrimination causing higher levels of participation in sex work or the drug trade), and inability to access legal assistance.\(^ {23} \)

In terms of preventing discrimination in health care, providing more access to health benefits is only the first step. The Trans Realities survey found that many transgender people do not have even basic health insurance. Many who do have health insurance, including San Francisco employees, have difficulty finding a doctor who is familiar and comfortable providing primary health care services to a transgender person. San Francisco’s transition-related coverage did not ensure that doctors would be educated on the particular medicals needs of transgender patients. Trans Realities reports that it is “not uncommon for transgender patients to be asked inappropriate questions about their anatomy when seeking services unrelated to their transition. . . . One man, who had made an appointment simply to refill his hormone prescription, found himself answering questions from two nurses about his sex life.”\(^ {24} \) However, San Francisco took the first very basic step by removing the transgender-specific exclusion from insurance coverage, leaving hope that as such coverage becomes more common, health care providers may begin to educate each other on how to provide sensitive health care to transgender patients.

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22. Id. at II.A.
23. See generally MINTER & DALEY, supra note 11.
24. MINTER & DALEY, supra note 11, at II.A.5.
B. The History of Transition-Related Medical Care

Approximately seventy years ago, as the field of plastic surgery began to develop, Dr. Harry Benjamin (an endocrinologist and gerontologist) first recognized the syndrome “gender identity disorder” (previously called “transexualism”) and outlined Standards of Care as a guideline for medical providers to follow in administering treatment to those diagnosed with gender identity disorder. Dr. Benjamin’s work inspired the creation of the Harry Benjamin International Gender Dysphoria Association Incorporated, which has been renamed the World Professional Association for Transgender Health (“WPATH”). People with gender identity disorder experience a strong and continuing cross-gender identification and a need to live and be accepted as a member of the opposite sex. Certainly not all transgender people are or want to be diagnosed with “gender identity disorder” or seek medical treatment. Some transgender people may make no physical changes at all. In their Trans Realities report, the Transgender Law Center in San Francisco indicated that 7 percent of those surveyed for the publication reported receiving no transition-related medical treatment at all, and that only 50 percent of respondents identified themselves as “transsexual.” For those who do wish to use medical intervention in their transition, however, the Benjamin Standards of Care (most recently revised in 2001) have formalized the process and provided medical guidelines to ensure standardized treatment protocols, including counseling, hormone therapy, and, when appropriate and desired, gender reassignment surgery.

As transgender civil rights movements developed and more transgender people moved into mainstream society, employers and insurance companies began to create exclusions in their coverage of

28. MINTER & DALEY, supra note 11. For a basic definition of “transsexual,” see id. n.5.
30. Mark Leno, Paying for Transgender Surgery; Sex Change in the City; Pain and Human Rights, S.F. CHRON., Apr. 29, 2001, at D8.
transgender employees so that by the 1980s such exclusions became standard. Now, most employers have to opt to include, rather than exclude transgender employees. Such exclusions do not prevent coverage of non-transition-related medical coverage for transgender people. For example, if a transgender person had an infection they may still receive antibiotics, but some insurance companies maintain a broad definition of “transition-related” and create false connections between illness and transition. These exclusions also do not forbid coverage of procedures used in medical transition when they are being performed on non-transgender people. For example, hormone therapy would be covered for a cisgendered male who identifies as a man. However, the same procedures, when administered to a transgender person for the purposes of their transition are carved out of the coverage. As San Francisco City Supervisor Mark Leno, an outspoken advocate of the transgender community, noted in 2001 in reference to San Francisco’s newly inclusive benefit plan, “[U]ntil now, a non-transgender employee with need of a mastectomy, hysterectomy, heart, kidney, or liver treatment would be covered, while a transgender employee could be denied. City employees have psychological counseling costs covered, but not if they mention ‘transgender’ to the therapist.”

C. Employers and Health Care

Employment discrimination based on gender identity is a key point of marginalization, ranked as a priority by at least 63 percent of respondents in the Trans Realities report across every demographic category. It is important to note initially that because of discrimination in hiring, as well as the ways in which anti-transgender bias can affect a person’s ability to be promoted and trained, transgender people often remain in entry-level or less-skilled positions, where they are less likely to be provided health insurance. Transgender people are also severely limited in the types of employment they can seek. They may be concerned that if the employer’s interest in them survives an initial interview, a routine check of their prior employment or government records may

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31. Telephone Interview with Jamison Green, transgender writer, activist, and educator, in San Francisco, Cal. (Jan. 28, 2007).
32. Leno, supra note 30.
33. MINTER & DALEY, supra note 11, at Appendix B-C.
34. Id. at II.A.4-5.
reveal their transgender status. If they come out on the job or are outed by coworkers, they may be fired or have their work shifts shortened or their duties changed. These experiences may be exacerbated if the employee’s position involves customer contact, or client relationships that the employer may fear losing due to the prejudice of clients, rather than their own prejudice.

Such discrimination plays out clearly in the “Good Jobs NOW!” survey and report, also conducted by the Transgender Law Center and National Center for Lesbian Rights. In that report, 21 percent of respondents identified as African American/Black, 5 percent as Asian American, 41 percent as European American/White, and 21 percent as Latina/Latino/Hispanic. Nearly 60 percent of respondents reported an annual income of less than $15,300 a year (where the San Francisco Foundation has found that a person making less than $23,750 a year is living in poverty); 40 percent reported having no form of bank account; 21 percent reported having a job that is part of the street economy (characterized in the survey as “sex work, narcotics, etc.”); and 57 percent reported having experienced employment discrimination. However, even in San Francisco, which has provided several different types of protection against discrimination, only 12 percent of respondents reported having filed any kind of complaint about the employment discrimination they experienced. It is possible that the low number of legal claims reflects other types of disenfranchisement, such as a lack of awareness concerning claims procedures, lack of access to knowledgeable and respectful legal assistance, poverty, privacy concerns, or fear of retaliation.

According to research conducted by the Human Rights Campaign (“HRC”) for their “Best Places to Work” annual survey, approximately 186 employers provide transgender benefits and have a non-discrimination policy that protects against gender identity discrimination. The companies surveyed reported that they provide a full range of transition-related coverage, including hormone treatment, mental health care, surgical procedures, and

35. Id. at II.A.4.
37. Id.
38. Id. at Summary Data A.
part-time recovery after surgery. However, these 186 employers are only slightly more than half of the 364 employers who have non-discrimination policies that protect against gender identity discrimination. This means that almost half of the surveyed companies that protect against gender identity discrimination continue to exclude their transgender employees from obtaining transition-related health care.\textsuperscript{40} HRC also noted that many of the employers who choose to provide transition-related health care are self-insured or self-funded, and have assumed "all or part of the risks of insurance coverage... [t]he employer puts money directly into a plan, which then pays for the covered benefits when the claims are incurred rather than paying premiums to insurance companies."\textsuperscript{41} While self-insurance is a cost-effective option for many large employers, it remains out of reach for most small employers.\textsuperscript{42} And while the numbers of private employers providing transition-related health care costs continues to grow, the City of San Francisco remains the only jurisdiction in the country to remove the exclusion from its health coverage of city and county employees,\textsuperscript{43} despite the approximately 100 cities, counties, and states that protect against gender identity discrimination in employment.\textsuperscript{44} These disparities in both public and private employment demonstrate that while workplace policies protecting against gender discrimination are becoming increasingly common, it is far more rare to find employers willing to financially invest in policies that increase workplace equality.

