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# De-Gendering Health Insurance: A Case for a Federal Insurance Gender Nondiscrimination Act

*Kate Walsham\**

## I. INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) is the most sweeping change to healthcare in the United States since Medicare was passed in 1965.<sup>1</sup> The ACA also creates the perfect platform from which to improve access to medical care for transgender people<sup>2</sup> by securing explicit protections for gender-confirming<sup>3</sup> and gender-incongruent<sup>4</sup> procedures while simultaneously being pragmatic and increasing efficiency. The exact

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1. David Leonhardt, *In Health Bill, Obama Attacks Wealth Inequality*, N.Y. TIMES, Mar. 24, 2010, at A1; *see also* The Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C., 26 U.S.C., 31 U.S.C., 30 U.S.C., 21 U.S.C., 29 U.S.C., 20 U.S.C.) [hereinafter ACA].

2. "Transgender" or "trans" are terms used throughout this note to describe people who express their gender differently than what is traditionally associated with the sex they were assigned at birth. "Transsexual" refers to a procedure that is considered one that changes a person's sex, or refers to a person who has undergone such a procedure. The term "transman" refers to a person who was assigned female at birth but who identifies as a man. Conversely, "transwoman" refers to a person assigned male at birth but who identifies as a woman. Transgender people may or may not choose to physically alter their bodies to reflect their gender identity. For a thorough discussion of some definitions of these terms and their history and the medicalization of those identities, *see* Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731, n.12 (2008) [hereinafter Spade, *Documenting*]; *see also, generally* Dean Spade, *Resisting Medicine, Re/Modeling Gender*, 11 BERKELEY WOMEN'S L.J. 15 (2003) [hereinafter Spade, *Resisting*] (describing trans people's interactions with the U.S. medical system).

3. "Gender-confirming care" refers to any procedures that help a transgender person realize their authentic gender. These might include hormone treatment or sexual reassignment surgery (SRS) or both. *Insurance Gender Nondiscrimination Act Analysis of Assembly Bill 1586, Hearing Before S. Comm. on Banking, Finance, & Ins.*, 2005-2006 Regular Session (Cal. 2005), available at [ftp://leginfo.public.ca.gov/pub/05-06/bill/asm/ab\\_1551-1600/ab\\_1586\\_cfa\\_20050613\\_175230\\_sen\\_comm.html](ftp://leginfo.public.ca.gov/pub/05-06/bill/asm/ab_1551-1600/ab_1586_cfa_20050613_175230_sen_comm.html) [hereinafter A.B. 1586 Analysis].

4. Gender-incongruent procedures are procedures typically required by people who have a different gender marker. *Id.*; *see also infra* Part II.B.2.

number of transgender people in the United States is unknown, but it is estimated to be between one and three percent of the adult population.<sup>5</sup> We can estimate that there are between three million and nine million transgender Americans.<sup>6</sup> Transgender people therefore represent a significant number of people whose healthcare access and outcomes should be accounted for in national legislation.

In 2005, California enacted a first-of-its-kind bill to ensure insurance protections for transgender Californians.<sup>7</sup> The Insurance Gender Nondiscrimination Act (IGNA),<sup>8</sup> which prohibits discrimination on the basis of gender and gender identity in insurance coverage, should be the model for the states and for federal regulations as the ACA's provisions go into effect. Adding a version of the IGNA to the ACA would be a cost-effective means of making healthcare more accessible for the transgender community, a particularly vulnerable group of Americans.

This note advocates for enactment of a federal Insurance Gender Nondiscrimination Act based on California's bill and the California Department of Insurance (CDI) regulations regarding enforcement of the IGNA. Part II briefly contextualizes the current problem transgender people face in accessing healthcare. It describes the history of transgender exclusions in both public and private insurance, and explores the scheme of insurance coding which informs whether or not a procedure is considered "transsexually related" and therefore excluded. It also describes individual instances of exclusions for gender-confirming treatment or gender-incongruent procedures. Part III explores California's IGNA in detail, addressing the IGNA's shortcomings and CDI's new enforcement regulations, enacted August 3, 2012, and effective as of September 2, 2012. Part IV analyzes the provisions of the ACA as they may apply to transgender people. First, it briefly describes the ACA's scope and its shortcomings as they relate to trans people's access to care, then it describes how cost-shifting changes brought about by the ACA's reforms will be affected by trans-inclusive policies. Part V addresses concerns that

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5. Kari E. Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 COLUM. J. GENDER & L. 88, 91 (2002) (quoting JAMISON GREEN & LARRY BRINKIN, S.F. HUMAN RIGHTS COMM'N, INVESTIGATION INTO DISCRIMINATION AGAINST TRANSGENDERED PEOPLE 9 (1994)).

6. There are approximately 314 million people in the United States. *US PopClock Projection*, U.S. CENSUS BUREAU, (Sept. 23, 2012), <http://www.census.gov/population/www/popclockus.html>.

7. Insurance Gender Nondiscrimination Act, 2005 Cal. Legis. Serv. 421 (West) [hereinafter A.B. 1586].

8. CAL. HEALTH & SAFETY CODE § 1365.5(a) (2005); CAL. INS. CODE § 10140(a) (2005). California's health insurance regulation statutes are bifurcated into the Health and Safety code and the Insurance code. The IGNA appears in both section 1365.5 of the California Health and Safety code and section 10140 of the California Insurance code—these provisions are identical. For simplicity, throughout this note, "A.B. 1586" and "IGNA" refer to both California code provisions. Where it is relevant, specific code sections are referenced.

covering sex reassignment surgery (SRS) and gender-confirming care would increase insurance cost beyond the reasonable risk absorption for the transgender population, and concludes that cost concerns are insufficient to warrant continued exclusions for transgender care.

## II. CONTEXT: A BRIEF HISTORY OF TRANSGENDER HEALTHCARE AND THE EXISTING PROBLEM OF ACCESSING CARE

The health insurance industry considers transgender people to be an insurance risk.<sup>9</sup> Because insurance generally exists to protect against the unexpected, an existing condition is not deemed an insurable risk because it is known.<sup>10</sup> Health insurance and healthcare provisions exist in an increasingly regulated market.<sup>11</sup> This regulation limits the ways in which health insurance is able to rely on standard market forces because regulations prevent insurers from excluding certain types of risk from their insurance pools.<sup>12</sup> The likelihood of an event's occurrence brackets the coverage limits of "risk spreading" insurance like fire or earthquake insurance, but in healthcare, there are other limitations on coverage.<sup>13</sup> The metric in market reliance for determining whether to cover a benefit for one individual in the insurance pool is the overall benefit of expenditure for the insured group—meaning that care or services will only be covered if it is generally beneficial for the entire group for one of its members to receive treatment.<sup>14</sup> In health insurance, regulations require insurers to take on more risk than market forces would otherwise allow.<sup>15</sup> For example, the Americans with Disabilities Act (ADA) prevents discrimination in employment on the basis of disability.<sup>16</sup> Employers with health insurance benefits for their employees therefore cannot ask potential employees to submit to a physical exam prior to committing to hiring and insuring that

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9. Liza Khan, Note, *Transgender Health Insurance at a Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform*, 11 YALE J. HEALTH POL'Y L. & ETHICS 375, 386–410 (2011).

10. *Id.* at 389.

11. *Id.*; see also, generally ACA, *supra* note 1.

12. Khan, *supra* note 9, at 389–90.

13. Wendy K. Mariner, *Health Reform: What's Insurance Got to Do with It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 AM. J.L. & MED. 436, 438 (2010) (“[I]t is possible to reconcile these conceptions if we recognize health insurance as a separate species of insurance[—]distinct in function, and therefore content, from conventional indemnity insurance models. Both regulation and industry practices already have moved health insurance a long way toward becoming an identifiably separate species by limiting some risk classification methods, but universal coverage requires purging or greatly circumscribing most tools of conventional insurance.”).

