

Recasting Transgender-Inclusive Healthcare Coverage: A Comparative Institutional Approach to Transgender Healthcare Rights

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*At the bottom we ask, what of this body is mine to own?
What marrow remains after others have digested their fill?*
—Kris Gebhard, “Disordered Bodies,” *The Naked Eye*¹

The transgender community is one of the most underserved and vulnerable populations in the American healthcare system.² As is the case for many Americans, lack of insurance prevents many transgender people from overcoming the increasing costs of healthcare in general.³ However, when it comes to health insurance, some transgender individuals face a unique and often insurmountable hurdle: the costs of transition-related healthcare.⁴ Transition-related healthcare includes the use of psychotherapy, hormone therapy, and/or surgical procedures for treating the psychological diagnosis of gender dysphoria.⁵ The overwhelming

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1. Kris Gebhard, *Disordered Bodies*, POEMS AND PSAS BLOG (Aug. 25, 2012), <http://krisgebhard.wordpress.com/2012/08/25/disordered-bodies/>.

2. AGENCY FOR HEALTHCARE RES. & QUALITY, U.S. DEP'T OF HEALTH AND HUM. SERVS., NATIONAL HEALTHCARE DISPARITIES REPORT 233 (2011) (discussing healthcare disparities and identifying transgender people as one of the most vulnerable populations).

3. JAMIE M. GRANT ET AL., NAT'L CTR. FOR TRANSGENDER EQUAL., NAT'L GAY & LESBIAN TASK FORCE, INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 76 (2011) [hereinafter NTDS] (“Nineteen percent . . . of the sample lacked any health insurance compared to 17% of the general population.”).

4. *Id.* at 77 (noting that high costs render care “inaccessible to most transgender people”); Liza Khan, *Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform*, 11 YALE J. HEALTH POL'Y L. & ETHICS 375, 380 (2011) (“[F]inancial and health insurance constraints may limit access to services . . .”).

5. WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 9–10 (7th ed. 2012) [hereinafter SOC] (documenting the most comprehensive, current best practices for transgender health care).

majority of medical authority has recognized transition-related care as effective, medically necessary treatment for gender dysphoria.⁶ Moreover, as the growing body of research on transgender health indicates, most transgender individuals receive some form of transition-related care at some point in their lives.⁷ Despite the importance and widespread usage of transition-related care among transgender populations, however, almost all individuals who obtain such care must pay unjustly burdensome prices because the majority of insurance providers exclude coverage for these services.⁸ As a result, many transgender individuals must forgo or limit the type and/or extent of care that they need, or otherwise place themselves in financially dangerous positions.⁹ Despite recent expansions within the American healthcare system,¹⁰ critical disparities in care persist.

Applying a theory of comparative institutional analysis,¹¹ this Note will examine transgender-inclusive healthcare coverage under employment-sponsored insurance (ESI) plans. By

6. *Id.* at 5 (describing medical treatment options as “medically necessary for many people”); Am. Med. Ass’n House of Delegates, *Removing Financial Barriers to Care for Transgender Patients*, Res. 122 (A-08), at 1 (2008), available at http://www.tgender.net/taw/ama_resolutions.pdf.

7. NTDS, *supra* note 3, at 77 (“Most survey respondents had sought or accessed some form of transition-related care. Counseling and hormone treatment were notably more utilized than any surgical procedures, although the majority reported wanting to “someday” be able to have surgery.”).

8. Kari E. Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 COLUM. J. GENDER & L. 88, 96 (2002) (“Many private insurance companies exclude [sex reassignment surgery] and hormone treatments from their coverage.”). See also Khan, *supra* note 4, at 391–401 (outlining the most common justifications insurers use to deny coverage as denial of a pre-existing condition, denial of coverage for cosmetic procedures, and denial of medical necessity).

9. As one transgender individual reported: “The transition and health care has been expensive, all at a time where my main source of income (my law practice) deteriorated. I have exhausted my savings and the equity from selling my home just to pay medical and living expenses.” NTDS, *supra* note 3, at 76.

10. In 2010, President Obama signed into law the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (to be codified in scattered sections of 29 U.S.C. and 42 U.S.C.). As key provisions become operative over the next couple of years, millions of underinsured and uninsured Americans will gain access to quality, affordable health services. CONG. BUDGET OFF., ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 3 (2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>.

11. See *infra* Part I.C for a detailed discussion of comparative institutional analysis.

examining the advantages and disadvantages of pursuing coverage across various institutions—the market, the political process, and the judicial system—this Note aims to shed light on which institution or combination of institutions can best secure affordable, equal access to transition-related procedures for transgender populations. Part I will contextualize this analysis by introducing these institutions and reviewing their role in shaping the current picture of transgender health. This Part will also present the theoretical framework for comparative institutional analysis and explain its utility in advancing this debate. Part II will apply this theoretical framework and explore the institutional costs and benefits of using the market, the political process, and the courts to secure transition-related benefits. Part III will synthesize the strengths and weaknesses of these institutions and discuss the impact of institutional decisions on the struggle for transgender rights.

I. An Overview of Transgender Healthcare Rights Across Institutions

While anti-transgender practices operate at all levels of the healthcare delivery system,¹² inaccessibility to medically necessary transition-related care is one of the most contested, politicized, and confusing pieces of this discriminatory picture.¹³ Problems with access to this type of care tend to arise at two points. The first point, which reflects ideological concerns, is medical diagnosis.¹⁴ The process of obtaining eligibility for transition-related care requires a diagnosis of gender dysphoria, which the fourth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV) defines as “discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth.”¹⁵ As critics have argued, this

12. NTDS, *supra* note 3, at 72 (finding that transgender individuals faced disrespect, harassment, violence, and outright denial of service “whether seeking preventive medicine, routine and emergency care, or transgender-related services”).

13. Dean Spade et al., *Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates*, 8 SEATTLE J. SOC. JUST. 497, 497 (2010) (“Gender-confirming healthcare for transgender people is widely misunderstood, and some of the most popular misunderstandings are reflected in administrative regulations.”).

14. Psychiatric diagnoses are made according to the Diagnostic and Statistical Manual for Mental Disorders. For a discussion on the politics of diagnosis, see, e.g., Judith Butler, *Undiagnosing Gender*, in *TRANSGENDER RIGHTS* 274 (Praisley Currah et al. eds., 2006).

15. AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL*

requirement forces transgender individuals to subscribe to a narrative of psychological disorder, which reinforces the pathologization of gender variance and renders transition-related care inaccessible to those who refuse to submit to a discourse of mental illness.¹⁶ The second point, which reflects more material concerns, is delivery of care. Once transgender individuals have been diagnosed, they must find a medical professional who is willing and able to provide treatment.¹⁷ Considering the fact that transgender individuals tend to face outwardly hostile, aggressively invasive, and/or exclusionary healthcare settings,¹⁸ this step can significantly restrict accessibility. Finally, even after establishing eligibility and locating a provider, problems with delivery often persist because many transgender individuals cannot afford the costs of transition-related care.¹⁹

Accordingly, efforts to secure transgender-inclusive healthcare reflect both ideological and material concerns. With regard to diagnosis, many activists have highlighted the need to de-pathologize transgenderism and have recommended that the medical community abandon mental disorder classification as a prerequisite to care.²⁰ With regards to delivery, a growing number

DISORDERS (4th ed. 2000). Although the DSM-IV uses "gender identity disorder," proposed revisions for the DSM-V refer to "gender dysphoria." See, e.g., Robert Marvin, *Proposed DSM-5 Revisions to Sexual and Gender Identity Disorder Criteria*, 12 AM. MED. ASS'N J. ETHICS 673, 673-77 (2010), available at <http://virtualmentor.ama-assn.org/2010/08/pdf/msoc1-1008.pdf>; see also SOC, *supra* note 5, at 5 ("A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.").

16. Butler, *supra* note 14, at 275 ("To be diagnosed with gender identity disorder is to be found, in some way, to be ill, sick, wrong, out of order, abnormal, and to suffer a certain stigmatization as a consequence of the diagnosis being given at all."); Dallas Denny, *Transgender Communities*, in TRANSGENDER RIGHTS, *supra* note 14, at 184 (referring to terms such as "transsexual" and "gender dysphoria" as "slave names"); Taylor Flynn, *The Ties That (Don't) Bind*, in TRANSGENDER RIGHTS, *supra* note 14, at 36 ("[P]resenting sex from a medico-mental health model risks pathologizing the lives and experiences of transgender individuals.").

17. According to the NTDS, "50% of the sample reported having to teach their medical providers about transgender care." NTDS, *supra* note 3, at 76; see also J. Denise Diskin, *Taking It to the Bank: Actualizing Health Care Equality for San Francisco's Transgender City and County Employees*, 5 HASTINGS RACE & POVERTY L.J. 129, 135 (2008) ("Many . . . have difficulty finding a doctor who is familiar and comfortable providing primary health care services to a transgender person.").

18. See *supra* note 12 and accompanying text. To elaborate, consider the following quote from an NTDS respondent: "I was forced to have a pelvic exam by a doctor when I went in for a sore throat. The doctor invited others to look at me while he examined me and talked to them about my genitals." NTDS, *supra* note 3, at 74.

19. See *supra* note 4 and accompanying text.

20. Butler, *supra* note 14, at 282; see also SOC, *supra* note 5, at 35 (addressing

of sources have comprehensively documented the existence of pervasive, anti-transgender discrimination within the medical context,²¹ and such discrimination is now illegal in some circumstances under federal law.²² Despite widely recognized issues surrounding affordability, however, little progress has been made to make transition-related care financially accessible to the individuals who want and need it. This Note will advocate for increased affordability by assessing how well various institutions can achieve this goal.

A. The Current Picture: Market Dominance, Political Inefficiency, and Judicial Inaction

Financial barriers to transition-related care persist because political inefficiency and judicial inaction have made the market the primary institutional decision-maker, even though the market is a woefully inadequate institution for securing transgender-inclusive benefits. Guided by economic principles, the majority of public and private healthcare insurance plans specifically exclude coverage for some or all transition-related services.²³ Insurers believe transgender-inclusive healthcare coverage is economically unsound²⁴ because they incorrectly assume all transgender individuals always seek the most expensive transition-related procedures.²⁵ Furthermore, because only transgender people

the informed consent model).

21. NTDS, *supra* note 3, at 72.

22. For instance, under the ACA, § 1557, it is illegal for covered entities to deny routine care to a patient on the basis of that person's transgender status. *See infra* notes 170, 171 and accompanying text.

23. Hong, *supra* note 8, at 96 (discussing exclusion clauses under private insurance plans); Nicole M. True, *Removing the Constraints to Coverage of Gender-Confirming Healthcare by State Medicaid Programs*, 97 IOWA L. REV. 1329, 1340 (2012) ("State Medicaid programs typically deny coverage for treatments falling under the last two stages of triadic therapy: hormone therapy and surgical procedures."); Spade et al., *supra* note 13, at 500 ("No state's Medicaid regulations explicitly include this care. Instead, twenty-eight states have no explicit regulations regarding this care, and either accept or reject claims for reimbursement on a case-by-case basis, while at least twenty-one states have explicit regulations excluding coverage of this care.").

24. Hong, *supra* note 8, at 96 ("Insurance companies defend the exclusion clause denying coverage . . . as a reasonable measure to contain costs and disallow superfluous procedures.").

25. To the contrary, not all transgender individuals seek medical intervention for transition procedures, and not all transgender individuals who seek intervention seek all available types of care. *See* Khan, *supra* note 4, at 402 ("[T]here is no one-size-fits-all treatment for gender variance."); Spade et al., *supra* note 13, at 497; *Health Insurance Discrimination for Transgender People*, HUM. RTS. CAMPAIGN, <http://www.hrc.org/resources/entry/health-insurance->

receive transition-related services,²⁶ insurers do not have to run the risk that these exclusions will alienate any significant portion of their customer base.²⁷

Political efforts to gain transition-related healthcare coverage despite perceptions of unreasonably high economic risk remain stunted by transphobic social norms.²⁸ Due to widespread anti-transgender bias, insurers can ignore studies that undermine the validity of economic rationales,²⁹ insist that transition-related care is medically unnecessary³⁰ despite medical authority that states otherwise,³¹ and rest assured that such exclusions will elicit little, if any, public admonition.³² Furthermore, political demands for transgender-inclusive employment legislation have been unsuccessful,³³ and similar demands for transgender-inclusive healthcare legislation have sidestepped the issue of transgender-inclusive healthcare.³⁴

In turn, society's unwillingness to respond to transgender

discrimination-for-transgender-people (last visited Apr. 21, 2013) (countering myths about the utilization of transition-related services).