D. The Costs of Medical Transition

In October 1997, the San Francisco Human Rights Commission prepared a report for the Health Service System Board on the actual needs and projected costs of lifting the exclusion of transition-

\textsuperscript{40} Id.
\textsuperscript{42} Id. at 20.
\textsuperscript{43} Id. at 21.
\textsuperscript{44} See Human Rights Campaign Database, supra note 4.
related medical care for transsexual individuals. The model of treatment they used was contained in the Standards of Care issued by the Harry Benjamin International Gender Dysphoria Association ("HBIGDA"). The HBIGDA Standards of Care are based on a diagnosis of "strong and persistent cross-gender identification" and "persistent discomfort about one's assigned sex," with "evidence of clinically significant distress or impairment in social, occupational, or other areas of functioning." The HBIGDA Standards of Care, which are the medically accepted treatment for the Gender Identity Disorder diagnosis, call for a "period of initial evaluation, diagnosis, and therapeutic counseling" which can vary in length or number of therapeutic sessions, and does not require lifelong therapeutic counseling. After therapeutic observation and treatment for three months, a regimen of hormone treatment may be prescribed. After another three months of "cross-living" and hormone therapy, a person who has an "absence of conflicting morbidity," a continuing severe dysphoria associated with his or her birth gender, and who has fully and successfully transitioned to their new gender may be determined by a doctor to be appropriate for surgical

45. The San Francisco Human Rights Commission is a city agency dedicated to "[providing] leadership and advocacy to secure, protect and promote human rights for all people," and maintains specific focus areas on LGBT/HIV issues, Employment and Housing, and Equal Benefits. San Francisco Human Rights Commission homepage, http://www.sfgov.org/site/sfhumanrights_index.asp. The Health Service System Board is a committee made up of health care providers, insurance company personnel, and city employees who make certain decisions about the San Francisco City and County employees' health care. HSSB website, http://www.myhss.org/index.html. It should also be noted that there is a distinction between transsexual and transgender identities. The exclusion in question in this paper affected both transsexual and transgender people, but lifting the exclusion most benefited transsexual employees, who by definition require the most surgery. While lifting this exclusion did not provide, necessarily, for better treatment of all transgender individuals in obtaining health care, it did remove an exclusion which disadvantaged everyone because transgender people are no longer prevented from accessing treatment based on any transition-related medical care they might seek, or merely on their transgender status. Also, the activist approach of lifting this health care exclusion did not do much for transgender individuals who do not identify their transition with Gender Identity Dysphoria or who feel the HBIGDA Standards of Care are inappropriate or insulting.

46. AM. PSYCHIATRIC ASS'N, supra note 27, at 576.

47. SAN FRANCISCO HUMAN RIGHTS COMM'N, INSURANCE COVERAGE FOR TRANSSEXUAL EMPLOYEES OF THE CITY AND COUNTY OF SAN FRANCISCO 5 (1997) (on file with author) [hereinafter SAN FRANCISCO HUMAN RIGHTS COMM'N, INSURANCE COVERAGE].

48. Id. at 5, citing HBIGDA Standard No. 6, p. 8, ¶ 4.6.2.
interventions.\textsuperscript{49} For male-to-female individuals, the Human Rights Commission found that hormone (typically Premarin\textsuperscript{TM}) costs ranged from under $200 to approximately $500 per year, with various types of vaginoplasty costing from $1,350 up to $30,000, depending on the type of procedure sought. Female-to-male individuals were expected to spend anywhere from $70 to $540 per year on testosterone, $4,000-$7,000 on a bilateral mastectomy, between $4,000 and $18,000 on a hysterectomy and oophorectomy, and anywhere from $5,500 to $38,000 for either phalloplasty or metoidioplasty.\textsuperscript{50}

A much more recent development on standards of transgender care occurred at the meeting of the American Medical Association ("AMA") in June of 2007. At that meeting, the Board of Trustees approved a number of recommended changes to the AMA policies governing physician ethics and non-discriminatory care. The Board of Trustees report detailing the changes states that "[w]ithin the health care system issues of discrimination and unique access barriers to important medical and social support services can occur" and that "[t]hese challenges are often beyond the control of the transgender patient."\textsuperscript{51} In the report, released on May 29, 2007, the Board of Trustees recommended that changes in the text of numerous anti-discrimination policies be made. The great majority of the changes added "gender identity" to the list of protected categories in anti-discrimination policies. Gender identity was added to Policy H-65.992, the AMA's statement of continued support of human rights and freedom, and most notably, Policy H-180.980, which had opposed the denial of health insurance on the basis of sexual orientation, was amended to add gender identity. The Board of Trustees also recommended modifications to the policies overseen by the AMA's Council on Ethical and Judicial Affairs. Policy E-10.05, which mandates that physicians cannot deny care based on a variety of criteria, was amended to include gender identity. Similarly, Policy E-9.12 was amended to mandate that physicians who offer their services to the public may not

\textsuperscript{49} Id. at 6, citing HBIGDA Standard 8, p. 9, \textsuperscript{¶} 4.8.1.
\textsuperscript{50} Id. at 6-7 (all costs are in 1997 dollars, and may not reflect current rates).
\textsuperscript{51} CECIL B. WILSON, RECOMMENDATIONS TO MODIFY AMA POLICY TO ENSURE INCLUSION FOR TRANSGENDER PHYSICIANS, MEDICAL STUDENTS AND PATIENTS \textsuperscript{1} (American Medical Association ed., 2007), available at \texttt{http://www.ama-assn.org/ama1/pub/upload/mm/467/bot11a07.doc}.
decline to accept patients because of their gender identity. Changes in AMA policies toward transgender patients may help alleviate some of the discrimination faced by transgender people when they seek out health care. However, these changes presently do not affect whether transgender patients have access to health care, and if they do, whether their transition-related costs may be covered.

III. Gender Change and Legal Rights

A. Privilege and Medical Transition in Gender-Appropriate Legal Identifications

In addition to being important to the employment, health care, and personal well-being of many transgender people, medical transition is often also required in order to obtain valid legal documents. In many cases, individuals seeking a valid drivers' license, state identification card, or birth certificate with their appropriate gender must provide a letter from a treating physician attesting to that transition, though it continues to be legally unclear the extent of treatment one must receive in order to be considered medically transitioned. If one doesn't go through some sort of transition-related medical supervision, it is difficult to get a license, state identification card, or birth certificate that shows the gender one feels is most appropriate because there is no physician who can attest to the person's gender status. The approach to legal sex designation that is based on medical transition results in two tiers of civil rights in the transgender community: those who medically transition and have access to appropriately-gendered legal documents, and those who do not. Not only does this create safety concerns, but it creates very real problems for daily-life necessities like renting an apartment, getting a phone, setting up a bank

account or credit card, accessing social services like mental health care or drug rehab, or applying for a job. In any situation where a person might be asked to present identifying documents, such as applying for a job, a transgender person must explain why their license or social security has the wrong gender on it and they must then out themselves as transgender to their potential employer, who then (despite discrimination laws) has a great deal of power to not hire them. If the transgender person wanted to then file a discrimination suit (bearing in mind that San Francisco is in the minority of cities that protect against gender identity discrimination), medical transition is likely to be a strong evidentiary indicator of “gender identity” as it is defined in many anti-discrimination laws.53

California does more to alleviate these conundrums than many other places. In California, a person’s name and gender markers can be changed on drivers’ licenses or state identifications based on a declaration from a person’s doctor, but the doctor need not disclose what type of medical treatment the person has undergone for their transition.54 As a result, a large portion of survey respondents chose to change the gender identification on their drivers’ license or state identification.55 In California, changing the gender on a birth certificate, on the other hand, requires at minimum an affidavit from a qualified surgeon who has performed a surgical procedure.56 However, states that have the most conservative policies have made it impossible to change the gender marker on a birth certificate.57 Other states may allow a modification of the gender marker, changing the gender on the document in a way that retains the previous gender marker, or by requiring stricter medical intervention before the gender marker can be changed.58 Not

54. MINTER & DALEY, supra note 11,at II.C.4. Note, however, that this policy not only assumes that a person has access to health care but that the provider they are able to access is informed and respectful enough of their transition to consider their sex “reassigned” based on the extent of medical care the patient, and not the doctor, feels is appropriate for them. Some doctors, in the interest of following the Harry Benjamin Standards of Care for Gender Identity Disorder, refuse to sign off on gender changes on documents until their patient has undergone a requisite amount of medical care, which is likely to be expensive, and unlikely to be covered by insurance.
55. See id.
56. See generally CAL. HEALTH & SAFETY CODE § 103425 (2007)
57. MINTER & DALEY, supra note 11.
58. CHONG, supra note 90.
surprisingly, only 6 percent of respondents to the Trans Realities survey choose to change the gender marker on their birth certificate. While this is not as serious an issue for many people due to the limited situations in which a birth certificate may be required, it still deprives many people of gender-congruent documents and discriminatorily marginalizes not only transgender people at large but especially transgender people who cannot afford or do not want to medically transition.

