

COVERAGE IN TRANSITION:
CONSIDERATIONS WHEN EXPANDING
EMPLOYER-PROVIDED
HEALTH COVERAGE TO LGBTI EMPLOYEES
AND BENEFICIARIES

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ABSTRACT

The rights of transgender individuals has been in the headlines during 2017 – ranging from President Trump’s tweet to announce a ban on transgender individuals from serving in the military due to the “tremendous medical costs” to a nationwide injunction imposed by a federal district court on the HHS regulations that prohibit health-care discrimination against transgender individuals under the Affordable Care Act (ACA).

*There are three important reasons why transgender rights are in the news. First, the Human Rights Campaign Foundation, designed to promote the lives of lesbian, gay, bisexual, and transgender (LGBT) people, scores employers in its Corporate Equality Index (CEI) based on their commitment to equal treatment for LGBT employees. To achieve a 100% score in its 2017 CEI, an employer must provide equal health coverage for transgender individuals without exclusion for medically necessary care. This includes medical benefits and services related to transgender transition (e.g., medically necessary services related to sex reassignment). Second, the Seventh Circuit in the summer 2017 decision of *Hively v. Ivy Tech Community College* held that Title VII’s prohibition on sex discrimination in the employment context extends to sexual orientation and gender identity. Third, HHS’ regulations prohibiting health-care discrimination against transgender individuals became effective January 1, 2017. As a result of litigation, the portion of those regulations that prohibit discrimination on the basis of gender identity are now subject to a nationwide ban. The Department of Justice’s motion requesting a remand and stay of the litigation so that HHS could reconsider its opinion was granted by the federal district court, but the injunction remains in effect.*

This article discusses the issues facing employers who are considering

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expansion of their group health plans to include transition-related medical benefits for transgender employees and their beneficiaries for the treatment of gender dysphoria. Issues include federal and state discrimination laws, federal income tax treatment, Title VII prohibitions on sex discrimination in the employment context, and ACA's prohibition against sex discrimination in the health care context. In the backdrop, the Supreme Court has granted cert in the Gloucester County School Bd. v. G.G. case, which will review Title IX's prohibition of sex discrimination in the education context as a school board's policy required students to use the restroom consistent with their birth sex, rather than their gender identity. As the ACA incorporates Title IX's prohibition of sex discrimination into the health care context, the Supreme Court's decision could have far reaching impact.

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INTRODUCTION

The issue of expanding group health coverage for an employer's lesbian, gay, bisexual, transgender, and intersex (LGBTI) employees and their beneficiaries has been evolving over time. Initially, the issue of providing benefits to LGBTI employees surfaced in the 1990s in the context of extending group dependent health coverage to employees with same-sex domestic partners. When Massachusetts became the first state to legalize same-sex marriages in 2004, employers faced the issue of extending group health coverage to employees and their same-sex spouses, in states where such marriages were valid. The issues of same-sex spousal coverage was resolved after the Supreme Court issued its rulings in *U.S. v. Windsor*¹ and *Obergefell v. Hodges*.² Thereafter employers who had not expanded group health coverage to same-sex spouses of their employees felt obliged to do so; failure to do so would subject them to claims of Title VII violations if coverage existed for opposite-sex spouses. We have come full circle now as employer face new concerns as to whether employer-provided health coverage should or must include medical procedures necessary for a transgender individual to transition to his/her gender identity, and if so, what tax implications would result for the employer and the employee. Other legal issues facing employers in the transgender context include dress code policies, gender pronouns, and bathroom laws.

One reason for this issue surfacing now is the 2017 Corporate Equality Index's (CEI) inclusion of medical benefits relating to transgender transition by a business for purposes of scoring a 100% score.³ That index is a method used by the Human Right Campaign

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1 *U.S. v. Windsor*, 570 U.S. 744 (2013).

2 *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015).

3 See HUMAN RIGHTS CAMPAIGN FOUNDATION, CORPORATE EQUALITY INDEX 2017, RATING WORKPLACES ON LESBIAN, GAY, BISEXUAL AND TRANSGENDER EQUALITY (15th ed. 2016), <https://perma.cc/67MJ-2MJZ>. There are 327 of the Fortune 500-ranked businesses that have official CEI ratings based on submitted surveys. Of these, 199 have achieved a 100% rating (compared to 151 in the prior year), with 12 of the top 20 Fortune-ranked businesses achieving this top score (e.g., Wal-Mart Stores, Inc., Exxon Mobile, Chevron Corp., Apple). In 2014, the HRC Foundation announced new criteria for the 2017 CEI, which would require a business's medical plan to provide comprehensive medical coverage for services related to transgender transition. In 2002, it launched a Corporate Equality Index (CEI) used to gauge an employer's inclusion of LGBTQ employees within their communities and applied it to 319 employers. By

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(HRC) to rate businesses that promote lesbian, gay, bisexual, transgender and queer (LGBTQ) inclusive policies and practices in the workplace. The 2017 CEI had a record number of 515 employers earning a top rate of 100%.⁴ The Human Right Campaign (HRC) Foundation is a not-for-profit entity focused on improving the lives of and encouraging employer to adopt LGBTQ-inclusive policies and practices.

As will be discussed in the article, better awareness, changes in the public's perception, evolving research and medical evidence, modifications in the regulatory agencies' perspective under the Obama Administration, and shifts in demand have led to the expansion of healthcare services and benefits for the transgender community. Medicare, the Federal Employee Health Benefits Program (FEHBP), state Medicaid programs, and commercial health insurer are all reconsidering changes in their policies.⁵

The Centers for Disease Control and Prevention (CDC) estimated 1.4 million adults (0.6%) in the United States have self-identified as transgender in its 2014 Behavioral Risk Factor Surveillance System (BRFSS).⁶ The survey asked individuals whether they viewed themselves as transgender, and if so, whether male-to-female, female-to-male, or gender nonconforming. The 2014 estimate was double that of a prior 2011 estimate that found approximately 700,000 individuals (0.3%) who identified themselves as transgender.

This article examines the legal issues surrounding the expansion of employer provided group health coverage to include transition-related medical benefits for transgender individuals and forecasts what to expect under the new Trump Administration. It begins with a glossary of terms that pertain to the LBGTI community and will be used throughout the article. It will then provide a background on the LBGTI legal landscape – including what constitutes medical necessity and what mandates exist under the federal nondiscrimination employment law of Title VII and Affordable Care Act (ACA). It will discuss the legal issues to be considered in expanding employer-provided health care coverage to LBGTI employees and beneficiaries and how the executive and judicial branches are likely to resolve such issues. It then ends the

2017, the number of employers measured by the CEI increased to 887, which included 327 Fortune 500 business, 102 Fortune 1000 businesses, 156 law firms, and 302 additional major businesses.

⁴ *Id.*

⁵ See Andrew L. Naugle & Susan Philip, *Transgender Healthcare Coverage: Prevalence, Recent Trends, and Consideration for Payers*, MILLIMAN (July 28, 2016), <https://perma.cc/DX2P-LVEP>.

⁶ See Andrew R. Flores, et al. *How Many Adults Identify as Transgender in the United States?*, THE WILLIAMS INSTITUTE (June 2016), <https://perma.cc/QB8R-9RAY>.

article with some best practices for employers to consider in expanding such coverage.

I. BACKGROUND

A. *Glossary of terms*

In the past, most societies regarded terms use such “sex” and “gender” to be synonymous. A person’s sex was assigned at birth as either male or female based on their genitals. In this sense, sex was viewed as a binary concept – only two fixed options – male or female. Recent research in neurology, endocrinology, and cellular biology are pointing to a broader biological basis for determining one’s gender. A 2015 Fusion “Millennial Poll” (referring to individuals aged 18-34) shows more of the millennials regarded gender as a “spectrum” rather than a binary determination.⁷

LGBTI is an acronym used to refer to lesbian, gay, bisexual, transgender/transsexual and intersex individuals. There are four LGBTI concepts that are usually referred to in the literature:

- one’s sex at birth (i.e., female or male);
- one’s gender identity (i.e., one’s internal sense of being a male or female which may or may not be visible to others and which differs from the sex assigned at birth);⁸
- one’s gender expression (i.e., how one person expresses his/her gender identity to others, which could be through dress, hairstyle, voice or body characteristics, to identify one self as more feminine or more masculine);
- sexual orientation (i.e., whether a person whose gender identity is sexually oriented to another person of the same sex): a lesbian as a female-identified person who has homosexual orientation towards other females; a gay as a male-identified person who has homosexual orientation

⁷ See Curtis M. Wong, *50 Percent of Millennials Believe Gender is a Spectrum*, *Fusion’s Massive Millennial Poll Finds*, HUFFINGTON POST (Feb. 2, 2016), <https://perma.cc/S3Z8-728R>.

⁸ The U.S. Department of Health and Human Services defines “gender identity” as “an individual’s internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may differ from an individual’s sex assigned at birth. The way an individual expresses gender identity is frequently called ‘gender expression,’ and may or may not conform to social stereotypes associated with a particular gender. A transgender individual is an individual whose gender identity is different from the sex assigned to that person at birth.” See *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. 96, 31384 (May 18, 2016).

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towards other males; or a bisexual as a female- or male-identified person who has emotional or sexual attraction to person of the same or different sex).

These four concepts have resulted in six different categories of individuals: lesbian, gay, bisexual, transgender/transsexual, intersex, and queer:

- A lesbian is a female-identified person who has homosexual orientation towards other females;
- A gay is a male-identified person who has homosexual orientation towards other males;
- A bisexual is either a female-identified or male-identified person who has sexual orientation towards the same or opposite sex;
- A transgender is a person whose gender identity, gender expression or gender behavior differs from the sex he/she was assigned at birth. Being a transgender person does not imply any special sexual orientation. Thus, a transgender person could have a homosexual, heterosexual, or bisexual orientation. Terms such as Trans male/Trans man/FTM (female to male) refers to a person who is identified as a female at birth now expressing identification as a male; similarly, Trans female/Trans woman/MTF (male to female) refers to a person who is identified as a male at birth now expressing identification as a female.
- A transsexual is a transgender person seeking to transition from male to female or female to male.⁹
- An intersex is a person who has both male and female sex organs and other sexual characteristics.
- A gender-fluid or genderqueer is a person who does not identify with a single fixed gender or sees themselves as being both male and female.

Other helpful vocabulary includes:

- The term “cisgender” refers to a person whose gender identity corresponds with the sex that he/she was identified as having at birth.

⁹ According to the National Center for Transgender Equality, “transgender” is regarded as an adjective and not a noun. Thus, it would be appropriate to refer to “transgender people,” but the term “transgenders” is regarded as inappropriate. See *Transgender Terminology*, NATIONAL CENTER FOR TRANSGENDER EQUALITY (Jan. 2014), <https://perma.cc/J59Z-RG9U>.

- The term “gender non-conforming” is used to describe individuals whose gender expression is different from society’s expectations related to that gender. For example, society does not expect a male individual to be wearing a dress or make-up.
- The term “gender transition” (or “transitioning”) is the process in which a transgender individual begins to live according to his/her internal identification of sex.

Gender transitioning can be a lengthy process. It may begin when the individual decides to make social changes (e.g., coming out to family, friends, and co-workers, hairstyle and clothing changes, using new names and pronouns, and being socially recognized as another gender). To the extent the individual wishes to make these social changes in the work environment, the use of different bathroom facilities becomes an issue for the employer. The transition may also involve legal changes to public documents (e.g., changing one’s name on one’s birth certificate or changing one’s name on a driver’s license and Social Security records). States vary greatly as to how an individual can change his/her gender marker on various documents. Thirty states, plus the District of Columbia, require documentation from a licensed professional in order to change one’s gender marker.¹⁰ Nineteen states mandate onerous proof of clinical treatment to change one’s gender marker; four states have unclear rules and policies regarding gender marker; and twelve states require proof of sex reassignment surgery, court order, and/or an amended birth certificate to change one’s gender marker.¹¹

Medical care provided in transitioning may involve treatments ranging from procedures designed to make the individual look more feminine or more masculine (e.g., electrolysis or shaving one’s Adam’s apple) to undergoing sex reassignment surgery to change one’s genitalia and breasts. What makes the issue confusing is that not all transgender individuals transition in the same way – some are happy with making social changes, but do not find it necessary to make physical changes to their bodies, while others find it critical to make physical changes to have their sex conform with their gender identity.

¹⁰ See *Identity Document Laws and Policies*, MOVEMENT ADVANCED PROJECT (Aug. 30, 2017), <https://perma.cc/RJT9-GHF3>.

¹¹ *Id.*

8 *J. EQUAL RIGHTS & SOCIAL JUSTICE* [Vol. 24: 1*B. What is Transition-Related Medical Care?*

Medical care related to gender transitioning may involve procedures and supplies, such as hormone therapy, mental health services, electrolysis and laser hair removal, and gender confirmation surgery (GCS). Contrary to the norm thinking, there is no single “transgender surgery.” Hormone therapy allows individuals to develop the secondary physical characteristics to reflect their internal gender, which may take years to complete. For Trans women (to go from male to female (MTF)), hormone therapy would involve taking estrogen and anti-androgens to promote breast development; redistribution of body fat and loss of muscle mass; changes in the thickness to body hair; increased skin softness; and decreased libido and fertility. For Trans men, (to go from female to male (FTM)), hormone therapy would involve taking testosterone to produce thicker, oilier skin; increase libido; stop menstrual periods; redistribute body fat and muscle mass; deepen one’s voice; and increase body hair.

Hormone therapy assists transgender individuals in developing the secondary physical characteristics to reflect their gender identity. But to truly change the sex of the individual, gender reassignment surgery or GRS (e.g., mastectomy, gonadectomy, and genital reconstructive surgery) is necessary to change the person’s genitalia and/or chest to reflect their identified gender. Breast augmentation or removal is referred to as “top surgery,” whereas altering of genitals is referred to as “bottom surgery.”