26. To clarify, transition-related services refer to treatment for gender dysphoria, and only transgender individuals receive diagnoses of gender dysphoria. However, many cisgender individuals receive the same medical treatment for different diagnoses. Insurers routinely cover hormone treatments for "menopause, prostate cancer, and growth hormone deficiencies," as well as surgical procedures like hysterectomies and breast reconstruction for women with breast cancer. Khan, *supra* note 4, at 404–05.

27. Transgender population estimates range from .25% to one percent of the population. NAT'L CTR. FOR TRANSGENDER EQUAL., UNDERSTANDING TRANSGENDER 1 (2009), available at http://transequality.org/Resources/NCTE_UnderstandingTrans.pdf.

28. Hong, *supra* note 8, at 100 (noting that transgender individuals lack the "necessary political clout" to secure coverage under private healthcare plans "due to the enormous social hostility they face"); Khan, *supra* note 4, at 388 (arguing that gender variance "does not provoke the popular sympathy and support that more common health conditions incite").

29. See *infra* Part II.B(i).

30. Khan, *supra* note 4, at 388, 391, 398–400.

31. See *infra* note 189.

32. Khan, *supra* note 4, at 378 (describing exclusions as "politically harmless" for employers).

33. The Employment Non-Discrimination Act, first introduced in Congress in 1994, has remained stalled in the legislature. See *Employment Non-Discrimination Act (ENDA)*, NAT'L GAY & LESBIAN TASK FORCE, http://www.thetaskforce.org/issues/nondiscrimination/ENDA_main_page (last visited Nov. 10, 2012). For information about why federal legislation protecting LGBT individuals in employment is necessary, see, e.g., Nat'l Ctr. for Transgender Equal., *ENDA by the Numbers*, http://transequality.org/Resources/enda_by_the_numbers.pdf (last visited Apr. 22, 2013).

34. See *infra* Part II.B(ii).

discrimination incites, and is incited by, judicial unwillingness to name, prohibit, or remedy it.³⁵ Indeed, legal challenges to both public³⁶ and private insurance³⁷ exclusions have generally failed to secure affordable, transgender-inclusive healthcare. Whereas courts have handled state Medicaid exclusions as matters of state legislation subject to federal restrictions,³⁸ courts have simply refused to handle exclusions in ESI plans altogether. Courts have not only interpreted ESI exclusions as “bargained-for” terms under contract law,³⁹ but have also denied protection under civil rights statutes because, until recently, courts did not consider transgender discrimination to constitute discrimination on the basis of sex.⁴⁰ Transphobic exclusions in the realm of private healthcare have thus essentially remained virtually untouchable by law. As illustrated, economic, political, and judicial institutions have so far failed to materially advance transgender equality with regards to transition-related care.

B. Legal and Political Developments: Emerging Institutional Shifts

Against the backdrop of these institutional failures, recent

35. See *infra* notes 39 and 40.

36. In the absence of state regulations excluding coverage, individuals have been successful. See, e.g., *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980); *Doe v. Minn. Dep’t of Pub. Welfare*, 257 N.W.2d 816 (Minn. 1977). Under state regulations excluding coverage, however, individuals have been unable to win coverage. See, e.g., *Smith v. Rasmussen*, 249 F.3d 755, 761 (8th Cir. 2001). “[T]o date, all of the courts that have been presented with an existing statutory or regulatory prohibition on coverage . . . have upheld the exclusionary provision and affirmed the denial of coverage.” True, *supra* note 23, at 1348.

37. Although these exclusions have been documented, it is important to realize that compared to exclusions under public insurance, there is very little documentation of denials from private insurers. See Hong, *supra* note 8, at 94.

38. See True, *supra* note 23, at 1341.

39. In the absence of exclusion clauses, claims for transition-related coverage have been successful. See *Davidson v. Aetna Life & Cas. Ins. Co.*, 420 N.Y.S.2d 450 (N.Y. Sup. Ct. 1979). Once exclusions are written into contracts, however, courts have refused to compel coverage. Hong, *supra* note 8, at 99 (“[A]ny disputes between a patient and her private insurer are a matter of contract law.”). Although this Note discusses judicial inaction in the age of transgender-specific exclusion clauses, the ironic backstory is that the judicial act of favorable contract law interpretation has spurred employers to author these clauses in the first place. This is not to say that *Davidson* was decided incorrectly, but rather that perhaps judicial action has stopped prematurely.

40. See, e.g., *Ulane v. E. Airlines, Inc.*, 742 F.2d 1081, 1085 (7th Cir. 1984). For an illustration of the expansion of “sex discrimination” under Title VII, see Cary Franklin, *Inventing the “Traditional Concept” of Sex Discrimination*, 125 HARV. L. REV. 1307 (2012).

legal and political advancements have revealed potential pathways to transgender-inclusive care. Within the legal system, the concept of transgender discrimination as a form of actionable sex discrimination—reified by numerous Courts of Appeals over the past decade⁴¹—has emerged as a viable path to achieving transgender rights. In *Macy v. Holder*,⁴² a transgender woman named Mia Macy applied for a job as a ballistics technician at a federal Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) laboratory in Walnut Creek, California.⁴³ At the time of her application, Macy presented as a man.⁴⁴ Given her extensive qualifications, ATF initially told her that the job was hers, but subsequently offered the position to a cisgender⁴⁵ candidate after Macy informed ATF of her intent to transition into a female.⁴⁶ While ATF agreed to process Macy's sex discrimination claim under Title VII, ATF argued that her "gender identity stereotyping" claim was conceptually distinct and could not be processed under Title VII.⁴⁷ The EEOC held that ATF had discriminated against Macy on the basis of her status as a transgender person, and further held that discrimination based on transgender status constituted impermissible discrimination on the basis of sex under Title VII of the Civil Rights Act of 1964.⁴⁸ By opening the door for transgender employees to bring discrimination claims under federal sex discrimination law, *Macy* calls into question employment practices—like health insurance exclusions—that solely disadvantage transgender employees. The legal recognition of transgender people as a protected class means that courts must intervene when employers engage in anti-transgender discrimination.⁴⁹

41. See *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2001); *Smith v. City of Salem*, 378 F.3d 566, 575 (6th Cir. 2004); *Rosa v. Park West Bank & Trust*, 214 F.3d 213, 215 (1st Cir. 2000); *Schwenk v. Hartford*, 204 F.3d 1187, 1201 (9th Cir. 2000); *Schroer v. Billington*, 577 F. Supp. 2d 293, 305 (D.C. 2008).

