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Section 1557: A Tragedy of Discrimination in Five Parts

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Prologue: Rulemaking and Court Battles

The Patient Protection and Affordable Care Act (ACA)[1] was a massive undertaking to create a "uniform national program for health insurance regulation in the United States."[2] The main attributes of the ACA include changing the underwritten policies of insurers, creating more competition in the health insurance industry, and offering health insurance protections for consumers.[3] The ACA passed in 2010 with mixed reviews.[4] Some viewed the ACA as a significant step forward for all Americans to have affordable health care.[5] Other individuals, organizations, and states saw the ACA as a constitutional abomination to vanquish for reasons including the belief the law impeded on their right to choose not to purchase health insurance[6] or hindrances on the practice of religious freedoms.[7] Hundreds of challenges to the ACA have arisen since 2010, including challenges to "contradictory language" in the statute or to provisions such as required contraception coverage on religious grounds.[8] The law has withstood the attack,

[1] Patient Protection and Affordable Care Act, 42 U.S.C § 18001 et seq. (2018).
[2] Timothy Stoltzfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them,* 5 ST. LOUIS U. J. HEALTH L. & POL'Y 27, 27 (2011).
[3] Stoltzfus Jost, *supra* note 2, at ___.
[4] *See* Eric Carstens, *Losing Our Religion: How the HHS Contraceptive Mandate Unconstitutionally Burdens Catholic Organization's Free Exercise Rights*, 20 TRINITY L. REV. 1 (2014) (examining the effects on Catholic organizations as the ACA acts as an impedance on the rights of those organizations); *see* Arthur Nussbaum, M.D., *Can Congress Make You Buy Health Insurance? The Affordable Care Act, National Health Care Reform, and the Constitutionality of the Individual Mandate*. 20 DUQ. L. REV. 411 (2012) (discussing the individual mandate); *see* Richard A. Epstein, *Bleak Prospects: How Health Care Reform Has Failed in the United States*, 15 TEX. REV. L. & POL. 1 (2010) (arguing that the ACA is unsustainable and will ultimately fail); *see* Ezekiel J. Emanual M.D., *Name the Much-Criticized Federal Program that has Saved the U.S. $2.3 Trillion. Hint: It Starts with Affordable*, STAT (Mar. 22,2019), https://www.statnews.com/2019/03/22/affordable-care-act-controls-costs/.; *see* James Hamblin, M.D., *The Precarious Success of Obamacare*, THE ATLANTIC, Mar. 16, 2015, https://www.theatlantic.com/health/archive/2015/03/for-those-that-hate-obamacare-do-you-know-why/387913/.
[5] *See e.g.*, Renée M. Landers, "*Tomorrow" May Finally Have Arrived—The Patient Protection and Affordable Care Act: A Necessary First Step Toward Health Care Equity in the United States*, 6 J. HEALTH & BIOMEDICAL L. 65 (2010) (discussing how while the ACA is imperfect, the ACA is step forward for American healthcare reform).
[6] Most notably, challenges from "twenty-six states, several individuals, and the National Federation of Independent Business brought suit in Federal District Court to challenge several provisions of the ACA including the individual mandate—which imposes a penalty on those who do have health insurance coverage—and the expansion of Medicaid by threatening to withdraw Medicaid funding to states if they did not increase maximum amount earned above the federal poverty level. *See generally* Nat'l. Fed'n. of Indep. Bus. et al. v. Sebelius, 567 U.S. 519 (2012).
[7] *See* Abbe R. Gluck & Thomas Scott-Railton, *Affordable Care Act Entrenchment*, 108 GEO. L.J. 495, 514-30 (2020) (discussing the hundreds of lawsuits that have tried to invalidate the ACA).
[8] *See* Gluck, *supra* note 7, at ___.

including an attack that resulted in the Supreme Court's decision to uphold the law[9] in *National Federation of Independent Business v. Sebelius*.[10] Various persons and entities continue to challenge the ACA, including one that could invalidate the statute because the tax for not purchasing health insurance is now nothing, which the Northern District of Texas held invalidates the entire ACA on constitutional grounds.[11]

One portion attacked is the anti-discrimination regulations in § 18116 of the ACA.[12] Under this section, an individual "shall not…be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving Federal financial assistance."[13] Section 1557 is the ACA's anti-discrimination provision, prohibiting discrimination in federally funded health programs, federally-administered health programs, and ACA created programs like the marketplace exchanges.[14] An exchange is "[a]nother term for the Health Insurance Marketplace, a service available in every state that helps individuals, families, and small businesses shop for and enroll in affordable medical insurance."[15] In determining which individuals the ACA's anti-discrimination provision protects, the ACA looks to which groups receive protection under[16] (1) the Civil Rights Act of 1964, also

[9] *Nat'l. Fed'n. of Indep. Bus,* 567 U.S. at 588. The Court held the act to be "constitutional in part and unconstitutional in part." The Court held that individual mandate that requires persons who do not obtain insurance to pay a tax was constitutional under Congress's power to tax. *Id.*
[10] There were five different holdings in the *National Federation of Independent Business v. Sebelius*. For a detailed breakdown of those individual holdings *see* Alicia Ouellette, *Health Reform and the Supreme Court: The ACA Survives the Battle of the Broccoli and Fortifies Itself Against Future Fatal Attack*, 16 ALB. L. REV. 87, 100 (2012-2013).
[11] *See* Texas v. United States, 352 F. Supp. 3d 665 (N.D. Tex. 2018) (holding that counter to *Sebelius* that claims were not likely to succeed, the individual mandate was a lawful exercise of the taxing power or the commerce clause).
[12] 42 U.S.C.§ 18116.
[13] 42 U.S.C.§ 18116(a).
[14] Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 870 (2012).
[15] U.S. CTRS. FOR MEDICARE & MEDICAID SERVICES, *Exchange*, HEALTHCARE.GOV, http://www.healthcare.gov/glossary/exchange, (last visited Apr. 15, 2020).
[16] 42 U.S.C.§ 18116(a).

known as Title VI;[17] (2) the Education Amendments of 1972, also known as Title IX, which is the anti-discrimination provision based on sex in an education setting;[18] (3) the Age Discrimination Act of 1975;[19] and (4) the Rehabilitation Act of 1973.[20] Rather than "creat[ing] new bases of prohibited discrimination," only those previously established would receive protection under the ACA.[21] However, when the Department of Health and Human Services (HHS) enacted the final rules under the Obama administration, HHS interpreted the term "on the basis of sex" to include both "termination of pregnancy" and "gender identity," categories that none of the anti-discrimination statutes listed above protect.[22] There were those opposed to the inclusion of new classes under § 1557 and wished to enjoin the regulation as the Plaintiffs in the case *Franciscan Alliance Inc. v. Burwell* sought to do, including a Catholic health care system and eight states, and individual providers.[23]

Opponents of the ACA and HHS's regulations also opposed another provision,[24] specifically a rule prohibiting denial or limitation of coverage "for specific health services related to gender transition if" those denials or limits of coverage "result in discrimination against a transgender individual."[25] This rule banned "categorical coverage exclusion or limitation for all health services related to gender transition."[26] HHS justified this rule by

[17] Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq. (2018) (prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal assistance).
[18] Title IX of the Education Amendments of 1972 20 U.S.C. § 1681 (2018) (this is the antidiscrimination provision based on sex in an education setting).
[19] The Age Discrimination Act of 1975 42 U.S.C. § 6101 (2018) (prohibits discrimination based on age in any program or activity receiving Federal Financial assistance).
[20] The Rehabilitation Act of 1973 29 U.S.C. § 794 (2018) (prohibiting discrimination based on disability about any program or activity receiving federal funding).
[21] Franciscan Alliance, Inc. v. Burwell, 227 F. Supp. 3d 660, 671 (N.D. Tex. 2016).
[22] *Id.*; 45 C.F.R. § 92.4.
[23] *Franciscan Alliance*, 227 F. Supp. 3d at 670. The other Plaintiffs include the states of Texas, Wisconsin, Nebraska, Kansas, Louisiana, Arizona, Kentucky, and Mississippi. *Id.* at 670 n.3. The other organizations involved in this case as plaintiffs were Specialty Physicians of Illinois LLC and Christian Medical & Dental Associations. *Id.* at 670.
[23] *Franciscan Alliance*, 227 F. Supp. 3d at 674.
[24] *See id.* at 672.
[25] 45 C.F.R. § 92.207(b)(5).
[26] 45 C.F.R. § 92.207(b).

reasoning that transition services, including surgery, were now the default standard of care for medical professionals treating transgender persons.[27] Opponents of this provision, such as Franciscan Alliance, Inc., a network of faith-based hospitals, expressed concerns that the regulation does include a minimum age requirement, meaning that insurers may have to cover transition services for children.[28] Providers feared this provision would require them to offer and perform procedures they did not believe were in the best interest of any patient no matter their age, taking control from the medical provider.[29]

Franciscan Alliance Inc.[30] and other Plaintiffs[31] sued to enjoin these rules from enforcement. As the U.S. District Court noted, Franciscan Alliance "does not believe that transition related-procedures are *ever* in the best interests of its patients and providing or covering *any* transition-related service would violate their deeply held religious beliefs."[32] The medical plans of the hospital system and the other plaintiffs specifically excluded transition services per "their beliefs."[33] The combined plaintiffs feared the loss of millions of dollars in funding each year from the federal government for following their religious beliefs as not adhering to these guidelines would result in the loss of those revenues.[34] Together the plaintiffs sought to enjoin 45 C.F.R. § 92.4;[35] this injunction would stop protections for "gender identity" and "termination of pregnancy."[36]