To engage in hormone therapy, most states require a letter from a mental health professional affirming that the individual has gender dysphoria and is in need of such therapy.¹² Gender dysphoria (previously referred to as gender identity disorder or GID) is a psychiatric diagnosis that is “characterized by an incongruence between one’s experienced/expressed gender and assigned sex at birth, and clinically significant distress or impairment of functioning as a result,” and such disparity persists for at least six months.¹³ Being a psychiatric diagnosis, there is no definite medical test to confirm. The condition is associated with “severe and unremitting emotional pain” and without treatment, can lead to anxiety, depression, and other mental health issues, including suicide.¹⁴ To qualify for sex reassignment surgery, the individual must have a persistent, well-documented diagnosis of gender

¹² See generally *Transgender Rights in the United States*, WIKIPEDIA, <https://perma.cc/T8ZK-N7LG>.

¹³ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter *DSM-V*].

¹⁴ *Id.*

dysphoria.

World Professional Association for Transgender Health (WPATH) has developed Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (referred to as the Standards of Care or Benjamin Standards of Care), which are now accepted as authoritative standards of care by the American Medical Association (AMA), the American Psychiatric Association (APA), and the American Psychological Association (APA).¹⁵ WPATH is an international association whose mission is to “promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health.”¹⁶ The Standards of Care indicate that treatment for gender dysphoria is “individualized,” meaning that what works for one person may not be the same as for another person.¹⁷ For individuals with severe gender dysphoria, hormone therapy is usually not enough. According the Standards of Care:

While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria. For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.¹⁸

Many large employers use the WPATH Standards of Care because they are relied upon in the HRC Corporate Equity Index scoring process.¹⁹ Insurance companies also have guidelines as to what medical

¹⁵ WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER-NONCONFORMING PEOPLE: 7TH VERSION (2012), <https://perma.cc/9ZR4-9NNA> [hereinafter *Standards of Care, Version 7*]. Those “Standards of Care” set forth a “triadic” treatment sequence which includes hormonal sex assignment (i.e., cross-gender hormones to effect changes in physical appearance to resemble the opposite sex); “real-life” experience in which the individual has a trial period of living as a member of the opposite sex; and sex reassignment surgery, consisting of genital sex reassignment and/or nongenital sex reassignment (e.g., changes to nose, throat, chin, cheeks, hips so as to produce a better resemblance to a member of the opposite sex).

¹⁶ See *Mission and Values*, WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH (WPATH), <https://perma.cc/7EUE-MAJW>. WPATH was formerly known as the Harry Benjamin International Gender Dysphoria Association (HBIIGDA).

¹⁷ See Standards of Care, Version 7, *supra* note 15, at 5 (“What helps one person alleviate gender dysphoria might be very different from what helps another person”).

¹⁸ *Id.* at 54-55.

¹⁹ To achieve ten points out of the total 100 points under the 2017 CEI, an employer must extend medical benefits to transgender individuals, including for service related to transgender transition (e.g., medically necessary services related to sex reassignment, hormone replacement therapies, medical visits and laboratory services, in accordance with the WPATH guidelines). Other barriers to coverage must also be eliminated: no separate dollar maximums or deductibility applicable to the coverage of sex reassignment surgeries and related procedures; if the provider network does not have adequate specialists, out-of-network providers must be covered at in-

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treatment will be covered under their insurance policies. Employers fully insuring their group medical benefits would be subject to such standards.

II. THE HEALTHCARE CONTEXT

A. *Group Health Plan Issues*

Employee Retirement Income Security Act (ERISA) is the federal law that regulates most employer's employee benefit plans – retirement and welfare plans. While it imposes some specific rights and benefits for the spouse of a plan participant in the retirement plan context (e.g., joint and survivor annuities as the normal form of payment for payments under a pension plan for married participants), it imposed no such mandates in the context of group health and welfare benefit plans.²⁰ ERISA has a broad preemption clause to preempt state laws that attempt to interfere with its rules, but it exempts state insurance laws as they relate to employee benefit plans.²¹ Pre-Windsor, some state insurance laws required that same-sex spousal coverage be offered under an insured group health plan if opposite-sex spousal coverage was offered. The question then turned on whether the group health plan in question was insured or self-insured. Now that all fifty states must recognize same-sex marriages, as a result of the Obergefell decision, the rights and protections for same-sex spouses under state law must continue to be protected under insured plans.

ERISA's Title II amended sections of the Internal Revenue Code to provide tax preferences to certain employee benefits. In the context of health plans provided through an employer, the Code excludes from taxation the cost of the employer-provided coverage and any reimbursements for medical costs to the employee and his/her dependents.²² The Windsor decision extended this exclusion from taxation for employer contributions for health coverage and plan

network rates, including coverage of travel and lodging expenses to such specialists; no other serious limitations (e.g., limiting the number of surgeries or excluding reversals of sex reassignment surgeries). There are five criteria in which an employer is evaluating for purposes of the 100 points: 35 points for equal employment opportunities policies; 30 points for employee benefits; 10 points for organizational LGBT competency; and 25 points for public commitment to LGBT-specific efforts. See HUMAN RIGHTS CAMPAIGN FOUNDATION, *supra* note 3, at 14, 16-18.

²⁰ 29 U.S.C. §1055(e) (2014); I.R.C. §401(a)(11)(A)(ii) (2014).

²¹ 29 U.S.C. §1144 (2006).

²² I.R.C. §105(c) (2015) (permitting a federal exclusion from the employee's income for coverage of the taxpayer's spouse or dependent).

reimbursements for benefits which covered a same-sex spouse.²³ As will be discussed below, such exclusion presumes that the coverage and reimbursements qualified as “treatments” that are “medically necessary” pursuant to the standards of IRC section 213. Similarly, an employer may take a federal tax deduction for premiums paid for group health insurance or for medical reimbursements paid from a self-insured group health plan.²⁴

B. Employer’s Health Plan Issues

In the context of coverage for transgender employees under an employer-provided group health plan, three issues emerge:

Whether benefits for medical services and supplies relating to gender transition can be denied on the basis that they are not medically necessary for a person of the employee’s gender as noted in the plan administrator’s record;

Whether the plan may simply have a blanket exclusion for benefits for medical services and supplies relating to gender transition; and

Whether the plan may have blanket exclusion for non-transition related care that would have an indirect impact on transgender employees. For example, the plan should continue to cover surgery unique to a male (e.g., prostate surgery) for a woman that has transitioned from being a male to a female but continues to retain the male body parts. The use of gender codes to reflect the employee’s transition eliminates this confusion for the plan administrator.

While ERISA is silent on these issues, one must look to enforceable federal law that would apply in the self-insured group health context or state law in the fully insured context to ascertain the answers to these questions. Normally one would look to health insurance claims data as a source of information as to whether transgender individuals are utilizing specific healthcare services if made available to them. However, current claims-based information is not a reliable estimate as to the number of individuals who are transgender, who have gender dysphoria, and related health care utilization. Milliman conducted a study of claims data covering 2 million lives over a four-year period (2009 to 2012) and discovered only 0.04% of the members had an insurance claim related to gender dysphoria.²⁵ This represents only a very small portion of the number of individuals self-reporting themselves as transgender in the BRFSS survey. Ten states

²³ Rev. Rul. 2013-17 (2013).

²⁴ I.R.C. §§106, 162 (2016).

²⁵ See Naugle & Philip, *supra* note 5.

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(California, Colorado, Connecticut, Delaware, Illinois, Massachusetts, New York, Oregon, Vermont, and Washington) and Washington, D.C. prohibit categorical exclusions of transition-related medical care for insured plans within those states.²⁶ Eight states (California, Connecticut, Maryland, Massachusetts, Minnesota, New York, Oregon, and Washington), plus the District of Columbia, require coverage of transgender benefits for their state employee health plans.²⁷ Twelve states require gender transition health benefits for their Medicaid populations.²⁸

C. Medical Necessity

Transgender participants or beneficiaries under an employer-provided group health plan will undoubtedly seek medical and/or psychological treatment for their transitioning covered by the plan. Most group health plans offered by employers cover benefits for services or supplies that are “medically necessary”, thereby excluding those deemed to be cosmetic in nature. What is “medically necessary” is usually defined by the plan as reasonable and necessary services or supplies for diagnosis or treatment of an illness or injury. However, courts and administrative bodies have been recognizing that medical transition-related services and supplies for gender dysphoria are now acceptable medical treatments, in a variety of different contexts.²⁹

²⁶ See *Transgender Healthcare*, HUMAN RIGHTS CAMPAIGN (Aug. 22, 2017), <https://www.hrc.org/state-maps/transgender-healthcare>.

²⁷ *Id.*

²⁸ *Healthcare Laws and Policies*, MOVEMENT ADVANCEMENT PROJECT (July 12, 2016), http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies.

²⁹ *O'Donnabhain v. Commissioner*, 134 T.C. 34 (T.C. 2010) (holding that hormone therapy and sex reassignment surgery were “for the . . . treatment . . . of” disease for purposes of I.R.C. §§213(d)(1)(A) and (9)(B) and not “cosmetic surgery” excluded from the definition of “medical care” under I.R.C. §213(d)(9)(A)); *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) (allowing the payment of Medicaid funds for the petitioner’s sex reassignment surgery as it was medically necessary); *Norsworthy v. Beard*, 87 F.Supp.3d 1164 (N.D.Cal. 2015) (granting transgender plaintiff’s motion for a preliminary injunction to have the California Department of Corrections and Rehabilitation provide access to adequate medical care, including sex reassignment surgery); HHS Appeals Board: DHHS Medicare NHD 140.3 re: Transsexual Surgery (Docket No., A-13-87, Doc’n No. 2576, May 30, 2014), (permitted Medicare coverage of transsexual surgery). *But see Mario v. P&C Markets, Inc.*, 313 F.3d 758 (2d Cir. 2003) (where plaintiff provided little evidence to show medical necessity for gender reassignment surgeries).

III. THE LEGAL CONTEXT

A. Federal Income Tax Context

I.R.C. §§105, 106 and 3121(a)(2) exempt from employer payroll and federal individual income tax amounts that an employee or his/her dependents received for medical care under employer-provided accident and health plans. Similarly, IRC §213 provides an individual taxpayer with a deduction from federal income taxes for expenses for medical care for the taxpayer, his/her spouse, or dependent that is not covered by insurance and that exceeds 7.5% of the taxpayer's adjusted gross income. Those tax exclusions refer to medical care as defined in IRC §213(d)(1).³⁰ That definition includes amount paid for the diagnosis, cure, mitigation, treatment, or prevention of a disease or for the purposes of affecting any function of the body.³¹ It specifically excludes costs associated with cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to correct a deformity that existed at birth or resulted from an accident of trauma.³² In contrast, cosmetic surgery is defined as any procedure designed to improve a patient's appearance and which does not meaningfully promote the proper function of the body or prevent or treat illness of disease.³³

The issue of the federal income taxation of medical care related to treatment for gender dysphoria was discussed in the 2010 Tax Court case of *O'Donnabhain v. Comm'r*.³⁴ At issue was whether hormone therapy, sex reassignment surgery, and breast augmentation surgery qualified for a medical expense deduction under IRC §213. Under the facts of the case, O'Donnabhain was born a genetic male with "unambiguous male genitalia," but was "uncomfortable" in that role since childhood.³⁵ As an adult, he married and fathered three children.³⁶ After his marriage ended, O'Donnabhain's feelings to be female increased and became more persistent, leading him to commence psychotherapy sessions.³⁷ After 20 weekly sessions, his therapist who was a licensed independent clinical social worker (LICSW) and psychotherapist diagnosed him with severe gender identity disorder

³⁰ See I.R.C. § 105(b) (2015) (referencing medical care as defined in § 213(d)).

³¹ I.R.C. § 213(d)(1)(A) (2017).

³² I.R.C. § 213(d)(9)(A) (2017).

³³ I.R.C. § 213(d)(9)(B) (2017).

³⁴ See *O'Donnabhain*, *supra* note 29, at 53.

³⁵ *Id.* at 35.

³⁶ *Id.*

³⁷ *Id.* at 35-36

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(GID).³⁸ Following the WPATH Standards of Care (previously referred to as the Benjamin Standards of Care), his therapist referred him to an endocrinologist for feminizing hormone therapy which resulted in positive effects for him.³⁹ O'Donnabhain then presented herself in public as a female, changed her name, and changed her gender designation and name on her driver's license.⁴⁰ She underwent surgery to feminize her face and also presented herself as a female at work.⁴¹

Due to her anxiety over her male genitalia, her therapist concluded that her prognosis without sex reassignment surgery was "poor," and thus, referred O'Donnabhain to a board-certified plastic and reconstructive surgery.⁴² A second licensed psychotherapist examined O'Donnabhain and offered a second recommendation for her sex reassignment surgery, noting that the petitioner "appears to have significant breast development secondary to hormone therapy."⁴³ The referral surgeon agreed that the petitioner was a good candidate for sex reassignment surgery, commenting in his notes that "examination of her breasts reveal [sic] approximately B cup breasts with a very nice shape."⁴⁴ The surgeon then performed sex reassignment surgery on the petitioner, as well as breast augmentation surgery so as to "more closely resemble the breasts of a genetic female."⁴⁵ O'Donnabhain then claimed the expenses associated with her hormone therapy, sex reassignment surgery, and breast augmentation surgery as an itemized deduction on her tax return.⁴⁶

The Tax Court held that expenses for hormone therapy and sex reassignment surgery for gender transition were deductible medical care expenses under I.R.C. § 213, as they were incurred in treating a disease or illness.⁴⁷ In determining whether gender identity disorder (GID) was a "disease" for purposes of I.R.C. § 213, the court cited two case law

³⁸ *Id.* at 36. THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 2000 text revision) [hereinafter *DSM-IV-TR*], published by the American Psychiatric Association advocates a diagnosis of GID if the "individual exhibits (1) a strong and persistent desire to be, or belief that he or she is, the other sex; (2) persistent discomfort with his or her anatomical sex, including a preoccupation with getting rid of primary or secondary sex characteristics; (3) an absence of any physical intersex (hermaphroditic) condition; and (4) clinically significant distress or impairment in social, occupational, or other important areas of functioning as a result of the discomfort arising from the perceived incongruence between anatomical sex and perceived gender identity." See *DSM-IV-TR* at 581.