42. 2012 WL 1435995 E.E.O.C. (2012).

43. *Id.* at *1.

44. *Id.*

45. Cisgender is a term used to describe people who generally identify as the gender they were assigned at birth. *Trans 101: Cisgender*, BASIC RTS. OR. (Oct. 11, 2011), <http://www.basicrights.org/uncategorized/trans-101-cisgender/>.

46. *Macy*, 2012 WL 1435995 E.E.O.C. at *1–2 (2012).

47. *Id.* at *2–3.

48. *Id.* at *11.

49. See Jack M. Balkin & Reva B. Siegel, *The American Civil Rights Tradition: Anticlassification or Antisubordination*, 58 U. MIAMI L. REV. 9, 22 (2003) (explaining that Title VII applies to all employers and protects members of protected classes from discrimination by their employers).

These legal expansions occur amidst a trend of positive, though limited, developments established through the political process. In the past decade, political pressures from interest groups have encouraged a growing number of employers to elect transgender-inclusive healthcare plans.⁵⁰ In 2001, as a result of lobbying and advocacy efforts, the City of San Francisco became the first major U.S. employer to adopt a transgender-inclusive healthcare plan for its employees.⁵¹ Between 2001 and 2004, the city collected and produced data conclusively demonstrating the low cost of transition-related benefits to employers.⁵² The availability of this data has undoubtedly made some employers more receptive to the idea of providing similarly inclusive healthcare plans.⁵³ In 2006, the Human Rights Campaign (HRC), a national LGBT advocacy organization, began documenting the accessibility of transgender-inclusive healthcare benefits in their annual Corporate Equality Index (CEI) publications.⁵⁴ Over the years, the addition of this criterion has pushed many employers to offer plans that cover transition-related benefits, as illustrated by the following graph:⁵⁵

50. Spade et al., *supra* note 13, at 500.

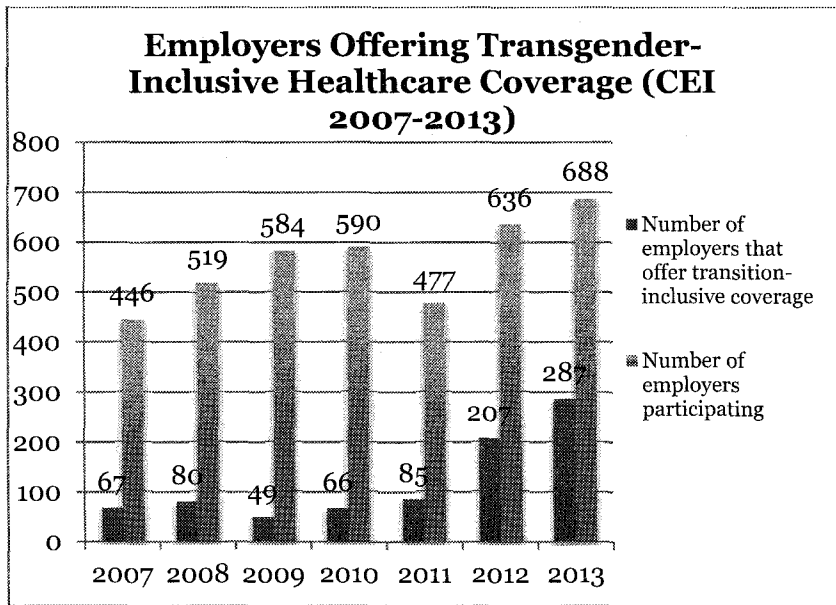
51. Diskin, *supra* note 17, at 129–30.

52. *Id.* at 159. For details on the data collection, see *infra* Part II.B.

53. The Human Rights Campaign publicizes this data to advocate for transgender-inclusive healthcare. *Transgender-Inclusive Benefits: Medical Treatment Cost and Utilization*, HUM. RTS. CAMPAIGN, <http://www.hrc.org/resources/entry/transgender-inclusive-benefits-medical-treatment-cost-and-utilization> (last visited Dec. 1, 2012).

54. See HUM. RTS. CAMPAIGN, *CORPORATE EQUALITY INDEX 2006: A REPORT CARD ON GAY, LESBIAN, BISEXUAL & TRANSGENDER EQUALITY IN CORPORATE AMERICA* (2006). Using a variety of criteria to assess workplace practices and policies, the CEI rates large United States employers for LGBT inclusivity. *Corporate Equality Index*, HUM. RTS. CAMPAIGN, <http://www.hrc.org/corporate-equality-index/#.UKQyzmnwIWE> (last visited Nov. 13, 2012).

55. All graphs are drawn from information available from the HRC. See *CORPORATE EQUALITY INDEX 2006*, *supra* note 54; HUM. RTS. CAMPAIGN, *CORPORATE EQUALITY INDEX 2008: A REPORT CARD ON GAY, LESBIAN, BISEXUAL & TRANSGENDER EQUALITY IN CORPORATE AMERICA* (2008); HUM. RTS. CAMPAIGN, *CORPORATE EQUALITY INDEX 2009: A REPORT CARD ON GAY, LESBIAN, BISEXUAL & TRANSGENDER EQUALITY IN CORPORATE AMERICA* (2009); HUM. RTS. CAMPAIGN, *CORPORATE EQUALITY INDEX 2010: A REPORT CARD ON GAY, LESBIAN, BISEXUAL & TRANSGENDER EQUALITY IN CORPORATE AMERICA* (2010); HUM. RTS. CAMPAIGN, *CORPORATE EQUALITY INDEX 2011: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL & TRANSGENDER EQUALITY* (2011); HUM. RTS. CAMPAIGN, *CORPORATE EQUALITY INDEX 2012: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL & TRANSGENDER EQUALITY* (2012); HUM. RTS. CAMPAIGN, *CORPORATE EQUALITY INDEX 2013: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL & TRANSGENDER EQUALITY* (2013). To be consistent with current HRC naming practices that began in 2008, the 2007 data reflects data from the



Although most U.S. employers continue to offer plans that contain blanket exclusions for transition-related care, the San Francisco example and visible trends in segments of corporate America shine some light on the efficacy of political processes in the battle for transgender-inclusive healthcare.