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[27] 81 Fed. Reg. at 31429.
[28] *Id.*
[29] Franciscan Alliance, Inc. v. Burwell, 227 F. Supp. 3d 660, 672-73 (N.D. Tex. 2016).
[30] According to their website this organization is "[a] trusted leader in providing faith-based, integrated healthcare" that "has stayed true to [the organization's] founding mission to care for everyone who comes through [its] doors." *See* FRANCISCANHEALTH, *About Us*, https://www.franciscanhealth.org/about-us, (last accessed Apr. 16, 2020).
[31] The other Plaintiffs include the states of Texas, Wisconsin, Nebraska, Kansas, Louisiana, Arizona, Kentucky, and Mississippi. *Franciscan Alliance*, 227 F. Supp. 3d at 670 n.3. The other organizations involved in this case as plaintiffs were Specialty Physicians of Illinois LLC and Christian Medical & Dental Associations. *Id.* at 670.
[32] *Franciscan Alliance*, 227 F. Supp. 3d at 674.
[33] *Id.* at 675.
[34] *Id.*
[35] *Id.*
[36] *See id.*

HHS fought back, claiming entitlement to *Chevron* deference,[37] which means the addition of gender identity and abortion status were within the scope of HHS's rulemaking authority.[38] HHS argued that because it is a rulemaking agency, HHS's interpretation of the meaning of "sex" under the statute should persist.[39] The court disagreed and held HHS lacked the authority to extend this definition—even when considering *Chevron* deference—because Congress did not provide HHS with the power to decide the scope and meaning of sex.[40]

Additionally, the court found that Congress had not intended a shift from the original definition of sex in Title IX of the Education Amendments of 1972 20 U.S.C. § 1681 (2018), which refers to sex binary terms, using the language "both sexes" or "one sex" throughout the section.[41] The court reasoned that if Congress intended to expand the definition of sex under the ACA, Congress would have included additional protections for gender identity within the final text of the ACA.[42] The court concluded that Congress did not intend the expansion of anti-discrimination protections to include gender identity as a protected class.[43] Interpretations of Title IX did not include gender identity at the time Congress passed Title IX.[44] Therefore, the ACA uses the term "sex" as defined when Title IX became law.[45] The court does not contend with more recent judicial interpretations of Title IX, where protections based on sex within Title

[37] *Chevron* deference describes the administrative law doctrine articulated in Chevron, U.S.A., Inc. v. Natural Resources Defense Council Inc., 467 U.S. 837 (1984). The Supreme Court held that a court reviewing an agency's interpretation of an ambiguous statute must defer to the federal agency's reasonable interpretation of that ambiguous statute. For a more detailed analysis of this topic *see* GEORGE CAMERON COGGINS and ROBERT L. GLICKSMAN, § 8:47, PUB. NAT. RESOURCES L., 2nd ed. 2020; *see also* Kent Barnett, et al., *Administrative Law's Political Dynamics*, 27 VAND. L. REV. 1463 (2018).
[38] Franciscan Alliance, Inc. v. Burwell, 227 F. Supp. 3d 660, 685 (N.D. Tex. 2016).
[39] *Id.*
[40] *Id.* at 687.
[41] *Id.*
[42] *Id.* at 688.
[43] Franciscan Alliance, Inc. v. Burwell, 227 F. Supp. 3d 660, 688 (N.D. Tex. 2016).
[44] *Id.*
[45] *Id.*

IX include protections of transgender students.[46]

The court also found the rule was "arbitrary, capricious, and contrary to law" because it did not include the religious protections expressly provided in the civil rights laws to which the ACA refers.[47] With the reasoning discussed above,[48] the court enjoined the protections under 45 C.F.R. § 92.207(b)(4) that prohibited categorical exclusions or limitations for services related to gender transition.[49] This injunction remains in effect today, and HHS's Office for Human Rights cannot enforce these two provisions.[50] A month after the court's decision, the Trump Administration transitioned into power, and HHS withdrew from its pending proceedings against Franciscan Alliance Inc. and has not appealed the court's decision or injunction.[51]

At this stage, an appeal is impossible because of the time elapsed since the court's judgment far exceeds the 30-day limit in Federal courts.[52] Therefore, a new and suitable case must arise to change the decision in *Franciscan Alliance*; however, any action from HHS is highly unlikely under the Trump Administration, as the administration did not pursue an appeal of *Franciscan Alliance*.[53] The situation is dire for transgender persons looking to receive any transition services because *Franciscan Alliance* still enjoins the final rule issued by HHS under the Obama Administration. Section 1557 should bar a federally funded insurer's refusal to cover transition services via the other statutes to which § 1557 refers.[54]

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[46] Whitaker v. Kenosha Unified Sch. Dist., 858 F.3d 1034 (7th Cir. 2017) (holding that discrimination against transgender students is sex discrimination under Title IX and the Equal Protection Clause); Dodds v. U.S. Dep't. of Educ., 845 F.3d 217 (6th Cir. 2016) (holding that discrimination against transgender persons was likely sex discrimination under Title IX and the Equal Protection Clause).
[47] Franciscan Alliance, Inc. v. Burwell, 227 F. Supp. 3d 660, 691 (N.D. Tex. 2016).
[48] The court also discusses the Religious Freedom Restoration Act, which is beyond the scope of this paper. *See id*. at 691-93.
[49] *Id*. at 696.
[50] U.S. DEP'T. OF HEALTH & HUMAN SERVS., *Section 1557 of the Patient Protection and Affordable Care Act*, HHS.GOV, https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html, (last visited Apr. 26, 2020).
[51] Franciscan Alliance, Inc. v. Price, No. 7:16-CV-00108-O, 2017 WL 3616652, at *5 (N.D. Tex., Jul. 10, 2017).
[52] F.R. App. P. 4(1)(A).
[53] *See Price*, 2017 WL 3616652, at *5.
[54] 42 U.S.C.§ 18116(a) (the statutes include Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972).

This paper argues that the regulations prohibiting (1) discrimination based on gender identity and (2) the protection against denial of coverage for health services related to gender transition must be reinstated as a matter of public health policy for equitable treatment of those with different gender identities under the law. This paper proposes a two-tiered approach to reinstitute these protections. First, transition services, including surgery, should be recognized as medically necessary by all federally funded or subsidized insurers and as an essential benefit for this population.[55] Second, an expansion of the definition of sex under the ACA is critical to provide transgender persons equal protection under the law. This goal is achievable statutorily or through judicial interpretation to include more than cisgender persons—those whose gender identity matches their biological sex.[56]

A continued reinterpretation of the definition of sex under Title IX would prevent insurers from discriminating by refusing or specifically excluding coverage for medically necessary transition treatments and services.[57] Statutorily, amendments to any of the statutes—such as Title IX—that the ACA looks to regarding which classes receive protection would also suffice. Another possibility is reinterpretations of the definition of sex under Title VII,[58] which applies to discrimination in the employment context, offer persuasive value. Finally, Congress could simply amend the ACA to explicitly offer protections for transgender persons, as one of the primary goals of the ACA still is consumer protection.[59]

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[55] While there is some controversy surrounding children using transition services including hormones and puberty blockers, that discussion is for other authors and the author assumes that parental consent exists for the services. This paper mostly focuses on how to counteract discrimination in the insurance place and enable payment for the services this population needs.

[56] Johns Hopkins defines cisgender as "a term for people whose gender identity generally matches the gender assigned for their physical sex. In other words, someone who does not identify as transgender." Linell Smith, *Glossary of Transgender Terms*, JOHNS HOPKINS MED., (Nov. 20, 2018), https://www.hopkinsmedicine.org/news/articles/glossary-of-terms-1.

[57] While the protections also included termination of pregnancy, such is not the focus of this paper and is for discussion by other authors.

[58] Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e et seq. (2018).

[59] Stoltzfus Jost, *supra* note 2.

This paper has five parts to illustrate the complexities and solutions to various issues. Part I describes the stories of individuals caught in a world where the denial of transition services has devastating effects. Part II defines key terms, discusses the mental health challenges experienced by many transgender persons, and analyzes the term gender dysphoria. Part III supplies an analysis of the term medical necessity, examines standard contractual language, and offers a review of current benchmark marketplace plans. Part IV analyzes the current state of Medicaid as it relates to transgender health care and shows why such protections under the ACA are necessary. Part V argues for reforms essential to make protections for transgender persons and coverage for transition services a reality for many transgender persons around the country.