³⁹ *O'Donnabhain*, 134 T.C. at 39.

⁴⁰ *Id.* at 39-40.

⁴¹ *Id.* at 40.

⁴² *Id.*

⁴³ *Id.* at 41.

⁴⁴ *Id.*

⁴⁵ *O'Donnabhain*, *supra* note 29 at 41.

⁴⁶ *Id.* at 42.

⁴⁷ *Id.* at 55.

factors used in finding a “disease” in the context of mental conditions: (1) a mental health professional’s finding that the “condition created a significant impairment to normal functioning, warranting treatment”⁴⁸ or (2) a listing of the condition in a medical reference text.⁴⁹ The court then noted that transition-related medical care was now recognized in DSM, the primary diagnostic tool of American psychiatry, as a diagnosis referred to as gender dysphoria.⁵⁰ The court also referenced WPATH’s Standards of Care, noting that they were recognized as authoritative by the American Medical Association, the American Psychiatric Association, and the American Psychological Association.⁵¹ The court held that GID was a “serious, psychologically debilitating condition,” and that the plaintiff’s condition according to the experts who testified was “severe” under the DSM-IV-TR standards.⁵² Given the testimony of her mental health professionals and the recognition of GID in diagnostic and other medical texts, the court held GID was a “disease” under IRC §213.⁵³

To counter the respondent’s assertion that GID was not a significant psychiatric disorder, the Tax Court also noted that seven of the U.S. Courts of Appeals rulings had held that severe GID was a “serious medical need” for purposes of the Eighth Amendment, which requires prisoners to receive adequate medical care.⁵⁴ It also noted that no U.S. Courts of Appeals have held otherwise.⁵⁵ It also cited to cases that held sex reassignment surgery was not “cosmetic surgery” for

⁴⁸ *Id.* at 55-57 (citing *Fay v. Comm’r*, 76 T.C. 408 (1981); *Jacobs v. Comm’r*, 62 T.C. 813 (1974); *Fischer v. Comm’r*, 50 T.C. 164 (1968); *Hendrick v. Comm’r*, 35 T.C. 1223 (1961)).

⁴⁹ *Id.* (citing *Starrett v. Comm’r*, 41 T.C. 877 (1964)).

⁵⁰ See *Danaipour v. McLarey*, 286 F.3d 1, 17 (1st Cir. 2002) (characterizing the DSM as the “leading psychiatric diagnostic manual”). See WORLD HEALTH ORGANIZATION INTERNATIONAL CLASSIFICATION OF DISEASES (10th rev.) (classifying gender dysphoria as “a serious medical condition”) and DSM-V, *supra* note 13.

⁵¹ *Norsworthy v. Beard*, 87 F.Supp. 3d 1164, 1170-71 (N.D. Cal. 2015) (noting that the standards “address a variety of therapeutic options, including changes in gender express and role, hormone therapy, surgery, and psychotherapy”).

⁵² See *O’Donnabhain*, *supra* note 29 at 61.

⁵³ *Id.*

⁵⁴ *Id.* at 62 (citing *Delonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003); *Allard v. Gomez*, 9 Fed. Appx. 793, 794 (9th Cir. 2001); *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir. 2000); *Brown v. Zavaras*, 63 F.3d 967, 970 (10th Cir. 1995); *Phillips v. Mich. Dept. of Corr.*, 932 F.2d 969 (6th Cir. 1991), *aff’g* 731 F.Supp. 792 (W.D. Mich. 1990); *White v. Farrier*, 849 F.2d 322, 325-27 (8th Cir. 1988); *Meriwether v. Faulkner*, 821 F.2d 408, 411-13 (7th Cir. 1987); *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997) (stating that gender dysphoria was a “profound psychiatric disorder”).

⁵⁵ *Id.* However, an en banc court of appeals has recently held that denial of sex reassignment surgery did not result in a deprivation of constitutional rights for purposes of the Eighth Amendment. *Kosilek v. Spencer*, 774 F.3d 63, 106 (1st Cir. 2014) (en banc), *cert. denied sub nom. Kosilek v. O’Brien*, 135 S.Ct. 2059, 191 L. Ed. 2d 958 (2015).

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purposes of State Medicaid statutes.⁵⁶

The court then moved on to the question of whether cross-gender hormone therapy, sex reassignment surgery, and breast augmentation surgery “[treated]” GID within the meaning of I.R.C. §§ 213(d)(1)(A) and (9)(B). Under the WPATH “Standards of Care,” hormone therapy, sex reassignment surgery, and under certain circumstances, breast augmentation surgery are prescribed treatments for GID.⁵⁷ In cases of severe GID, the court accepted the petitioner’s expert opinion that sex reassignment surgery was the only known effective treatment, as it was supported by several psychiatric reference texts.⁵⁸ Thus, the court affirmed that hormone therapy and sex reassignment surgery were “well recognized and accepted” treatments for severe GID and thus “treated” the disease within the meaning of I.R.C. § 213(d)(9)(B).⁵⁹

But the Tax Court held that the petitioner failed to show why breast augmentation surgery “treated” GID and thus denied the deductibility of those expenses.⁶⁰ The WPATH “Standards of Care” recommended breast augmentation surgery for a male-to-female patient if the physician determines that “breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social gender role.”⁶¹ As the record indicated the petitioner’s breasts before surgery were “within a normal range of appearance” and that there was no documentation regarding the petitioner’s comfort level with those breasts “in the social gender role.”⁶² Thus, the court held that the breast augmentation surgery did not “treat” GID within the meaning of I.R.C. § 213, and was merely to improve her appearance (i.e., cosmetic in nature).⁶³ Consequently, it was excluded from deductible “medical care.”⁶⁴ This case illustrates that the determination of whether breast augmentation surgery was medically necessary turned on the facts of the individual case.

While not an issue in this case, if an employer were to provide medical coverage for services or supplies related to gender transition to its employees, spouse or dependents based on the WPATH Standards of

⁵⁶ *Id.* at 71 (citing *G.B. v. Lackner*, 80 Cal. App. 3d 64, 145 Cal. Rptr. 555, 559 (Ct. App. 1978); *Davidson v. Aetna Life & Cas. Ins. Co.*, 101 Misc. 2d 1, 420 N.Y.S.2d 450, 453 (N.Y. Sup. Ct. 1979)). *But see Smith v. Rasmussen*, 249 F.3d 755, 759-61 (8th Cir. 2001) (denying reimbursement of sex reassignment surgery under the State Medicaid plan as such surgery was “cosmetic” and alternate GID treatments were available).

⁵⁷ *See O’Donnabhain*, *supra* note 29 at 65.

⁵⁸ *Id.* at 68-69.

⁵⁹ *Id.*

⁶⁰ *Id.* at 83.

⁶¹ *Id.*

⁶² *Id.* at 72-73.

⁶³ *See O’Donnabhain*, *supra* note 29 85.

⁶⁴ *Id.* at 73.

Care, the gross income exclusion provided to employees for such coverage under I.R.C. §§ 105 and 106 should apply as those provisions explicitly cross-reference the same definition of medical care in I.R.C. § 213(d). Thus, if such coverage followed the protocol of the WPATH Standards of Care, there should be no income tax consequences for transitioning individuals for such medical services and supplies. However, the WPATH Standards of Care do not automatically recommend breast augmentation surgery for Trans Females, but instead require the physician prescribing the hormones and the surgeon document that breast enlargement after 18 months of hormone therapy was not sufficient “for comfort in the social gender role.”⁶⁵ Similarly, an employer would be entitled to a tax deduction for the premiums it pays for group health insurance that is medically necessary or for the benefits paid from a self-insured group health insurance that used a medically necessary standard for payment.

B. Medicaid and Medicare Context

In the 1992 case of *M.K. v. Division of Medical Assistance and Health Services*, M.K. requested the New Jersey Medicaid Program authorize her phalloplastic surgery (i.e., surgery to construct a penis and scrotum for a female-to-male transition) in order for her to become a male transsexual.⁶⁶ Such surgery had been denied by the state through its Chief Psychiatric Consultant, on the ground that it funded only services “medically required for diagnosis or treatment of a disease”⁶⁷ and that the surgery in question was “experimental and/or cosmetic and no an essential part of gender alteration.”⁶⁸ In affirming an Administrative Law Judge’s order, the Director of the Division of Medical Assistance and Health Services held in favor of the petitioner, M.K. Finding no New Jersey case law on Medicaid coverage of sex reassignment surgery, it turned to the Eighth Circuit opinion of *Pinneke v. Presisser* in which the court held that Iowa’s absolute exclusion of sex reassignment surgery from its Medicaid plan was an arbitrary denial of benefits determine solely on this particular “diagnosis, type of illness, or condition.”⁶⁹ It affirmed that court’s reasoning that sex reassignment surgery is the “only medical treatment available to treat a true

⁶⁵ *Id.* at 39.

⁶⁶ *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, 1991).

⁶⁷ *Id.* at *4 (citing the New Jersey statute N.J.A.C. 10:49—1.5 (2010)).

⁶⁸ *Id.* at *5.

⁶⁹ *Pinneke v. Presisser* 623 F.2d 546, 549 (8th Cir. 1980) (citing *Doe v. Minnesota Department of Public Welfare*, 257 N.W.2d 816, 820 (Minn. 1977)).

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transsexual.”⁷⁰ Thus, it held that the decision as to whether this surgery was “medically necessary” turned on the opinion of the treating physician, not government officials.⁷¹ As a result of the testimony of M.K. treating physicians that supported the concept of phalloplastic surgery and the fact that the petitioner was a good candidate for the procedure, the Director held that it was medically necessary and should be covered under Medicaid.⁷²

In a May 2014 decision from the Department of Health and Human Service (HHS) Appeals Board, the agency reversed its National Coverage Determination (NCD), which had denied Medicare coverage of all transsexual surgery under its “reasonableness standard.”⁷³ An NCD is a finding by HHS as to whether a service or supply is covered by Medicare, which bars payment for services or supplies “not reasonable and necessary for the diagnosis or treatment of illness or injury.”⁷⁴ In its prior determinations, the HHS regarded transsexual surgery as “experimental” in nature due to the lack of long-term studies and the high rate of serious complications resulting from such procedures.⁷⁵ However, due to the DSM-IV-TR’s characterization of transsexualism as a diagnosed medical condition, this evidence has been rebutted.⁷⁶ The new evidence also indicated that such surgery was safe. This decision is further precedent that transition-related medical treatment for gender dysphoria is medically necessary.

C. Cruel and Unusual Treatment for Purposes of the Eighth Amendment

The Tax Court in the *O’Donnabhain* decision referenced the U.S. Courts of Appeals rulings that held that severe GID was a “serious medical need” for purposes of the Eighth Amendment. The *Norsworthy*

⁷⁰ *M.K. v. Division of Medical Assistance and Health Services*, supra note 66 at *4 (N.J. Adm. May 7, 1991).

⁷¹ *Id.* at *8.

⁷² *Id.* at *9.

⁷³ DHHS Medicare NCD 140.3, Transsexual Surgery (Docket No. A-13-87, Doc’n No. 2576, May 30, 2014).

⁷⁴ *Id.* (citing section 1862(a)(1)(A) of the Social Security Act, 42 U.S.C. § 1395y(a)(1)(A) (2016)).

⁷⁵ *Id.* (citing to a 1981 report by the former National Center for Health Care Technology of the HHS Public Health Service as to the safety and effectiveness of transsexual surgery).

⁷⁶ *Id.* (quoting the DSM’s description of GID as “a persistent discomfort with one’s assigned sex and with one’s primary and secondary sex characteristics, which causes intense emotional pain and suffering” and “if left untreated, can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death”).

*v. Beard*⁷⁷ case from the Northern District of California is illustrative of these rulings. In that case, the plaintiff was a transsexual woman who was incarcerated at a state prison in California beginning in 1987 under a sentence of seventeen years to life.⁷⁸ She began to identify herself as a transsexual woman in the mid-1990s and was diagnosed with gender dysphoria in January 2000.⁷⁹ She notified the prison staff as early as 1996 that she sought to have hormone treatment and an eventual vaginoplasty, which is the definitive male-to-female sex reassignment surgery.⁸⁰ She did receive years of hormone therapy and counseling; by 2012, her treating psychologist recommended sex reassignment surgery as being a “clinical and medical necessity for her health and well-being.”⁸¹ A physician with expertise in transgender patients recommended that Norsworthy, who by then had contracted hepatitis C due to a prison rape, discontinue the long-term use of hormone therapy due to its effect on her liver function.⁸² Noting that removal from hormone therapy would worsen Norsworthy’s gender dysphoria, which could result in serious depression, thoughts about suicide, or self-harm, her physician thought sex reassignment surgery would reduce these risks. It was not until Norsworthy learned about the *Kosilek*⁸³ decision, which granted an injunction to inmate Michelle Kosilek whereby the Massachusetts Department of Corrections was required to provide sex reassignment surgery for a prisoner with severe gender dysphoria, that she submitted a Patient/Inmate Health Care Appeal, seeking “adequate and sufficient medical care” for her gender dysphoria, including sex reassignment surgery.⁸⁴ That appeal was denied after three levels of review. Dr. Raymond Coffin, a psychologist assigned to the third level of appeal, concluded that the documentation available in Norsworthy’s case did not indicate that sex reassignment surgery was “medically necessary,” as required by the California Department of Corrections and Rehabilitation (CDCR) regulations.⁸⁵

Due to the denial, Norsworthy filed for a preliminary injunction requiring the defendants to provide her sex reassignment surgery on the grounds that the defendants violated 42 U.S.C. § 1983 by denying her medically necessary treatment for gender dysphoria in violation of the

⁷⁷ *Norsworthy v. Beard*, 87 F.Supp.3d 1164 (N.D.Cal. 2015).