The findings in Trans Realities reflect that the legal needs of transgender communities are not only diverse but also impacted by other social oppressions like race and class. The National Center for Lesbian Rights and the Transgender Law Center recommend to legal and social service providers that in addition to identifying and meeting the specialized needs of transgender clients, addressing issues like language access, institutional racism, sexism, and homophobia is essential to benefiting transgender clients and clients at large. They also recommend to local and state lawmakers that existing identity document laws and policies be revised to recognize gender transition in the ways in which people actually experience it, rather than tying their gender status to their medical status. In addition, they emphasize the need for transgender people, like all marginalized groups, to be included in the creation of laws and policies that affect their ability to express their gender identity. At the same time, however, they recommend that health insurance exclusions be removed for government employees, and that cities, counties, and the state need to lead the way in providing equal health benefits for all employees.

In the end, however, the analysis of transgender communities’ legal needs with respect to health care coverage must include a fuller analysis of transition-related procedures. Despite survey results indicating that those who identify as transgender take very diverse paths in their transition, much public policy is premised on the assumption that surgery is a part of every transgender person’s transition, or assumes that the ultimate goal of every transgender

59. See MINTER & DALEY, supra note 11.
60. Id. at III.B.3.
61. Id. at III.C.3.
62. Id. at III.C.5.
63. Id. at II.C.3.
person is, in fact, to be transsexual. While many transgender people use some type of medical care to facilitate their transition, and while many policies relating to changing gender designation on official documents assume some kind of shared medical experience, there are a great many people who never seek out medical care for their transition, or only seek it out in very limited ways. For example, the Trans Realities survey showed that only three out of four respondents used hormones as part of their transition, and 7 percent of respondents had no transition-related medical treatment at all.\textsuperscript{64} No more than 15 percent of survey respondents have had “sex reassignment” surgery, and of those, only 8 percent have had genital reconstructive, or “bottom” surgery.\textsuperscript{65} The legal issue arising is that, due to misconceptions and lack of information, many courts and agencies require some kind of “sex reassignment surgery” in order to change the gender identification on official documents.

Some courts even interpret “sex reassignment” surgery to refer only to bottom surgery. This leaves the great majority of people stuck between two unworkable options: either obtain a surgery that is not necessary or appropriate for them, or live with documentation that doesn’t reflect their true identity and that, when incongruous with a person’s expressed identity, can expose a person to discrimination, hate violence, or unnecessary personal and financial risks arising because the person must “come out” as transgender every time they must show identification or undergo a routine background check.\textsuperscript{66} For individuals for whom surgeries are appropriate, these risks are compounded by class: poor people are less likely to be able to afford the required sex reassignment surgeries, and therefore are even more susceptible to the dangers arising from incongruent documents.\textsuperscript{67}

\textsuperscript{64} Id.
\textsuperscript{65} Id.
\textsuperscript{66} Id. at II.C.3-4.
\textsuperscript{67} Activist Jamison Green notes that transgender advocates have been trying to address this since the early 1990s with legislative proposals, but the most progressive of these have so far failed for lack of willingness (on legislator’s parts) to interrupt popular understanding of the primacy of the sexed body, given current ideas about the factors that constitute essential sex – in other words, we have so far failed to educate legislators and the public sufficiently to overcome religious and homophobic moralist objections.
B. The Need For Broader Federal Protection From Discrimination Under Title VII

While several states and cities have chosen to extend their anti-discrimination statutes to include transgender people, federal law continues to exclude such protection based on gender or sexual orientation. Title VII outlaws workplace discrimination and harassment based on sex, race, religion, and national origin, but fails to include both sexual orientation and gender in its protections. Some courts have broadened the understanding of sex discrimination by ruling that sex discrimination can be perpetrated against both men and women including "discrimination against people whose expression of their gender diverge[s] from the expectations of their peers," thus creating room for protection of transgender employees under particular factual circumstances. In these cases, initial pleadings and pre-trial discovery statements are essential to establish a case as being a gender non-conformity case rather than a sexual orientation discrimination case. The courts have held unanimously that harassment and discrimination cases premised solely on anti-gay motives are not covered by Title VII, while those that can be structured as cases in which the discrimination is motivated by discomfort due to gender non-conformity of the victim are accepted by the courts.

The Sixth Circuit set the broadest interpretive precedent in Smith v. City of Salem, being the first federal circuit court to hold that gender identity discrimination violates Title VII and that transsexuals, when defined as persons whose gender identity is discordant from their biological sex, can assert Title VII sex discrimination claims under the Price Waterhouse v. Hopkins

68. See Human Rights Campaign Database, supra note 4.
71. These decisions also create room for gender expression encompassing far more people than just those self-identifying as transgender, including individuals whose gender is perceived as non-conforming in part because of their sexuality, and heterosexual individuals who may not act in conformity with stereotyped gender.
72. Leonard, supra note 70, at 152-53.
73. Id. at 151.
The precedent created by *Price Waterhouse* was that "sex" under Title VII encompassed gender and discrimination based on failure to conform to sex stereotypes, making discrimination based on one’s gender synonymous with discrimination based on one’s sex, which can be experienced by absolutely anyone of any sex. Therefore, any discrimination against an employee for transitioning from one sex to another also had to be covered under Title VII. This reading, as applied to a public employee as it was in *Smith*, also allowed the court to hold that gender non-conformity discrimination against transsexual employees fell within the theory of "disparate treatment" sex discrimination, which is subjected to heightened scrutiny under the Equal Protection Clause. While this decision, and other cases similarly following *Price Waterhouse* in other circuits, have not given rise to a large number of published decisions, they have opened the door for litigation around the rights of transgender employees. However, this litigation has centered

74. Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004). Interestingly, the Sixth Circuit only a few weeks earlier denied a claim brought by a transsexual employee in *Johnson v. Fresh Mark Inc.* No. 03-334, 2004, U.S. App. LEXIS 9997 (6th Cir. May 18, 2004) (per curiam) on the grounds that the employee, who was hired as a woman but after being discovered to hold a driver’s license designating her as male was told she could only use the men’s restroom. In that case, the Sixth Circuit specifically rejected the application of *Price Waterhouse* to the plaintiff’s claim.

75. This is a reading which makes particular sense if one defines “gender” as the internal identification with, and external expression of masculinity or femininity, which is sometimes but not always in conjunction with “sex”, defined as the possession of a male or female body. Or, from Zachary A. Kramer, *Seventh General Issue of Gender and Sexuality Law: Article: Some Preliminary Thoughts on Title VII’s Intersections*, 7 GEO. J. GENDER & L. 31, 34 (2006): “[The] traditional view treats sexuality as a knowable network of sexual categories. . . . There are, in this view, two sexes – men and women – separated by biological, natural traits, who are given to sexual behavior that derives from and utilizes those biological traits. Men and women are further classified as having a gender – that is, a cultural expression of their biological sex. Traditionally, while we expect men to express a masculine gender and women to exhibit a feminine gender, even the traditional view recognizes that some men and women are gender nonconformists, people whose gender expressions belie their biological sex. There is also a third category that constitutes a critical component of the sexuality picture. All men and women, be they gender conformists or non-conformists, are also oriented sexually to either men or women, or in the case of bisexuals, both men and women. Within this schema, the three categories, while mutually dependent and closely related, are severable and distinct. They overlap, but each is its own beast, its own complex system.”