Part I: A Case Study

The discrimination and disparate impacts caused by the denial of transition services has a human cost. This section outlines multiple stories that show the effects of existing insurance practices on a transgender person. While this section focuses on the story of one person, Jasmine, this is not an uncommon problem.[60]

There are troubling stories of the inability to pay for medically necessary procedures for transgender persons. Jasmine Glenn is a transgender woman who would call friends while sobbing and threatening to kill herself with the knife she gripped in her hand.[61] To combat the desire to self-harm and to attempt to conform to what society believed she should be, a man, she would do "crazy" things.[62] Jasmine would drink, race her car, and even jump through bonfires to prove her masculinity to a world that did not understand who Jasmine was.[63] Jasmine's

[60] *See generally* Emanuella Grinberg, et al., *To be herself, she needs to change her body. But first, comes the battle with insurers*, CNN, (May 31, 2018, 10:49 PM), https://www.cnn.com/2018/05/31/health/transgender-surgery-insurance/index.html.
[61] Grinberg, *supra* note 60.
[62] Grinberg, *supra* note 60.
[63] Grinberg, *supra* note 60.

alcoholism also led to multiple drunk driving arrests; she was drinking to the point of blackout.[64]

Jasmine changed in her thirties. She could accept herself *as* Jasmine; she could live as a woman but needed to transition.[65] Like other transgender persons, Jasmine always had to prove her gender to "meet the criteria set by physicians, insurance companies, and lawmakers."[66] The "countless hours" spent on the phone with her insurance company or researching information and cases to support her push for medically necessary treatments became an all-consuming battle.[67]

Resilient, Jasmine began to pay for her hormones in 2012—out-of-pocket—because she lacked insurance to cover the necessary therapies to transition and become her true self.[68] Jasmine eventually obtained insurance coverage via Medicaid in Michigan.[69] Yet, securing insurance began what seems like an eternal struggle—the perpetual battle to receive treatment.[70]

Once she had obtained a pre-authorization—an insurance term for preapproval—for vaginoplasty through appeal, she had not yet received authorization for the hair removal required as a prerequisite.[71] By the time she had started the hair removal treatments, the pre-authorization for the vaginoplasty had expired.[72] When she tried again, the insurer completely denied her claim.[73] The insurer told her the surgery was—as a strict prohibition—no longer covered.[74] Jasmine continued her battle against her insurance company and depression—a side-effect of her gender dysphoria.[75] Jasmine is not alone. The suffering that Jasmine faces is all too common.[76]

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[64] Grinberg, *supra* note 60.
[65] Grinberg, *supra* note 60.
[66] Grinberg, *supra* note 60.
[67] Grinberg, *supra* note 60.
[68] Grinberg, *supra* note 60.
[69] Grinberg, *supra* note 60.
[70] Grinberg, *supra* note 60.
[71] Grinberg, *supra* note 60.
[72] Grinberg, *supra* note 60.
[73] Grinberg, *supra* note 60.
[74] Grinberg, *supra* note 60.
[75] Grinberg, *supra* note 60.
[76] *See* Grinberg, *supra* note 60. This article includes multiple examples from other transgender persons about their battle for insurance coverage of medically necessary services.

While this paper chooses to focus on Jasmine's story, others face the consequences of trying to navigate current insurance practices. Derrick Robinson turned to alcohol and was only finally able to obtain a bilateral mastectomy following receiving a letter from his psychologist.[77] Autumn Trafficante was very careful in financially planning her transition, all the while battling suicidal thoughts.[78] Autumn's insurance would deny her claims, forcing Autumn to take on extra work, take a line of credit, and borrow from relatives to pay $70,000 for facial feminization surgery.[79]

The problem spreads far beyond a limited choice of individuals. Sergeant Anna Lange of Georgia decided to undergo gender transition a few years into her marriage.[80] Knowing that her ex-wife would move into rural Houston County, she followed to be close to her son.[81] While she tried a different position, she went back to being a police officer in the county.[82] Anna flew to New York after her surgeon confirmed her county insurance plan would cover the procedures.[83] Despite these assurances, she received notification that her insurer would not cover the procedure required.[84] Stories like Sargent Anna's; stories like Jasmine's—they barely scratch the surface of what is a systemic problem. The problem is partially to blame on semantics and classifications, which the next section explores.

Part II: Definitions, Terms, & Mental Health

The harms that Jasmine and other transgender persons face when navigating the complexities of health insurance require background on the persons and the situations they

[77] Grinberg, *supra* note 60.
[78] Grinberg, *supra* note 60.
[79] Grinberg, *supra* note 60.
[80] Keren Landman, *Fresh Challenges to State Exclusions on Transgender Health Coverage*, NPR, (Mar. 12, 2019 at 5:15 AM), https://www.npr.org/sections/health-shots/2019/03/12/701510605/fresh-challenges-to-state-exclusions-on-transgender-health-coverage.
[81] Landman, *supra* note 80.
[82] Landman, *supra* note 80.
[83] Landman, *supra* note 80.
[84] Landman, *supra* note 80.

face—and why these services are critical.[85] As such, this part contains two subsections. The first subsection outlines some general terms and discusses why the meanings of some terms—most notably the meaning of the word "sex" in a legal context—needs revision to one that embraces gender identity as a central component. The second subsection highlights some of the possible procedures and services that transgender persons may need while transitioning with a spotlight on how mental health is always a consideration in that process. The second subsection also offers a brief examination of the complex issue of gender dysphoria and its necessity as a diagnosis. Defining gender dysphoria as a mental disorder is controversial;[86] however, this paper does not take a stance about that controversy.

1. Terms Regarding the Person

A review of the terminology used by transgender persons is necessary to understand why transition services are medically essential to preventing harm, such as those experienced by Jasmine. The term transgender refers to individuals "whose gender does not match their biological sex at birth."[87] Gender non-conforming behaviors are those that clash with society's expectation that one must fall into one of two gender roles.[88] Gender non-conforming and transgender are not the same. A person who is gender non-conforming may not be a transgender person, and any transgender person may not be gender non-conforming.[89] By contrast, cisgender persons possess both reproductive organs and the social gender assigned at birth.[90]

The definition of sex is fluid and changes with context. For example, HHS's proposed

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[85] *See* Kellan Baker & Andrew Cray, *Why Gender-Identity Nondiscrimination in Insurance Makes Sense*, CTR. FOR AM. PROGRESS, (May 2, 2013), http:// cdn.americanprogress.org/wp-content/uploads/2013/05/BakerNon discriminationInsurance-6.pdf.
[86] *See generally* Walter Bockting, *Are Gender Identity Disorders Mental Disorders, Recommendations for Revision of the World Professional Association for Transgender Health's Standards of Care*, 11 INT. J. of TRANSGENDERISM 53, 53-62 (2009).
[87] KIMBERLY TAUCHES, *Transgender*, ENCYCLOPEDIA OF GENDER AND SOCIETY, 844, 844 (2009).
[88] *GLAAD Media Reference Guide – Transgender*, GLAAD, https://www.glaad.org/reference/transgender, (last visited Mar. 31, 2020) [hereinafter GLAAD].
[89] GLAAD, *supra* note 88.
[90] B. Aultman, *Cisgender*, 1 TRANSGENDER STUDIES QUARTERLY, 61-62, 61 (2014)

rule dated May 24, 2019, states that "HHS would apply Congress's words using their plain meaning when [written], instead of attempting to redefine sex discrimination."[91] The opinion in *Franciscan Alliance* states that "the term 'sex' was commonly understood to refer to the biological differences between males and females."[92] The court also states that Congress intended the definition of sex to refer to the two sexes as the original language from the statute refers to "students of one sex" or "both sexes,"[93] suggesting a dichotomy that would eliminate the possibility of other gender identities.[94] Sex under this definition is a constant and unyielding scientific fact—one that is inconsistent with the experiences of many persons. This rigid definition is a form of biologism, the belief that what distinguishes humans are biological factors.[95] In biologism, these biological factors are "both deterministic to and the essence of specific human phenomena," including both gender and sex.[96]

Other definitions refer to sex as "the classification of a person as male or female. At birth, infants are assigned a sex, usually based on the appearance of their external anatomy."[97] This definition is more flexible. While our genetic evidence *may classify* persons into one gender, that does not mean that the category is immutable. Human experience is ever-changing. Some courts have moved to a more contemporary understandings of human experience. These courts have found that "transgender status and gender identity are "obvious, immutable, or distinguishing

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[91] U.S. DEP'T. OF HEALTH & HUMAN SERVS. – OFFICE OF CIVIL RIGHTS, *Fact Sheet: HHS Proposes to Revise ACA Section 1557 Rule*, HHS.GOV 3 (May 24, 2019), https://www.hhs.gov/sites/default/files/factsheet-section-1557.pdf.
[92] Franciscan Alliance, Inc. v. Burwell, 227 F. Supp. 3d 660, 688 (N.D. Tex. 2016).
[93] Counter to the Congressional intent advocated here, the simple existence of persons born intersex—individuals who are not considered by medical experts as "normal" males or females—suggests such definitions of sex that create a dichotomy of merely male and female are complicated, and may also eliminate protections for intersex individuals under any anti-discrimination provision, such as Title VII. *See generally* Illana Gelfmann, *Because of Intersex: Intersexuality, Title VII, and the Reality of Discrimination "Because of…[Perceived] Sex"*, 34 N.Y.U. REV. OF L. & SOC. CHANGE 55 (2010).
[94] *Franciscan Alliance*, 227 F. Supp. 3d at 687.
[95] Sari M. Van Anders, *Bio/logics*, 1 Transgender Studies Quarterly 33, 33-34 (2014).
[96] An also interesting note here is that biologism may also include the belief that other human experiences are predeterminate including race and socioeconomic status. Anders, *supra* note 96 at 33.
[97] GLAAD, *supra* note 88.

characteristic[s]" and "transgender people are unarguably a politically vulnerable minority."[98]

The problem with rigid definitions is that they are strict and unyielding. Whether that is intentional or not, rigid definitions create difficulty in seeing any other possibility. The goal is to overcome the tendency to limit sex to its biologic definition by offering transgender persons the same benefits as cisgender persons. These protections include those statutes where sex is a protected class, including the ACA.