⁷⁸ *Id.* at 1169-70.

⁷⁹ *Id.* at 1170.

⁸⁰ *Id.* at 1172.

⁸¹ *Id.* at 1172-73.

⁸² *Id.* at 1173.

⁸³ *Kosilek v. Spencer*, 889 F. Supp. 2d 190 (D. Mass. 2012), *aff’d*, 740 F.3d 733 (1st Cir. 2014), *rev’d en banc*, 774 F.3d 63 (1st Cir. 2014).

⁸⁴ See *Norsworthy v. Beard*, *supra* note 77 at 1173-74.

⁸⁵ *Id.* at 1175-76.

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Eight Amendment’s prohibition against cruel and unusual punishment and the Fourteenth Amendment’s Equal Protection Clause.⁸⁶ To prevail on the merits of “unnecessary and wanton infliction of pain” proscribed by the Eighth Amendment, the U.S. Supreme Court in *Estelle v. Gamble* requires a showing of a deliberate indifference to the serious medical needs of a prisoner.⁸⁷ In the Ninth Circuit, this requires the petitioner (1) to show a serious medical need that could result in future injury or wanton infliction of pain and (2) a purposeful act or failure to respond by the defendants to the prisoner’s pain or medical need and the harm associated by such indifference.⁸⁸

The court held that Norsworthy was likely to succeed in showing a serious medical need. Dr. Ettner, an expert retained by Norsworthy, testified that Norsworthy exceeded the WPATH criteria for surgery and criticized Coffin’s evaluation as it revealed “a profound misunderstanding of, and lack of scientific information regarding, the nature, assessment, and treatment of gender dysphoria.”⁸⁹ A second expert retained by Norsworthy concurred with Dr. Ettner and stated that, based on her medical records, she met the criteria established by the WPATH Standards of Care for sex reassignment surgery as a medically necessary treatment.⁹⁰ The defendant’s expert remarked that Norsworthy was unable to fulfill the Standard of Care that required her to live in society as a woman for at least one year prior to surgery due to her incarceration and regarded this surgery “always an elective procedure.”⁹¹ But the court rejected the defendant’s arguments as the evidence supported a conclusion that Norsworthy’s untreated symptoms of gender dysphoria can be a serious medical need.⁹² The court criticized the opinion of the defendant’s expert as he misrepresented the Standards of Care and made generalizations regarding gender dysphoric prisoners, as opposed to making an individualized assessment of Norsworthy.⁹³ The evidence also alluded that the surgery was denied due to CDCR’s blanket exclusion for sex reassignment surgery for a transgender prisoner.⁹⁴

In this decision, the district court affirms the use of the Standards of Care in determining what is “medically necessary” for the treatment

⁸⁶ *Id.* at 1180-81.

⁸⁷ *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

⁸⁸ See *Norsworthy v. Beard*, *supra* note 77 at 1185-86 (citing to the Ninth Circuit’s opinion in *Jett v. Penner*, 439 F.3d 109, 1096 (9th Cir. 2006)).

⁸⁹ *Id.* at 1186-87.

⁹⁰ *Id.* at 1186.

⁹¹ *Id.* at 1179.

⁹² *Id.* at 1189.

⁹³ *Id.* at 1192.

⁹⁴ *Id.* at 1191.

of transgender patients.⁹⁵ It also shows the importance of applying those standards to the individual in question with respect to his/her serious medical needs. This court rejected the use of blanket exclusions and the theory that sex reassignment surgery is always elective in nature.⁹⁶

D. ERISA Context

In contrast, the Second Circuit in *Mario v. P&C Food Markets, Inc.*,⁹⁷ upheld the denial of an ERISA claim by a plan administrator for gender reassignment services or procedures. A female employee, Margo Mario, suffered from gender dysphoria and transsexualism and began the transition process from female to male (from Margo to Marc).⁹⁸ After receiving hormone therapy and a bilateral mastectomy, the employee sought reimbursement from the employer's self-funded health plan. The plan administrator denied coverage on the grounds that such services were not "medically necessary," as required by the plan document, and stated that any future claims for services related to gender reassignment would also be denied.⁹⁹ Mario filed suit against the employer for violations under ERISA, Title VII, and New York state law.¹⁰⁰

As to the ERISA claim, the court made a distinction as to who had the burden of proof, which depended upon the wording of the plan. To the extent "medical necessity" was required for entitlement to the benefit under the plan, the burden of proof would be on the plan participant. In contrast, if the lack of medical necessity is found in the "exclusions" section of the plan, the burden of proof would be upon the plan sponsor.¹⁰¹ Such a distinction was not "particularly helpful" in this case as "medical necessity" was required in the "summary of benefits" section and in the "exclusions" section of the plan. Thus, the court concluded that "[U]nless the contrary is specified," the phrase "medical necessity" would refer to what was medically necessary "for a participant patient," which involved an assessment as to what would be suitable for this individual.¹⁰² If the plan administrator could demonstrate that "in the ordinary case," the treatment was not medically necessary, then the patient has the burden of showing his/her case is

⁹⁵ *Id.* at 1170-72.

⁹⁶ *Id.* at 1187.

⁹⁷ *Mario v. P&C Food Mkts., Inc.*, 313 F.3d 758, *passim* (2d Cir. 2002).

⁹⁸ *Id.* at 761-62.

⁹⁹ *Id.* at 762.

¹⁰⁰ *Id.* at 762-63.

¹⁰¹ *Id.* at 765.

¹⁰² *Id.*

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“the extraordinary one necessitating the treatment.”¹⁰³

The court held that the plan administrator had conducted a substantial investigation as to whether such claims were eligible for payment, doing research on the issue of transsexuals, inquiring into the policies of other employers and insurers regarding such coverage, consulting with medical centers specializing in transsexualism and sexual reassignment surgeries, and talking with medical personnel employee of the plan administrator (including a psychiatrist who viewed sex reassignment for the treatment of gender dysphoria as cosmetic in nature).¹⁰⁴ Thus, the court determined that the plaintiff had not refuted evidence to contradict the plan administrator’s determination that “there was substantial disagreement in the medical community about whether gender dysphoria was a legitimate illness and uncertainty as to the efficacy of reassignment surgery.”¹⁰⁵ As such, the plaintiff’s case was no different than an ordinary case and thus the ERISA denial for benefits would survive a *de novo* standard of review.¹⁰⁶

The controversy regarding treatment for gender dysphoria that the Second Circuit was referring to arguably has been rebutted since 2002. The American Medical Association (AMA) issued a resolution in 2008, declaring its support for public and private health insurance coverage for the treatment of GID as there was sufficient medical research that proved the medical necessity of mental health therapy, hormone therapy and sex reassignment surgery.¹⁰⁷ In its resolution, it states “GID, if left untreated, can result in clinically significant psychological distress, dysfunction, debilitation, depression and, for some people without access to appropriate medical care and treatment, suicidality and death.”¹⁰⁸ Likewise, the American Psychiatric Association (APA) regards the treatment of gender transition surgeries as being medically necessary and therefore recommends their coverage by public and private insurers.¹⁰⁹ The APA also opposes categorical exclusions of

¹⁰³ *Id.*

¹⁰⁴ *Id.* at 765-66.

¹⁰⁵ *Id.* at 766.

¹⁰⁶ *Id.*

¹⁰⁷ *Resolution on Removing Financial Barrier to Care for Transgender Patients*, AM. MED. ASS’N, <https://perma.cc/ZF26-DBS9> (“An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID . . . Therefore, be it resolved that the AMA supports public and private health insurance coverage for treatment of gender identity disorder.”).

¹⁰⁸ *Id.*

¹⁰⁹ *Policy on Transgender, Gender Identity, & Gender Expression Non-Discrimination*, AM. PSYCHOL. ASS’N, <http://www.apa.org/about/policy/transgender.aspx> (“APA recognizes the efficacy, benefit and medical necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments”).

coverage for such medically necessary treatment when prescribed by a physician.¹¹⁰ The WPATH affirms that medical procedures to confirm the gender that the individual identifies with are not “cosmetic” or “elective” or “for the mere convenience of the patient.”¹¹¹

While these policies refute the argument that gender reassignment is not “medically necessary,” the Mario case may provide a hurdle for transsexual individuals to the extent they need to establish that their case is exceptional (i.e., different than the ordinary case).

If the group health plan is insured, ERISA does not preempt state insurance law and some state insurance laws prohibit exclusions for transition-related care under their gender nondiscrimination laws. For example, California’s Insurance Gender Nondiscrimination Act prohibits discrimination on the basis of “sex” which “includes a person’s gender identity and gender expression. “Gender expression” means a person’s gender related appearance and behavior whether or not stereotypically associated with a person’s assigned sex at birth.”¹¹² Similarly, the Department of Insurance, Securities and Banking of Washington, D.C., issued a bulletin highlighting that the D.C. statute prohibiting discrimination in health insurance includes discrimination based on gender identity or expression.¹¹³ Connecticut mandates that “medically necessary services related to gender dysphoria should not be handled differently from medically necessary services for other medical and behavioral health conditions.”¹¹⁴ Other states with similar prohibitions include Colorado, Delaware, Illinois, Massachusetts, New York, Nevada, Oregon, Vermont, and Washington.¹¹⁵

¹¹⁰ JACK DRESCHER ET AL., AM. PSYCHIATRIC ASS’N, POSITION STATEMENT ON ACCESS TO CARE FOR TRANSGENDER AND GENDER VARIANT INDIVIDUALS (2012), <https://perma.cc/K8UR-MW23> (“The American Psychiatric Association (1) [r]ecognizes that appropriately evaluated transgender and gender variant individuals can benefit greatly from medical and surgical transition treatments, (2) [a]dvocates for removal of barrier to care and supports both public and private health insurance coverage for gender transition treatment, (3) [o]pposes categorical exclusions of coverage for much medically necessary treatment when prescribed by a physician.”)

¹¹¹ WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, POSITION STATEMENT ON MEDICAL NECESSITY OF TREATMENT, SEX REASSIGNMENT, AND INSURANCE COVERAGE IN THE U.S.A. (2016), <https://perma.cc/GM8S-GSS4> (“The medical procedures attendant to gender affirming/confirming surgeries are not ‘cosmetic’ or ‘elective’ or ‘for the mere convenience of the patient.’ These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition. In some cases, such surgery is the **only** effective treatment for the condition, and for some people genital surgery is essential and life-saving.” (emphasis in original)).

¹¹² Cal. Ins. Code § 10140 (2012).

¹¹³ See Chester A. McPherson, Interim Commissioner, *Bulletin 13-IB-01-30/15 (Revised)* (Feb. 27, 2014), <https://perma.cc/SJ8W-6UR5>.

¹¹⁴ State of Conn. Ins. Dep’t, Bulletin IC-34, “Gender Identity Nondiscrimination Requirements,” (Dec. 19, 2013).

¹¹⁵ See *Transgender Healthcare*, HUMAN RIGHTS CAMPAIGN (Aug. 22, 2017), <https://www.hrc.org/state-maps/transgender-healthcare>.

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Similarly, a federal district court upheld the plan administrator's denial of a transgender participant's claim for short-term disability benefits following breast augmentation surgery related to transitioning from male to female.¹¹⁶ The plaintiff, Charlyze Marie Baker, transitioned from male to female, first undergoing hormone replacement therapy which was covered under her employer's ERISA health plan.¹¹⁷ As a result of the hormone therapy, Baker developed size B-C breasts, but decided to undergo breast augmentation surgery (i.e., implant surgery).¹¹⁸ Baker then sought benefits from the plan administrator, Aetna, from the employer's short-term disability plan for post-surgery recovery. The plan administrator denied the claim on the grounds that her surgery was not caused by an illness, injury, or pregnancy-related condition, as required under the plan for benefits.¹¹⁹ Thus, the plan administrator held that Baker's breast augmentation surgery was not medically necessary to treat gender dysphoria because she had already developed average-size female breasts as a result of the hormone therapy, making the surgery unnecessary.¹²⁰ It noted that hormone replacement therapy allowed people transitioning from male to female to grow breasts, while no similar alternative existed for people transitioning from female to male. The court affirmed Aetna's interpretation of the ERISA plan to be legally correct, and not an abuse of its discretion, noting that Baker's initial claim described the surgery as cosmetic and that Aetna had not treated male-to-female transitions any differently from Baker's situation.¹²¹

These ERISA cases illustrate the difficulty plan participants and beneficiaries may have in challenging medical necessity denials by plan administrators. ERISA cases require the plaintiff to exhaust the plan's internal claim procedures before proceeding to court for recovery of benefits.¹²² The goal is to avoid premature judicial intervention.¹²³ Thus, it is critical for the participant or beneficiary to have a complete medical

¹¹⁶ *Baker v. Aetna*, 260 F.Supp.3d 694, 2017 WL 1881309 (N.D. Tex. May 9, 2017).

¹¹⁷ *Id.* at *1.

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.* at *4.

¹²¹ *Id.* at *5; *Baker v. Aetna*, 260 F.Supp.3d 694 (N.D. Tex. 2017).