76. Smith v. City of Salem, *supra* note 74.


78. Schwenk v. Hartford, 207 F.3d 1187 (9th Cir. 2000); Rosa v. Park West Bank & Trust Co., 214 F.3d 213 (1st Cir. 2000).
almost solely around the ability of transgender employees to use the workplace restroom most appropriate and convenient to them, though the question of restrooms remains open on the federal field. In short, while some transgender plaintiffs have raised actionable Title VII discrimination claims under sex discrimination, none has successfully done so using the argument that discrimination against transgender people is itself unlawful.

In his law review article on Title VII, Zachary Kramer argues for an intersectional interpretation of employment discrimination law. He observes that under Title VII's current approach, a claim raised by a straight Latino man would be treated exactly the same as a claim raised by a gay Latino man, even though the two men likely suffered very different discrimination, but that Title VII's current coverage would only fully capture the claims of the straight Latino man. Kramer argues for discrimination to be considered via the intersectionality approach, which considers a person's identity to be a cohesive feature of the person bearing its own materiality, rather than an amalgamation of a number of different identities. This approach seems more responsive to discrimination claims in the area of sex and gender because those who discriminate are unlikely to draw the fine distinctions between sex, gender, and sexuality that the law requires in order to make a valid claim. Similarly, an employer or coworker who harasses or discriminates based on sex or gender is likely also to be (ironically) indiscriminate in choosing other marginalized categories to harass about as well, such as race, national origin, or religion. An intersectional approach might more


80. In fact, it is not unlawful. For example, if one were to discriminate against a transgender person specifically because they were transgender (and not because of your perception of their conformity to gender or because they were in the process of changing from one to the other) it would be perfectly legal. This situation might change, however, if Congress were to pass the Employment Nondiscrimination Act. However, it does not appear as though Congress will do so anytime soon, nor is it clear that the gay, lesbian, and bisexual activists lobbying for the passage of the bill will choose to include transgender protections in ENDA, as it is feared that the bill will not pass if transgender protections are included. Kramer, supra note 73, at 42. This debate is, sadly, but one example of the ways in which transgender rights are viewed as distinct from and in opposition to gay, lesbian, and bisexual rights, and how the social persecution of the queer community generally can lead to increased discrimination within the community as factions within fight over the scraps of equality being tossed their way.

81. Kramer, supra note 75, at 57.

82. Id.
broadly remedy discrimination suffered by sexual minorities, rather than rendering their claim inactionable if the perpetrator of their discrimination mistakenly reads their gender non-conformity as being an issue of sexuality instead of gender. While broadly inclusive anti-discrimination ordinances like San Francisco’s seems to render intersectionality moot, it is still useful to consider, given that the current range of sex, gender, and sexuality identities currently defined in our culture, as well as their interaction with developing race and class identities, is likely to continue to grow and change over time.

IV. San Francisco as a Site for Change

The City of San Francisco employed 27,622 people (less elected and appointed officials, as-needed employees, school and college district employees, and court employees) as of September 2006. Of the total number of employees, the largest numbers were employed in the professional category with 7,619 employees, or about one third of the total workforce. The professional category, which includes lawyers, social workers, registered nurses, and accountants, is one of the most highly paid job categories. Whites make up 41.7 percent of these employees, and 11.5 percent of the overall number of White city employees work in this category. The service maintenance category, which includes laundry operatives, custodial employees, gardeners, construction laborers, and transit car cleaners, is the next largest with 5,204 employees. Service maintenance workers are among those city workers that are least paid. Only 18.2 percent of those workers are white, and they employ only 3.4 percent of the city’s White workers. My purpose

84. Id.
85. Id.
86. Id. at 14.
87. Id. at 25.
in providing this breakdown is not to analyze the efficacy of the city’s equal employment measures, but rather to argue that the racial composition of city employees cross-referenced by earning power demonstrates the proportionally high impact of providing transition-related health care to job classifications that are typically paid less and held by people of color. In this case, I argue that employees in the professional category might be less debilitated by transition-related medical costs, but that their fellow employees in the more working-class category of service maintenance workers, who might be more debilitated by the costs, are also benefiting.

One of the aspects of San Francisco law that made it a likely site for such a progression in non-discriminatory health benefits is that San Francisco has very broad ordinances preventing discrimination. For example, Chapters 12B and 12C of the San Francisco Administrative Code require that all contracting agencies of the city, their departments, and any agencies acting on behalf of the city must include in all contracts and property contracts a provision obligating the contractor not to discriminate based on “fact or perception of a person’s race, color, creed, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, domestic partner status, marital status, disability or Acquired Immune Deficiency Syndrome or HIV status (AIDS/HIV status), weight, [and] height,” as well as requiring such a provision in all subcontracts.88 Also, the San Francisco Police Code prohibits “a club which is not distinctly private” to deny entry or use of facilities based on the same protected characteristics.89 San Francisco also created a Human Rights Commission, the purpose of which is to “give effect to the rights of every inhabitant of the City and County,” to provide expert advice to city agencies, boards, and employees in undertaking ameliorative practices, and to promote and provide equal opportunity for all people.90 While activists who worked on creating the benefit plan in San Francisco do not believe it is necessary to have such anti-discrimination laws in place in order to attain similar benefits in other cities, they found the laws helpful in bolstering the argument that the city had already committed to equal rights for its citizens, and that transition-related

88. See Human Rights Campaign Database, supra note 4 at § 12B1.
89. S.F., CAL., POLICE CODE art. 33B, § 3300B.3 (2002).
90. See Human Rights Campaign Database, supra note 4.
medical care was merely a necessary implementation of those equal rights. Similarly, the existence of a Human Rights Commission is helpful in that it can provide ready activists institutional knowledge and relationships that can push such a movement forward. However, it is not necessary to have a Human Rights Commission if there is sufficient participation from community members who can invest time and energy in similar processes.

When transgender activists began to advocate for the city to provide equal health care to transgender employees in the early 1990s, the City of San Francisco had an exclusion in its benefits plan, preventing city health insurance coverage for any health needs either directly or indirectly due to transition. Upon first glance, the fact that a new development in antidiscrimination policy might first form in San Francisco seems natural, given the strong legislative and social support for such protections. Also, San Francisco’s Health Service System includes approximately 37,000 people working for the city, public schools, community college district, an estimated 17,000 retired employees, as well as the dependents of all current and retired employees, which is likely another 100,000 people.

Given the stated legal needs of transgender communities, (namely access to legal documentation showing the appropriate name and gender, respectful and knowledgeable health care, and stable employment free of discrimination) San Francisco’s decision hit all the major areas of need for transgender people.

Admittedly, there is very limited census data on transgender communities in San Francisco (excepting that already cited), in part because of the diversity of definitions used to describe all types of different gender identities and in part because there is very little institutional interest in documenting this population in a formalized census. While there is no way to know exactly how many city residents, much less city employees, identify as transgender or hope to seek out gender reassignment surgery, hormones, or merely medical care, it is possible to examine the impact of providing the benefits in other ways. First, it is important to rely on anecdotal evidence from transgender community activists who worked on

removing San Francisco’s exclusion. These activists report that since the benefits have been made available, the people choosing to take advantage of them have come from all different types of city and county employment; from high-ranking, highly paid officials and administrators, to blue-collar minimum-wage service maintenance workers. Inferentially, then, it is possible to recognize the provision of benefits as not only a victory for transgender communities, but also as a victory for communities of color and working class communities facing similar experiences of oppression.