14. Khan, *supra* note 9, at n.77.

15. Khan, *supra* note 9, at 389–90.

16. 42 U.S.C.A. § 12112 (West 2009).

person.<sup>17</sup> The ADA, therefore, increases the risks that health insurers are required to take on.<sup>18</sup>

Treatment for transgender people has been traditionally excluded from risk sharing frameworks in both public and private insurance. Treatment exclusion is partially tied to the ADA,<sup>19</sup> which is relevant for two reasons. First, it explicitly excludes transsexualism from the definition of disability.<sup>20</sup> This exclusion allows discrimination towards trans people in public insurance.<sup>21</sup> Second, the public accommodations provisions of the ADA do not reach insurance contents.<sup>22</sup> This means that the ADA allows for diagnosis and treatment exclusions in insurance generally. For example, HIV is often an excluded diagnosis, meaning that people diagnosed with HIV will not have their medication covered by insurance even though HIV is considered a disability under the ADA.<sup>23</sup>

In public insurance, “[t]he Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.”<sup>24</sup> If a procedure is determined to be medically necessary, Medicaid will cover that procedure.<sup>25</sup> “Thus, coverage of sex-reassignment surgery under Medicaid turns on each state’s determination of whether or not the procedure is medically necessary” for the patient.<sup>26</sup> Some states have found that Medicare should cover SRS on a case-by-case basis when medically necessary, while other states have not.<sup>27</sup>

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17. 42 U.S.C.A. § 12201 (West 2012).

18. R. Nick Gorton, *Transgender Health Benefits: Collateral Damage in the Resolution of the National Health Care Financing Dilemma*, 4 SEXUALITY RES. & SOC. POL’Y J. OF NAT’L SEXUALITY RES. CTR. 81, 81–85 (2007).

19. 42 U.S.C.A. § 12211 (West 2009).

20. “[T]he term ‘disability’ shall not include transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders.” 42 U.S.C.A. § 12211. This definition goes on to list “compulsive gambling, kleptomania, or pyromania [, and] psychoactive substance use disorders resulting from current illegal use of drugs” as other conditions excluded by the ADA. For a more in depth analysis of the ramifications of these exclusions, see generally Hong, *supra* note 5.

21. See generally Hong, *supra* note 5 (discussing categorical exclusions in health insurance).

22. Sara Rosenbaum, *Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Federal Reform Options*, 37 J.L. MED. & ETHICS 103, 109 (2009).

23. *Id.* at 107.

24. 42 C.F.R. § 440.230(b) (2011).

25. *Id.*

26. Jerry L. Dasti, *Advocating a Broader Understanding of the Necessity of Sex-Reassignment Surgery Under Medicaid*, 77 N.Y.U. L. REV. 1738, 1757 (2002).

27. See, e.g., *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980) (holding Iowa’s policy of denying Medicaid benefits for sex reassignment surgery to be “an arbitrary denial of benefits based solely on the ‘diagnosis, type of illness, or condition.’”); *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001) (holding Medicaid confers broad discretion on the States to adopt their own standards and that Iowa’s decision not to cover Smith’s

Insurers are able to restrict access to certain procedures and for certain diagnoses because the ADA does not prohibit limitations in insurance coverage based on specific actuarial risk that is also not prohibited under state law.<sup>28</sup> “Thus, private health insurers can single out certain conditions (e.g., HIV/AIDS) for complete or near-total coverage exclusion, so long as the exclusion applies to all plan members.”<sup>29</sup> Despite the fact that these exclusions appear to be discriminatory, and “despite rulings by the federal agencies to the contrary, courts have deferred to the concepts of actuarial fairness and risk classification, even where actuarial justification is absent.”<sup>30</sup> These rulings do not take into account the fact that the ADA’s insurance safe harbor only permits treatment and diagnosis exclusions where they are actuarially justified.<sup>31</sup> Because transsexualism is specifically excluded from the ADA, actuarially unsound practices are insufficient to show that gender-confirming procedures should be covered, and “obtaining federal protections through the ADA involves convincing courts not only that gender identity disorder is a legitimate illness needing treatment but also that the exclusion within the law itself is unconstitutional.”<sup>32</sup> It is within this framework that insurance companies have had the leeway to exclude coverage for transgender people.<sup>33</sup>

Transgender people face a number of difficulties accessing gender-confirming care when they are insured. Insurance companies routinely classify transgender status as a preexisting condition exempt from treatment, or classify gender-confirming treatments as cosmetic or elective because they seek to change anatomy that is considered normal and functional.<sup>34</sup> These classifications place transgender insureds seeking gender-confirming care in a bureaucratic limbo in which doctors recognize that gender-confirming care is a necessary medical procedure for transgender patients, but insurance companies generally refuse to cover transition-related care.<sup>35</sup> The “AMA supports public and private health

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phalloplasty was within that discretion); *G.B. v. Lackner*, 80 Cal. App. 3d 64 (1978) (holding Medi-Cal coverage could not be denied for a transgender woman’s SRS where her doctor determined it was medically necessary).

28. 42 U.S.C.A. § 12201 (West 2009).

29. Rosenbaum, *supra* note 22, at 109.

30. *Id.*

31. *Id.*

32. Gorton, *supra* note 18, at 84.

33. “Exclusions” in this section refer both to explicit contractual provisions in various health plans which state that certain benefits are excluded from coverage and to the effect of receiving a denial of coverage even if a benefit is not in fact listed under the “exclusions” section of a health plan.

34. Khan, *supra* note 9, at 390–99; *but see Lackner*, 80 Cal. App. 3d at 70 (finding castration and penectomy did not qualify as cosmetic surgery defined by Medi-Cal as surgery having the purpose of “alter[ing] the texture and configuration of the skin and the skin’s relationship with contiguous structures of the body,” and holding that Medi-Cal must provide coverage for medically necessary SRS).

35. Khan, *supra* note 9, at 391, n.79.

insurance coverage for treatment of gender identity disorder as recommended by the patient's physician" and "opposes the denial of health insurance on the basis of . . . gender identity."<sup>36</sup> Insurance companies, on the other hand, do not see providing gender-confirming care to be essential, or generally beneficial to the groups they insure.<sup>37</sup> Another difficulty with re-classifying gender-confirming care as medically necessary is that procedures that are often classified as elective or cosmetic surgeries for nontrans patients, such as facial feminization surgery or breast augmentation, can be medically necessary for trans patients.<sup>38</sup> This creates a perverse incentive for medical providers to ban all such surgeries because a ban limits insurance liability.

#### A. MEDICAL CODING AND THE ICD-9

Classifying SRS and gender-confirming care as nonessential medical care is not effective for limiting access to these procedures if doctors working with transgender patients use diagnostic and treatment codes that obfuscate their patients' transgender status. The current scheme of medical coding includes a system of diagnostic and procedure codes known as the ICD-9.<sup>39</sup> These codes specify every conceivable ailment for each piece of anatomy and allow doctors to specify what treatment they plan to provide for that ailment.<sup>40</sup> Because the ICD-9 includes so much information, in many cases there are multiple codes that will achieve the same objective for a patient by classifying the same treatment differently.<sup>41</sup>

Transgender people seeking gender-confirming care are routinely denied when their care is coded as transsexual-related care.<sup>42</sup> The following ICD-9 diagnostic codes: 302.51, trans-sexualism with asexual history; 302.52, trans-sexualism with homosexual history; 302.53, trans-sexualism with heterosexual history; 302.6, GID in children; and, 302.85, GID of adolescence or adult life are often denied because these codes are directly related to and expressly prohibited by many insurance plans'

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36. *AMA Policies on GLBT Issues, Patient Centered Policies at H-185.950, H-180.980*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glb-adv-adv-committee/ama-policy-regarding-sexual-orientation.page#> (last visited Feb. 10, 2012).

37. Gorton, *supra* note 18, at 85.

38. Khan, *supra* note 9, at 394–95.

39. Classifications: International Classification of Disease (ICD), World Health Org., <http://www.who.int/classifications/icd/en/> (last visited Feb. 27, 2012). The ICD-10 has been available and used by other countries for the last fifteen years but U.S. insurers have not yet adopted it. Tom Sullivan, *5 Lessons the U.S. Can Learn from Other Countries' ICD-10 Moves*, ICD-10 WATCH (Mar. 01, 2010, 10:52 AM), <http://www.icd10watch.com/blog/5-lessons-us-can-learn-other-countries-icd-10-moves>.

40. *2009 ICD-9-CM: Diseases and Injuries Tabular Index*, <http://icd9cm.chrisendres.com/> (last visited Mar. 2, 2012).