2. Mental Health, Gender Dysphoria, and the Necessity of Transition

Transgender persons of all ages face similar adverse effects on physical and mental health. For transgender persons, the consequences of lack of access to such services generate continuous and unyielding harm. Transgender persons of any age may encounter social rejection by peers or family, verbal or physical abuse, increased stress, and educational difficulties.[99] A 2007 study that relied on reports from fifty-five transgender youth regarding their life-threatening behaviors—such as suicide attempts and suicidal thoughts—73% faced at least verbal abuse by their parents.[100] Among these difficulties, another study found that 45% of transgender youth had thought of killing themselves; half of those persons said that it was related to transgender identity.[101] Other mental health concerns among transgender youth include anxiety, substance abuse, posttraumatic stress disorder, and depression.[102]

Mental health concerns are similar for adults, including the possibility of suicide ideation and self-harm.[103] Studies have found that between 50 to 80% of transgender persons have

[98] F.V. v. Barron, 286 F. Supp. 3d 1131, 1145 (D. Idaho 2018) (citing Norsworthy v. Beard, 87 F.Supp.3d 1104 (N.D. Cal. 2015)).
[99] AM. PSYCHOLOGICAL ASS'N TASK FORCE ON GENDER IDENTITY AND GENDER VARIANCE 10 (2009), https://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf.
[100] Arnold H. Grossman & Anthony R. D'Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37 SUICIDE & LIFE-THREATENING BEHAVIOR 527, 528 (2007).
[101] SUICIDE PREVENTION RESOURCE CTR., SUICIDE RISK AND PREVENTION FOR LESBIAN, BISEXUAL, AND TRANSGENDER YOUTH 27 (Effie Malley et al. eds., 2008).
[102] Johanna Olson, *Management of the Transgender Adolescent*, ARCH. PEDIATR. ADOLSEC. MED. 165 (2011).
[103] ERIC YARBROUGH, TRANSGENDER MENTAL HEALTH 11 (2018).

experienced verbal, physical, and sexual abuse, harassment, discrimination, violence, or forced sex.[104]

Doctors may label a transgender person with a mental disorder defined in standard medical texts. The central "medical diagnosis," enabling access to healthcare services and programs—when these services are available—is gender dysphoria. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) states that gender dysphoria "involves a difference between one's experienced/expressed gender and assigned gender, and significant distress or problems functioning" as a result of that difference.[105] These circumstances must last at least six months, and the patient must show at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
2. A strong desire to be rid of one's primary and/or secondary sex characteristics
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender."[106]

There are separate requirements for child diagnosis of gender dysphoria.[107] However, the outcomes are similar. The American Psychiatric Association notes that "diagnostic terms facilitate care and access to insurance coverage that supports mental health; these terms can also

[104] LAURA ERICKSON-SCHROTH, TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY 310 (Laura Srickson-Schroth ed. 2014).
[105] Ranna Parekh, M.D., M.P.H., *What is Gender Dysphoria*, AM. PSYCHIATRIC ASS'N., https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria, (last visited Apr. 17, 2020).
[106] Parekh, *supra* note 105.
[107] Six of the following must be present for at least six months and must also have "an associated significant distress or impairment injunction." The factors are: (1) A strong desire to be of the other gender or an insistence that one is the other gender; (2) A strong preference for wearing clothes typical of the opposite gender; (3) A strong preference for cross-gender roles in make-believe play or fantasy play; (4) A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender; (5) A strong preference for playmates of the other gender; (6) A strong rejection of toys, games and activities typical of one's assigned gender; (7) A strong dislike of one's sexual anatomy; and (8) A strong desire for the physical sex characteristics that match one's experienced gender. Parekh, *supra* note 105.

have a stigmatizing effect."[108] This effect includes identification as being mentally ill or pathological.[109]

Identification as mentally ill or pathological causes significant difficulties for transgender persons. Several psychiatric diagnostic texts classify transgender persons as having mental disorders, including the DSM-5 and the *International Statistical Classification of Disorders* (ICD).[110] This other attempt to identify transgender persons as mentally ill or inferior carries with it numerous side-effects such as "stigmatization, discrimination, social exclusion, and transphobic violence."[111] This misleading definition of gender identity suggests to some that those with diverse sexual identities are somehow broken and require conversion therapy to "correct their deviance."[112] A natural tension exists between these two sentiments.

The term transition is a process whereby a transgender person moves from living aligned with the gender assigned at birth to that of their gender identity.[113] There is a misnomer that this process only centers around surgery; instead, it is a process each individual takes at their own pace; not every step needs completion.[114] Some may skip hormones or surgery but take other steps to transition.[115] Medical transition is but one possible stage in the process.[116] A medical transition may encompass treatments and services like hormones, surgery, and mental health counseling.[117] There are several significant surgical procedures that more closely align a person's inward and outward appearance.[118] The physical process can begin for minors, but the

[108] AM. PSYCHIATRIC ASS'N, *Gender Dysphoria*, (2013), https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf.
[109] Amets Suess, Karine Espinera, and Pau Crego Walters, *Depathologization*, 1 Transgender Studies Quarterly 73, 73 (2014) [hereinafter Suess].
[110] Suess, *supra* note 109.
[111] Suess, *supra* note 109.
[112] Yarbough, *supra* note 103 at 93.
[113] Smith, *supra* note 56.
[114] Smith, *supra* note 56.
[115] Yarbough, *supra* note 103 at 129.
[116] Yarbough, *supra* note 103 at 129.
[117] Yarbough, *supra* note 103 at 129.
[118] Smith, *supra* note 56.

complexities and ethical concerns of surgery or hormones as a child with or without parental permission are not discussed in this paper. Other authors have thoroughly discussed those issues.[119] This paper assumes there is no question that the minor should have access to these procedures, if that minor has parental consent and is about to begin their transition but encounter bureaucratic roadblocks of insurance that are unethical and discriminatory.[120]

Another potential step in the transition process is legal transition, which includes acts such as a legal name change or a change of gender marker on identification.[121] There is also a significant social component to transition that should not go unnoted.[122] The timetable for transition can be a few months or span decades.[123] This process is not an insignificant journey within a person's life; for many, the journey is beneficial. A person's quality of life improves when they have started the process of transitioning.[124]

These situations combine the stigmatization of mental health, the concept that "something" is wrong, and the difficulties that transgender persons face. Even a diagnosis does not automatically guarantee the provision of services or coverage by one's insurance company. Persons can still be denied coverage because of a specific exclusion, a procedure not being deemed a "medical necessity," or for not being able to navigate a complicated appeals process—all of these are described in the next section. Necessary to begin change and enable greater access for transgender persons to transition services is to (1) provide that transition care, as a

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[119] *See* Federica Vergain, *Why Transgender Children Should Have the Right to Block Their Own Puberty With Court Authorization*, 13 FIU L. REV. 903 (2019); *see also* Emily Ikuta, *Overcoming the Parental Veto: How Transgender Adolescents Can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL. INTERDISC. L.J. 179 (2016); *see also* Brendan S. Abel, *Hormone Treatment of Children and Adolescents with Gender Dysphoria: An Ethical Analysis*," LGBT BIOETHICS: VISIBILITY, DISPARITIES, AND DIALOGUE, SPECIAL REPORT, 5 HASTINGS CENTER REPORT 44 (2014); *see also* N. P. Spack, *Management of Transgenderism*, 309 J. OF THE AM. MED. ASS'N 478 (2013).
[120] Anemona Hartocollis, *The New Girl in School: Transgender Surgery at 18*, N.Y. TIMES. (June 16, 2015), https://www.nytimes.com/2015/06/17/nyregion/transgender-minors-gender-reassignment-surgery.html.
[121] Hartocollis, *supra* note 120.
[122] Hartocollis, *supra* note 120.
[123] Yarbough, *supra* note 103 at 129.
[124] Yarbough, *supra* note 103 at 131.

mental health service, is an essential health benefit; (2) sex should include those beyond those who are cisgender; and (3) *Franciscan Alliance* should be overturned, and the original final rule should persist through a reinterpretation of the definition of sex. Those changes would prevent insurers from being able to specifically exclude or refuse to offer treatments medically necessary for persons to live as they see themselves.

Part III: Insurance and Medical Necessity

There is a constant battle between those in health care seeking profit, such as insurers, and patients.[125] Health insurance is big business; the industry realized net earnings of $23.4 billion in 2018, which was a substantial increase from $16.1 billion in 2017.[126] The insurers face a tremendous amount of growth and have an interest in accumulating profit. By contrast, patients, including those in transition, are concerned about themselves and their health needs. Still, the insurer is unwilling to provide such care or may make it difficult for the seeker of coverage[127] to do so by overburdening them with a complicated appeals process.

This section addresses that tense relationship in three separate subsections. The first subsection examines conceptions of "medical necessity," why that seemingly harmless term results in the denial of coverage for many individuals and demonstrates that health services related to gender transition are "medically necessary" under the ACA. The second subsection looks at EHB-benchmark plans—state selected plans that must include coverage of specific "essential benefits"[128]—from two states (New Jersey and New York) to examine their effects on

[125] Peter Ubel, *Is the Profit Motive Ruining American Healthcare?*, FORBES, (Feb. 12, 2014, 10:32 AM), https://www.forbes.com/sites/peterubel/2014/02/12/is-the-profit-motive-ruining-american-healthcare/#d8b891837b97.
[126] NAT'L ASS'N OF INS. COMM'RS, *U.S. Health Insurance Industry – 2018 Annual Results*, https://naic.org/documents/topic_insurance_industry_snapshots_2018_health_ins_ind_report.pdf, (last visited Apr. 26, 2020) (as of Apr. 26, 2020 the 2019 report is unavailable).
[127] *See* Grinberg, *supra* note 60. Sometimes the inclusions are blanket inclusions. Other times the policies are unclear or may say they offer services for gender reassignment, only to include other recommended treatments or services. Grinberg, *supra* note 60.
[128] 45 C.F.R. § 156.111(b).

transgender individuals. An essential health benefit is "a set of 10 categories of services health insurance plans must cover under the Affordable Care Act."[129] The ten categories include but are not limited to mental health and substance use disorder services as well as prescription drugs.[130] The third subsection examines the regulatory path for transition procedures and services to become an EHB. The final section explores the insurance appeals process, analyzing that process and why the process is not an adequate substitute for covering transition services when recommended by an individual's doctor and consented to by an informed patient.