¹²² See 29 U.S.C. § 1133 (1974). See also U.S. Department of Labor claims procedure regulations under 29 C.F.R. § 2560.503-1 (2017).

¹²³ See e.g., *Lindemann v. Mobil Oil Corp.*, 79 F.3d 647, 649-51 (7th Cir. 1996); *Hickey v. Digital Equip. Corp.*, 43 F.3d 941, 945 (4th Cir. 1995); *Variety Children's Hosp. v. Century Med. Health Plan*, 57 F.3d 1040, 1042 (11th Cir. 1995); *Costantino v. TRW, Inc.*, 13 F.3d 969, 974-75 (6th Cir. 1994); *Communications Workers of Am. v. AT&T*, 40 F.3d 426, 432 (D.C. Cir. 1994); *Simmons v. Wilcox*, 911 F.2d 1077, 1081 (5th Cir. 1990); *Leonelli v. Pennwalt Corp.*, 887 F.2d 1195, 1199 (2d Cir. 1989); *Drinkwater v. Metro Life Ins. Co.*, 846 F.2d 821, 825-26 (1st Cir. 1988).

record before the plan administrator, including evidence to rebut a finding that such services are not “medically necessary.” Also a plan administrator’s denial of benefits is often reviewed by the courts only for abuse of discretion, as ERISA plans generally contain sufficient discretionary authority for the plan administrator to interpret the terms of the plan, and the courts use only the record before the plan administrator in its review.¹²⁴ While the ACA added revised internal claims and appeals and external review processes applicable to group health plans to ensure a full and fair review of the claim, it still behooves the plaintiff to construct a complete record before a plan administrator.¹²⁵ The record should also contain sufficient testimony from medical professionals to rebut any presumption that the medical claims are not “medically necessary.”

E. Recent Supreme Court Cases

Two recent U.S. Supreme Court decisions – *U.S. v. Windsor* and *Obergefell v. Hodges* – have called into question how employers may treat LGBTI individuals. The U.S. federal law regarding employment discrimination – Title VII of the Civil Rights Act of 1964 (“Title VII”) – has also been evolving at the agency level (i.e., the Equal Employment Opportunity Commission (EEOC)) and with the federal courts. The ACA has its own civil rights protections to prevent discrimination in the context of health care.

The Supreme Court has decided two major cases involving LGBTI rights in 2013 and 2015 – *U.S. v. Windsor* and *Obergefell v. Hodges*. The *U.S. v. Windsor* decision reviewed the constitutionality of the federal law known as the Defense of Marriage Act (DOMA), which was passed in 1996 in the wake of Hawaii’s consideration of same-sex marriages.¹²⁶ Section 2 of DOMA provided that no state would be required to recognize, for state law purposes, a same-sex marriage that was valid as a same-sex marriage in another state, nor did the state have to recognize state rights or claims arising under that relationship.¹²⁷ This permitted states to disregard the validity of a same-sex marriage that was otherwise legal in the state in which the ceremony was performed (the “state of celebration”). Thus, the marriage of a same-sex couple legally married in a state did not have to be recognized by another state

¹²⁴ See *Conkright v. Frommert*, 599 U.S. 506 (2010); *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

¹²⁵ See Patient Protection and Affordable Care Act, 42 U.S.C. § 2719 (1973). See also Labor Reg. §2590.715-2719 (2015).

¹²⁶ *U.S. v. Windsor*, 570 U.S. _ (2013).

¹²⁷ *Id.*

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if the couple moved to that state (“state of residence”). DOMA section 3 referenced the Dictionary Act for the definition of marriage for any federal law, ruling, or regulation. Under the Dictionary Act, marriage meant only a legal union between one man and one woman, and “spouse” referred only to a person of the opposite sex who was a husband or wife.¹²⁸

The constitutionality of DOMA section 3 was at the core of the June 26, 2013, Supreme Court decision in *United States v. Windsor*.¹²⁹ The case involved a federal estate tax refund suit initiated by a surviving same-sex spouse unable to claim the marital estate tax deduction under federal law, as it failed to recognize her valid same-sex marriage executed in Canada. While the case involved federal estate taxes for a same-sex couple, it had far reaching implications for all federal law purposes.¹³⁰ In *Windsor*, the Supreme Court struck down the constitutionality of DOMA section 3 “as a deprivation of the liberty of the person protected by the Fifth Amendment.”¹³¹ Hence, it made it clear that for federal law purposes, the federal government must recognize same-sex marriages in states that recognize those marriages. As DOMA section 2 was not at issue in this case, nor in the case of *Hollingsworth v. Perry*,¹³² the Court did not have to address the issue of whether a state could limit marriage to simply opposite-sex couples.

The *Windsor* decision had immediate implications for ERISA plans, as ERISA mandates rules applicable to employer-provided retirement and group health and welfare employee benefit plans. While ERISA does not require spousal coverage under group health and welfare employee benefit plans, some state insurance laws require that same-sex spousal coverage be offered if opposite-sex spousal coverage was offered under an insured group health plan. As ERISA preserves state insurance laws from preemption, the effect of *Windsor* would depend on whether the employee benefit plan was insured or self-insured (and if insured, the state where the policy was written). Many employee benefit plans used the DOMA section 3 definition of “marriage” and “spouse,” except for insured plans where the state insurance laws required same sex spouses to be recognized. As ERISA amended federal labor and tax laws, both the DOL and IRS regulate it.

For self-insured group health plans, if spousal coverage was being offered to an opposite sex spousal, it would presumably now have to be offered to a same sex spouse or face possible issues under Title VII and

¹²⁸ *Id.* at 2683.

¹²⁹ *Id.* at 2682-83.

¹³⁰ *Id.* at 2683.

¹³¹ *Id.* at 2695.

¹³² *Hollingsworth v. Perry*, 570 U.S. 693 (2013).

other anti-discrimination laws and/or policies. However, as will be discussed below, sexual orientation is not a protected class under Title VII and its protections extend to the employee himself/herself, not his/her spouse. The Windsor decision was silent as to federal recognition of same sex couples united under state civil unions or domestic partnership laws. It has no direct application for transgender rights other than language that could be cited as dicta that states would have the right to declare whether transgender individuals could marry an opposite sex or same sex individual.¹³³

The Supreme Court took up the question of whether states could deny marriage to same-sex couples in the June 26, 2015 decision of *Obergefell v. Hodges*.¹³⁴ By consolidating four cases from jurisdictions that banned same-sex marriages and refused to recognize the validity of same-sex marriages performed elsewhere, the Court considered whether such bans and nonrecognitions violated the U. S. Constitution.¹³⁵ In its landmark 5 to 4 decision, it held that such state laws prohibiting same-sex couples from exercising their fundamental right to marry and prohibiting the recognition of same-sex marriages validly entered into in other jurisdictions violated the due process and equal protection guarantees of the Fourteenth Amendment of the U.S. Constitution.¹³⁶ Thus, it permitted same-sex couples to marry in all 50 states and directed the states to recognize same-sex marriages validly performed in other jurisdiction. For employee benefit health and welfare plans, insured plans would be required to extend spousal benefit coverage to same-sex spouses. For self-insured plans ERISA does not mandate spousal welfare coverage, but employers offering coverage only to opposite-sex spouses and not same sex-spouses have a significant risk of being challenged under state and federal discrimination laws.¹³⁷ Thus, most employers have extended their group health coverage to same-sex spouses of plan participants. However, the results of *Obergefell* led many employers to discontinue domestic partner coverage under their group health plans as there was no longer a legal barrier to same-sex marriages.

¹³³ *U.S. v. Windsor*, 570 U.S. ___, 133 S. Ct. 2675, 2692-93 (2013) (“This [marital] status is a far-reaching legal acknowledgment of the intimate relationship between two people, a relationship deemed by the State worthy of dignity in the community equal with all other marriages. It reflects both the community’s considered perspective on the historical roots of the institution of marriage and its evolving understanding of the meaning of equality.”)

¹³⁴ *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015).

¹³⁵ *Id.* at 2593.

¹³⁶ *Id.* at 2602.

¹³⁷ Todd A. Solomon, Brian J. Tiemann & Jacob M. Mattinson, *Employee Benefits Implications of Supreme Court Decision on Same-Sex Marriage*, MCDERMOTT, WILL & EMERY, LLP (June 30, 2015), https://www.mwe.com/en/thought-leadership/publications/2015/06/employee-benefits-implications-of-supreme-court-___.

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The Obergefell holding did not create federal recognition of same-sex partners united in a civil union or domestic partnership under prior state law. Like the Windsor decision, it has no direct application for transgender individuals other than language that could be cited as dicta that transgender individuals may have a fundamental right to marry under the Constitution.¹³⁸

IV. TITLE VII ISSUES

One of the three core statutes prohibiting employment discrimination includes Title VII.¹³⁹ It makes it unlawful for a covered employer to “fail or refuse to hire or to discharge any individual, or otherwise to discriminate with respect to his compensation, terms, conditions, or privileges of employment,” or to “limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual’s . . . sex.”¹⁴⁰ That statute is administered by the federal agency, the Equal Employment Opportunity Commission (EEOC).¹⁴¹ At the time of passage of Title VII, the statute provided no definition of the word “sex.” As an aside, discrimination on the basis of sex under Title VII must be because of the employee’s sex. Thus, failure of an employer-provided health coverage to grant benefits for transition-related medical care to an employee’s spouse or dependent would presumably not be grounds for a Title VII action as the action is not targeted based on the employee’s sex.¹⁴² Hence, the complaint for employment discrimination under Title VII would be from the employee who is denied coverage for transition-related medical care. But note, while the Eight Circuit in *Tovar v. Essentia Health* recently dismissed a mother’s complaint under Title VII and the state analog (Minnesota Human Rights Act (MHRA)) against her employer and the plan administrator for failing to provide coverage for her son’s transgender dysphoria treatment, it did allow the complaint to move

¹³⁸ See *Obergefell v. Hodges*, 135 S. Ct. at 2598 (“the Court has long held the right to marry is protected by the Constitution . . . Marriage is ‘one of the vital personal rights essential to the orderly pursuit of happiness by free men.’”).

¹³⁹ The other two core statutes are The Age Discrimination in Employment Act (ADEA), 29 U.S.C. § 623 (2016) and The Americans With Disabilities Act (ADA), 42 U.S.C. § 1201 (1981).

¹⁴⁰ 42 U.S.C. §§ 2000e-2(a)(1), (2) (1991). See also 42 U.S.C. § 2000e-16(a) (1991). Distinctions must be made based on the qualification for the job and the person’s sex.

¹⁴¹ Enforcement of the rights created under Title VII are dependent upon the complaint filing charges of discrimination and “exhausting” the administrative processes under the EEOC.

¹⁴² See *Tovar v. Essentia Health*, 857 F.3d 771, 775 (8th Cir. 2017) (holding that the protections of Title VII do not extend to discrimination against the plan participant’s son).

forward as a discrimination claim under the Affordable Care Act's Section 1557 (to be discussed below).¹⁴³

Courts have generally interpreted the term "sex" under Title VII to refer to the physical and biological differences between males and females.¹⁴⁴ While the courts generally used the terms "sex" and "gender" interchangeably, social scientists make a distinction. While "sex" refers to the difference between males and females based on their physical organs, "gender" is regarded as a broader term referring to the outward appearances and gestures that one manifests in identifying one's self as a male or female.

C. Gender Stereotyping

The Supreme Court held in the famous case of *Price Waterhouse v. Hopkins*¹⁴⁵ that "gender stereotyping" was considered sex discrimination under Title VII. In that case, Price Waterhouse was found liable for gender stereotyping a female employee by failing to elevate her status to partner. In her evaluations by the other partners, she was regarded as too aggressive, and thus in need of "a course at charm school."¹⁴⁶ She was advised that she should "walk more femininely, talk more femininely, dress more femininely, wear make-up, have her hair styled, and wear jewelry" in order to advance to partner level.¹⁴⁷ By refusing to advance Ms. Hopkins to partner status due to her failure to conform to the employer's gender-based expectations, Price Waterhouse discriminated on the basis of her sex. The Court held that Title VII prohibits "in the specific context of sex stereotyping, an employer who acts on the basis of a belief that a woman cannot be aggressive, or that she must not be, has acted on the basis of gender."¹⁴⁸ Hence, discriminating against Ms. Hopkins because her actions did not conform to her gender was prohibited under Title VII.

¹⁴³ *Id.* at 775.

¹⁴⁴ *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976). The Supreme Court held that males are also protected against employment discrimination because they are male under the same standards that would be applied to women. See *Oncale v. Sundowner Offshore Servs.*, 523 U.S. 75 (1998).

¹⁴⁵ *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

¹⁴⁶ *Id.* at 256.

¹⁴⁷ *Id.* at 235.

¹⁴⁸ *Id.* at 250.

C. Sexual Orientation

While many states and hundreds of municipalities prohibit discrimination based on sexual orientation, and Presidential Order 13160 prohibits such discrimination against federal employees, the courts have long held that sex discrimination claims by gay and lesbian employees are claims of sexual orientation, which is not protected under Title VII.¹⁴⁹ But this distinction is less true in complaints where sexual harassment is being alleged.¹⁵⁰ The courts have limited Price Waterhouse to allegation of sexual discrimination when the individual exhibits gender characteristics generally affiliated with individuals of the opposite sex (e.g., attributing the characteristics of Ms. Hopkins' behavior as masculine, while she was a female).¹⁵¹ This draws a line between discrimination against a person perceived to be gay or lesbian – which is not protected by Title VII – and discrimination against a person because of her masculine or feminine gender characteristics.¹⁵²

While courts have extended Title VII's prohibition of race discrimination to apply to an employee's association with a person of another race (e.g., interracial marriage or interracial friendship), they have rejected such "bootstrapping" in the context of discrimination against an employee because of his/her spouse's sex or friend's sex.¹⁵³ Hence, discrimination against a lesbian employee would not be actionable because she was married to a same-sex spouse.