41. *Id.*

42. PROJECT HEALTH, CODING FOR TRANSITION-RELATED SERVICES FOR TRANSGENDER PATIENTS (2012) (on file with author).

transsexual treatment exclusion provisions.<sup>43</sup> ICD-9 codes which are not routinely denied as being transsexual treatment include: 259.9, unspecified endocrine disorder; 257.2, other testicular hypofunction; 256.39, other ovarian failure; 752.7, indeterminate sex and pseudohermaphrodisism; V58.69, long-term (current) use of other medications; and, 611.1, hypertrophy of breast.<sup>44</sup> By carefully choosing insurance-covered diagnostic codes that accurately reflect their patients' medical conditions, doctors have been able to find ways for their trans patients to receive gender-confirming care even in the face of explicit exclusions for transsexual care.<sup>45</sup> By carefully coding their trans patients' care, some doctors appear to recognize the existing trans exclusions in insurance policies are improper status discrimination.

Coding schemes are also connected with the software that governs insurance companies' determinations of whether or not a plan will cover the cost of a coded procedure.<sup>46</sup> In this process, the doctor's chosen ICD-9 codes will indicate the treatment and the diagnosis necessitating that treatment.<sup>47</sup> When a claim requesting coverage for a treatment/diagnosis combination goes to the insurance company, the insurer's claims process will check whether the patient's insurance plan ever covers the procedure, whether the procedure is appropriate for the diagnosis, whether the diagnosis is appropriate for the person based on gender among other factors, and whether the patient's history or other factors including gender and age comport with the provider's understanding of the circumstances when the insurer offers coverage.<sup>48</sup>

#### B. EXCLUSION OF MEDICALLY NECESSARY PROCEDURES AND COUNTERINTUITIVE DENIALS

Medically necessary procedures include both gender-confirming care procedures and gender-incongruent procedures. Transgender patients' experiences with being denied care for each of these types of treatments illustrate the harm that results from treatment failures. As these stories show, both the patients and the insurance companies suffer from an inefficient and problematic system.

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43. PROJECT HEALTH, *supra* note 42.

44. *Id.*; but see *Clinical Policy Bulletin: Gender Reassignment Surgery*, AETNA, [http://www.aetna.com/cpb/medical/data/600\\_699/0615.html](http://www.aetna.com/cpb/medical/data/600_699/0615.html) (last visited Oct. 11, 2011) (denying coverage for SRS where nontransgender-specific ICD-9 Code is used).

45. PROJECT HEALTH, *supra* note 42.

46. Telephone Interview with Christina Diaz, Customer Serv. Representative, Blue Shield of Cal. (Mar. 2, 2012); E-mail from Anonymous, Software Engineer, Epic Sys. to author (Dec. 9, 2011).

47. Telephone Interview with Christina Diaz, *supra* note 46; E-mail from Barbara Hernandez, Corporate Spokesperson, Epic Sys. to author (Mar. 2, 2012) (claiming diagnosis/treatment analysis and coding process as proprietary information).

48. Telephone Interview with Christina Diaz, *supra* note 46.

### 1. Gender-Confirming Care Procedures

One transman (A) lives in a jurisdiction that does not require proof of surgery to correct his identity documents.<sup>49</sup> He was therefore able to obtain a driver's license and other ID with the appropriate gender marker and name without ever having surgery.<sup>50</sup> Some years after he had corrected his ID, he sought a double mastectomy both because he desired it as gender-confirming care, and because there was a history of breast cancer in his family for which the procedure would serve as prophylaxis.<sup>51</sup> If he had applied for a double mastectomy before his paperwork had been corrected, he would have been applying for a "female" procedure as a person with "female" documents. As it was, his documents indicated that a mastectomy would be a gender-incongruent procedure and was therefore not covered.<sup>52</sup> He explains: "[I] could have gotten it covered as preventative mastectomy, because my grandfather died of breast cancer in his 50's [sic]. But because I'd changed my ID years ago, no surgery for me, even though my family history of breast cancer was specifically male."<sup>53</sup> This is exactly the sort of bureaucratic absurdity that burdens both transgender patients and the healthcare system generally.<sup>54</sup> This man's double mastectomy served two medically sound purposes. First, it functioned as well-established preventative care for breast cancer.<sup>55</sup> Second, it was appropriate treatment for his GID. However, because his plan excluded any transition-related surgical procedures, a procedure that served both a transition-related purpose and a cancer-preventative purpose was not covered.<sup>56</sup> A gender congruency check on A's doctor's order showed a mismatch for a mastectomy since men are not approved for breast cancer preventative

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49. Tgjer, Comment to *Law Student Looking for Letters Denying Insurance Coverage to Trans People*, REDDIT, [http://www.reddit.com/r/asktransgender/comments/nelnq/law\\_student\\_looking\\_for\\_letters\\_denying\\_insurance/c38isbt](http://www.reddit.com/r/asktransgender/comments/nelnq/law_student_looking_for_letters_denying_insurance/c38isbt) (last visited Feb. 20, 2012).

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

54. A double mastectomy would cost the insurance company approximately \$7,600 as a preventive measure. If the mastectomy were due to cancer, it would cost \$1,000 for a biopsy showing cancer, \$7,600 for the surgery, and potentially \$11,000 or more in radiation and/or chemotherapy treatments. See *Healthcare Blue Book: Your Free Guide to Healthcare Pricing*, CAREOPERATIVE, <http://healthcarebluebook.com> (last visited Feb. 10, 2012).

55. *Preventive Mastectomy*, NAT'L CANCER INST., <http://www.cancer.gov/cancertopics/factsheet/Therapy/preventive-mastectomy> (last visited Feb. 19, 2012) ("Preventive mastectomy may be an option for a woman whose mother, sister, or daughter had breast cancer, especially if they were diagnosed before age 50 [sic]. If multiple family members have breast or ovarian cancer, then a woman's risk of breast cancer may be even higher."). The risk factor for the preventative treatment is gender neutral "family member," nonetheless the risk of cancer is only considered for women. *Id.*

56. Tgjer, *supra* note 49.

treatment because their risk factors do not make that treatment reasonable for insurers to take on.<sup>57</sup>

Another transman (B) whose insurance plan classified him with a female gender marker was also denied coverage for a double mastectomy.<sup>58</sup> A letter he received from his insurance company indicated a procedure code of 19303,<sup>59</sup> defined as a “Simple Complete Mastectomy” procedure, which “includes removal of all breast tissue, along with a portion of skin and nipple through an elliptical incision.”<sup>60</sup> This is a standard procedure and there is no indication based on the code itself that it is trans specific.<sup>61</sup> B was denied coverage for his mastectomy because his doctor’s notes or the diagnostic code accompanying the treatment request indicated that the procedure would treat his gender identity disorder, and/or because he did not meet his insurer’s standards for preventive mastectomy.<sup>62</sup>

A transwoman (C) was receiving estrogen therapy, which was covered by her insurer.<sup>63</sup> Her doctors prescribed an unusually high dosage of estrogen to counteract her body’s unusually high production of testosterone.<sup>64</sup> The unusually high doses of estrogen exposed her to an increased risk of stroke and other complications.<sup>65</sup> Her doctors “determined that this [risk] was not a safe or sustainable situation and recommended that she undergo an orchiectomy (removal of testicles).”<sup>66</sup> Despite this procedure being a medically necessary, preventive treatment, she was denied coverage for the surgery on the basis of an express exclusion for transgender surgery in her plan.<sup>67</sup> This plan originated in California; therefore exclusion was unlawful under the IGNA. However, without explanation, the California Department of Managed Health Care (DMHC) did not enforce the law to override the policy’s express exclusion.<sup>68</sup>

## 2. General Preventative Care and Treatment

Transgender people are routinely denied coverage for basic care when their care would typically be covered, or even mandated, for a person

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57. See *supra* text accompanying notes 46–49.

58. Letter from HMO to B (Apr. 5, 2011) (on file with author).

59. *Id.*

60. *Coding Breast Diseases and Surgery, Part 2*, ADVANCE FOR HEALTH INFO. PROFESSIONALS (Apr. 23, 2007), <http://health-information.advanceweb.com/Article/Coding-Breast-Diseases-and-Surgery-Part-2.aspx>.

61. See *supra* text accompanying notes 46–49.

62. See *supra* note 55.

63. Shannon Minter et al., *A New Approach to Healthcare Equality for Transgender People: California’s Insurance Gender Non-Discrimination Act*, 2 LGBTQ POL’Y J. HARV. KENNEDY SCH. 35, 39 (2012).

64. *Id.* at 40.