1. Medical Necessity

Medical necessity is a flexible definition that can either result in denial or approval of coverage for treatments outside a set coverage area.[131] The insurer decides whether a service is medically necessary and should be a covered benefit for the person asking for its coverage.[132] The doctor does not make the decision. The patient or the patient's parent does not make the decision. The insurance company makes a choice. There is a natural tension between what the patient and doctor may both believe is the right course of treatment and the insurer's goals. That decision to not cover preferred care by the insurer may reduce financial costs.[133] Still, other economic considerations require examination as well, such as the cost to the individual denied coverage.

In the 1990s, a team at Stanford University developed a model contractual language for

[129] U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *Essential Health Benefits*, HEALTHCARE.GOV, http://www.healthcare.gov/ glossary/essential-health-benefits, (last visited Apr. 15, 2020).
[130] U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *What Marketplace health insurance plans cover*, HEALTHCARE.GOV, http://www.healthcare.gov/ glossary/what-marketplace-plans-cover, (last visited Apr. 15, 2020).
[131] INST. OF MED., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST 28 (2012) [hereinafter EHB].
[132] EHB, *supra* note 131.
[133] Actuaries, as the insurance industries determiner of what procedures costs, typically overestimate the cost associated with gender reassignment surgery. The primary paradigm accepted by the industry is that all transgender persons want gender reassignment surgery, which would be a significant financial cost. The opposite is true. Many transgender persons avoid such surgeries for a variety of personal reasons, including risk aversion. *See* J. Denise Diskin, *Taking to the Bank Actualizing Health Care Equality for San Francisco's Transgender City and County Employees*, 5 Hastings Race and Poverty L.J. 129 (2008).

medical necessity.[134] The result of this team was what became known as the "Stanford Model Contractual Language for Medical Necessity" for health insurance contracts.[135] This model is by far the one most encountered during research. The language states:

> "For contractual purposes, an intervention will be covered if it is an otherwise category of service, not specifically excluded, and *medically necessary*. An intervention may be medically indicated yet not be a covered benefit or meet this contractual definition of *medical necessity*. A health plan may choose to cover interventions that do not meet this contractual definition of *medical necessity*."[136]

A few ideas are central to this language. First, insurance always reserves the ability to cover any or no interventions. The insurer is the one with the ultimate decision-making power—not the patient and not the doctor. Second, any intervention receives coverage *if not specifically excluded* and *medically necessary*. There are some problems with this second point. These treatments and services are generally either specifically excluded or defined as not medically necessary. Clauses like these enable insurance companies to create a "Get Out of Covering Card" to avoid paying for services.

The American Medical Association's definition is more acceptable but still not perfect. Medical necessity, according to the American Medical Association, is:

> "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration, and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience for the patient, treating physician, or other health care provider."[137]

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[134] INST. OF MED. OF THE NAT'L ACADS., PERSPECTIVES ON ESSENTIAL HEALTH BENEFITS WORKSHOP REPORT: STANFORD MODEL CONTRACTUAL LANGUAGE FOR MEDICAL NECESSITY, 163-64, 2012 [hereinafter Stanford Model].

[135] Stanford Model, *supra* note 134.

[136] Stanford Model, supra note 134 at 228. Other languages drop the specifically excluded language of the Stanford Model. However, some of these have other language useable to exclude such as "not primarily for the convenience of the patient, physician or health care provider." There is no elaboration of that language. Such language may prevent the use of, for example, puberty blockers for children who seek to delay puberty prior to seeking hormone therapies. The language could also exclude services such physical therapy in favor of invasive procedures, but that is beyond the scope of this paper.

[137] Stanford Model, supra note 134 at 228.

While the languages sound similar, there are several clear distinctions. First is the final distinction under (c). This language shows that—contrary to the Stanford Model—that the insurer is not the primary decision maker. This language is more patient centric as it removes the economic incentive from the insurer's pocket and gives control of medical decisions back to patients and providers. Second, there is no language in this definition of "specifically excluded" procedures. This distinction is vital because it opens the possibility of payment for all medical purposes. The primary issue, however, is in the "illness, injury, disease, or its symptoms" language. Such a problem may be the result of pure semantics, but persons of different gender identities do not suffer from any of those listed. Those individuals merely wish for the ability to align their true self with their physical person. However, many have argued that transition therapies and services can cure or treat depression and anxiety.[138]

2. ACA EHB-Benchmarks Plans

Balancing the goal of the ACA and the reality of affordability is a constant struggle. The purpose of the ACA was to provide access to health insurance coverage, including through marketplace plans.[139] The secondary goal is to keep costs low so that such coverage will remain affordable.[140] Developing a marketplace plan is a two-step process.[141] The first step is an examination of what " a typical employer plan" consists of and using that plan as a baseline. Second, is the inclusion of the 10 categories of essential benefits into that plan, cutting and

[138] While plausible for hormone therapy to be a treatment for depression or anxiety, our society is not yet able to view non-cissexuals (including those who are pansexual and asexual) as "normal people." Mental health care in this health care system in general is haphazard—but it is better than nothing. Thus, a tension exists between a label that should not exist and living in an "antiquated" society. *See* Alice Dreger, *Why Gender Dysphoria Should No Longer be Considered a Medical Disorder*, PacificStandard, (June14, 2017), https://psmag.com/social-justice/take-gender-identity-disorder-dsm-68308.
[139] EHB, *supra* note 131 at 1.
[140] EHB, *supra* note 131 at 12. The highlights of accessibility include affordability, ease of access, and increases in spending. There is an irony that some plans make it difficult for transgender persons to receive services based on affordability and ease of access. Even if insurers will approve an unlisted procedure, this approval is behind the veil of a vague approval and then appeal process.
[141] EHB, *supra* note 131 at 1.

trimming non-essential coverages as necessary to reach cost targets.[142] Marketplace plans arise through bridging "a typical employer plan" and ten special enumerated categories of essential benefits which all plans must-have.[143] Each state also requires some benefits by the law of that state.[144]

The New Jersey Benchmark Model Plan for 2020 adopts the baseline and model for what procedures and treatments the policy will cover. Excluded are "surgery, sex hormones, and related medical, psychological, and psychiatric services" for gender transition or complications arising therefrom.[145] The model plan also only covers prescriptions for three reasons and, as such, would determine whether hormone treatments or other transition therapies would be covered for transgender persons. First is if the drug is "approved for the treatment of the Covered Person's illness or injury by the Food and Drug Administration."[146] Next is if the Food and Drug Administration has approved it for treatment elsewhere *and* if one or two compendia lists the drug.[147] Third, the drug requires recommendation by a clinical study or recommendation in a significant peer-reviewed professional journal.[148]

In contrast, New York's benchmark plan does not explicitly exclude transition services but instead does not cover any services not listed as covered in the plan.[149] Any services regarding transition for youth or adults are not listed in the covered procedures.[150]

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[142] EHB, *supra* note 131 at 1.
[143] EHB, *supra* note 131 at 1.
[144] U.S. CTRS. FOR MEDICARE & MEDICAID SERVICES, *Information on Essential Health Benefits (EHB) Benchmark Plans*, http://www.cms.gov/CCIIO/reources/data-resources/ehb, (last visited Apr. 24, 2020).
[145] HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, *Small Group Health Benefits Policy*, 88 https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/PA-BMP.zip, (last visited Apr. 24, 2020) [hereinafter Horizon].
[146] Horizon, *supra* note 145 at 66.
[147] More specifically, *The American Hospital Formulary Service Drug Information* or *The United States Pharmacopeia Drug Information*. Horizon, *supra* note 145 at 66-67.
[148] Horizon, *supra* note 145 at 67.
[149] OXFORD HEALTH INS. INC., *Certificate of Coverage*, 61, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/NY-BMP.zip, (last visited Apr. 24, 2020).
[150] *See* OXFORD HEALTH INS. INC., *supra* note 149.

3. Essential Health Benefits and Section 42 U.S.C. § 18022(b)(4)(C) – "Other Groups"

Including transition services as a subset of Essential Health Benefits (EHB), under the "other groups" definition of § 18022(b)(4)(C) would ensure plans include transition services. EHBs[151] cover a wide range of medical services and procedures taken and developed with a framework that leads to potentially discriminatory results. To create the list of EHBs, HHS compares standard small employer plans and then issues state requirements for essential covered services to meet a targeted premium.[152]

The language in § 18022(b)(4) defines how a service becomes an EHB and implies a method for transition services to achieve EHB status. Under § 18022(b)(4) are the elements regarding consideration for which practices and procedures become EHBs covered by a benchmark plan.[153] The secretary of HHS must balance each of the factors so that none substantially outweighs another.[154] There can be no discrimination because of age, disability, or expected length of life.[155] The plans also cannot deny individuals the rights to EHBs as a result of their age, life expectancy, disability, or medical dependency.[156] EHBs must "take into account the health care needs of *diverse segments* of the population, including women, children, persons with disabilities, *and other groups*."[157] Notably, the phrase "and other groups" is unclear. This phrase could apply to any significant subgroup within the United States—transgender persons in general. Therefore, one method to provide safeguards for those looking to transition is to make transition services considered an EHB—these services are critical to an "other group" within the

[151] U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *Essential Health Benefits*, http://www.healthcare.gov/glossary/essential-health-benefits, (last visited Apr. 15, 2020).
[152] EHB, *supra* note 131.
[153] 42 U.S.C. § 18022(b)(4); There are those insurance companies who specifically exclude such procedures because they are not part of a state's EHB There is no incentive for such procedures when there is no one or no rule to stop this discriminatory practice. *See* Grinberg, *supra* note 60.
[154] 42 U.S.C. § 18022(b)(4)(A).
[155] 42 U.S.C. § 18022(b)(4)(B).
[156] 42 U.S.C. § 18022(b)(4)(D).
[157] 42 U.S.C.§ 18022(b)(4)(C) (emphasis added).