C. The Analytic Framework: Comparative Institutional Choice

In the wake of promising legal and political developments arises an important question: what is the most efficient and strategic way to proceed? Which alternative can best achieve—or come closest to achieving—affordable, transgender-inclusive healthcare: continued reliance on the market process, increased political advocacy, or perhaps a Title VII lawsuit that could undercut economic and politically discriminatory rationales? Markets, political processes, and court systems alike have strengths and weaknesses that could simultaneously help and hinder the fight for transition-related care. In order to predict

which path to action might produce the best results, this Note will apply a theory of comparative institutional analysis to assess the relative capabilities of each institution to achieve this goal.

At its core, “[c]omparative institutional analysis begins with an analysis of how institutions shape forms of economic organization and the consequence of this for performance outcomes.”⁵⁶ The central focus of comparative institutional analysis, which has been applied to numerous disciplines and geographies,⁵⁷ is the “duality of structure and agency.”⁵⁸ More specifically, because each institutional setting possesses unique sets of rules and actors,⁵⁹ the setting-specific interactions between rules and players will yield different results.⁶⁰ A comparison of these interactions should therefore inform strategy. Several key principles ground this analysis. First, actors influence institutions through behavior and institutions mold actors through regulative, normative, and cognitive pressures.⁶¹ Relatedly, neither actor interests nor institutional pressures are exogenous or static because both morph over a trajectory of dynamic tension.⁶² Finally, while all institutions function well in ideal, “frictionless”⁶³

56. Glenn Morgan et al., *Introduction*, in OXFORD HANDBOOK OF COMPARATIVE INSTITUTIONAL ANALYSIS 5 (Glenn Morgan et al. eds., 2010) [hereinafter CIA HANDBOOK].

57. *Id.* at 7 (describing comparative institutional analysis’ international focus on the European and Asian contexts, as well as its research application across areas “from politics to business and management to sociology”).

58. Gregory Jackson, *Actors and Institutions*, in CIA HANDBOOK, *supra* note 56, at 66.

59. *Id.*

60. Susan Freiwald, *Comparative Institutional Analysis in Cyberspace*, 14 HARV. J.L. & TECH. 569, 575 (2001) (“As a positive matter, the analysis predicts the different outcomes that will arise in various institutional settings based on the actors’ incentives in each setting.”).

61. Jackson, *supra* note 58, at 67; Gregory Jackson, *Actors and Institutions*, in CIA HANDBOOK, *supra* note 56, at 76:

Regulative institutions are based on the making and enforcement of rules, such as formal laws that regulate behaviour. Normative institutions are rooted in collective moral understandings about legitimate behaviour. Cognitive institutions are those based on taken-for-granted definitions of the situation and worldviews. These categories are analytically distinct, and imply different mechanisms of institutionalization and carriers of institutional effects. Empirically, however, institutions may be underpinned by all three dimensions to various degrees.

Id.

62. *Id.* (“While the parameters of an institution appear as exogenous and fixed to actors in the short-term, they must be considered variable in the long run.”).

63. NEIL K. KOMESAR, *LAW’S LIMITS: THE RULE OF LAW AND THE SUPPLY AND DEMAND OF RIGHTS* 22 (2001):

It will not do to compare a real world, highly imperfect adjudicative

contexts, high numbers and high complexity consistently result in low institutional performance;⁶⁴ institutions "move together"⁶⁵ in the sense that factors that increase or decrease performance tend to do so across the board. Comparative institutional analysis thus helps us select the best option from a range of "bad or unattractive alternatives."⁶⁶

In his book, *Law's Limits: The Rule of Law and the Supply and Demand of Rights*, Professor Neil Komesar sets forth a participation-centered model of comparative institutional analysis that ties institutional performance with "the pattern of participation of important . . . actors common to all the institutions."⁶⁷ The "central tenet" of this approach is that social policy goals depend upon the participation of interested parties, and that parties will participate in furthering a goal only when the benefits of participation outweigh its costs.⁶⁸ Participation benefits relate to "the distribution of benefits or stakes across the relevant populations."⁶⁹ Conversely, participation costs⁷⁰ relate to the costs of organizing action and disseminating information, which increase significantly when actors are numerous and issues are complex.⁷¹ Here, it is critical to recognize the dynamism between institutions and actors noted above; while actor participation dictates institutional change, the rules and procedures of institutions control participation.⁷² Based on this approach,

process with a frictionless political process. Like the frictionless market and the frictionless adjudicative process, a frictionless political process is an obvious solution. But it is also an unavailable solution. Like all real-world institutions, the political process is never frictionless.

Id.

64. *Id.* at 21-22 (observing that the market, judicial system, and political process deteriorate at high numbers and high complexity).

65. *Id.* at 23.

66. *Id.* at 24.

67. *Id.* at 30. This approach turns "an eye toward making significant contributions to public policy debates." Freiwald, *supra* note 60, at 575.

68. Freiwald, *supra* note 60, at 575-76. If informational and organizational costs outweigh the benefits of a favorable outcome, actors cannot participate or advocate for their interests. *Id.* at 576.

69. KOMESAR, *supra* note 63, at 30.

70. Transaction costs in the market, litigation costs in court, or political participation costs. *Id.*

71. *Id.*

72. KOMESAR, *supra* note 63, at 31 ("[I]nstitutional economists believe that economic activity is a function of transaction costs and that transaction costs are a function of laws, rules, and customs."); Freiwald, *supra* note 60, at 577 ("[I]nstitutions themselves create their own costs that affect whether a given institution will adequately take account of all interests.").

comparative institutional analysis is significant because it illustrates how the delegation of institutional responsibility impacts the allocation of individual rights.⁷³

This type of analysis is useful here because the topic of transgender healthcare presents a complex intersection of health, employment, and civil rights issues that no institution has successfully grasped. The failure to arrive at a just solution for this issue relates to the high number of interested actors against coverage, the low number of interested actors in favor of coverage, and the complexity of the issue at hand. At a minimum, transgender-inclusive ESI plans implicate virtually all employers, the health insurance providers with which they contract, and all transgender and cisgender employees who help bear the cost of group health plans. Professor Komesar notes that high numbers may be particularly detrimental to institutional performance when “transactions have serious effects on others not party to the transaction.”⁷⁴ In this case, employers transact with insurance companies to purchase exclusionary ESI plans that deny transgender employees the option for medically necessary coverage. Although transgender employees are the individuals most harmed by these transactions, they remain voiceless because their small population size prevents them from realistically influencing employer decisions.