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.* at 41.

whose gender marker and physiology are congruent.<sup>69</sup> Procedures typically required by people with a different gender marker are known as “gender incongruent procedures.” D, for example, was informed that his claim for a pap smear “will not be covered if the diagnosis and/or procedure codes are for female procedures” after his gender marker has been changed to male.<sup>70</sup> E was denied coverage for a bone density scan.<sup>71</sup> He had a family history of osteoporosis.<sup>72</sup> He was over fifty, which was within the appropriate age for a woman with his medical and family history to receive a bone density scan.<sup>73</sup> But, E had updated his gender marker to reflect his male gender identity. Without any change in his risk factors, E’s male gender marker was sufficient to bar coverage of a medically necessary scan.<sup>74</sup> E appealed his denial to the DMHC and because of California’s IGNA, DMHC reversed the denial.<sup>75</sup>

Robert Eads, a transman, and the subject of the 2001 documentary *Southern Comfort*, was diagnosed with ovarian cancer in 1996.<sup>76</sup> With that diagnosis he sought treatment from dozens of doctors, each of whom turned him away for fear that treating a transgender patient would harm their practices.<sup>77</sup> By the time he was able to find a hospital willing to treat him in 1998, his cancer had metastasized and despite aggressive treatment he died at the age of fifty-three.<sup>78</sup>

### III. CALIFORNIA INSURANCE GENDER NONDISCRIMINATION ACT—A.B. 1586

In 2005, California became the only state thus far to recognize and address the persistent problem transgender people face accessing care even when they have insurance that would cover the care by enacting A.B. 1586, the IGNA.<sup>79</sup> The state recognized the issue by stating that while transgender insureds “may identify themselves as a certain sex, they may still need medical services typically given to members of the opposite sex. . . . A health plan that automatically denies coverage of gynecological services for men as inappropriate could then deny appropriate and medically necessary services for transgender enrollees.”<sup>80</sup> The IGNA thereby establishes an “equality framework” for insurance in California

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69. CAL. CODE REGS. tit. 10 §§ 2561.1, 2561.2 (2012).

70. Letter from HMO to D (Oct. 24, 2007) (on file with author).

71. Letter from HMO to E (May 19, 2010) (on file with the Transgender Law Center).

72. *Id.*

73. Letter from HMO to E (Jan. 26, 2011) (on file with the Transgender Law Center).

74. Letter from HMO to E (May 19, 2010), *supra* note 71.

75. Letter from HMO to E (Jan. 26, 2011), *supra* note 73.

76. SOUTHERN COMFORT (Q-Ball Productions 2001).

77. *Id.*

78. *Id.*

79. Minter, *supra* note 63, at 37; A.B. 1586 Analysis, *supra* note 3; A.B. 1586, *supra* note 7.

80. A.B. 1586 Analysis, *supra* note 3.

where if an insurer covers a procedure for a nontransgender patient, it must cover that procedure for a transgender patient.<sup>81</sup>

A. IGNA ELIMINATES GENDER AS LEGITIMATE BASIS FOR DENYING CARE

The IGNA does not mandate that a plan cover any particular type of benefit, procedure, or treatment.<sup>82</sup> But it does require that if a plan provides a particular benefit, procedure, or treatment for a nontransgender person, it must do so for a transgender person as well.<sup>83</sup> The bill sought to address problems such as “charging higher premiums without sound actuarial justification; refusal to cover medically necessary treatments, including gender-specific treatments . . . that would be covered for other people; and refusal to cover treatments related to gender transition when the same treatments are covered for other conditions.”<sup>84</sup> For example, if pap smears are covered by the insurance plan generally, the fact that a person’s gender marker is male cannot prevent him from receiving insurance coverage for his pap smear.<sup>85</sup> By requiring that the same care be made available to all insurance plans’ enrollees, A.B. 1586 invalidated a discriminatory scheme from insurance companies’ plan administration.<sup>86</sup>

B. CALIFORNIA DEPARTMENT OF INSURANCE: NEW REGULATIONS ARE INSTRUCTIVE

California insurance is regulated by two different systems of laws, each of which is regulated by its own agency.<sup>87</sup> The Knox-Keene Act regulates HMO insurance and is enforced by the DMHC.<sup>88</sup> The California insurance code regulates PPO insurance and is enforced by the CDI.<sup>89</sup> Each regulatory agency has discretion in its enforcement of the IGNA.<sup>90</sup> For a variety of reasons that include a lack of knowledge on the part of both patients and providers about the new law’s protections, prohibitions, and requirements, and inconsistent enforcement by administrative agencies, the IGNA has not been especially effective since being adopted in 2005.<sup>91</sup> In

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81. Minter, *supra* note 63, at 37.

82. A.B. 1586, *supra* note 7, at § 3.

83. *Id.*; Minter, *supra* note 63, at 38.

84. Minter, *supra* note 63, at 37.

85. CAL. CODE REGS. tit. 10 § 2561.2 (2012).

86. Minter, *supra* note 63, at 37–38.

87. *Laws Relating to Health Care Plans in California*, DEP’T OF MANAGED HEALTH CARE, <http://wpsso.dmhc.ca.gov/regulations/> (last visited Feb. 20, 2012); see *About Us: An Introduction to CDI Operations*, CAL. DEP’T OF INS., <http://insurance.ca.gov/0500-about-us/0100-cdi-introduction/> (last visited Oct. 22, 2012) [hereinafter *About Us*].

88. *Laws Relating to Health Care Plans in California*, *supra* note 87; Minter, *supra* note 63, at 37.

89. *About Us*, *supra* note 87; Minter, *supra* note 63, at 37.

90. CAL. INS. CODE § 10140(f) (West 2012).

91. Minter, *supra* note 63, at 38.

response to these shortcomings, CDI has issued regulations for enforcement of the IGNA.<sup>92</sup>

These regulations begin by defining and describing key terms, including gender identity and gender transition.<sup>93</sup> They next lay out four categories of discrimination covered by the IGNA and subject to regulation:

- (1) Denying, cancelling, limiting or refusing to issue or renew an insurance policy on the basis of an insured's or prospective insured's actual or perceived gender identity, or for the reason that the insured or prospective insured is a transgender person;
- (2) Demanding or requiring a payment or premium that is based in whole or in part on an insured's or prospective insured's actual or perceived gender identity, or for the reason that the insured or prospective insured is a transgender person;
- (3) Designating an insured's or prospective insured's actual or perceived gender identity, or the fact that an insured or prospective insured is a transgender person, as a preexisting condition for which coverage will be denied or limited; or
- (4) Denying or limiting coverage, or denying a claim, for services including but not limited to the following, due to an insured's actual or perceived gender identity or for the reason that the insured is a transgender person:
  - (A) Healthcare services related to gender transition if coverage is available for those services under the policy when the services are not related to gender transition, including but not limited to hormone therapy, hysterectomy, mastectomy; or
  - (B) Any healthcare services that are ordinarily or exclusively available to individuals of one sex when the denial or limitation is due only to the fact that the insured is enrolled as belonging to the other sex or has undergone, or is in the process of undergoing, gender transition.<sup>94</sup>

These comprehensive and detailed regulations provide clear guidance about prevalent discriminatory practices against transgender people.<sup>95</sup> Each of the four provisions of the CDI regulations specifically explains which existing insurance practices are foreclosed by the IGNA and by

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92. CAL. CODE REGS. tit. 10 § 2561.2 (2012).

93. *Id.*

94. *Id.*

95. *Id.*

CDI's enforcement of that bill.<sup>96</sup> The legislation itself covers "actual and perceived gender identity" through reference to the Penal Code's definition of "sex."<sup>97</sup> CDI's decision to enumerate "actual and perceived gender identity" in each of the four CDI provisions clarifies what the IGNA sought to accomplish.<sup>98</sup> The CDI regulations were filed with the California Secretary of State on August 3, 2012, and went into effect on September 2, 2012.<sup>99</sup> These regulations are a definitive step in the right direction but it is not yet possible to tell how successful they will be.

#### IV. PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The 2010 ACA legislation is potentially an important advancement for transgender healthcare. ACA is the most comprehensive change to healthcare in the U.S. since Medicare was enacted in 1965.<sup>100</sup> Three of its most sweeping provisions will directly affect transgender patients' access to healthcare generally and potentially will affect trans patients' access to gender-confirming and gender-incongruent care as well.<sup>101</sup> To understand why the ACA is the appropriate vehicle for gender nondiscrimination protections in healthcare provisions, a basic understanding of the scope and limitations as they relate to transgender patients of the ACA is necessary.