"diverse segments" of the population. Allowing the provision of such services through insurance enables persons to become their true self.

4. A Lack of (Effective) Appeal

The limitations of contractual language are significant and often protect insurers. There is an argument that insurers offer patients an "escape valve" of sorts through the appeals process. To explore this process, a detailed description of a complete procedure is below. The first procedural step is to file a prior authorization claim with your insurance company.[158] The company should return judgment upon the request in writing within 15 days.[159]

A filing of an appeal must now occur. This internal appeal requires (1) completion of all the forms required by the insurer or a letter with proper identifying information; and (2) any additional information such as a letter from a doctor.[160] The appeal must be filed within 180 days of the receipt of rejection but can then require an external appeal.[161] The insurance company then has another 30 days to approve or reject paying for the requested care.[162] There does not appear to be an incentive for the insurance company to expedite this process for non-emergency care.

The external review becomes possible after the denial of the internal review, which could be as many as 225 days after the first request. The written request for external review must be filed within 120 days of the denial via internal review.[163] Some states have their own appeals process, of which there is up to a $25.00 fee to file the appeal.[164] The only possible objection

[158] U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *Internal Appeals*, HEALTHCARE.GOV, http://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals/, (last visited Apr. 15, 2020) [hereinafter Internal Appeals].
[159] Internal Appeals, *supra* note 158.
[160] Internal Appeals, *supra* note 158. Healthcare.gov recommends keeping all paperwork and documenting all interactions with the insurance company, whether by phone, email, letter, and so forth. Internal Appeals, *supra* note 150.
[161] Internal Appeals, *supra* note 158.
[162] Internal Appeals, *supra* note 158.
[163] U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *External Review*, HEALTHCARE.GOV, http://www.healthcare.gov/appeal-insurance-company-decision/external-review/, (last visited Apr. 15, 2020) [hereinafter External Review].
[164] External Review, *supra* note 163.

raiseable in this circumstance is "[a]ny denial that involves medical judgment where you or your provider may disagree with the health insurance plan."[165] As such, the review process may end here for the majority of those seeking transition services.

The Stanford Model Contractual Language and similar models put the dead-end here in the appeals process. The process limits the options of the patient when an insurer considers a procedure or service not medically necessary. If the patient can navigate the complicated process, any specifically excluded claim is not eligible for the appeals process. The insurance company also has no incentive in approving any procedure that they do not consider medically necessary. Most persons would surrender upon discovering the time required for this drawn-out process and, for low-income individuals, the possibility of having to pay to file. Therefore, the appeals process is ineffective for those seeking transition via insurance coverage for required services.

The most practical solution to guarantee coverage of such services to transgender individuals is to side-step these contractual and bureaucratic walls and other hurdles to treatment. However, rather than offering a human-friendly solution to a well-established problem, the current legal frameworks offer a mixed bag for those dependent on government protections. Those protections initially offered are on perpetual hold, and even those who rely on government assistance in the form of Medicaid have no options based on one thing: where they live.

Part IV: Medicaid

Just like private insurers, not all is perfect within government-funded and determined health care programs. Medicaid is a joint federal and state-funded program administered by the various states.[166] States rules can vary. Some states do not offer coverage for transition services

[165] External Review, *supra* note 163.
[166] U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., *Medicaid*, MEDICAID.GOV, http://www.medicaid.gov/medicaid/index.html/, (last visited Apr. 15, 2020).

at all. While other states cover transition services, there are battles in states like Wisconsin and Iowa over the coverage of such services. The needle is moving toward a more inclusive future.

1. States That Do Not Offer Medicaid Coverage

Medicaid is an essential provider of health care services to transgender persons because transgender persons are more likely to depend on Medicaid coverage.[167] A large number of states either have no explicit policy concerning transgender health coverage or specifically exclude it in their state employee benefit plans. Of the fifty states, ten explicitly exclude transgender care and health care coverage from their state Medicaid plan.[168] Twelve states expressly prohibit transition-related care coverage in their state employee health plan.[169] Tennessee, for example, includes "sex change or transformation" surgery specifically in its list of ninety-one stated exclusions for coverage in its Medicaid program.[170] Despite these exclusions, there are battles in some states to determine the constitutional legitimacy of such exclusions. One such state is Wisconsin.

2. Battleground: Wisconsin - Flack

Wisconsin is a battleground where injunctions have foiled the state's pure ban on

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[167] *See* CTR FOR AM. PROGRESS ET AL., PAYING AN UNFAIR PRICE: THE FINANCIAL PENALTY FOR BEING TRANSGENDER IN AMERICA, (2015). This publication supplies several reasons why transgender persons encounter financial difficulties, which places these individuals in the lower income bracket required for Medicaid coverage. Reasons provided include (1) employment discrimination forces transgender workers into lower paying jobs or unemployment; (2) housing discrimination results in quoted higher prices or housing, which could lead to higher expense or living in less desirable areas; (3) cost increases resulting from extended housing searches; (4) delayed and thus more costly medical care as preventative care is delayed or avoided due to cost; (5) the costs of transition related care, such as annual hormone or lab test costs; (6) borrowing money to pay for healthcare expenses; (6) loss of productivity and employment because employment opportunities may not provide sick leave; (7) more expensive lending due to employment difficulties and increased encounters to law enforcement can affect interest rates and lead to unfair lending practices; (8) difficulty obtaining credit to support education expenses, business start-up expenses, or other expenses such as housing; (9) higher costs associated with filing and processing fees for identity documents; (10) refusal to supply identity documents to transgender persons; (11) lack of proper identification prevents employment opportunities; (12) harmful school environments leading to dangerous situations and decreased academic performance and graduation rates, leading to less employment opportunities; and (13) inability to access financial aid for further educational opportunities.

[168] MOVEMENT ADVANCEMENT PROJECT, *Healthcare Laws and Policies*, https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies, (last visited April 26, 2020) [hereinafter MAP].

[169] MAP, *supra* 168.

[170] TENN. COMP. R. & REGS. 1200-13-13-.10 (2020).

transgender services and surgery, most notably in *Flack v. Wisconsin Department of Health Services*.[171] *Flack* was decided in 2019 and held that the provisions of Wisconsin Medicaid for both gender-conforming surgery and hormone therapies violated (1) the Affordable Care Act;[172] (2) the Medicaid Act;[173] and (3) the Equal Protection Clause.[174]

In this case, two transgender individuals with gender dysphoria challenged an exclusion for medically prescribed gender-conforming surgery and related hormones under Wisconsin Medicaid.[175] The court found that the regulations originally were developed under the guise that such procedures were costly.[176] The Wisconsin Department of Health Services (WDHS) then could not provide any evidence as to how the procedures were experimental, ineffective, or unsafe.[177] Beyond this case, such an argument is questionable since sex assignment surgeries for infants are so safe that even states have elected to force the surgeries upon young infants.[178] Counter to WDHS's argument, even those who make the appeal decisions found the provision lacking.[179] Those persons "acknowledg[ed] that gender-conforming hormone and surgical

[171] *See* Flack v. Wis. Dep't. of Health Servs., 395 F. Supp. 3d 1001, 1003 (W.D. Wis. 2019).
[172] *Id.* at 1014-15.
[173] *Id.* at 1019.
[174] *See id.* at 1020-22
[175] *Id.* at 1003.
[176] *Id.* at 1008
[177] *See Flack*, 395 F. Supp. 3d at 1008.
[178] Such an argument is questionable given that there are examples that exist, such as in M.C. ex rel. Crawford v. Amrheim, 598 Fed.Appx. 143 (4th Cir.2015). where intersex infants do not choose to have surgery. The adults ma ke the choice. In *M.C.*, a family was to adopt the infant. Before the adoption, M.C. remained in custody of the State of South Carolina. During that time, state actors decided M.C. needed to have gender reassignment surgery. The state actors and the doctors performed the procedure to make M.C. "male." Ironically, the state chose M.C.'s sex through a surgery that in other contexts, such as the views of the Wisconsin Department of Health, are unsafe and experimental. Just five years later, the South Carolina legislature is currently considering a bill called the *Youth Gender Reassignment Prevention Act*, which subjects health care professionals to the threat of license revocation to practice. H.R. 4716, 123d Sess. (S.C. 2020). Among the provisions of this act—in addition to the suppression of treatments such as surgeries and puberty blocking hormones—the proposed legislation also prevents "interventions to align the patient's appearance or physical body with the patient's gender identity" and "interventions to alleviate symptoms of clinically significant distress resulting from gender dysphoria." *Id*. The bill ends the surgical part of transition, but medical professionals may not advise those with gender dysphoria to dress in conformity with their identified gender. *Id*. This bill may also prevent treatment for depression as it relates to gender dysphoria. *Id*. Conflictingly, the bill allows mental health counseling. *Id*. Drug therapies are plausibly "interventions to alleviate symptoms." *Id*.
[179] *Flack*, 395 F. Supp. 3d at 1008.

treatments for gender dysphoria can be medically necessary and that the [current exclusion] conflicts with current medical practice."[180] The same surgeries and medications were covered to treat other conditions,[181] including the use of hormones.[182]

The court regarded WDHS's arguments that the ACA antidiscrimination provisions do not apply in this case as "nonsense;" those arguments do not need examination.[183] However, the court dwelled on whether WDHS had the power under the Medicaid Act to exclude such services as medically unnecessary using an argument based on Fifth Circuit law that experimental procedures could be medically unnecessary.[184] The court decided that this is an antiquated ruling from 1980 and that the medical profession "has reached a formal consensus as to the safety *and* efficacy of surgical treatments for severe gender dysphoria."[185] The court concluded that "the state's adoption, or at least continued enforcement, of the Challenged Exclusion is unreasonable as a matter of law and not entitled to deference."[186] The court barely addressed the Equal Protection issue other than to say that both parties agreed that heightened scrutiny applied, and there was no apparent benefit to public health from the exclusion.[187]