This issue is complex because of the procedural nuances inherent in American health insurance systems and the political and moral judgments that transgender-inclusive care implicates. Technical difficulties such as the interplay between state and federal management of health insurance, variations across individual, small-group, and large-group markets, and the future repercussions of the Affordable Care Act (ACA) make questions about content regulation challenging to address.⁷⁵ In addition, Professor Komesar observes that less mechanical, more ideological complexities, such as “concerns about aesthetics or community values,”⁷⁶ may equally frustrate institutional performance. Transgender-specific healthcare exclusions involve more than economic rationales; socially engrained views about the intrinsic

73. KOMESAR, *supra* note 63, at 20 (“[V]ariation in institutional choice dictates variation in law and rights.”).

74. *Id.* at 25.

75. See Amy B. Monahan, *The ACA, the Large Group Market, and Content Regulation: What's a State to Do?*, 5 ST. LOUIS U. J. HEALTH L. & POLY 83, 86–92 (2011) (problematizing issues of content regulation under the ACA).

76. KOMESAR, *supra* note 63, at 25.

nature of biological sex characteristics⁷⁷ and the rigidity of the gender binary turn transition-related healthcare into a site of moral contestation.⁷⁸ These cisgender norms complicate determinations of medical necessity, the role of employer responsibility, and the exercise of transgender autonomy.

Taking Professor Komesar's approach to comparative institutional analysis, this Note will explore how well the market (the current model), the political process (the emerging model), and the judicial system (the potential future model) work to achieve the goal of transgender-inclusive healthcare under ESI plans. By comparing the strengths and weaknesses of institutional structures and the costs and benefits of actor participation within each context, this Note aims to discern which institution can effectively secure transition-related benefits. Ultimately, this Note serves to strategize future efforts by contextualizing the consequences of the status quo, political and/or legislative (in)action, and judicial intervention.

D. A Note on Diagnosis and the Importance of Transition-Related Care

This section will preface the analysis with two contextual points. The first is that aside from insurance coverage and financial accessibility, there remain other significant hurdles to transgender-inclusive healthcare. Problematizing affordability issues does not directly address the stigma inherent in requiring a mental disorder diagnosis for transition-related care.⁷⁹ However, concerns about the medically imposed framework of eligibility should not necessarily preclude efforts to increase financial accessibility once this problematic eligibility has been granted. "[I]f the diagnosis is now the instrument through which benefits and status can be achieved, it cannot be simply disposed of without finding other, durable ways to achieve those same results."⁸⁰ Improving affordability within the current system remains imperative, insofar as no such other, durable method exists. Admittedly, because points of inaccessibility to

77. Anne C. DeCleene, *The Reality of Gender Ambiguity: A Road Toward Transgender Health Care Inclusion*, 16 L. & SEXUALITY 123, 131-33 (2007) (referring to the "God" method).

78. Dean Spade, *Compliance Is Gendered*, in TRANSGENDER RIGHTS, *supra* note 14 at 228 (referring to "rigidly defined and harshly enforced understandings of binary gender").

79. See *supra* note 16 and accompanying text.

80. Butler, *supra* note 14, at 280.

transgender-inclusive healthcare function together, advocating for access within the current framework necessarily runs the risk of implicitly legitimizing its mechanics.⁸¹

The second point is that affordability matters because transition-related care can be life-changing and even life-saving for many transgender individuals.⁸² Although not all transgender individuals wish to obtain transition-related healthcare, ensuring accessibility to this type of care can have significant individual, social, and systemic benefits. These benefits, however, are largely contextual, in that they relate directly to the individual, social, and systemic costs of gender variance in a violently cisgender society.⁸³ On an individual level, transgender populations face disturbingly high rates of individual suffering and self-harm;⁸⁴ according to the National Transgender Discrimination Survey (NTDS), forty-one percent of all respondents had attempted suicide.⁸⁵ Transgender populations also experience high levels of violence by others.⁸⁶ For example, the NTDS reports that transgender populations face elevated levels of physical assault (thirty-five percent),⁸⁷ harassment, mistreatment, or discrimination in employment (ninety percent),⁸⁸ and harassment in education (seventy-eight percent),⁸⁹ and places of public accommodation (fifty-three percent);⁹⁰ and denial of services in housing (nineteen percent)⁹¹ and healthcare (nineteen percent).⁹²

81. *Id.*

82. NTDS, *supra* note 3, at 77.

83. See, e.g., Nat'l Ctr. for Transgender Equal., *Ending Anti-Transgender Violence*, available at http://transequality.org/Resources/NCTE_Blueprint_for_Equality2012_Ending_Violence.pdf (last visited Apr. 22, 2013) (detailing the extent of anti-transgender violence).

84. Anne A. Lawrence, *Transgender Health Concerns*, in *THE HEALTH OF SEXUAL MINORITIES* 491–92 (Ilan H. Meyer & Mary E. Northridge eds., 2007) (finding that transgender individuals “appear to be at increased risk for completed suicide, suicide attempts, and other forms of self-harm”).

85. NTDS, *supra* note 3, at 82. The average rate for attempted suicide in the United States is 1.5%. *Id.*

86. By violence, I mean physical violence and non-physical forms of discrimination like harassment and bullying. “The attempt to split bias from violence has been this society’s most enduring and fatal rationalization.” PATRICIA WILLIAMS, *THE ALCHEMY OF RACE AND RIGHTS* 61 (1992). A broader understanding of violence helps us think more critically about the ways in which social forces prevent transgender people from accessing opportunities.

87. NTDS, *supra* note 3, at 3.

88. *Id.*

89. *Id.*

90. *Id.* at 5.

91. *Id.* at 4.