Part of the reason that San Francisco’s city supervisors made the decision they did is because the projected costs of coverage were relatively low. At the time of the vote, there were only a dozen city employees who openly self-identified as transgender.93 Of those, some had already undergone surgical transition and only required ongoing hormone treatment. Additionally, not every transgender person chooses to undergo surgical transition, where the highest costs lie.94 While the supervisors who voted against the bill feared that a flood of closeted city employees might decide to come out and transition after the exclusion was lifted, most activists working for the benefits knew such fears were unfounded, and that while a few city employees might choose to take advantage of the benefit, lifting the discriminatory exclusion was worth the cost of providing the treatment.95 But for the greatest majority of the transgender population in San Francisco, the city’s decision was merely academic because they do not work for the city. However, the argument was significant in that San Francisco became the first city to say it was committed to full socio-economic equality for trans people; not just for those who can afford to pay for their transition themselves, but also for those who can’t.

Thus, San Francisco’s inclusion of transition-related medical care in its standard employee health insurance set two precedents. First, the city showed that anti-discrimination laws must address institutional discrimination, not merely that discrimination is illegal, in order to provide true equality for transgender people. Second, the city showed a growing community of private employers that providing transition benefits was cheap enough to implement. San

94. Id.
95. Interview with Marcus Arana, supra note 91.
Francisco's decision demonstrated the ability to see through stereotypes: LGBT populations generally are stereotyped as being primarily white and upper middle class, but as even the limited results of the surveys conducted in San Francisco by the Transgender Law Center reveal, people with transgender identities exist in all communities, races, and socio-economic groups. Similarly, city employees are often assumed to be white, middle class, clerical workers, but the reality is that city jobs include very low-wage work held primarily by poor people of color. Therefore, San Francisco's decision to provide health care coverage for transition costs to its trans employees has the potential to make a great deal of difference in the lives of transgendered city employees who might otherwise be marginalized on many levels in their ability to access/afford any health care at all, let alone health care for transition costs.

V. The Benefit Plan Then and Now

This section analyzes San Francisco's legislative process in getting transition-related health care benefits for transgender employees passed. Because no legal scholarship has been done and no lawsuits filed dealing with the benefit, the reporting of the various city agencies' process in passing the benefit was largely done through interviews with activists involved in the effort of raising the restriction, city employees who have taken advantage of the benefit, and contemporary local media coverage. Through this reporting, I will evaluate the dynamics of the plan's passage, and whether in the end it did what it set out to do.

Members of the transgender community always knew that getting health care was an issue. But until San Francisco's Board of Supervisors included gender identity discrimination in Chapter 12 of the San Francisco Administrative Code in 1994, health care equality was such a distant goal that it was easily surpassed by more pressing needs. However, many activists at the time hoped

96. For more specific reporting of the experiences of transgender people of different demographics, see generally TransRealities, Good Jobs Now!, and Transgender Americans: A Handbook for Understanding, as well as SAN FRANCISCO HUMAN RIGHTS COMM'N, INSURANCE COVERAGE, supra note 47, at Appendix D, 44.
that an anti-discrimination ordinance might provide leverage for increasingly progressive legislation like that of the health care inclusion.97 A group of community activists and city employees began negotiating with the city’s Insurance Committee98 and the Health System Service Board ("HSSB") to get the exclusion lifted.99 At first the Insurance Committee was evenly split for and against lifting the exclusion, with the committee chair against it.100 The HSSB is accustomed to the kind of discussion going on surrounding this benefit, as every procedure or health issue that is proposed for coverage by the city’s insurance plan must first go through a process with the HSSB, which evaluates the need for the coverage against its cost and, through a combination of employee and retiree input and evaluations by medical and insurance company practitioners, devises a proposal for the benefit plan.101 The proposal then goes to the city supervisors as part of the overall budget approval process for the city employee health care plan, and the city supervisors vote to approve the funding of the benefit plan.102

In 1997, a report was compiled by the Human Rights Commission, which contacted doctors to determine the actual costs of trans care and come up with the estimated actuarial costs of providing the benefit.103 Later, in another report using the numbers gathered in 1997, actuaries devised a formula for estimating the costs to the city of providing the benefit, based on similar health care coverage provided by British Columbia. In that report, actuaries estimated that thirty-five people would take advantage of the full $50,000 benefit, costing the HSSB $1.75 million for the first year.104 From that figure, the HSSB came up with the $1.70 per month additional health care costs for city employees, which was accepted by the city supervisors in their 2001 budget, putting the new benefits into effect. In 1997, however, when those numbers were initially gathered and a benefit plan was discussed, San

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97. See Telephone Interview with Jamison Green, supra note 31.
98. A group composed of city employees who negotiate over health care issues.
99. See Telephone Interview with Jamison Green, supra note 31.
100. See id.
101. See id.
102. See id.
103. SAN FRANCISCO HUMAN RIGHTS COMM’N, INSURANCE COVERAGE, supra note 47, at 3.
104. Interview with Marcus Arana, supra note 91.
Francisco’s city government was suffering from financial constraints, and activists were unable to get the support necessary from the HSSB. Concerns centered around money, as well as moralistic concerns around the city funding what some considered cosmetic surgery or a spurious alternative lifestyle choice and the fear that removing the exclusions would encourage people to flock to city employment to obtain sex changes for themselves or their partners.\(^{105}\) The 1997 report noted, however, that costs of treatment would be ameliorated by the fact that not every city and county employee would need to undergo every procedure, and that in some cases coexistent medical conditions such as HIV disease, hemophilia, or liver disease would preclude individuals from undergoing certain aspects of the sex reassignment treatment.\(^ {106}\)

Meanwhile, beginning in 1996, activists approached the city supervisors to advocate for funding for the benefits, and received positive responses. However, a reporter for San Francisco's main newspaper, the *San Francisco Chronicle*, happened to be at the meeting also, and the word of the requested budgetary allowance for the benefits spread very quickly. In September of 1996, *Chronicle* columnists published an article about the requested benefits,\(^ {107}\) spurring a flood of highly sensationalized television and radio coverage, rife with jokes about “only in San Francisco” and “cutting-edge politics.”\(^ {108}\) Much of the media coverage was far more incendiary than the actual debate, there was no organized opposition to the benefits from either city employees or citizens at large\(^ {109}\) (though in 2001 opposing Supervisor Tony Hall cited a “flood of constituent opposition”\(^ {110}\)). Jamison Green, one of the activists involved, recalls that much of the media attention was of the “only in San Francisco” variety, and reflected a great deal of ignorance about medical transition, often comparing the surgeries to

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\(^{105}\) Id.  
\(^{106}\) SAN FRANCISCO HUMAN RIGHTS COMM’N, INSURANCE COVERAGE, supra note 47, at 8.  
\(^{108}\) Id.  
\(^{110}\) Gordon, *Vote*, supra note 90.
strictly elective cosmetic surgeries like nose jobs.¹¹¹ The ill-informed and unfair media coverage led to transgender activists picketing the *Chronicle*, and resulted in columnists Matier and Ross agreeing to get the activists column space on the *Chronicle*'s opinion page.¹¹²

For several reasons, most primarily the city's lack of finances, the project stalled until 2001, when the Human Rights Commission and community and city employee activists began to advocate for it again. By 2001, San Francisco was reaping the benefits of the dot-com era, and had elected Willie Brown as mayor, who put many more liberal appointees into place in various city positions. Some of the membership of the HSSB had changed as well, and with the support and advocacy of the medical professionals on the Board, an agreement was reached between the Transgender Task Force and the HSSB members. The benefit plan they created covered the costs of hormone treatment, psychotherapy, and surgical procedures, but required an initial diagnosis of gender dysphoria.¹¹³ Initially, there was a cap on lifetime surgical costs of $50,000 and a one-year enrollment period, meant to prevent a feared "flood" of transgender people to city employment hoping to take immediate advantage of the benefits.¹¹⁴ Then, as part of the city process to approve all agency budget changes, Supervisor Mark Leno drafted a budget resolution setting aside the money necessary to provide the health care coverage, lifting the exclusion. It is important to note that the ordinance in question was a policy act, not legislation like the anti-discrimination ordinance had been, but rather a budget item, proposed by the HSSB to the Board of Supervisors, and part of a larger allocation for an expanded benefits package that included acupuncture, hearing aids, infertility treatment and Viagra prescriptions.¹¹⁵ The resolution required nine out of eleven votes from the city supervisors in order to pass, and in the end, there were just that many.