But the EEOC and some courts – most notably the Seventh Circuit—have more recently taken a contrary position of whether claims of sexual orientation discrimination and/or gender identity discrimination may be classified as claims of discrimination "because of sex" under Title VII.

¹⁴⁹ See, e.g., *Etsitty v. Utah Transit Auth.*, 502 F.3d 1215 (10th Cir. 2007); *King v. Super Serv., Inc.*, 68 F. App'x 659, 664 (6th Cir. 2003); *Simonton v. Runyon*, 232 F.3d 33, 35 (2d Cir. 2000) ("The law is well-settled in this circuit and in all others to have reached the question that [plaintiff] has no cause of action under Title VII because Title VII does not prohibit harassment or discrimination because of sexual orientation"); *Higgins v. New Balance Athletic Shoe, Inc.*, 194 F.3d 252, 261 (1st Cir. 1999); *Wrightson v. Pizza Hut of Am., Inc.*, 99 F.3d 138, 143-44 (4th Cir. 1996); *Dillon v. Frank*, 1992 U.S. App. LEXIS 766, at *12 (6th Cir. Jan. 15, 1992) ("The circuits are unanimous in holding that Title VII does not proscribe discrimination based on sexual activities or orientation."); *Williamson v. A.G. Edwards & Sons*, 876 F.2d 69, 70 (8th Cir. 1989); *DeSantis v. Pac. Tel. & Tel. Co., Inc.*, 608 F.2d 327 (9th Cir. 1979); *Blum v. Gulf Oil Corp.*, 597 F.2d 936, 938 (5th Cir. 1979) (per curiam).

¹⁵⁰ See *Oncale v. Sundowner Office Servs., Inc.*, 523 U.S. 75, 81 (1998) (holding that same-sex sexual harassment was actionable under Title VII in the context of a hostile work environment as "the conduct at issue was not merely tinged with offensive sexual connotations, but actually constituted 'discrimination . . . because of . . . sex.'")

¹⁵¹ See *Nichols v. Azteca Rest. Enters.*, 256 F.3d 864, 874 (9th Cir. 2001).

¹⁵² See *Hamm v. Weyauwega Milk Prods., Inc.*, 332 F.3d 1058, 1062 (7th Cir. 2003).

¹⁵³ See *DeSantis Co., Inc. v. Pac. Tel. & Tel. Co., Inc.*, 608 F.2d 327, 329 (9th Cir. 1979).

In the 2015 decision of *Baldwin v. Department of Transportation*, the EEOC took up the issue as to whether a complainant's claim of discrimination based on sexual orientation under Title VII was actionable.¹⁵⁴ The complainant argued that he was not selected for a permanent position as a front line manager because he was gay (i.e., his sexual orientation).¹⁵⁵ The EEOC held that "sexual orientation is inherently a 'sex-based consideration,' and an allegation of discrimination based on sexual orientation is necessarily an allegation of sex discrimination under Title VII."¹⁵⁶ Thus, if his employer took his sexual orientation into account in an employment action, a complaint for sex discrimination can be alleged.¹⁵⁷ The EEOC argued a number of theories to justify its conclusion. First, it reasoned that sexual orientation cannot be understandable without reference to sex as it refers to the sex of someone to whom one is sexually and romantically related to. By discriminating against an employee due to his sexual orientation, the employer is treating that employee less favorably because of his sex.¹⁵⁸ Second, sexual orientation discrimination is an associational discrimination on the basis of sex because the employer is treating the employee differently for "associating with a person of the same sex."¹⁵⁹ While such associational discrimination applies in the context of race discrimination, it should not be limited solely to that context, according to the EEOC. Third, sexual orientation discrimination involves discrimination based on gender stereotypes as prohibited by the Supreme Court in *Price Waterhouse*.¹⁶⁰ Such claims should be allowed to be made by gays and lesbians if they can demonstrate they were treated adversely because of their sexual orientation. Finally, sexual orientation discrimination and harassment "[are] often, if not always, motivated by a desire to enforce heterosexually defined gender norms."¹⁶¹ As such, discrimination based on an employee's non-conformity with sex stereotypes (e.g., a gay male not conforming to the gender stereotypes associated with males) is valid sex discrimination claim. This reasoning was convincing to a federal district court months later, although it dismissed the claims based on its

¹⁵⁴ *Baldwin v. Dep't. of Transportation*, EEOC DOC 0120133080, 2015 WL 44397641 (July 15, 2015).

¹⁵⁵ *Id.* at *2.

¹⁵⁶ *Id.* at *5.

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* at *6.

¹⁶⁰ *Baldwin v. Dep't. of Transportation*, EEOC DOC 0120133080, 2015 WL 44397641, at *7 (July 15, 2015).

¹⁶¹ *Id.* at *8 (citing *Centola v. Potter*, 183 F. Supp. 2d 403, 410 (D. Mass. 2002)).

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merits.¹⁶²

A few district courts followed suit allowing gay and lesbian employees to allege discrimination on the basis of sexual orientation under Title VII.¹⁶³ But the real “shake up” in jurisprudence came in April of 2017, with the Seventh Circuit decision in *Hively v. Ivy Tech Community College*.¹⁶⁴ Previously, the Seventh Circuit in *Ulane v. Eastern Airlines, Inc.* concluded that Congress had nothing more than the traditional notion of ‘sex’ in mind when it voted to outlaw sex discrimination, and thus sexual orientation was distinct from sex discrimination.¹⁶⁵

But in *Hively*, the full panel Seventh Circuit reversed the lower court’s dismissal of the complainant’s sexual orientation discrimination claim under Title VII. *Hively* was openly lesbian and was allegedly discriminated against by her employer when her part-time position was terminated and her employer failed to provide her with a full-time position.¹⁶⁶ *Hively* argued two theories for her contention that sex discrimination included discrimination based on sexual orientation: first, that she was treated differently only because of her sexual orientation, and second, that she was discriminated against due to her intimate associations with a person of the same sex.¹⁶⁷

Justice Wood used three rationales to support Title VII’s prohibition against sexual orientation in *Hively*. First, she applied a “comparative method” in interpreting the statute – asking simply whether *Hively*’s protected characteristic played a role in an adverse employment decision.¹⁶⁸ If *Hively* had been a man married to a woman and all variables were the same, *Ivy Tech* would not have refused to promote her and would not have fired her. In the court’s mind, that is

¹⁶² See *Isaacs v. Felder Servs., LLC*, 2015 WL 6560655, at *3 (M.D. Ala. 2015) (citing *Baldwin v. Dep’t. of Transportation*, EEOC DOC 0120133080, 2015 WL 44397641, (July 15, 2015)).

¹⁶³ See *Terveer v. Billington*, 34 F.Supp. 3d 100, 2014 WL 1280301, at *9 (D.D.C. Mar. 31, 2014) (allowing a gay’s claim for sex discrimination because his “sexual orientation was not consistent with the defendant’s perception of acceptable gender roles”; *Golinski v. Office of Pers. Mgmt.*, 824 F. Supp. 2d 968, 982 n.4 (N.D. Cal. 2012) (stating that “[s]exual orientation discrimination can take the form of sex discrimination”); *Koren v. Ohio Bell Tel. Co.*, 894 F.Supp. 2d 1032, 1038 (N.D. Ohio 2012) (allowing the plaintiff to pursue a Title VII sex discrimination claim because he was mistreated for “tak[ing] his [male] spouse’s surname – a ‘traditionally’ female practice”). But see *Evans v. Georgia Reg’l Hosp.*, 2015 WL 5316694, at *3 (S.D. Ga. Sept. 10, 2015) (stating it “simply not unlawful under Title VII to discriminate against homosexuals or based on sexual orientation”), report and recommendation adopted, 2015 WL 6555440 (S.D. Ga. Oct. 29, 2015); *Currie v. Cleveland Metro. Sch. Dist.*, 2015 WL 4080159, at *3 (N.D. Ohio July 6, 2015).

¹⁶⁴ *Hively v. Ivy Tech Community College*, 853 F.3d 339 (7th Cir. 2017).

¹⁶⁵ *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984).

¹⁶⁶ *Hively*, 853 F.3d at 340.

¹⁶⁷ *Id.* at 345.

¹⁶⁸ *Id.* at 345.

“paradigmatic sex discrimination,” as Ivy Tech is disadvantaging her “because she is a woman.”¹⁶⁹

Secondly, the court used the Supreme Court’s gender stereotyping theory to apply to both gender conformity and gender nonconformity situations. According to the court, Hively, as a lesbian, was the “ultimate case of failure to conform to the female stereotype” (in terms of modern America, where heterosexuality is the norm) and thus any “line between a gender nonconformity claim and one brought based on sexual orientation” was simply “gossamer-thin.”¹⁷⁰ The discrimination alleged here would not exist “without taking the victim’s biological sex (either as observed at birth or as modified, in the case of transsexuals) into account.”¹⁷¹ Thus, it viewed discrimination on the basis of sexual orientation to be based on assumptions regarding the proper behavior for someone of a given sex. Hence negative behavior against a plaintiff – woman or man – who “dresses differently, speaks differently, or dates or marries a same-sex partner” is based on sex and therefore prohibited by Title VII.¹⁷²

Finally, the court agreed that association discrimination theory that has been applied in the racial context applies equally to discrimination based on color, national origin, religion, or sex, as the statute “draws no distinction.”¹⁷³ In his concurrence, Judge Posner concludes that Title VII’s term “sex” refers both to gender and sexual orientation.¹⁷⁴

The Seventh Circuit also references the Supreme Court’s recent decision in *Obergefell* in which it “challenged laws burden[ing] the liberty of same-sex couples” demanding they now “abridge central precepts of equality.”¹⁷⁵ The court concludes that it would take “considerable calisthenics to remove the ‘sex’ from ‘sexual orientation.’”¹⁷⁶

While the Second Circuit held in a 2017 case that an openly gay male could proceed with a claim of gender stereotyping, its one panel lacked the power to reconsider whether he could pursue a sexual orientation discrimination claim under Title VII due to the circuit’s

¹⁶⁹ *Id.* at 345.

¹⁷⁰ *Id.* at 346.

¹⁷¹ *Id.* at 347.

¹⁷² *Hively*, 853 F.3d at 347.

¹⁷³ *Id.* at 349 (citing to *Holcomb v. Iona Coll.*, 521 F.3d 130, 138-39 (2d Cir. 2008) (allowing a Title VII claim where a white male was treated adversely as a result of his marriage to an African-American woman); *Parr v. Woodmen of the World Life Ins. Co.*, 791 F.2d 888,892 (11th Cir. 1986) (allowing a Title VII claim where an employer failed to hire a white applicant due to his marriage to an African-American woman)).

¹⁷⁴ *Id.* at 353.

¹⁷⁵ *Id.* at 350 (citing *Obergefell v. Hodges*, 135 S.Ct. 2584, 2604 (2015)).

¹⁷⁶ *Id.*

precedent.¹⁷⁷ Two of the three judges on the panel concurred that the Second Circuit should revisit its precedent in an appropriate case.¹⁷⁸

C. Transgender or Transsexual Discrimination

For Title VII purposes, discrimination against transgender or transsexual employees has been distinguished from sexual orientation discrimination as such individuals may be undergoing an actual physical or biological change to become a different sex. In the case of *Schwenk v. Hartford*¹⁷⁹, a prison guard assaulted a male-to-female transgender prisoner who was going to seek sex reassignment surgery. The court held that the male guard targeted the prisoner “only after he discovered that she considered herself female” and was “motivated, at least in part, by [her] gender.”¹⁸⁰ Relying on *Price Waterhouse*, the Ninth Circuit held that sex discrimination includes discrimination due to the failure to “conform to socially-constructed gender expectations.”¹⁸¹ As such discrimination against transgender females “as anatomical males whose outward behavior and inward identity [do] not meet social definitions of masculinity” is discrimination “because of sex.”¹⁸²

Similarly, in the case of *Smith v. City of Salem*, Smith was “biologically and by birth male” but was transitioning to become a female under the medical protocols of GID.¹⁸³ With complaints from co-workers that Smith was “not masculine enough,” his employer subjected him to psychological evaluations and eventually suspended Smith.¹⁸⁴ The district court rejected Smith’s complaint for sex-stereotyping on the theory it really was an allegation of discrimination based on “transsexuality.”¹⁸⁵ But the Sixth Circuit reversed and held that discrimination against a transsexual for failing to act or identify with his or her gender “is not different from discrimination directed against [the plaintiff] in *Price Waterhouse* who, in sex-stereotypical

¹⁷⁷ See *Christiansen v. Omnicom Group, Inc.*, 852 F.3d 195, (2d Cir. 2017) (per curiam).

¹⁷⁸ *Id.* at 202 (Katzmann, J., concurring).

¹⁷⁹ *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000).

¹⁸⁰ *Id.* at 1202

¹⁸¹ *Id.* at 1201-02.

¹⁸² *Id.* (emphasis added). *But cf. Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215-16 (1st Cir. 2000) (refusing to extend *Price Waterhouse* in the context of the bank’s rejection of a loan application by a biologically-male plaintiff dressed in “traditionally feminine attire” on the ground his “attire did not accord with his male gender” as illegal sex discrimination under the Equal Credit Opportunity Act, 15 U.S.C. §§1691-1691f).

¹⁸³ *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004).

¹⁸⁴ *Id.* 569-70.

¹⁸⁵ *Id.* at 571.

terms, did not act like a woman.”¹⁸⁶ Hence, the Price Waterhouse definition of sex as “sex stereotype” was not limited to biological sex. Thus, it permitted Smith to pursue his claim for relief under Title VII for sex discrimination.