Finally, transgender populations face systemic forms of violence as well. Transgender populations face disproportionately high levels of incarceration⁹³ and homelessness,⁹⁴ and may be unable to obtain identification documents that match their lived gender.⁹⁵ Often, violence stems from overlapping personal, societal, and systemic forces.

Transition-related healthcare has the potential to help alleviate many forms of violence. Personally, transition-related care may empower transgender individuals who require medical facilitation to fully realize their lived gender, and this sense of physical, emotional, and spiritual congruence can have positive health outcomes.⁹⁶ Perceived congruence between bodily and performative gender by others may also reduce levels of violence within society.⁹⁷ Furthermore, utilization of gender-confirming medical care has provided grounds for legal recognition and issuance of updated identification documents.⁹⁸ Taken together, individually experienced, socially perceived, and systemically acknowledged congruence between expressed and documented gender identity works to open various economic opportunities to transgender populations.⁹⁹

At the outset, this view of gender-confirming care is largely illusory because it presents medically facilitated gender conformance as a solitary solution, and it portrays a falsely linear progression of overlapping, often cyclical events.¹⁰⁰ Gender conformance is not a solution to ending anti-transgender violence

92. *Id.* at 6.

93. NTDS, *supra* note 3, at 163 (statistics for incarceration “exceed those of the general population for prisons, in some cases by many times”).

94. *Id.* at 107 (“1.7% of the sample responded that they were currently homeless or living in a shelter, which is nearly double the percentage that the National Coalition for the Homeless estimates for the U.S. population.”); *id.* at 112 (reporting that nineteen percent of respondents reported homelessness “as a result of discrimination or family rejection based on gender identity,” which is “2.5 times higher than the general population lifetime rate of homelessness”).

95. Seventy-nine percent of respondents had not updated all of their documents; thirty-three percent were unable to update any documents. *Id.* at 5.

96. Transition-related care can “maximize [transgender individuals’] overall health, psychological well-being, and self-fulfillment.” SOC, *supra* note 5, at 1.

97. For instance, gender conformance decreases violence within healthcare settings. NTDS, *supra* note 3, at 75.

98. Spade, *supra* note 78, at 228.

99. *Id.* at 217–18 (discussing the gendered nature of economic coercion).

100. Lawrence, *supra* note 84, at 642 (“Trans-people are subjected to both interpersonal and structural prejudice and discrimination, which in practice are very difficult to disentangle.”).

or discrimination, but “[t]he isolating of only some of these processes for critique, while ignoring others, is a classic exercise in domination.”¹⁰¹ Gender-confirming healthcare also cannot open economic opportunities if a lack of economic opportunities bars individuals from obtaining such care. Furthermore, understanding gender conformance as merely a remedial response to violence hinders understanding medically facilitated transitions as acts of autonomy and self-determination.¹⁰² With these shortcomings in mind, however, outlook may help conceptualize the role that gender-confirming healthcare can play at individual, social, and institutional levels in order to illuminate why ensuring its availability is a crucial component of securing transgender rights.

II. A Comparative Institutional Analysis of Transgender Healthcare Rights: Weighing the Costs and Benefits of Economic, Political, and Legal Participation

A. The Market: The Current Model

Except for the recent and limited institutional shifts discussed below, market processes have governed transition-related coverage under ESI plans since exclusion policies became the norm.¹⁰³ The historic inability of political processes to support transgender health,¹⁰⁴ combined with judicial unwillingness to intervene, has made the market the default institutional choice for determining the right to transition-related care. It is important to recognize that this relegation of decision-making still constitutes an institutional choice that implicates structural and participatory costs and benefits. As this Section will explain, the procedural limitations of free market principles and the inability of transgender employees to exercise consumer rights have resulted in a virtual bar to transition-related services. These costs make market regulation antithetical to the goal of healthcare equality.

101. Dean Spade, *Dress to Kill, Fight to Win*, LTTR, <http://lttr.org/journal/1/dress-to-kill-fight-to-win> (last visited Nov. 5, 2012).

102. *Id.* (countering the assumption that transition-related surgery has a single meaning).

103. See *Davidson v. Aetna Life & Cas. Ins. Co.*, 420 N.Y.S.2d 450 (N.Y. Sup. Ct. 1979).

104. See Spade, *supra* note 78, at 228–33 (identifying the limits of the “gay rights” agenda).

1. The Structural Costs and Benefits of the Market

In theory, the key institutional benefit of the free market is its ability to make virtually all products available.¹⁰⁵ Therefore, under market principles, goods that are unpopular—for instance, transgender-inclusive healthcare plans—will remain available for consumption as long as consumer demand exists.¹⁰⁶ As the absence of transition-related coverage demonstrates, however, some products remain unavailable for purchase despite demands. Relatedly, Professor Komesar notes that the “miracle of the market” occurs only when actors can transact independently, thus allowing “the atomistic forces of competition to deliver goods and services from many to many.”¹⁰⁷ When participation costs prevent actors from exercising consumer autonomy, a system that conditions product availability on the bargaining power of consumers perpetuates exclusion, turning the theoretical benefit of non-regulation into a cost.¹⁰⁸ Although blanket exclusions for transition-related care constitute legally “bargained-for” terms of employment contracts, employees rarely have the power to bargain for terms of coverage: individual employees are generally stuck with the insurance carriers and plans selected by their employers,¹⁰⁹ and “individual consumers simply do not have the power to force a multi-million dollar company to change any terms of the blanket policy it offers to thousands, if not millions, of customers.”¹¹⁰ Furthermore, in this case, bargaining power implicates not simply the willingness to pay more, but the willingness to accept employment. The institution of the market thus imposes severe costs to the goal of transition-related care.

2. The Costs and Benefits of Market Participation

The current bar to coverage for transition-related care reflects unequal levels of participation between employers and employees. For employers, the primary benefit of participating in

105. KOMESAR, *supra* note 63, at 27.

106. *Id.* at 27–28 (“Pro-market proponents can claim this informal world [of market transactions] as their own because it shows that individuals can imaginatively and creatively operate outside of legislatures, bureaucracies, and courts.”).

107. *Id.* at 25.

108. *Id.* at 28 (noting that people skeptical of the market “see these informal settings as indicative of the power of cooperation and the real possibility of communitarian activity”).