¹¹¹ Interview with Jamison Green, supra note 29. See generally Matier & Ross, supra note 107; Tony Hall, Paying for Transgender Surgery, S.F. CHRON., Apr. 29, 2001, at D8; Appendix B.


¹¹⁴ Id.

¹¹⁵ Id.
The struggle for support from city supervisors was not without its own dramas, however. After the initial media coverage in 1996, the *Chronicle* began covering the revival of the issue as early as February of 2001, shortly after the HSSB approved the new benefit plan.116 On April 23, 2001, the plan came up for a vote again, but was continued because two city supervisors were out of town on business. One of those supervisors, openly gay Tom Ammiano, was a strong supporter of the benefit plan, and the other, now-Mayor Gavin Newsom, was expected to cast a supporting vote as well.117 The budget proposal had strong, vocal support from several city supervisors. Support came not just from Supervisor Mark Leno (who along with being a longtime transgender advocate, also oversaw the HSSB on behalf of the city supervisors and drafted the budget proposal that the Supervisors voted on), but also supervisors Chris Daly and Matt Gonzalez. Other supervisors, however, remained largely silent on the issue. In the April 23rd supervisors meeting, Supervisor Tony Hall surprised activists and supporters by announcing that he planned to vote against the budget, despite his previous vote in favor of a commendation for HSSB to recognize their work in pursuing sex change benefits.118 Supervisor Hall quickly became a vocal opponent of the measure, citing not only “constituent opposition” but also his belief that “it is not the basic function of the city health plan to provide funding for elective procedures that benefit only a tiny portion of the population… [but] to provide emergency, preventive and continuing care for all employees who may be victims of disease or injury.”119

Despite the strong support and lobbying from many Supervisors, a great deal of uncertainty remained leading up to the final vote on April 30th. At one point, during the discussion leading up to the vote, Supervisor Gerardo Sandoval stepped out of the room. When he did not return, and the time to take the vote drew near, Supervisor Leno noticed his absence and sent the sergeant-at-arms to retrieve him, knowing the vote would be very close. When the measure finally passed with the requisite nine votes, Supervisor Hall and Supervisor Leland Yee cast the only two votes against it,

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118. Id.
with Supervisor Sandoval’s reappearance providing the key vote necessary to the victory. Since then, in a manner true to San Francisco’s political climate, Sandoval has become accountable for his decision. The issue of Sandoval’s attempted exit during the key vote resurfaced in his 2006 City Assessor’s race, when he attempted to get a key endorsement from a gay Democratic political organization in the city and was asked to account for his actions.

While the exclusion of transgender people from the city employee’s health care plan has been lifted and transgender employees have been able to access transition-related health care for nearly six years, the agreement was not without compromise. For example, much of the negative media attention comparing gender transition to getting a nose job was relatively effective, and activists were forced to compromise on “cosmetic” procedures that are typically part of transition treatment.120 For example, for many transgender women (persons born male but who medically transition to become female) electrolysis is a necessary part of transition. For some, it is an even more pressing medical concern than genital surgery because they feel they are not fully respected in their gender socially when they have visible facial hair. However, electrolysis is still not covered for transgender city employees because it is not covered for non-transgender people (even though it is not typically a safety, or even gender-related concern for non-transgender people), and because the media opposition to the benefits were successful in framing certain transgender health needs as “cosmetic” concerns, pitting them against people with “real needs” that remained unaddressed by the insurance plan.121

Other compromises in the benefit plan were rectified in July of 2004 as part of a scheduled evaluation of the impact of the benefit plan. In that overhaul, the required one-year waiting period before making a claim for benefits was removed because it violated the rules of the Department of Managed Care.122 Also, because some genital surgeries, particularly for transgender men, can cost up to $70,000, the lifetime surgical maximum for coverage was raised from $50,000 to $75,000.123 In the end, San Francisco’s expenditures

120. Interview of Marcus Arana, supra note 91.
121. See Matier & Ross, supra note 107; Hall, supra note 111.
122. Id.
123. Id.
for surgeries have been far lower than those projected. According to
data collected from the HSSB by the Human Rights Commission,
San Francisco city employees paid $5,339,567 in revenues between
July 1, 2001, when the benefits went into effect and June 30, 2004.124
During that same period, however, only eleven surgical claims were
filed, far short of the thirty five claims per year projected in the 1997
actuarial report.125 Those eleven claims cost the city only
$182,374.33, making starkly clear how without merit many of the
arguments against providing the coverage were.126

Since the passage of the resolution, several individuals have
transitioned under the city's benefits.127 Activist Jamison Green
reports that the employees who have used the benefits have been
from a wide variety of city departments, with varying races and
levels of earning power.128 Lifting the exclusion has had some
unforeseen benefits as well. Given San Francisco’s Equal Benefits
ordinance, which mandates that employers in San Francisco provide
equal health care to domestic partners and spouses of employees,
the partners of city employees have been able to use the transition
benefits as well.129 Also, the benefits cover medical complications
that might arise due to transition issues. For example, when one is
frequently required to give oneself intramuscular injections, an
abscess can form at the injection site, which can quickly become a
dire medical situation if not treated immediately. One city
employee suffered such a situation and would have had over
$100,000 in medical bills if the exclusion had not been

124. SAN FRANCISCO HUMAN RIGHTS COMM’N, San Francisco’s Transgender Health
125. Interview of Marcus Arana, supra note 91.
126. See Human Rights Campaign Database, supra note 4.
127. “In total, from July 2001 when the exclusion was removed through August 2005,
the HSS[B] has . . . paid out $183,000 on 11 claims.” Memorandum from City & County
of S.F., Human Rights Commission on San Francisco City and County Transgender
128. Telephone Interview of Jamison Green, supra note 31.
129. Human Rights Campgaign, Benefits for Transgender Employees and Dependents, Case
Study: City and County of San Francisco, http://www.hrc.org/issues/workplace/
benefits/4815.htm (last visited Nov. 17, 2007).
130. Interview with transgendered individual (name withheld due to medical
privacy concerns).
find themselves in serious, even debilitating medical debt simply by virtue of being transgender.

VI. Organizing Lessons Learned

A. Why Not a Lawsuit?: Legal Action versus Organizing

To the legal community, it might seem intuitive that a lawsuit would be the best way to deal with a discriminatory city practice in a city that provides protection against such discrimination. In the case of transition-related health care, however, there are several problems with this approach. First, there is very little legal precedent in the combined categories of discrimination on the basis of gender and health care coverage. Next, it is not clear who the defendant in a lawsuit would be: the city, for failing to provide the benefits? The provider, for having the exclusion? Does the anti-discrimination law require the city to negotiate with the insurance provider for the benefits? And is it even a discriminatory exclusion, or merely cost-effective? However, even if one could overcome the procedural difficulties in finding an appropriate defendant and legal theory, there is still the problem of educating and organizing the judicial community. It may be difficult to make the case to judges that transition-related medical procedures are medically necessary, and that they should be covered. In such a situation, a judge might end up narrowly interpreting the law and limiting access for the majority of transgender people in need of basic care.¹³¹

California has partially answered these questions with the passage of AB 1586, which in September of 2005 amended the California Health and Safety Code and the California Insurance code to prohibit health care discrimination based on a number of factors, including sex (which authors of the bill provide shall have the same meaning as "gender").¹³² The amendments add "sex" to the categories already protected by statute. As a result, the Health and Safety Code now provides that no health care service plan may refuse to enter into a contract due to the sex of any contracting

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party, and the benefits of such health care contracts may not be subject to any exclusions based on the sex of plan members. Additionally, the Insurance Code now provides that no insurer may refuse to accept an application for insurance “except for reasons applicable alike to persons of every . . . sex.” While AB 1586 does not mandate that health providers provide coverage for any particular benefit, nor does it require that companies drop their exclusions or cover transition-related procedures, it does prohibit plans and insurers from denying coverage for a benefit included in their policy based on sex. Therefore, insurance plans may no longer deny a procedure like prostate care to a person because they are legally a woman. While it’s not clear yet how this law will be used, the law explicitly states “there will be no more denial of procedures to people based solely upon their transgender status or perceived gender incongruence.”