##### A. SCOPE AND LIMITATIONS OF AFFORDABLE CARE ACT

There are four basic provisions of the ACA that are applicable to evaluating whether or not the ACA will effectively provide transgender insureds with the care they need. First, the ACA prohibits exclusion from health insurance on the basis of preexisting conditions.<sup>102</sup> Second, the ACA mandates coverage of essential health benefits.<sup>103</sup> Third, the ACA has both individual and provider nondiscrimination provisions.<sup>104</sup> Finally, through its "individual mandate," the ACA will change the existing healthcare cost-shifting framework.<sup>105</sup>

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96. CAL. CODE REGS. tit. 10 § 2561.2 (2012).

97. A.B. 1586, *supra* note 7. ("Sex" as used in this section shall have the same meaning as 'gender,' as defined in Section 422.56 of the Penal Code."); CAL. PENAL CODE § 422.56(c) (West 2012) ("Gender" means sex, and includes a person's gender identity and gender expression. 'Gender expression' means a person's gender-related appearance and behavior whether or not stereotypically associated with the person's assigned sex at birth."). The CDI regulations also include definitions of "actual gender identity," "perceived gender identity," "transgender," and "gender transition." CAL. CODE REGS. tit. 10 § 2561.1 (2012).

98. CAL. CODE REGS. tit. 10 § 2561.2 (2012).

99. CAL. CODE REGS. tit. 10 §§ 2561.1, 2561.2 (2012).

100. Leonhardt, *supra* note 1.

101. *See infra* Part IV.A.

102. ACA, *supra* note 1, at § 2704.

103. *Id.* at §§ 1302, 2707.

104. *Id.* at §§ 2706, 1557.

105. *Id.* at § 1501.

### 1. Preexisting Condition Discrimination and Health Status Discrimination

First, the ACA prohibits preexisting condition exclusions or other discrimination based on health status.<sup>106</sup> Transgender patients will no longer need to worry about being excluded from receiving health insurance altogether due to their transgender status.<sup>107</sup> While this is excellent news for those seeking access to health insurance generally, there is no guarantee that the protections will extend to coverage of those preexisting conditions if it is determined that procedures or care is “medically unnecessary.”<sup>108</sup> Transgender patients have traditionally lost the battle over whether gender-confirming care should be categorized as medically necessary.<sup>109</sup>

### 2. Mandated Coverage of “Essential Health Benefits”

Second, the ACA mandates that coverage for all individual or small group market health insurance packages include comprehensive coverage for “essential health benefits.”<sup>110</sup> These benefits include provisions that could easily cover transition-related care, including mental health treatment, prescription drugs, preventive and wellness services, and chronic disease management.<sup>111</sup> The essential benefits listed in the ACA are not exhaustive.<sup>112</sup> The Secretary of Health and Human Services (HHS) is responsible for defining essential benefits beyond those enumerated in the statute.<sup>113</sup> The essential health benefits will be limited by what has already been considered “essential” in existing health plans: “[t]he Secretary shall ensure that the scope of the essential health benefits under [section 1302] is equal to the scope of benefits provided under a typical employer plan.”<sup>114</sup> The Secretary of Labor is to make that determination herself by conducting “a survey of employer-sponsored coverage to determine the benefits typically offered by employers.”<sup>115</sup> As discussed above, most insurance plans on the market, both employer-sponsored and independently available, exclude transition-related care.<sup>116</sup> Transgender people and their advocates can hope that the Secretary of Labor chooses to model the basic provisions of care on one or a few of the 207 companies who answered the Human

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106. ACA, *supra* note 1, at § 2704.

107. *See supra* text accompanying notes 27–38.

108. *See supra* text accompanying notes 27–38.

109. Khan, *supra* note 9, at 411.

110. ACA, *supra* note 1, at §§ 1302, 2707.

111. *Id.* at § 1302(1).

112. *Id.*

113. *Id.* at § 1302(2).

114. *Id.*

115. *Id.*

116. HUMAN RIGHTS CAMPAIGN, CORPORATE EQUALITY INDEX 2012, 18, 28 [http://asp.hrc.org/documents/CorporateEqualityIndex\\_2012.pdf](http://asp.hrc.org/documents/CorporateEqualityIndex_2012.pdf) (last visited Sept. 21, 2012) (only 207 out of 636 employers rated by the HRC Corporate Equality Index fully cover transgender treatments).

Rights Campaign's corporate equality index survey affirming transgender healthcare coverage; however, that is unlikely.<sup>117</sup> The Secretary's choice of plans will end up further entrenching the current status quo of limiting access to gender-confirming and gender-incongruent procedures.

Under a framework set in an HHS bulletin last December, states will have some discretion to select Qualified Health Plans (QHPs) from existing plans in the state, including selecting their own "benchmark" plans for the items and services included in the essential health benefits package.<sup>118</sup> States were given the following options from which to select their benchmark plans: "[o]ne of the three largest small group plans in the state; [o]ne of the three largest state employee health plans; [o]ne of the three largest federal employee health plan options; [or t]he largest HMO plan offered in the state's commercial market."<sup>119</sup> California has already established its health exchange and has identified its three largest health plans by enrollment to serve as benchmark QHPs: Kaiser Foundation Health Plan, Inc., Anthem Blue Cross Life & Health Co., and Blue Cross of California.<sup>120</sup> Currently none of these plans provide comprehensive transgender health coverage, and each has an explicit exclusion for SRS.<sup>121</sup> California responded to the HHS bulletin by requesting clarification regarding cost sharing between federal and state governments.<sup>122</sup> The ACA requires states to defray the cost of state-mandated benefits in excess of essential health benefits for QHPs.<sup>123</sup> A state may choose a plan that does not include all of that state's existing health benefit mandates but may be required to pay for adding additional state-mandated health benefits

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117. HUMAN RIGHTS CAMPAIGN, *supra* note 116.

118. *HHS to Give States More Flexibility to Implement Health Reform*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Dec. 16, 2011) <http://www.hhs.gov/news/press/2011pres/12/20111216b.html>; *Essential Health Benefits Bulletin*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT (Dec. 16, 2011), [http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf) [hereinafter HHS Bulletin].

119. *Id.*

120. Henry J. Kaiser Family Foundation, *Establishing Health Insurance Exchanges: An Update on State Efforts*, FOCUS ON HEALTH REFORM, 2, 4-5 (Aug. 2012), [www.kff.org/healthreform/upload/8213.pdf](http://www.kff.org/healthreform/upload/8213.pdf); *Essential Health Benefits: Illustrative List of the Largest Three Small Group Products by State*, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT (Jan. 31, 2012), [http://cciio.cms.gov/resources/files/Files2/01272012/top\\_three\\_plans\\_by\\_enrollment\\_508\\_20120125.pdf](http://cciio.cms.gov/resources/files/Files2/01272012/top_three_plans_by_enrollment_508_20120125.pdf).

121. CAL. PHYSICIANS' SERV., SHIELD SPECTRUM PPO PLAN 2000, 59 (Jan. 1, 2012); KAISER FOUND. HEALTH PLAN, INC., 2012 INDIVIDUAL PLAN MEMBERSHIP AGREEMENT AND DISCLOSURE FORM AND EVIDENCE OF COVERAGE FOR KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES, 45 (Jan. 1, 2012).

122. Letter from Toby Douglas, Dir., Cal. Dep't of Health Care Servs., et al., to Kathleen Sebelius, Sec'y of U.S. Dep't of Health & Human Servs. (Jan. 31, 2012), <http://www.healthexchange.ca.gov/Documents/Joint%20CA%20comment%20letter%20on%20EHB%20to%20Sec%20Sebelius%201-30-12.pdf> [hereinafter California Health Benefit Exchange Letter].

123. HHS Bulletin, *supra* note 118, at 9.

between 2014 and 2016.<sup>124</sup> Because each of the benchmark plans currently excludes SRS and none has a comprehensive transgender inclusion provision, these plans may further entrench trans-exclusions, notwithstanding the California IGNA which already suggests that trans-exclusions are unlawful.<sup>125</sup>

Having federally mandated essential health benefits is a step toward full healthcare for all Americans. Even in California, benchmark plans are unlikely to include transgender healthcare. Unfortunately, the absence of a transgender-inclusive benchmark plan will likely make advancements for transgender coverage more difficult to enact without a federal requirement that transgender care be covered.