Likewise, the Eleventh Circuit held that an employer’s firing of a transgender woman was based on her gender non-conformity and thus actionable under Title VII.¹⁸⁷ The employer felt that the employee’s appearance in woman’s attire was “inappropriate,” “unsettling,” and “unnatural.”¹⁸⁸ According to the court, “[t]he very acts that define transgender people as transgender are those that contradict stereotypes of gender-appropriate appearance and behavior.”¹⁸⁹ Thus, the court concludes there is an analogy between discrimination against transgender individuals and discrimination on the basis of gender-based behavioral norms.¹⁹⁰ The Eleventh Circuit affirmed its position in a 2016 case of *Chavez v. Credit Nation Auto Sales, LLC*.¹⁹¹

The EEOC relied on some of these cases in the 2012 complaint of *Macy v. Holder*, where it clarified that allegations of discrimination based on gender identity are recognizable under Title VII’s sex discrimination prohibition.¹⁹² The EEOC interprets Title VII to protect against discrimination based on a person’s sex and gender – the latter of which includes not only one’s biological sex but the “cultural and social aspects associated with masculinity and femininity.”¹⁹³ Thus, when an employer discriminates against an employee because the person is transgender, it is making a gender-based distinction, which violates Price Waterhouse’s assertion that “an employer may not take gender into account in making an employment decision.”¹⁹⁴ Thus, intentional

¹⁸⁶ *Id.* 574-75. *But see Sommers v. Budget Mktg., Inc.*, 667 F.2d 748, 750 (8th Cir. 1982) (holding that “sex” under Title VII is to be given its “plain meaning” and does not include discrimination based on transsexualism).

¹⁸⁷ *Glenn v. Brumby*, 663 F.3d 1312, 1321 (11th Cir. 2011).

¹⁸⁸ *Id.* at 1320.

¹⁸⁹ *Id.* at 1316-17 (quoting Ilona M. Turner, *Sex Stereotyping Per Se: Transgender Employees and Title VII*, 95 CAL. L. REV. 561, 563 (2007)).

¹⁹⁰ *Id.*

¹⁹¹ *Chavez v. Credit Nation Auto Sales, LLC.*, 641 F. App’x 883, 884 (11th Cir. 2016) (holding that “[s]ex discrimination includes discrimination against a transgender person for gender nonconformity.”).

¹⁹² *Macy v. Holder*, EEOC DOC 0120120821, 2012 WL 1435995 (April 20, 2012) (also recognizing that such complaints are to be processed under Part 1614 of the EEOC’s federal sector EEO complaint process). The EEOC also cites a “steady stream” of district court cases that protect against discrimination of transgender individuals on the basis of sex stereotyping, noting *Schroer v. Billinton*, 577 F. Supp. 2d 293 (D.D.C. 2008)). *See also United States v. Southeastern Oklahoma State Univ.*, No. CVI-15-324-C, 2015 WL 4606079 (W.D. Okla. July 10, 2015) (allowing Rachel Tudor’s claim of sex discrimination to proceed due to the university’s denial of her tenure because of her transgender status).

¹⁹³ *Macy*, 2012 WL 1435995 at *16.

¹⁹⁴ *Id.* at *19 (quoting *Price Waterhouse*, 490 U.S. 228, 244 (1989)).

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discrimination against a transgender employee because he or she is transgender is discrimination “based on sex” for purposes of Title VII.¹⁹⁵ Whether the EEOC’s above determinations change under the Trump Administration remains to be seen. In his Twitter account, President Trump in July of 2017 announced that he would reverse the Obama administration’s decision to allow transgender people to serve in the military. He cited the “tremendous medical costs” associated with transgender service personnel as the reason for the reversal.¹⁹⁶ On August 29, 2017, Defense Secretary Jim Mattis announced a freeze on President Trump’s ban on transgender individuals serving in the military so that a panel of experts could be assembled to provide advice and recommendations in carrying out President Trump’s directive.¹⁹⁷ In the meantime, the policy regarding transgender individuals serving in the military will remain in place.¹⁹⁸

The Seventh Circuit in the *Hively* decision explicitly stated that the discrimination alleged would not have existed without taking the victim’s biological sex into account, whether or not that sex was determined at birth and modified “in the case of transsexuals.”¹⁹⁹ Hence, it would clearly entertain discrimination against a transsexual as a sex discrimination claim under Title VII. As the Supreme Court has not explicitly ruled that Title VII protects transgender or transsexual employees, the above cases show a trend in finding equal protection.

V. ACA PROTECTIONS AND HHS REGULATIONS

A. ACA Section 1557

The “rules of the game” changed for group health plans with the passage of the Affordable Care Act (ACA). Its Section 1557 prohibits discrimination by any health program or activity receiving federal financial assistance (referred to as covered entities) on the grounds of race, color, national origin, sex, age, or disability, by incorporating by

¹⁹⁵ *Id.* at *34-35.

¹⁹⁶ See Julie Hirschfeld Davis & Helene Cooper, *Trump Says Transgender People Will Not Be Allowed in the Military*, N.Y. TIMES (July 26, 2017), <https://www.nytimes.com/2017/07/26/us/politics/trump-transgender-military.html?mcubz=3>.

¹⁹⁷ See Dan Lamothe, *Transgender Ban Frozen as Mattis Moves Forward with New Review of Options*, WASHINGTON POST (Aug. 29, 2017), https://www.washingtonpost.com/news/checkpoint/wp/2017/08/29/pentagon-chief-mattis-freezes-trumps-ban-on-transgender-troops-calls-for-more-study/?utm_term=.7cbbc3ec09e0.

¹⁹⁸ *Id.*

¹⁹⁹ See *Hively*, 853 F.3d at 346-47.

reference four federal nondiscrimination statutes.²⁰⁰ Given the incorporation of Title IX of the Education Amendments of 1972, covered entities are required to provide individuals with equal access to health programs and activities without discrimination on the basis of sex. As such, it is the first federal civil rights law to prohibit sex discrimination in health care. The scope of Section 1557 extends its protections to the marketplaces. The Department of Health and Human Service (HHS) was given authority to promulgate regulations to implement Section 1557.²⁰¹

HHS issued controversial proposed regulations under Section 1557 in September of 2015, thereby expanding the definition of “sex” for purposes of the prohibition against sexual discrimination to include sexual orientation and gender identity.²⁰² It received 24,875 comments, the majority of which were letters from individuals. It finalized those rules in early 2016, affirming its prior view. The rules were generally effective July 18, 2016, but changes to health insurance or group health plan benefit designs were deferred until January 1, 2017.²⁰³

Under the final regulations, all health programs and activities, any part of which received federal financial assistance, are covered.²⁰⁴ Generally, a health program or activity would include health services, health coverage, and all operation of an entity principally engaged in provided health services or coverage (e.g., hospitals and insurers). Federal financial assistance includes any grants, loans, credits, subsidies, and cost-sharing subsidies under ACA Title I and Medicare Part D payments.²⁰⁵ Hence, it applies to an employer-sponsored plan that is funded through the insurance by an insurer who participates in the ACA marketplace, as well as a self-funded plan administered by an insurer who participates in the ACA marketplace. Even if the plan itself is not sold through the marketplace nor does it receive any federal assistance, the plan is involved with an entity (i.e., the insurer) who receives federal funding via the premium credits it receives for eligible individuals who purchase insurance on the marketplace. Similarly, an employer that sponsors a self-funded retiree health plan that applies for

²⁰⁰ 42 U.S.C.S §18116 (2010). Section 1557 specifically applies Title VI of the Civil Rights Act, Pub. L. No. 88-352, 78 Stat. 241 (1964), The Education Amendments of 1972, Pub. L. 92-318, 86 Stat. 235 (1972), the Age Discrimination Act, Pub. L. 94-135, 89 Stat. 728 (1975), and the Rehabilitation Act, Pub. L. 93-112, 87 Stat. 355 (1973).

²⁰¹ 42 U.S.C.S §18116(c) (2010).

²⁰² Proposed Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172 (Sept. 8, 2015). See *Summary of HHS's Final Rule on Nondiscrimination in Health Programs and Activities*, KAISER FAM. FOUND. (July 14, 2016), <https://perma.cc/Q3WM-6PMG>.

²⁰³ Nondiscrimination in Health Program and Activities, 81 Fed. Reg. 31,440 (May 18, 2016), § 92.1, at 31466 (May 18, 2016).

²⁰⁴ § 92.4, 81 Fed. Reg. at 31466-67.

²⁰⁵ § 92.4, 81 Fed. Reg. at 31467.

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retiree drug subsidy under Medicare Part D will be a covered entity subject to Section 1557.

The final regulations define “on the basis of sex” for purposes of discrimination to include discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy (or recovery from such termination), recovery from childbirth or related medical conditions, sex stereotyping, and gender identity.²⁰⁶ It defines “gender identity” to mean a person’s internal sense of gender, which may be male, female, neither, or both and which may be different from the person’s assigned sex at birth.²⁰⁷ The regulations defines “sex stereotypes” as stereotypical notions of masculinity or femininity, which include expectations as to how an individual should act (e.g., behavior, clothing, hairstyle, activities, voice, mannerisms, or body characteristics) to represent or communicate their gender to others.²⁰⁸ These stereotypes can include expectations that an individual will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. For purposes of Section 1557, a “transgender individual” as a person whose gender identity is different from the sex of that person assigned at birth.

The regulations mandate that covered entities provide individuals equal access to health programs and activities without discrimination on the basis of sex.²⁰⁹ This includes treating an individual consistent with their gender identity (including access to facilities) and not denying or limiting health care services on the theory that the individual seeking those services belongs to a different gender than the individual’s sex assigned at birth, gender identity, or recorded gender.²¹⁰ Hence, a plan would presumably violate Section 1557 if it denied coverage for a pap smear where medically necessary for a participant who identified or was perceived as a male.

Regarding health plans’ exclusions from coverage, the regulations prohibit categorical coverage exclusions for all health services related to gender transition, effective on or after January 1, 2017.²¹¹ The rule views categorizations of all transition-related treatment as cosmetic or experimental to be “outdated and not based on current standards of care.”²¹² The rule covers a “range of transition-related services” which includes treatment for gender dysphoria and is “not limited to surgical treatments and may include, but is not limited to, services such as

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ § 92.4, 81 Fed. Reg. at 31468.

²⁰⁹ § 92.206, 81 Fed. Reg. at 31471.

²¹⁰ *Id.*

²¹¹ § 92.1, 81 Fed. Reg. at 31472.

²¹² Preamble, 81 Fed. Reg. at 31429.

hormone therapy and psychotherapy, which may occur over the lifetime of the individual.”²¹³ While the regulations do not affirmatively require the covered entity to cover specific procedures or treatments for transition-related care, when coverage for a specific service related to gender transition is denied, HHS will consider whether coverage is provided in other circumstances.²¹⁴ For example, if medical services for hormone therapy, mastectomy, or hysterectomy are covered by the plan outside of the gender transition context, an explanation will be need to justify their exclusion in the gender transition context. The regulations affirm that covered entity can still impose a “medically necessity” requirement for a covered service, without defining the scope of that term.²¹⁵ The regulations were effective beginning on or after January 1, 2017 for health insurance and group health plans.²¹⁶ In the preamble to the regulations, HHS references a study by the National Center for Transgender Equality and the National Gay and Lesbian Task Force which found that more that “one-quarter of the more than 6,400 transgender and gender-nonconforming respondents reported . . . being denied needed treatment[,] . . . being harassed in health care settings[,] . . . [and] postponing medical care because of discrimination by providers.”²¹⁷ As such, discouraging or postponing necessary treatment could lead to negative health consequences.

Regarding the three issues facing group health plans that we began with, any blanket exclusions for transition-related medical care would be prohibited under Section 1157; any other blanket exclusions for non-transition medical care that would otherwise be covered outside the gender transition context (e.g., a pap smear for a Trans male) would have to be justified; but the use of a “medical necessity” standard would be acceptable.

HHS has been enforcing Section 1557 since ACA’s enactment and its Office of Civil Rights (OCR) reports that insurance discrimination complaints have been increasing, the majority of which are gender identity discrimination cases.²¹⁸ Section 1557 also provides a private right of action, which does not require exhaustion of administrative

²¹³ Preamble, 81 Fed. Reg. at 31435-36.

²¹⁴ § 92.207, 81 Fed. Reg. at 31472.

²¹⁵ *Id.*

²¹⁶ § 92.1, 81 Fed. Reg. at 31466.

²¹⁷ Preamble, 81 Fed. Reg. at 31460 (citing Kellan E. Baker, *Open Doors for All, Sexual Orientation and Gender Identity Protections in Health Care*, CENTER FOR AMERICAN PROGRESS (Apr. 30, 2015), <https://perma.cc/6D6F-9GQY>).

²¹⁷ *Id.* at 31466.

²¹⁸ See *OCR Enforcement under Section 1557 of the Affordable Care Act Sex Discrimination Cases*, HHS.GOV (Aug. 1, 2016), <https://perma.cc/B7CL-CR5W>.

remedies prior to filing suit.²¹⁹

B. ACA's Essential Health Benefits

ACA also requires non-grandfathered health plans in the individual and small group market to cover a set of 10 categories of services, referred to as “essential health benefits” (EHB).²²⁰ These include doctor services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth care, mental health and substance use disorder, and many more. Under the regulations issued by HHS, the issuer is not deemed to have provided “essential health benefits” if “its benefit design, or the implementation of its benefit design, discriminates based on the individual’s . . . other health conditions.”²²¹ While section 1302(b)(4) of the ACA directs HHS to address standards to be used in defining EHB, including elements related to discrimination as to an individual’s age, disability, or expected length of life, the regulations expanded discrimination to include race, color, national origin, sex, gender identity, and sexual orientation.²²² Thus, it is likely that these regulations will be challenged as HHS expanded the scope of discrimination for purposes of EHB.