Choosing to win health coverage for city employees by organizing rather than filing a lawsuit was likely the most politically expeditious choice. Rather than getting a judge to force the city and/or insurance companies to comply with a ruling, the organizers worked to build support within city management, the Board of Supervisors, and insurance companies. By organizing enough supervisors into a vote for removing the exclusion, the activists who worked on this measure had to build support among the supervisors’ constituents, as well as among the supervisors themselves. They also had to convey the double-sided message that removing the exclusion and providing health care equality for transgender people was both important and economically attainable. Because the organizers were able to get a very large employer like the city to remove the exclusion willingly, they won a double victory; they were simultaneously able to encourage insurance companies to begin thinking about transition-related health care as a product that could be good for business. Other organizing campaigns to win similar coverage, such as the successful move to get transition-related health care for the employees of the University of California, the largest public employer in the state, have continued to drive the message home to

133. Id. at (a)-(b).
134. Id. at § 2, 10140(a).
135. Szymanski, supra note 131.
insurance companies. As more and more public and private employers sign on, providing transition-related health care will become an increasingly profitable option for insurance companies.

B. Identifying Allies and Using the Media

The fight of San Francisco transgender activists and allies to gain transition-related health care coverage required the identification of several different types of allies, from several different communities. First, activists had to obtain approval for the removal of the exclusion from the HSSB, which required identifying allies both in the medical community and on the Board itself. Next, the allies and the organizers had to work together to perfect a message that would effectively convey their goals and arguments. This process was replicated with the city Board of Supervisors. Some allies, like then-Supervisor Mark Leno, stepped forward immediately and provided necessary support in organizing other supervisors. Some supervisors did not act as advocates, but committed they would vote for the budget proposition. And, like in most activist movements, there were some losses: Supervisor Tony Hall who had once been an ally on similar issues, reversed his position and was ardently opposed to the transition-related health care plan. Throughout, organizers additionally had to reach out to city employees, who would ultimately be asked to pay for the plan, however small the increased payment by each individual employee.

Another key component for allies and activists was their use of media attention. In 1996, and later when the city Board of Supervisors moved toward a vote, members of the Transgender Community Task Force spent a great deal of time working to counteract the local media's portrayal of health care for medical transition as a crazy idea. They consistently put out a message focusing on the discriminatory nature of the exclusion, the relatively low cost of the coverage to the city, and put out basic facts about transgender people and medical transition. Additionally, when the San Francisco Chronicle columnists Phillip Matier and Andrew Ross wrote a column in 1996 falsely intimating that transition procedures would be very costly, that the lifting of the exclusion would apply to all San Francisco employers (and not just the city as an employer), and that transgender people were demanding special rights, the
Task Force held a rally outside the Chronicle's offices on the busy corner of 5th and Mission Streets. Rally attendees distributed a flier detailing the myths being disseminated by the Chronicle and later coverage by the Associated Press and local television stations. As a result of the rally, the Chronicle gave editorial space to Jamison Green and Susan Stryker to discuss transition-related medical coverage and to dispel many of the rumors and transphobia being circulated in the media. The Task Force also distributed a question-and-answer sheet to their vocal allies and particularly the Board of Supervisors so they could ensure their message was uniform, and so their allies on the Board of Supervisors could feel confident answering many of the questions held by constituents and media sources. As a result of this combined effort to create positive media coverage and equip allies with the education and language they needed to provide positive responses, activists and allies were able to neutralize some of the negativity and fear coming from those opposing the coverage.

By 2001, activists found that a sea change seemed to have occurred, and that local and, even national media outlets were seeking to present a dialogue of pros and cons on the issue. The San Francisco Chronicle dedicated space on their editorial page to the debate, including articles by transgender activists, supervisor and ally Mark Leno, and opposing Supervisor Tony Hall. The newspaper also printed several letters to the editor from all sides of the issue. Additionally, representatives from the Human Rights Commission, local activists, and Supervisor Mark Leno appeared on local and national radio and television shows to discuss the impact of the benefits on the city, its employees, and the transgender community in San Francisco. Activists found that after fending off the media attacks of 1996 and 1997, they were now allowed to be part of a conversation by 2001.

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136. See Appendix A.
137. See Appendix B.1, B.2.
V. Conclusion: Remaining Obstacles to Full Coverage

Having the health care benefits in place has no doubt vastly improved the socio-economic position of the employees who have accessed it.\(^{138}\) Inferentially, it has also increased levels of equality for transgender city employees who are working class or people of color because, as populations with less pre-existing wealth, the benefits derived from not having to pay for their procedures are proportionally greater, as are the legal and health benefits derived from medically transitioning.\(^{139}\) However, some of the particulars of the benefit plan continue to fall short in fully meeting the needs of transgender people in accessing health care.

Despite the lack of formalized study on how accessible employees have found their medical coverage to be when transition-related services are covered, anecdotal evidence reveals that one of the most serious remaining areas of inequality continues to be the ability of patients to find a doctor in the city health care system that is knowledgeable in transgender health care issues and sensitive to the needs of transgender patients. In short, transgender patients still need educated and respectful medical care, even if their medical care is paid for. Transgender patients, like any other group with specialized medical needs, wish to use the doctors who provide the best results, especially for procedures like genital or chest reconstruction which have a cosmetic element. Historically, very few surgeons have performed these surgeries, and those that do have performed a great deal of them and so have developed a level of expertise. Because so few health care plans cover these surgeries, however, the doctors who have developed expertise are typically in private practice, operating under "cash and carry" payment plans.\(^{140}\) Many of these doctors are reluctant to accept insurance for the procedures they provide because they have only limited discretion to determine their fees if they go through insurance companies. Marcus Arana of the Human Rights Commission points out that the health systems and HMOs with whom employers contract need to develop more expertise in-house, and begin not only to train doctors in trans-specific procedures but also to shift the

\(^{138}\) Telephone Interview with Jamison Green, supra note 31.

\(^{139}\) Id.

\(^{140}\) Interview with Marcus Arana, supra note 91.
paradigms so doctors who already have expertise in certain surgical procedures learn how to shift their knowledge to serve transgender patients. 141

Also, it is imperative to note that the extension of these benefits still requires that the employee seeking medical transition be diagnosed with gender dysphoria or gender identity disorder. While this is not a problem for some, there are others who feel such a distinction pathologizes their gender in a way that is inherently discriminatory. Still others feel that extending the benefits in this way prioritizes the needs of people who identify with a binary model of gender (i.e., that "female" and "male" are mutually exclusive and distinct categories) but does little to remedy health care discrimination for people who feel their identity falls somewhere in between male and female, or for whom medical intervention in their gender is inappropriate. 142 Similarly, legal recognition of gender changes continue to require at least some degree of medical intervention and reflects a binary approach to gender identities, which continues to disadvantage many non-traditionally gendered people. And finally, while removing the exclusion of health coverage for transgender employees makes a great deal of difference to those with health insurance, it offers little tangible benefit to the increasing numbers of people, transgender and not, who lack health insurance entirely. Activists who worked on the San Francisco initiative continue to work on many fronts to rectify these inequities.