### 3. Individual and Provider Nondiscrimination

Third, the ACA mandates nondiscrimination in healthcare in two provisions.<sup>126</sup> The first addresses discrimination against individuals.<sup>127</sup> The second addresses discrimination against providers.<sup>128</sup> The ACA incorporates the nondiscrimination provisions of the 1964 Civil Rights Act, Title IX, the ADA, the 1975 Age Discrimination Act, and section 504 of the 1973 Rehabilitation Act into all federally funded or supported health programs.<sup>129</sup> These protections will apply to the health exchanges and to QHPs.<sup>130</sup> Unfortunately, as discussed above, transgender status is not explicitly protected by any of these federal laws, and is expressly excluded from the ADA.<sup>131</sup> The HHS Office of Civil Rights has stated that they believe “that Section 1557’s sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity and will accept such complaints for investigation.”<sup>132</sup> While this assurance is of enormous importance at the moment, a change in administration could eliminate these protections without a statutory reform. The ACA also mandates that all health insurance providers “shall not discriminate with respect to

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124. California Health Benefit Exchange Letter, *supra* note 122, at 2.

125. See sources cited *supra* note 121; A.B. 1586, *supra* note 7.

126. ACA, *supra* note 1, at §§ 1557, 2706.

127. *Id.* at § 1557.

128. *Id.* at § 2706.

129. *Id.* at § 1557(a).

130. ACA, *supra* note 1, at § 1557(a).

131. See *supra* Part II; see also Hong, *supra* note 5, at 112–13 (discussing interpretations of Title VII and Title IX regarding transgender people).

132. Letter from Leon Rodriguez, Dir., Health and Human Servs., Office of Civil Rights, to Maya Rupert, Fed. Policy Dir., Nat’l Ctr. for Lesbian Rights (Aug. 6, 2012), available at <http://www.metroweekly.com/poliglot/HHSResponse8612.pdf>. The Secretary of Housing and Urban Development made a similar decision, issuing proposed regulations that forbid discrimination on the basis of gender identity. Equal Access to Housing in HUD Programs—Regardless of Sexual Orientation or Gender Identity, 76 Fed. Reg. 4194 (proposed Jan. 24, 2011) (to be codified at 24 C.F.R. pts 5, 200, 203, 236, 570, 574, and 982).

participation under the plan or coverage against any healthcare provider.”<sup>133</sup> This means that, provided transition-related care is covered as an essential health benefit, the fact that specialists are necessary for many gender-confirming care procedures will not be an obstacle for transgender patients.<sup>134</sup> Taken together, these protections provide trans patients with significant hope for security in their health care access.

#### 4. Cost-Shifting Framework

When the individual mandate portion of the ACA goes into effect it will almost entirely eliminate the detrimental effects of the cost-shifting scheme that currently drives U.S. healthcare costs; without modification, however, it will not eliminate these burdens for trans people.<sup>135</sup> “Cost shifting refers to the practice of charging insured patients a higher price for a given healthcare service to cover the cost of delivering that service to all of the patients, both insured and uninsured, seen by a given provider.”<sup>136</sup> For the majority of people insured after the individual mandate goes into effect, insurance premiums will be more directly correlated with their healthcare needs.<sup>137</sup> As of 2011, the ACA requires that at least eighty percent of all premium dollars an insured pays the insurance company goes to healthcare, not to bureaucratic overhead.<sup>138</sup> Cost shifting has meant that trans insureds pay into an insurance system so that other patients can receive care that trans people also need but for which trans patients are often denied coverage.<sup>139</sup> With the ACA’s new provisions, it is unclear whether this will change for trans-related healthcare needs, especially for gender-incongruent treatments or hormone therapies that are available to nontrans people but which are restricted for trans people.<sup>140</sup> It will be a test of the ACA’s efficacy whether cost provisions have a positive effect on trans insureds.

#### B. AFFORDABLE CARE ACT AS A VEHICLE FOR FEDERAL EXPANSION OF COVERAGE REGARDLESS OF GENDER

Explicitly protecting access to preventative care and maintenance care for all Americans without allowing the gender identity of the insured to affect their receipt of care will serve the ACA’s purpose of reducing uninsured individuals in America, expanding coverage, and reducing

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133. ACA, *supra* note 1, at § 2706(a).

134. *Id.*

135. *Id.* at § 1501.

136. Gorton, *supra* note 18, at 82.

137. *A More Secure Future: What the New Health Law Means for You and Your Family*, THE WHITE HOUSE, <http://www.whitehouse.gov/healthreform/healthcare-overview> (last visited Sept. 23, 2012).

138. *Id.*

139. J. Koenig, *Distributive Consequences of the Medical Model*, 46 HARV. C.R.-C.L. L. REV. 619, n.4 (2011); Gorton, *supra* note 18, at 82.

140. *See supra* Part II.B.

costs.<sup>141</sup> The ACA is the most obvious vehicle through which to expand protections like those in California for transgender patients throughout the country because the ACA has centralized much of healthcare's governance in the federal government.<sup>142</sup> Adding a gender nondiscrimination provision, similar to A.B. 1586 and accompanied by regulations similar to those enacted by CDI this year, to the ACA is the most sensible way to ensure transgender people have access to care after the insurance access provisions of the ACA go into effect in 2014.<sup>143</sup> The fight for healthcare protections for transgender people on the federal level would be difficult, but that difficulty only underscores the necessity of the protections.<sup>144</sup>

As discussed above, the ACA will mandate coverage of "essential healthcare" which will likely include most procedures that are frequently denied to transgender people because the procedures are considered gender-incongruent.<sup>145</sup> The ACA's main purpose is to increase Americans' access to affordable preventative and maintenance healthcare.<sup>146</sup> The most likely mechanism of this change would be on a state-by-state basis through the American Health Benefit Exchanges that each state is required to establish by January 2014.<sup>147</sup> State-by-state changes would necessitate passage of an IGNA equivalent through each state legislature, which likely would meet with limited success.<sup>148</sup> The fact that enacting a federal protective bill will be difficult does not mean that it should not be attempted.<sup>149</sup> Failure itself would lead to greater awareness of the problems

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141. See, e.g., *The Affordable Care Act: The Impact of Health Insurance Reform on Health Care Consumers Before the S. Comm. on Health, Education, Labor and Pensions*, 112th Cong. (2011) (statement of Kathleen Sebelius, Secretary, Health & Human Servs.) available at <http://www.help.senate.gov/imo/media/doc/Sebelius2.pdf>. [hereinafter Statement of Secretary Sebelius].

142. See generally ACA, *supra* note 1.

143. ACA, *supra* note 1, at § 1253; see also A.B. 1586, *supra* note 7; CAL. CODE REGS. tit. 10 §§ 2561.1, 2561.2 (2012).

144. Protecting trans people through federal legislation has historically not been met with success. The most visible effort to secure protections in recent years has been through the now eight-times-failed Employment Non-Discrimination Act. See *H.R. 3017 (111th): Employment Non-Discrimination Act of 2009*, GOVTRACK.US, <http://www.govtrack.us/congress/bill.xpd?bill=h111-3017&tab=related> (last visited Feb. 27, 2012) (discussing the history of the Employment Non-Discrimination Act which was introduced in the 103rd, 104th, 105th, 106th, 107th, 108th, 110th, and 111th congressional sessions).

145. ACA, *supra* note 1, at § 1302(b).

146. See Statement of Secretary Sebelius, *supra* note 141.

147. *Fact Sheet: The Affordable Care Act: Supporting Innovation, Empowering States*, THE WHITE HOUSE, <http://www.whitehouse.gov/the-press-office/2011/02/28/fact-sheet-affordable-care-act-supporting-innovation-empowering-states> (last visited Sept. 7, 2012).

148. Efforts to make state-by-state changes in other areas of transgender protections have been met with varying success. See generally Spade, *Documenting*, *supra* note 2; Spade, *Resisting*, *supra* note 2. Efforts to enact federal legislation protecting transgender people have also met with limited success. See *supra* note 144.

149. There has been one notable recent success protecting transgender people on the federal level. The Matthew Shepherd and James Byrd Hate Crimes Act enumerates "gender identity" as a protected characteristic. Hate Crime Acts, 18 U.S.C.A. § 249 (West 2009).

transgender insureds face and awareness alone might lead to better treatment.

## V. COST OF INCLUDING GENDER-CONFIRMING AND GENDER-INCONGRUENT PROCEDURES IN INSURANCE

There is a cost for every denial of treatment.<sup>150</sup> For most denials of treatment that cost is negligible with respect to the cost of the procedure in question. When denials become consistent realities for insureds, however, the cost of those denials and their appeals begin to become noticeable.

