Transgender Health Care Exclusions, Present and Future

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Lavender Law 2015

Barriers to Coverage of Transition-Related Medical Care

- Coverage Exclusions
  - Many health plans exclude benefits for services or supplies related to gender transition, such as psychological services, hormone therapy, and surgery.
  - Plan administrators may attempt to apply these exclusions broadly, including applying them to exclude all medical benefits for transgender employees.
- Medical Necessity Denials
  - Benefits for a medical service or supply are denied as not medically necessary for a person of the employee's gender as reflected in the plan administrator's records.
  - Benefits for a medical service or supply are denied as not medically necessary because related to gender transition.
  - Benefits for certain transition-related procedures are denied as cosmetic.

COVERAGE EXCLUSIONS

Avenues to Challenging Coverage Exclusions

- State nondiscrimination law and administrative guidance
- Recent federal developments (Medicare, FEHB, Executive Order 13672)
- Affordable Care Act
  - § 1557
  - Essential Health Benefits
- Title VII of the Civil Rights Act of 1964

State Administrative Guidance Prohibiting Coverage Exclusions

- Nine states plus D.C. prohibit categorical exclusions of transition-related care.
  - CA, CO, CT, IL, MA, NY, OR, VT, WA (more limited guidance in MD)
  - For example, CT's bulletin requires that "medically necessary services related to gender dysphoria should not be handled differently from medically necessary services for other medical and behavioral health conditions."
- Based on state non-discrimination laws. Some also rely on ACA non-discrimination provisions.
- Applies to insured plans within those states. Self-funded plans are not subject to these rules.

State and Local Government Developments: District of Columbia and Maryland

- In 2013, DC prohibited trans care exclusions in insurance plans regulated by the Department of Insurance and eliminated exclusions in Medicaid. Whitman-Walker and other advocates are working on implementation.
- In 2014, in response to complaints filed by Free State Legal Project, Maryland eliminated trans care exclusions in the health plan for State employees and retirees. In January 2015, the State proposed an amendment to its Medicaid regulations to eliminate a similar exclusion.
- Maryland insurance regulations applicable to the essential health benefits package required of insurers on the State's exchange under the ACA, permit exclusion of "treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery." In January 2014, the Maryland Insurance Administration issued a "clarifying" bulletin, declaring that "the exclusion should be narrowly applied to items and services that are directly related to the gender reassignment process." A legal challenge to the trans care exclusion in a private insurance plan is pending before the MIA (as of May 2015).

Recent Federal Developments

- June 2014 OPM guidance: FEHB insurers may cover transition-related care.
  - But OPM continues to give carriers the option of excluding transition-related health care
  - Few carriers have opted to provide inclusive coverage for 2015 plan year
- May 2014 decision from HHS Appeals Board: categorical exclusions not valid under "reasonableness standard" governing Medicare coverage.
  - DHHS Medicare NHD 140.3 re: Transsexual Surgery (Docket No. A-13-87, Dec'n No. 2576, May 30, 2014).
- Executive Order 13672 prohibits federal contractors from discriminating on the basis of gender identity. Enforced by Department of Labor (OFCCP).
- Ongoing advocacy with FEHB, VA, HHS.

ACA-Based Challenges to Coverage Exclusions

- ACA § 1557, 42 U.S.C. § 18116(a)
  - 2012 HHS guidance: prohibits gender identity discrimination.
  - *Rumble v. Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (brought against provider, not insurer).
  - HHS regulations forthcoming.
- ACA Essential Health Benefits
  - "An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's . . . other health conditions." 45 CFR 156.125(a).
  - Prohibition on sex and gender identity discrimination. 45 CFR 156.125(b); 45 CFR 156.200(e).

Title VII Challenges to Coverage Exclusions

"It shall be an unlawful employment practice for an employer--

> (1) to . . . otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's . . . sex . . ."

42 U.S.C. § 2000e-2.

- Applies to plans sponsored by employers, labor organizations. JR2

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JR2 When the employer's health plan is purchased from an insurance company, can the insurer be reached under Title VII?

I suggest adding: (1) recourse to Title VII requires the employee's willingness to be "out" as trans to the emplouyer and to risk an adversarial stance with the employer; (2) on the other hand, enlisting the employer as an ally in pressuring the insurance company can lead to results for the employee much quicker than litigation.

Jacob Richards, 5/27/2015

Title VII Challenges Cont.

- Cases finding that discrimination against transgender people violates Title VII. *See, e.g.*, *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008).
- EEOC Ruling in *Macy v. Holder*, EEOC DOC 0120120821, 2012 WL 1435995 (Apr. 20, 2012).
- *Newport News Shipbuilding and Dry Dock Company v. EEOC*, 462 U.S. 669 (1983).
- *United States v. Southeastern Oklahoma State University, et al.* (W.D. Oka. 5:15-cv-00324-C).

MEDICAL NECESSITY DENIALS

Types of Medical Necessity Denials

- Denial of coverage for "incongruous" sex-specific care (e.g. pap smears for trans men coded as M in insurance records).
- Denial of coverage based on determination that transition-related care is not medically necessary.
- Denial of coverage for certain transition-related procedures based on determination that they are not medically necessary or cosmetic (e.g. breast reconstruction surgery, facial reconstruction surgery).

Avenues for Challenging Medical Necessity Denials

- Challenging through plan's internal claim process.
- External review of medical necessity denials.
- Nondiscrimination challenges (Title VII or state law).
- ERISA claims where denials run contrary to plan terms, or represent unreasonable interpretation of plan terms (employer-sponsored plans).

Resources on Medical Necessity

- WPATH Standards of Care.
- American Medical Association statement and statements of other major medical associations.
- *O'Donnabhain* and Medicare decisions extensively review medical evidence.
- Expert testimony may be appropriate in certain cases.

Medical Necessity in the Courts

- Courts and administrative authorities have held in a variety of contexts that gender transition-related services and supplies are the accepted treatment for gender identity disorder or gender dysphoria.
  - *O'Donnabhain v. CIR*, 134 T.C. 4 (2010) (collecting cases)
  - *M.K. v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 38, 1992 WL 280789 (N.J. Adm. May 7, 1992)
  - *Norsworthy v. Beard*, No. 14-CV-00695-JST, 2015 WL 1478264 (N.D. Cal. Mar. 31, 2015)
  - Medicare decision
- But one court held in an ERISA case that a transgender plaintiff failed to show that hormone therapy and mastectomy were medically necessary for treatment of gender dysphoria. *Mario v. P&C Markets*, Inc., 313 F.3d 758 (2d Cir. 2003). Plaintiff in *Mario* apparently presented little evidence going to medical necessity.

Ongoing Advocacy Efforts

- California Departments of Insurance and Managed Health Care, Maryland Insurance Administration
- HHS advocacy on ACA § 1557 regulations
- Implementation of Medicare decision

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