While *Flack* does not address most of the issues with completeness as the arguments of the opposing side were lacking, there are at least two critical takeaways from this case. First, the parties here both acknowledged that transgender persons are a quasi-suspect class and, therefore, any analysis under the Equal Protection Clause would warrant heightened scrutiny. Second is the

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[180] *Id.*
[181] *Cf.* Noa Ben-Asher, *The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties*, 29 Harv. J.L. & Gender 51, 60-62 (2006) (discussing that such procedures for the intersex, and particularly infants, are routine and encouraged in many places).
[182] *Flack*, 395 F. Supp. 3d at 1009-10.
[183] *Id.* at 1014
[184] *Id.* at 1015
[185] *Id.* at 1015-16 (citing Lankford v, Sherman, 451 F.3d 496, 511 (8th Cir. 2006) (holding that a state has discretion to determine optional services, but a state's failure to provide coverage for services that are non-experimental, medically necessary is per se unreasonable and inconsistent with the stated goals of Medicaid).
[186] *Flack*, 395 F. Supp. 3d at 1018.
[187] *Id.* at 1023.

notion that an insurer should cover a service or procedure if it is non-experimental, safe, effective, and recognized as the proper standard of care. This case from Wisconsin moves the needle as to where the law needs to go to ensure proper protections for transgender persons in receiving the care they need, should they opt for that care. To continue to deny these transition therapies to a wide range of community members is not only a tragedy; such denial is unethical.

3. Battleground: Iowa

Iowa's provisions of coverage for transition services through Medicaid is a political war. In March 2019, the Iowa Supreme Court ruled that the state's previously stated exclusion of transgender health coverage was a violation of the state's civil rights law and, thus, illegal.[188] In this case, the Iowa legislature had amended the *Iowa Civil Rights Act* to add "gender identity" to protected characteristics.[189] The Iowa Supreme Court determined whether or not that language of the prohibition of surgical procedures related to "gender identity disorders" was a violation of the statute or the Iowa Constitution.[190] The defending agency argued that all Medicaid beneficiaries in Iowa were not entitled to gender-affirming surgical procedures because they are performed primarily for psychological issues.[191] The court held the opposite. The plan denied coverage because they were for the purpose related to gender identity, which would be a violation of the *Iowa Civil Rights Act.*[192] The Iowa Supreme Court did not discuss the constitutional issue because the statute banned discrimination.[193]

The legislature did not surrender in response to this decision. Just two months later the governor signed a bill into law that allows Medicaid and other state-funded health care providers

[188] Good v. Iowa Dep't. of Human Servs., 924 N.W.2d 853, 856 (Iowa 2019).
[189] *Id.*
[190] *Id.*
[191] *Id.* at 862. The court notes that this is only because the surgeries are related to transsexualism. There are surgeries performed for other psychological reasons that the Medicaid plan covers.
[192] *Id.*
[193] *Id.*

to exclude transgender-related care.[194] This gap leaves the possibility of even gender-affirming care, let alone hormones or surgery, in doubt for citizens in Iowa.[195] While Iowa law continues to protect civil rights for transgender persons in some ways (most notably, housing and advertising), the law specifically excludes transgender persons from receiving surgery.[196] It specifically provides that "This section shall not require any state or local government unit or tax-supported district to provide for sex reassignment surgery or any other cosmetic, reconstructive, or plastic surgery procedure related to transsexualism, hermaphroditism, gender identity disorder or body dysmorphic disorder."[197]

Such language is a blatant, direct, and overt act to exclude this quasi-suspect class from potential violations of the Due Process and Equal Protection Clauses. Transgender persons are a quasi-suspect class because (1) transgender persons have been subject to a long history of discrimination that continues to this day; (2) transgender status as a defining characteristic bears no relation to perform or contribute to society (3) transgender status and gender identity have been found to be obvious, immutable, or distinguishing characteristics; and (4) transgender people are unarguably a politically vulnerable minority.[198] While this view is thus far in the minority, it is gaining some momentum. Circumstances like those in Iowa illustrate the need for the judicial adoption of an expanded definition of sex to provide protections to transgender persons as already exist for cisgender persons. The change in judicial interpretation would also stop the war in states like Wisconsin and Iowa. There is no reason that a state should have the power to target and exclude a specific procedure based on a person's gender identity.

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[194] MOVEMENT ADVANCEMENT PROJECT, *Healthcare Laws and Policies: Medicaid Coverage for Transition-Related Care*, https://www.lgbtmap.org/img/maps/citations-medicaid.pdf, (last visited Apr. 26, 2020) [hereinafter Medicaid Coverage].
[195] *See* Medicaid Coverage, *supra* note 194.
[196] IOWA CODE ANN. § 216.7 (West 2019).
[197] F.V. v. Barron, 286 F. Supp. 3d 1131, 1144 (D. Idaho 2018) (citing Adkins v. City of New York, 143 F. Supp. 3d 134 (S.D.N.Y. 2015)).
[198] Adkins v. City of New York, 143 F. Supp. 3d 134, 139-140 (S.D.N.Y. 2015).

Discussed below are the problems requiring resolution to move the needle toward adequate protections for transgender persons in their health coverage; their resolution would enable transgender persons to have access to the care that they need. Whether these human beings decide they want to transition, are transitioning, or are looking to take another step in that process, they deserve and are entitled to medical treatment that is necessary to enable them to live as they truly are.

Part V: Legal Transitions and Changes

While the situation for transgender persons may seem bleak, there exist some simple yet difficult changes necessary for the law to protect this population and guarantee them the essential services they need. This part examines those necessitated changes in two subsections. The first explores legislative and regulatory ways to offer protections to transgender persons through neutralizing the "medically necessary." The second discusses judicial transformation and better interpretations of the definition of sex than the weak reasoning found in *Franciscan Alliance*.

1. Transforming "Not Medically Necessary" into "Totally Medically Necessary"

As shown above, insurers can discriminate with too much ease. The problem stems from insurers looking out for their bottom line or relying on age-old prejudices to keep transgender persons from continuing their transition journey. Individuals, like Jasmine, find themselves caught in unnavigable web of legal and bureaucratic hindrances to their needs and goals. The systems presently permitted by the language of § 1557 as it currently stands enable discrimination to perpetuate, whether covert—such as in the insurance appeals process—or overt—as in explicit bans in Medicaid programs.

Recognition of transition services as medically necessary is critical. While data is not obtainable at present, the other costs associated with lack of transition treatment, including treatments for other conditions such as depression, should receive adequate consideration. The

coverage of these services may reduce or eliminate added costs. There would also be a gain in human value as treatment may provide a way to prevent persons from taking more drastic and violent steps. As Jasmine recounted, she was consistently suicidal. There is a value to all human life.

Categorizing transition services as an EHB would require coverage of services related to transition. One might think EHBs include transition services and procedures already. One of the main EHB categories is mental health of which coverage is required in all market-place based plans.[199] The same is true for Medicaid Plans.[200] However, even some of the "model" marketplace plans—even from liberal states like New Jersey—have many impediments to transition services. Still, states like Wisconsin in *Flack* try to argue that "it has always been this way." Unfortunately for the Wisconsin Department of Health Services, times change to the point where procedures are no longer experimental but standard, prescriptions such as hormone therapies are standard treatments for other patients, and even the persons denying the claims made by transgender persons do not understand why such care is not covered.[201] Even though gender dysphoria is a "mental health disorder," transition services and procedures do not receive the same coverage as other mental health services; coverage for gender dysphoria should receive the same protections as other designated mental health conditions. A quick edit to the end of the Mental Health essential benefit to add "including transition services" should suffice.[202]

The fastest way to enable this transformation from a rigged system into one that allows positive human experiences and growth is through legislation. Legislative action at the Federal

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[199] U.S. CTRS. FOR MEDICARE & MEDICAID SERVICES, *What Marketplace health insurance plans cover*, HEALTHCARE.GOV, http://www.healthcare.gov/glossary/what-marketplace-plans-cover, (last visited Apr. 15, 2020).
[200] Sarah Rosenbaum, et al., *Medicaid Benefit Designs for Newly Eligible Adults: State Approaches*, THE COMMONWEALTH FUND, May 11, 2015, https://www.commonwealthfund.org/publications/issue-briefs/2015/may/medicaid-benefit-designs-newly-eligible-adults-state-approaches.
[201] Flack v. Wis. Dep't. of Health Servs., 395 F. Supp. 3d 1001, 1008 (W.D. Wis. 2019).
[202] This need not implicate health care providers from not providing services because of their religious beliefs. The effects of the Religious Freedom Restoration Act are outside the scope of this paper.

level in the current political climate seems unlikely. However, advocacy at the local level for change can be useful for many. New Jersey has a model statute for contracts for insurance companies that offer health coverage—even though this statue relates to inmates' health care.[203] This statute prevents insurers from "denying or limiting coverage, or denying a claim, for services including but not limited to the following, due to a covered person's gender identity or expression or for the reason that the covered person is a transgender person."[204] Such a statute, if extended to all and not just inmates, would significantly knock down walls to treatment for transgender persons seeking transition. Currently, nineteen states and The District of Columbia have laws or mandates against blanket exclusions for gender-affirming treatment in benefits packages.[205]

As a global example, Argentina is an effective model for the way legislation needs to shift to enable effective and necessary transitions. In 2012, Argentina led the way in developing the rights of transgender persons in ways that no nation before it had done.[206] With unanimous Senate support, the law in Argentina now (1) allows a person to change their gender on official documents without surgery or psychiatric diagnosis and (2) requires public and private medical professionals "to provide free hormone therapy or gender reassignment surgery for those who want it—including those under the age of 18."[207]

With such legislative changes, "medically necessary" loses its teeth, and the complex processes or specific exclusions no longer work. Such would be a boon for those seeking transition services.