### A. CURRENT SYSTEMIC INCONSISTENCIES FOR TRANS PEOPLE COST MONEY

For every denial, there is an appeals process that the denied person can go through in an effort to achieve a different outcome.<sup>151</sup> In private insurance markets, when a patient is denied coverage the insured receives a letter denying coverage.<sup>152</sup> This letter will describe the procedure for appealing the denial.<sup>153</sup> Typically the first step in an appeal is to contact the insurance company, provide information about the denial of coverage, and request a review of the denial.<sup>154</sup> Reviewing denials takes time and costs the insurance company money.<sup>155</sup> Additionally, if the review is not in the insured's favor, she can appeal to a state agency like the CDI, which costs the state money.<sup>156</sup> If neither of these efforts is successful, the insured can bring a private suit against the insurance company.<sup>157</sup>

Transgender people who are routinely denied care for gender-incongruent procedures are sometimes given workaround procedures from their insurance companies to preempt both the monetary and time costs associated with the appeals process for each denial. Unfortunately, these workarounds, developed and implemented on an ad hoc basis, provide little aid or insight for those who may seek a workaround themselves. This is arbitrary, unfair, and expensive: the opposite of what healthcare-provision ought to be.<sup>158</sup> D, whose insurance company routinely denied his claims for "female" procedures was able to obtain a special code number to use whenever he called the company to appeal gender-incongruent procedure

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150. *How to Appeal a Health Insurance Denial*, WALL ST. J., (Aug. 6, 2009, 11:07 AM), <http://guides.wsj.com/health/health-costs/how-to-appeal-a-health-insurance-denial/>.

151. *Id.*

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. *Consumer Health Care Providers Guide to the Complaint Process*, CAL. DEP'T OF INS., <http://www.insurance.ca.gov/0100-consumers/0060-information-guides/0050-health/health-careguidecomplaintprocess.cfm> (last visited Sept. 23, 2012).

157. Cal. Civ. Code § 3428(k)(1) (West 2000).

158. Interview with D, in S.F., Cal. (Feb. 2, 2012).

denials.<sup>159</sup> For reasons unknown to him, his insurance ID number itself was insufficient for the company's coding structure and he needed to have a second number of equivalent length and complexity to provide them for each denial he received.<sup>160</sup> The company thereby truncated D's denial appeals by simply requiring him to call once, provide this number, and confirm the reasoning behind the number.<sup>161</sup> Though this certainly saved the company money, it also left D feeling like a FedEx package.<sup>162</sup> It was less efficient than if there simply were no denials for gender-incongruent procedures, and the company's solution did not improve care for anyone else.

The same company who held D's insurance gave another transman, F, a different procedure by which to appeal his routine denials for gender-incongruent procedures. F did not receive a special tracking number, but was instead told to send all of his denial appeals inquiries through a specific "case manager."<sup>163</sup> Again, F's denial appeals process was streamlined somewhat, but the cost was not minimized.<sup>164</sup> This procedure required a specific employee.<sup>165</sup> Had that person left or been unavailable, F might have found himself needing to launch a formal appeal, costing the company more money.<sup>166</sup>

Knowing that the processes for two different men with the same insurance company are different, it is not hard to extrapolate the inconsistencies in administration across health insurers. The ACA includes a "value for premium payments" provision which mandates that all insurance companies spend eighty percent of the premiums paid on treatment and limit company overhead expenditures to twenty percent of the premiums paid.<sup>167</sup> Because there is a processing cost for denials, companies could run into trouble dealing with people who are routinely miscategorized and denied coverage on the basis of their medical history because these costs diminish the proportion of premium revenues spent on treatment.<sup>168</sup>

#### B. STATISTICS OF FREQUENCY OF PROCEDURES

As discussed above, transgender patients face two different kinds of exclusionary treatment in healthcare: exclusions for routine medicine when

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159. Interview with D, *supra* note 158.

160. *Id.*

161. *Id.*

162. *Id.*

163. *Id.*

164. *Id.*

165. *Id.*

166. *Id.*

167. ACA, *supra* note 1, at § 2718 (requiring insurance companies to account for non-claims costs and to reimburse premium payers whose premium revenues have not been applied to claims payments but to other expenditures).

168. *Id.*

that care is considered gender-incongruent, and exclusions for gender-confirming care.<sup>169</sup> A decision to include any procedure or treatment in an insurance plan requires an actuarial examination of the cost implications of the change.<sup>170</sup> Looking at the actual fiscal impact of covering transgender patients shows covering both gender-incongruent procedures and gender-confirming care does not cost much.

1. Preventative and Routine Care Is Accessed with Equivalent Frequency for Both Trans and Nontransgender Insureds

Healthy transgender people require equivalent routine care to healthy nontransgender people. For routine care, transgender insureds will not burden the healthcare system. By making it easier for transmen to access gynecological care and for transwomen to access prostate and testicular care, there should be no proportionate increase in the number of general wellness exams doctors perform.<sup>171</sup> Additionally, preventative healthcare is an important goal furthered by the ACA because by providing preventative medicine, the healthcare system overall experiences fewer high-cost emergency medical problems caused by chronic diseases.<sup>172</sup> Hormone therapies are prescribed and used by nontransgender people so frequently that hormone treatment can be considered routine care because it is ongoing and requires minimal interaction with doctors.<sup>173</sup> “The potential economic value to be gained in better health outcomes from uninterrupted coverage for all Americans is estimated to be between \$65 [billion] and \$130 billion each year.”<sup>174</sup> A study conducted in 2008 found that the cost to all insureds of adding hormone replacement therapy (HRT) for all transgender patients who desire it would be eighteen dollars per year.<sup>175</sup> As the health care situation stands, “[a]bout 80% of HRT Rx costs are maintenance costs, currently covered on most insurance plans because the patient is documented as their new gender.”<sup>176</sup> Preventive care is universally beneficial; even expenditures on preventive care for a group of

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169. See *supra* Parts II, III.

170. Khan, *supra* note 9, at 398–90.

171. There will be an increase in doctor visits overall because more people will be insured. See Hendrik Schmitz, *More Health Care Utilization with More Insurance Coverage? Evidence from a Latent Class Model with German Data*, APPLIED ECONOMICS (forthcoming Dec. 2012) (on file with author).

172. ACA, *supra* note 1, at § 1302(b)(1)(I).

173. For example, from 2006–08 approximately twenty-five percent of women ages fifteen to forty-four were using some form of hormonal birth control on a regular basis. William Mosher & Jo Jones, *Use of Contraception in the United States: 1982–2008*, 23 VITAL & HEALTH STATISTICS 29, Aug. 2010 at 21; see also, generally Mary A. Horton, *Cost of Transgender Health Benefits* (2008), <http://www.tgender.net/taw/thb/THBCost-OE2008.pdf> [hereinafter Horton, *Cost*].

174. INST. OF MED. OF THE NAT’L ACADS., HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA 2 (Nat’l Acads. Press ed., 2003).

175. Horton, *Cost*, *supra* note 173, at 7.

176. *Id.*

people who deviate from cultural norms and who are “typically perceived as less deserving of quality care” will improve healthcare outcomes across the board by reducing emergency medical costs.<sup>177</sup>

2. Sex Reassignment Surgery Is Infrequently Performed and Will Likely Not Drastically Increase in Frequency as an Insured Benefit

Transgender identity is a medicalized identity.<sup>178</sup> Surgical status and access to ongoing medical treatment in the form of hormones and in most states, evidence of SRS is still required in order to change gender on identity documents.<sup>179</sup> Requirements are based on the 1992 Model Law, which provided “that a person wanting to change their sex on their birth certificate should present a court order certifying that their sex has been changed by surgical procedure.”<sup>180</sup> Even in the face of existing surgical intervention requirements to access accurate documentation, sexual reassignment surgeries are rarely performed.<sup>181</sup> “Perhaps the most common misunderstanding is the belief that all transgender people undergo genital surgery as the primary medical treatment for changing gender. In fact, gender confirming healthcare is an individualized treatment that differs according to the needs and pre-existing conditions of individual transgender people.”<sup>182</sup>

There are between three and nine million trans Americans.<sup>183</sup> While this number is instructive, the estimated prevalence of SRS is only 1:1000, or approximately 3000–9000.<sup>184</sup> According to an analysis of surgeries performed in 2001, only 866 male-to-female (MTF) primary (bottom) surgeries were performed and only 336 female-to-male (FTM) primary (top) surgeries were performed.<sup>185</sup> It has been roughly estimated that only

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177. Gorton, *supra* note 18, at 85; INST. OF MED. OF THE NAT'L ACADS., *supra* note 174, at 3 (“The burden of uncompensated (charity) care amounted to \$35 billion in 2001 and is largely borne by taxpayers. The public supports 75 to 85 percent [sic] of this care through federal, state and local government programs.”).