C. Challenges to HHS Regulations

Similar to HHS, other federal agencies have opined whether Title IX’s prohibition of “sex” discrimination (incorporated by reference by Section 1557 of the ACA) includes gender identity. Title IX provides that “[n]o person . . . shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.”²²³ The Department of Education regulations implementing Title IX permit “separate toilet, locker rooms, and shower facilities on the basis of sex” provided the facilities are “comparable” for students of both sexes.²²⁴ But in an opinion letter dated January 7, 2015, the Department’s Office for Civil Rights interpreted the regulations to require schools to treat transgender

²¹⁹ See *supra* note 203, at §§ 92.301 – 92.302.

²²⁰ 42 U.S.C. § 18022(b) (2014).

²²¹ 45 C.F.R. § 156.125(a) (2013).

²²² 45 C.F.R. §§ 156.125(b), 156.200e (2017).

²²³ 20 U.S.C. § 1681(a) (1986).

²²⁴ 34 C.F.R. § 106.33 (2000).

students consistent with their gender identity.²²⁵ A similar opinion letter dated May 13, 2016 was issued jointly by the U.S. Department of Justice and a U.S. Department of Education, stating that Title IX requires public school districts to permit transgender students access to restrooms, locker rooms, and athletic teams of their choosing based on their gender identity.²²⁶

In the case of *Gloucester County School Bd. v. G.G.*, the Fourth Circuit took up the issue of whether a school board could initiate a policy requiring students to use the restroom consistent with their birth sex, rather than their gender identity.²²⁷ In that case, G.G., a transgender boy sought to use the boys' restroom at his high school, but was denied access due to a new school board policy banning such action.²²⁸ He sued the school board on the grounds of sex discrimination in violation of Title IX and the Equal Protection Clause of the Constitution.²²⁹

The District Court dismissed G.G.'s Title IX claim, as it would not afford deference to the Department's interpretation of its own regulations.²³⁰ The Fourth Circuit found the Department's interpretation of its regulations as it applied to transgender individuals to be ambiguous, and thus, not entitled to Auer deference "unless the Board demonstrates that the interpretation is plainly erroneous or inconsistent with the regulation or statute."²³¹ As the regulations themselves were silent on the issue of which restroom transgender individuals should use, the Court did not find the Department's interpretation to be "erroneous or inconsistent with the text of the regulation."²³² In fact, the Court noted that the interpretation was the result of the "agency's fair and considered judgment" and that the Department had been enforcing this position since 2014.²³³ The Supreme Court granted certiorari on October 28, 2016 on this decision on three questions: (1) whether the Court should retain the Auer doctrine, (2) if the Auer doctrine is retained, should deference extend to an unpublished agency letter, and (3) with or without deference to the agency, should the Department's specific interpretation of Title IX and 34 C.F.R. § 106.33 be given

²²⁵ Letter from James A. Ferg-Cadmima, Acting Deputy Sec'y for Pol'y, Off. for C.R., to Emily Prince, Esq. (Jan. 7, 2015) (on file with Bricker & Eckler, LLP).

²²⁶ Letter from U.S. Dept. of Educ. & U.S. Dept. of Just., to Colleague, (May 13, 2016) (on file with U.S. Dept. of Educ.).

²²⁷ *G.G. v. Gloucester Cnty Sch. Bd.*, 822 F.3d 709 (4th Cir. 2016); *Gloucester Cty. Sch. Bd. v. G.G.*, 136 S. Ct. 2442 (2016) (recalling mandate and issuing stay).

²²⁸ *G.G.*, 822 F.3d at 714.

²²⁹ *Id.* at 715.

²³⁰ *Id.* at 723.

²³¹ *Id.* at 721 (citing to the Supreme Court's decision in *Auer v. Robbins*, 519 U.S. 452, 461 (1997)).

²³² *Id.* at 722.

²³³ *Id.*

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effect. As of yet, we have no resolution.

This case has relevance in a number of recent cases challenging Section 1557 of the ACA. In the case of *Robinson v. Dignity Health*, a district court grant a motion to stay a transgender employee's complaint that an employer's denial of "sex transformation" surgery under its health plan violated Section 1557 of the ACA and Title VII.²³⁴ The employer intended to amend its health care plan beginning in January of 2017 so that it would no longer exclude treatment, drugs, services, and supplies relating to sex transformations, but as of the date of the complaint, it had not.²³⁵ Since the interpretation of Title IX "on the basis of sex" (which has been incorporated into the text of Section 1557) is before the Supreme Court, the court concluded a stay would "serve the orderly administration of justice and simplify the issues of the litigation."²³⁶ The court noted that the Ninth Circuit interpreted Congress as providing "similar substantive standards" in ascertaining the meaning of "on the basis of sex" for Title IX and Title VII purposes.²³⁷

In contrast, in the case of *Franciscan Alliance, Inc., et al. v. Burwell*, eight states and three faith-based health care providers sued HHS and Secretary Burwell in late 2016 challenging the new rule "Nondiscrimination in Health Programs and Activities," as it would require providers to perform and provide insurance coverage for gender transitions and abortions, contrary to religious beliefs or medical judgment.²³⁸ The court rejected extending Chevron deference to HHS's interpretation of "sex discrimination" under the new rule, as the meaning of "sex" in Title IX has long been held to refer to the "biological and anatomical differences between male and female students as determined at their birth."²³⁹ Thus, HHS' interpretation that "sex discrimination" included discrimination on the basis of gender identity contradicted existing law and thus, it had exceeded its statutory authority in violation of the Administrative Procedure Act.²⁴⁰ Thus, it granted the plaintiffs' motions for a nationwide preliminary injunction, enjoining HHS from enforcing the prohibition on discrimination on the

²³⁴ *Robinson v. Dignity Health*, No. 16-CV-3035 YGR, 2016 WL 7102832 (N.D. Cal. 2016).

²³⁵ *Id.* at *2-3.

²³⁶ *Id.* at *2.

²³⁷ *Id.*

²³⁸ *Franciscan Alliance, Inc., et al. v. Burwell*, 227 F.Supp.3d 660 (N.D. Tex. 2016).

²³⁹ *Id.* at 687 (citing to *Tex. v. United States*, 201 F.Supp.3d 810 (N.D. Tex. 2016)).

²⁴⁰ *Id.* at 691. (the case also discussed whether the regulations violated the Religious Freedom Restoration Act (RFRA) (which provides that the "[g]overnment may substantially burden a person's exercise of religion only if it demonstrates that application of the burden to the person . . . is the least restrictive means of furthering [a] compelling government interest"); 42 U.S.C. § 2000bb-1(b) (2017)).

bases of gender identity and termination of pregnancy under its new rule.²⁴¹ The ruling was issued on December 31, 2016 and has not been appealed by the Trump Administration during 2017. As the injunction does not prevent an individual from bringing a private lawsuit to enforce his/her rights under the new rule, it may not have had a great deal of influence on plan sponsors in changing health care coverage beginning on or after January 1, 2017, so as to be consistent with the new Section 1557 regulations.

Similarly, a group of Catholic organizations in North Dakota sought to block the HHS regulations on the grounds that requiring them to provide insurance coverage for gender reassignment surgery violated their religious teachings and beliefs. In light of the nationwide preliminary injunction imposed by the U.S. District Court in Texas, the district court in North Dakota granted a similar preliminary injunction.²⁴²

The Department of Justice (DOJ) filed a brief in the federal district court for the Northern District of Texas in the Franciscan Alliance lawsuit in May of 2017. It asked the court for a stay of the litigation and a remand so that HHS may reconsider the regulation at issue.²⁴³ The brief did not confess HHS's error, new evidence, or intervening events to support the remand request, but stated that HHS had identified "substantial and legitimate concerns" over the remand and stay. In contrast, the Franciscan Alliance requested a rejection of such a remand, but instead a ruling of summary judgment in their favor.²⁴⁴ It requested the court vacate the rule. The court granted the DOJ's motion for remand and stay, affirming that its original preliminary injunction order would remain in full force and in effect.²⁴⁵

As mentioned earlier, the Eight Circuit in the *Tovar v. Essentia Health* litigation allowed a mother's suit to continue against the employer and plan administrator for sex discrimination under Section 1557 as the employer's plan categorically excluded coverage for gender reassignment for her son's dysphoria.²⁴⁶ The Court made no mention of the nationwide injunction against Section 1557 imposed by the U.S. District Court for the Northern District of Texas. Judge Benton dissented with the holding as it pertained to allowing the Section 1557

²⁴¹ *Id.* at 693.

²⁴² *Catholic Benefits Ass'n v. Burwell*, No. 3:16-cv-432-RRE-ARS (D. N.D. filed Dec. 28, 2016); *North Dakota v. Burwell*, No. 3:16-cv-386-RR-ARS (D. N.D. filed Nov. 7, 2016).

²⁴³ *Franciscan Alliance, Inc. et al. v. Price*, No. 7:16-cv-00108-O, 2017 WL 3616652 (N.D. Tex. 2017).

²⁴⁴ *Id.*

²⁴⁵ *Id.*

²⁴⁶ *Tovar v. Essentia Health*, 857 F.3d 771 (8th Cir. 2017).

claim to proceed against the plan administrator.²⁴⁷ The District Court had dismissed that portion of the complaint on the grounds that the plaintiff did not allege an injury caused by or redressable by a third-party plan administrator, who was simply following the terms of the plan it was administering.²⁴⁸ Judge Benton noted that the commentary issued by the HHS's Office for Civil Rights would impose liability under Section 1557 to the plan administrator only if it discriminated in the administration of the plan, or had shared common ownership or control with the employer, or it served as a "subterfuge" in allowing the employer to continue to administering a discriminatory health plan.²⁴⁹ None of those facts were alleged by the employee in her complaint. On June 7th, Tovar filed for a rehearing by all of the judges of the Eighth Circuit, alleging that the three-judge panel erred in treating her claims of sex discrimination under Title VII and MHRA the same.²⁵⁰

VI. CONCLUSION AND BEST PRACTICES

HHS is reconsidering its definition of sex discrimination for purposes of Section 1557. Given President Trump's July 26th Twitter announcement to reinstate the ban on transgender personnel serving in the military in light of the "tremendous medical costs," this may signal that HHS will decide that sex discrimination under Section 1557 does not include gender identity. However, the Supreme Court has granted cert in the *Gloucester County School Bd. v. G.G.* in which it may define the scope of sex discrimination for purposes of Title IX (which is incorporated by reference in Section 1557). For employers, many have amended their group health plans to prohibit categorical exclusions for treatment for dysphoria and to delineate what services and supplies will be covered for transgender employees, their spouses and dependents, so as to comply with the HHS regulations as of January 1, 2017. But unlike pension and profit sharing plans covered by ERISA, there are no anti-cut provisions applicable to welfare plans covered by ERISA. Hence what an employer covers in 2018 could be different and less desirable than what was covered in 2017, but query whether employers will want to do that.

As to the tax treatment of employer-provided medical coverage for transition-related care, the Tax Court affirmed that coverage which is

²⁴⁷ *Id.* at 780.

²⁴⁸ *Id.* at 781.

²⁴⁹ *Id.* at 780-81.

²⁵⁰ *Tovar v. Essentia Health*, No. 16-3186, petition for rehearing filed June 7, 2017 (8th Circ. 2017).

medically necessary to treat the disorder of gender dysphoria would be excludable from federal income tax, whereas supplies and services related to cosmetic treatments would be taxable. This leaves open the question of what is cosmetic in nature – would electrolysis and shaving of one’s Adam apple be regarded as such. From the case law discussed above, there are not many cases that delineate the line between what is medically necessary versus what is cosmetic for a variety of different contexts. Many large employers are providing medical coverage for transition-related care and not imputing any federal income tax for such coverage. Similarly, employers may take federal tax deduction for medically necessary medical coverage for employees, their spouses, and dependents.

Those employers concerned with their HRC CEI ranking have put in place the full range of medical services relating to transgender transition consistent with the WTPATH Standards of Care. Beginning in calendar year 2018 (for the 2019 CEI), all of the employer’s plans will need to exclude blanket exclusions for transition-related care and provide comprehensive transgender benefits under the CEI scoring process.²⁵¹ Other employment practices considered to be “best practices” by HRC include:

- Having non-discrimination policies that cover sexual orientation and gender identify as protected classes with respect to the full range of employment decisions (e.g., hiring, firing, and promoting);
- Having global non-discrimination policies and codes of code for their employees who work outside the United States;
- Establishing standards of conduct for supplies and vendors that reflect the non-discrimination policies of the employer;
- Providing parity between benefits (e.g., health, retirement, disability) for opposite-sex spouses and same-sex partners/spouses and including transgender-inclusive health insurance coverage for medically necessary treatment and care;
- Supporting organizational policies that promote LGBT inclusion (e.g., diversity training, LGBT metrics and evaluation tools, and gender transition guidelines);
- Encouraging transgender employees, with guidelines regarding supportive restroom/facilities, dress code and documentation guidance.²⁵²

²⁵¹ See *supra* note 3, at 13.

²⁵² See *supra* note 3, at 20-32.

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President Trump's tweet raises the issue of the cost of transition-related medical care costs. A 2015 study indicated negligible increases in an employer's medical costs but that was due to the low utilization rate by employees.²⁵³ However, as more employees and their beneficiaries are becoming more open about their transgender status, the utilization rate may rise.

²⁵³ *Study covering transgender health care would be cost effective for insurance companies*, JOHNS HOPKINS UNIV. (Dec. 3, 2015), <https://perma.cc/W86P-46A7>.