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[203] N.J. STAT. ANN. § 30:7E-7 (West 2017).
[204] N.J. STAT. ANN. § 30:7E-7(b)(4) (West 2017).
[205] Grinberg, *supra* note 60.
[206] Emily Schmall, *Transgender Advocates Hail Law Easing Rules in Argentina*, N.Y. TIMES, May 24, 2012, https://www.nytimes.com/2012/05/25/world/americas/transgender-advocates-hail-argentina-law.html.
[207] Schmall, *supra* note 207.

2. Solidifying the Definition of Sex

The evolving definition of sex within Title IX could help save § 1557 if courts continue to move in that direction. *Franciscan Alliance* held that under Title IX, the original language of the statute that supplies the definition off sex, protections are limited to those who are cisgender.[208] However, the statute is almost fifty years old.[209] Interpretation within a modern context should be used adapt this out-of-date definition to a contemporary meaning. The law is a living, breathing thing. One cannot consume oneself with "what it was in the past" while ignoring the present or future. Society learns, grows, and adapts. That is not to say the law should continuously shift as the country requires some consistency; however, that does not mean that laws and interpretations are immutable. Even the Supreme Court has overturned itself before, such as *Brown v. Board of Education* overturning *Plessey v. Ferguson*.[210] The language in *Brown v. Board* even acknowledges that new knowledge and "modern authority" change meaning and interpretation of the law.[211] Therefore, the definition of sex within the Title IX context could change to match more contemporary meanings and interpretations. Changes to the standard of medical care for transgender persons—as noted in *Flack*, which also recognizes the scientific and social shifts[212]—are comparable evidence to the psychological evidence in *Brown v. Board*.[213] Science and social change evolve meanings into contemporary ones. The judiciary lives; the judiciary cannot remain in 1972 forever.

Several cases support this movement within the Title IX context. For example, in *Grimm v. Gloucester County School Board*, the judge held that claims of discrimination based on transgender status were *per se* actionable under Title IX, which warranted the claim to be

[208] Franciscan Alliance. Inc. v. Burwell, 227 F. Supp. 3d 660, 687 (N.D. Tex. 2016).
[209] The 50-year anniversary of the statute is 2022 because the statute became law in 1972.
[210] Brown v. Bd. of Ed. of Topeka, Shawnee Cty., Kan., 347 U.S. 483, 484-85 (1954).
[211] *See id.*
[212] Flack v. Wis. Dep't. of Health Servs., 395 F. Supp. 3d 1001, 1008 (W.D. Wis. 2019).
[213] Brown v. Bd. of Ed. of Topeka, Shawnee Cty., Kan., 347 U.S. 483, 484-85 (1954).

reviewed via intermediate scrutiny.[214] Such holdings have several possible ramifications, all of which should occur under the law.[215] First, gender identity would be a protected class under the category of sex, as listed as Title IX. Second, as a result of that categorization, § 1557 would inherit "transgender" as a protected class; however, prospective plaintiffs such as Franciscan Alliance Inc. would highlight that the court in *Franciscan Alliance* already stated the original definition controls. The issue is one of interpretation, and whether as the ties change statutes can take on new meanings. While not necessarily statutory, *Brown v. Board* provides a framework for this. In *Brown v. Board* psychological impacts on the "separate but equal" policy swayed the Court's reasoning to change how the Court interpreted the Fourteenth Amendment.[216] Here, a similar concept could apply. The definition of sex could change depending on new ways of thought and thinking. The court in *Flack* recognized this fact, and the persons denying the approval requests for transgender patients in Wisconsin realized that times change. Battles must end; there must be movement forward.

Finally, those protections offered under the law subject any review to intermediate scrutiny. Subjecting reviewed laws to intermediate scrutiny means that programs like Medicaid would have to show that the policies were more than merely rationally related to the outcome.[217] Here, there is no such relationship. There may be more monetary savings, should that be the state's logic, in providing coverage for transition services rather than ongoing and potentially expensive mental health treatment. The movement to intermediate scrutiny would be a boon for transgender persons. As Title IX would also adopt that definition, gender identity would become

[214] Grimm v. Gloucester Cty. Sch. Bd., 302 F. Supp. 3d 730 (E.D. Va. 2018).
[215] For similar holdings, *see also* Whitaker By Whitaker v. Kenisha Unified Sch. Dist. No. 1 Bd. of Educ., 858 F.3d 1034 (7th Cir. 2017); *see also* A.H. v. Minersville Area Sch. Dist., 408 F. Supp. 3d 536 (M.D. Pa. 2019); *see also* Adams by and through Kasper v. Sch. Bd. of St. Johns Cty, Florida, 318 F. Supp. 3d 1293 (M.D. Fla. 2018); *see also* Evancho v. Pine Richland Sch. Dist., 237 F. Supp. 2d 267 (W.D. Pa. 2017).
[216] *See* Brown v. Bd., 347 U.S. at 484-8.
[217] U.S. v. Virginia, 518 U.S. 515, 533 (1996).

protected under § 1557, affording transgender persons all the protections they had before the *Franciscan Alliance* injunction, including protections in marketplace plans.

Such guarantees within coverage would be a boon for transgender persons. People like Jasmine, frustrated by their insurance company repeatedly, could receive their benefits without having to try to navigate a complex system. Mental health issues that surround the population of transgender persons in the United States would decrease. There is nothing but positive outcomes. The definition of sex should encompass gender identity rather than being a mere "biological" definition. Life is not that black and white.

Since 2010, various circuit courts have decided cases in favor of transgender persons[218] in the employment related context under Title VII of the Civil Rights Act of 1964[219] or on another basis. While not mentioned in the ACA itself, there are potential ramifications and spillover of the definition of sex from Title VII. A new definition of sex under Title VII would have significant persuasive value to the interpretation of sex as it relates to Title IX and the ACA. If Title IX's definition of sex was to match the new definition of sex under Title VII, the ACA would offer protections like those under the original final rule issued by HHS, which included gender identity.

The Supreme Court has already heard arguments in a landmark case that could have broad implications for the rights of transgender individuals beyond its Title VII question. On April 22, 2019, the Supreme Court granted certiorari in the case of R.G. & G.R. Harris Funeral

[218] *See* EEOC v. R.G. & G.R. Harris Funeral Homes, Inc., 884 F.3d 560 (6th Cir. 2018) (holding that terminating employer based on transgender status or on the basis of transitioning violates Title VII); Glenn v. Brumbly, 663 F.3d 1312 (11th Cir. 2011) (holding that termination of employee based on bathroom concerns, transgender status, and transitioning was sex-based discrimination and violated Equal Protection under the Constitution); Whitaker v. Kenosha Unified Sch. Dist., 858 F.3d 1034 (7th Cir. 2017) (holding that discrimination against transgender students is sex discrimination under Title IX and the Equal Protection Clause); Dodds v. U.S. Dep't. of Educ., 845 F.3d 217 (6th Cir. 2016) (holding that discrimination against transgender persons was likely sex discrimination under Title IX and the Equal Protection Clause).

[219] This part of the Civil Rights Act prevents discrimination in the workplace. *See* Title VII of the Civil Rights Act of 1974 (2018). The ACA does not specifically mention this part of the Civil Rights Act. The ACA does specifically mention Title VI and Title IX.

Homes, Inc. v. Equal Employment Opportunity Commission, et al., to answer "[w]hether Title VII prohibits discrimination against people based on (1) their status as transgender [and] (2) sex stereotyping."[220] Oral arguments were heard on October 8, 2019,[221] and the Court has not yet rendered a decision. The answer to these questions has broad ramifications. Answering the first question in the affirmative significantly alters the landscape for other civil rights provisions such as Title IX. If yes, it is more than plausible that the same expansive protected status would expand the definition of sex in Title VII. Should that happen, Title IX would offer protections for transgender persons under the definition of sex. Expanding the definition of sex under Title IX carries those same protections into the ACA and § 1557.[222] The long tragedy would be over, as protections would be offered to transgender persons and the services they require in all federally funded programs including insurers offering market-place based plans and Medicaid. Not medically necessary would transform into medically necessary, and persons like Jasmine would not have to fight excruciating battles to get the services they need.

Epilogue

The problem facing transgender persons when battling discrimination is disheartening. Ethically, the right thing to do—the just thing to do—is to move the needle in such a way to offer protection to these individuals, whether child or adult, looking for surgery or not looking for surgery. Something must change. The definition of sex must encompass gender identity. There must be statutory protections, whether on a state or federal level. This tragedy cannot go on any further. Transgender persons should have the chance to be who they are and receive the same protections as cisgender persons under the law. The judiciary must reinterpret, or the legislature

[220] Equal Emp't. Opportunity Comm'n v. R.G. & G.R. Harris Funeral Homes, Inc, 884 F.3d 560 (6th Cir. 2018), *cert. granted*, 139 S. Ct. 1599 (Mem) (2019).
[221] *See* Transcript of Oral Argument, *R.G. and G.R. Harris Funeral Homes, Inc. v. Equal Emp't Opportunity Comm'n*, 139 S.Ct. 1599 (2019) (No. 18-107).
[222] Should these events not occur, the alternative is legislative action through Congress as a check on the Supreme Court decision.

must rewrite; the battles must cease.