178. For extensive discussion of medicalization of trans identities, see Spade, *Resisting*, *supra* note 2; Harper Jean Tobin, *Against the Surgical Requirement for Change of Legal Sex*, 38 CASE W. RES. J. INT'L L. 393 (2006-07); for a more nuanced discussion of medicalizing gender, see generally Noa Ben-Asher, *The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties*, 29 HARV. J.L. & GENDER 51 (2006).

179. Spade, *Documenting*, *supra* note 2, at Appendix 1.

180. *Id.* (as of 2008 only sixteen states would grant driver's licenses without proof of surgery); see also *Policy Brief: Birth Certificate Gender Markers*, NAT'L CTR. FOR TRANSGENDER EQUAL. (June 22, 2011, 10:07 PM), <http://transgenderequality.wordpress.com/2011/06/22/policy-brief-birth-certificate-gender-markers/>.

181. Mary A. Horton, *The Incidence and Prevalence of SRS Among US Residents* 3 (2008) <http://www.tgender.net/taw/thb/THBPrevalence-OE2008.pdf> [hereinafter Horton, *Incidence*].

182. Dean Spade, *Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates*, 8 SEATTLE J. FOR SOC. JUSTICE 497, 497 (2010).

183. See sources cited *supra* notes 5–6.

184. Horton, *Incidence*, *supra* note 181, at 3.

185. *Id.* at 5. “Bottom” surgery refers to a surgical alteration of genitalia. “Top” surgery refers to a double mastectomy with chest reconstruction. *Id.*

60% of FTM patients undergo any sort of bottom surgery—hysterectomy/oophorectomy at 50%, metoidioplasty at 5%, and phalloplasty at 6%.<sup>186</sup> Even at these very rough estimates, it is easy to appreciate the fact that not all trans people choose to undergo surgical procedures to alter their genitalia or other sex characteristics.

A small portion of the discrepancy between transgender people and the number of SRS's performed can be attributed to common misconceptions about the success rate of these procedures. There have been misconceptions in both the medical and transgender communities that phalloplasty is not nearly as "successful" as vaginoplasty.<sup>187</sup> This misconception adversely affects the ability of transmen to access appropriate documentation in those jurisdictions that require evidence of "corrected" genitalia and overshadows the overwhelmingly positive reports of those transmen who have had successful genital surgeries.<sup>188</sup>

A larger portion of the discrepancy between the number of transsexual people in the U.S. and the number of people seeking SRS is certainly due to the cost of the procedures. Typical approximate costs for some SRS procedures are as follows: hysterectomy, \$8,500; mastectomy, \$9,200; vaginoplasty, \$6,000; phalloplasty, \$40,000.<sup>189</sup> Hysterectomies and mastectomies are among the most commonly performed inpatient surgeries already and these procedures are covered for many diagnoses.<sup>190</sup> Other commonly covered, commonly performed surgeries include the following: coronary bypass surgery, \$56,200; radical prostatectomy, \$12,200; tonsillectomy, \$2,600; appendectomy, \$9,900.<sup>191</sup>

With covered procedures, some increase in the number of SRS's performed would be expected. However, looking at San Francisco as a case study can assuage concerns that the cost of covering SRS will be prohibitively expensive. In 2001, San Francisco became the first city to adopt policies that included SRS coverage for all of its employees.<sup>192</sup> The

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186. Horton, *Incidence*, *supra* note 181, at 8.

187. The definitions of success seem to be not only based on statistics of complications but on a comparison to nontransgender male penile structure and function for the constructed phallus. Albert Leriche, et al., *Long-Term Outcome of Forearm Free-Flap Phalloplasty in the Treatment of Transsexualism*, 101 BRIT. J. UROLOGY INT'L 1297, 1299 (2008) ("93% of the patients reported that the phalloplasty allowed them to accord their physical appearance with their feeling of masculinity."). *But see, e.g.*, Khan, *supra* note 9, at 384; Spade, *Resisting*, *supra* note 2, at 31.

188. As of 2008 only sixteen states would grant driver's licenses without proof of surgery. Spade, *Documenting*, *supra* note 2, at app. 1.

189. *Healthcare Blue Book*, *supra* note 54; Horton, *Cost*, *supra* note 173 at 2; Joshua Riverdale, *Why Not Phalloplasty?*, GENDER OUTLAW: FTM TRANSITION BLOG (Nov. 22, 2008 4:33 pm), <http://genderoutlaw.wordpress.com/2008/11/22/why-not-phalloplasty/>.

190. *Common Surgical Procedures*, WEIL CORNELL MEDICAL COLLEGE, [http://www.cornellsurgery.org/patients/health/surgery\\_common.html](http://www.cornellsurgery.org/patients/health/surgery_common.html) (last visited Feb. 22, 2012).

191. *Id.*; *Healthcare Blue Book*, *supra* note 54.

192. Gorton, *supra* note 18, at 85.

policy only provided direct benefits to “a dozen transgender people who were among the 27,000 city employees of San Francisco.”<sup>193</sup> However, by providing these benefits “the San Francisco experience has provided actuarial data demonstrating that fears about the high costs of SR[S] were completely unfounded—by more than an order of magnitude.”<sup>194</sup> The San Francisco decision “in addition to providing direct benefits to a handful of people . . . provided concrete data to address future opposition to including SR[S] in other health plans.”<sup>195</sup> Because in 2001 there were no insurance plans that covered SRS, San Francisco self-insured its employees.<sup>196</sup> “Between 2001 and 2004, they collected an additional \$5.6 million of which only \$186,000 was paid on 11 claims. *The actual additional cost during that period was less than \$1 per employee per year.*”<sup>197</sup> A more detailed analysis of the costs associated with adding SRS to insurance conducted in 2008 found that the total extrapolated cost of SRS would be approximately \$0.063/insured person/year.<sup>198</sup>

### C. SOFTWARE EXISTS THAT AVOIDS THE GENDER QUESTION ALREADY

As medical and insurance software becomes de rigueur, coverage and denials become more automated.<sup>199</sup> In processing whether a coded procedure/diagnosis combination will be covered, there are a series of calculations and formulas that are used, some of which are gender specific.<sup>200</sup> To account for the reality that gender-incongruent procedures are necessary and covered, some of the medical coding software would need to be retooled.<sup>201</sup> An initial recoding could be as simple as adding an additional check for a preapproval on a patient for a specific procedure. If, for example, a patient like D was denied a pap smear once, went through an appeal, and was granted that procedure once, there could be a flag either for a second round of code dealing with gender-incongruent procedures, or a human eye. This would streamline the denial process, would be low cost, and would diminish the impact both on patients and on insurance carriers of repeated denials for covered claims. The infrastructure of medical insurance software is growing.<sup>202</sup> The ACA presents an opportunity to encourage insurance and health information efficiencies on a national level.

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193. Gorton, *supra* note 18, at 85.

194. *Id.*

195. *Id.*

196. *Id.*

197. *Id.* at n.5 (emphasis added).

198. Horton, *Cost*, *supra* note 173, at 5.

199. Milt Freudenheim, *Digitizing Health Records, Before It Was Cool*, N.Y. TIMES, Jan. 14, 2012, at BU1.

200. Telephone Interview with Christina Diaz, *supra* note 46; E-mail from Anonymous, *supra* note 46.

201. Telephone Interview with Christina Diaz, *supra* note 46; E-mail from Anonymous, *supra* note 46.

202. Freudenheim, *supra* note 199.

## VI. CONCLUSION

The ACA presents an opportunity for transgender people and their advocates to create a federal protection for access to healthcare regardless of gender. The California A.B. 1586 and the CDI regulations recently promulgated regarding that provision constitute a well-built framework on which HHS and Congress should base a nondiscrimination in insurance policy that specifically addresses the unique concerns of transgender patients. Ensuring that transgender patients have access to necessary gender-incongruent procedures will save insurers and the federal government money because insurers will not need to pay for the cost of denials for covered procedures. Furthermore, as the San Francisco test case shows, adding SRS as a covered benefit for plans covered by the ACA will result in minimal cost, particularly when measured against the existing cost of implementing the ACA. Transgender Americans should have their interests protected through enactment of a federal insurance gender nondiscrimination provision.

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