As this paper enumerates, there are many, many reasons that extending public employee health care to include transition-related medical care is a good decision for public employers. Ever-increasing numbers of cities are choosing to include gender identity in their anti-discrimination laws, even as they continue to maintain discriminatory health care for their own employees. To date, San Francisco remains the only city in the United States covering transition-related medical care, despite its relatively low cost. This paper is meant to be a guide for organizers and activists to help make the argument for similar benefits in their own cities. Hopefully, by continuing to demonstrate the fundamental equality

141. Id.
142. Id.
of transgender people by removing institutional discrimination, cities can become models for transgender equality.
Bay Area Media Beg the Question: What Disenfranchised Group Can We Exploit Next to Sell a Few Papers?

On September 23rd, the San Francisco Chronicle printed an inflammatory article in the Matier and Ross column sensationalizing the issue of health care coverage for transsexual City employees. Matier and Ross set the transphobic tone for all the mainstream media coverage that followed. They might as well have said that a tiny band of aliens are holding City government hostage, threatening to bankrupt it. Only in San Francisco, they sneered.

FACT: What Matier and Ross didn’t tell you is that singling out transsexual people and excluding their necessary medical treatment from insurance coverage is discriminatory, and in violation of San Francisco City and County Ordinances.

The Associated Press jumped on the alien bandwagon with their own inflammatory spin. Claiming there are 6000 transsexuals in San Francisco, and characterizing the need for health care as the demand of a special interest group, they trotted out the SF Republican Party Chair to dismiss our legitimate concerns. Only in San Francisco, they mocked.

FACT: There are 6000 Transgendered people in San Francisco (according to social service agency estimates). Transgendered people include all persons whose physical sex and gender expression are not necessarily synonymous (regardless of their sexual orientation). Transsexual people are a small portion of all transgendered people.

FACT: There are approximately 25,000 City employees, and as far as we know there are only seven who also happen to be transsexual. All seven of them may not require surgery, but they do have other routine health care needs for which they deserve treatment.

TV Coverage Follows Suit
KRON and KGO news ran inflammatory and transphobic coverage about the issue, too, with anchorperson editorializing that trivialized and ridiculed our situation. The media use transsexual people as an excuse to exercise their tabloid muscles while pretending to practice serious journalism. They treat us as less than human because they are ignorant, and they don’t have time to learn the truth in a sound byte. Only in San Francisco?

We will not be exploited. Our lives are not a joke.

Don’t believe the hype: Get the Facts. Learn about us.

Sponsored by The Transsexual Menace and Transsexual Menace Inc. San Francisco Chapters
Insurance Coverage for Transsexuals — Q & A
From the San Francisco Transgender Community Task Force

Q. Why is the Board of Supervisors considering paying for sex changes for City workers who are transsexual?
A. The Board of Supervisors is NOT paying for or "legalizing” sex change surgery. They are considering asking the Health Services System Board to consider eliminating the exclusion of health care for transsexual people. (Surgical sex reassignment is already legal!)

Q. Why is this important?
A. Because San Francisco’s Ordinances prohibit discrimination against transgendered people. Transsexual people are a small portion of the population included under the umbrella political term of "transgender." We believe that the exclusion of transsexual treatment is based on ignorance of the transsexual medical condition and prejudice against it. Singling out transsexual people and excluding their necessary medical treatment from insurance coverage is discriminatory. Exclusions are often written in such a way that any health care may be denied transsexual people because it is assumed that any health problem that may arise is incident to their transsexuality. This means that out of fear of denial of services, transsexual people may not seek routine, basic health care. Such care may even be denied to them in some cases. We want to protect the health and well being of all people.

Q. If this exclusion is removed will the taxpayers have to pay $30,000 for each transsexual in the City?
A. NO! Only City employees are covered by the City Plan, which is an 80/20 plan. If the exclusion is removed, the few City workers who are transsexual (and who have chosen the City Plan over all other possible plan options) would be able to have the medically necessary portions of their treatment covered at 80%. Not all transsexual employees will require surgical sex reassignment—they may have already received it, or they may not want to have it. All health care costs are distributed across the insured pool and over time, so factored in with all the other medical costs that are being paid out during any given period, there should be virtually no noticeable increase in costs for the City. The City pays only the premium for each worker, and that cost is already budgeted. Taxpayers should not be directly affected by this policy change.

Q. Are there really 6000 transsexuals in San Francisco?
A. NO! It is estimated that there are 6000 transgendered people in San Francisco. No one knows exactly how many are transsexual, but there are probably fewer than 500. There are approximately 25,000 city employees, and, as far as we know, there are only 7 who also happen to be transsexual. Again, those 7 people may not want or require surgical sex reassignment even though they are transsexual.

Q. Since many people believe transsexualism is a lifestyle choice and that the treatment is cosmetic and elective, why should it be eligible for medical coverage?
A. Transsexualism is a medical condition, not a lifestyle choice. Most professionals agree that the only treatment for the condition is medical treatment. Of course there are elective aspects to the treatment, just as there are in many other medical conditions such as allergies or even cancer treatments.
Q. Who should decide which procedures are covered?
A. We believe that trans-related treatment is a matter best left between an individual and his or her physician.

Q. Why are these people making these demands at a time when we have so many more pressing issues in the City, such as homelessness, that affect so many more people?
A. We realize that this seems like a trivial matter to people who don’t like to think about people who are different from them. All that we did was raise the issue with one of the Supervisors as an item of discrimination that needs to be rectified. It is a simple administrative change in policy, which would ensure the City is in compliance with its own ordinance, and also would demonstrate (over time) for other insurance pools that this exclusion is arbitrary, discriminatory, applied prejudicially, and can be removed without creating havoc. The media decided that this was an issue they could exploit, and, judging from the editorializing and misinformation that has been printed and broadcast, they are having a wonderful time. If this is such a non-issue, it should be acted on and forgotten, simply because it is the right thing to do to treat people fairly. The opposition’s use of dismissive rhetoric is an attempt to distort the issue. In this City there are numerous transsexuals among the homeless, and one significant factor in their homelessness is institutionalized discrimination.

Q. What about the position that some insurance companies take in excluding transsexual treatment because it is experimental.
A. Even a cursory review of the medical literature in several disciplines will show that doctors have been providing this treatment for over 50 years.

Does this mean that the City is encouraging people to get sex changes?
A. NO! Not any more than maternity coverage encourages people to have babies.

Q. Doesn’t the City have a moral obligation to discourage transsexual behavior?
A. The City has a moral obligation to prohibit discrimination based on race, religion, color, ancestry, age, sex, sexual orientation, gender identity, disability, or place of birth in employment, housing, public accommodations, businesses, educational institutions, and City and County facilities and services. There is nothing inherently criminal in being transsexual.

Q. Why is it that you don’t know how many transsexuals there are?
A. Because the condition has been so marginalized and because of bias against it, many transsexual people do not wish to make themselves visible, and the medical establishment at large has not been much interested in studying the actual population, even though the subject of gender and its impact on the body is one that has fascinated biological and social scientists for centuries.

Q. Why must you people flaunt your aberrant behavior? Why can’t you keep your abnormal lives out of public view?
A. Because we are human beings and American citizens, residents of this State and this City. We work (whenever we are able and permitted to do so), pay taxes, and otherwise contribute to society in virtually every occupation. We have always existed—in all races, classes, and cultures since history has been recorded, and we are finally finding a collective voice that gives us the courage to resist the ignorance and inhumanity that oppresses us. We are your children, your brothers and sisters, your parents, your neighbors. We do not need to be ashamed, and we are entitled to obtain quality medical care. People who have not had to think about how their gender expression differs from their body often have difficulty conceptualizing our condition, and they allow their personal discomfort to justify trivializing our situation.