109. Khan, *supra* note 4, at 394.

110. Hong, *supra* note 8, at 100.

market transactions that exclude coverage is the freedom to avoid paying insurance claims for transition-related care.¹¹¹ Theoretically, the costs of employer participation in such an institution might include the loss of potential consumers who could help spread insurance risks,¹¹² or the loss of labor to competitors if maintaining employment contracts with transgender employees constituted a material business interest.¹¹³ However, due to the small number of transgender employees in American workplaces, the risks of labor losses are negligible.¹¹⁴ Furthermore, employers tend to assume that individuals with gender variance will always seek medical intervention;¹¹⁵ that treatment for these conditions would be radically expensive and burdensome for the company;¹¹⁶ and that extending this type of care would attract a flood of transgender individuals who would enroll to exploit these benefits.¹¹⁷ The determination that transgender populations lack an “insurable interest”¹¹⁸ as high-risk consumers thus negates the risks of losing cost-spreading insurance consumers. Because the benefits significantly outweigh the costs, market participation is possible for employers.

In contrast, the oppressive transaction costs for transgender employees render participation impossible. Although transgender employees have immeasurably high stakes in securing the freedom to purchase medically necessary healthcare, these benefits cannot offset the organizational and informational costs of individual participation. On the organizational side, small numbers impede establishing a significant demand for transgender-inclusive

111. Khan, *supra* note 4, at 389 (“It is not difficult to see why health insurers operating in an unregulated, competitive market would be inclined to exclude transition-related care from their list of covered benefits.”). *But see* Hong, *supra* note 8, at 97 (insisting that this benefit is a pretext for discrimination because some employers elect coverage).

112. *See* Monahan, *supra* note 75, at 91 (discussing cost efficiencies of health insurance in the group market).

113. As the HRC CEI has shown, publically demonstrating a commitment to diversity is a material business interest. *See supra* Part II.B(i).

114. Diskin, *supra* note 17, at 139 (“[I]t is far more rare to find employers willing to financially invest in policies that increase workplace equality.”). The exception is when the loss of transgender labor is tied to larger issues of LGBT equality. In these instances, the true cost is not the risk of losing transgender labor itself, but the risk that failing to satisfy a commitment to LGBT equality will threaten economic success. In general, these costs only seriously arise for large employers. *See supra* Part II.B(ii).

115. *See supra* note 25 and accompanying text.

116. *See supra* note 24 and accompanying text.

117. Khan, *supra* note 4, at 389 (referring to the “moral hazard problem”).

118. *Id.* at 388.

healthcare; on the informational side, the difficulty of educating reluctant employers about the importance of coverage impedes justifying a supply. For transgender employees, the high costs of participation thus relate directly to the structural constraints of bargaining for diffuse interests.¹¹⁹ Although some insurance carriers¹²⁰ offer transgender-inclusive healthcare plans, transgender employees cannot afford to participate in the transaction process because the costs of influencing employer purchases as individuals are impossibly high.

B. The Political Process: The Emerging Model

In some circumstances, activists have had some success in shifting the regulation of transition-related care under ESI plans from market forces to the political process. The political process has illustrated significant structural advantages, which include the capacity to question and contradict “neutral” financial costs, the power of group representation, and the ability to present coverage optimistically as a benefit to employers and employees alike. Conversely, the political process also poses structural disadvantages due to its reliance on employer goodwill, its unequal influence based on employer size, and its inability to articulate complex forms of discrimination. Although the costs and benefits of political participation often parallel the costs and benefits of market participation, the political process may equalize the burdens of participation between employers and employees in some cases.

1. The Structural Benefits of the Political Process

One major institutional benefit of the political process is its capacity to address inequalities in the market.¹²¹ Under market principles, employer assumptions about the costs of coverage are assumed to reflect realities in supply and demand, and thus remain unchecked. In the political process, however, appeals to

119. Freiwald, *supra* note 60, at 577 (“The ability of market transactions to resolve conflicts involving diffuse interests depends on whether the transaction costs involved exceed the benefits. Those benefits correspond to the participants’ stakes in the outcome.”).

120. HUM. RTS. CAMPAIGN, TRANSGENDER-INCLUSIVE HEALTH CARE COVERAGE AND THE CORPORATE EQUALITY INDEX 15–16 (2012) [hereinafter HRC COVERAGE] (providing a list of major insurance carriers that administer coverage under at least one plan).

121. Spade, *supra* note 78, at 230 (documenting the growth of the transliberation movement and its potential to address the economic oppression of capitalism).

social justice may allow dedicated interest groups to question the validity and fairness of these assumptions.¹²² Indeed, transgender activists have utilized the political process to challenge the assumption that insurance coverage would automatically result in insurmountable economic burdens for the employer. In 2001, the City of San Francisco became the first major American employer to provide transgender-inclusive healthcare to its employees.¹²³ Lobbying from transgender activists between 1996 and 2001 provided the impetus for these inclusive changes.¹²⁴ Significantly, the political process through which the city secured these employee benefits produced a paper trail of financial statistics. Originally, opponents of expanded coverage feared that transgender people would “flock”¹²⁵ to the city for expensive sex change procedures, and the city projected that in the first year, thirty-five individuals would claim transition-related benefits for a total annual cost of \$1.75 million.¹²⁶ In fact, in the first three years, the city spent only \$182,374.33 on eleven claims.¹²⁷ By pushing the City of San Francisco to confront the economic unreasonableness of exclusion, political pressures helped to counter false assumptions about the true costs of such care,¹²⁸ and influenced some employers to adopt more trans-inclusive policies.

Secondly, the political process allows members of socially unpopular minority groups to gain visibility and power through broader group representation.¹²⁹ In the case of transgender-inclusive healthcare, the HRC’s CEI provides a clear example. As

122. See, e.g., *Transgender Inclusive Benefits: Medical Treatment Cost and Utilization*, HUM. RTS. CAMPAIGN, <http://www.hrc.org/resources/entry/transgender-inclusive-benefits-medical-treatment-cost-and-utilization> (last visited Dec. 1, 2012).

123. See *supra* note 51 and accompanying text.

124. Diskin, *supra* note 17, at 155–58 (documenting the efforts of transgender activists in 1996 and again in 2001).

125. *Id.* at 155.

126. *Id.* at 154.

127. *Id.* at 159. For a more detailed breakdown, see *San Francisco Transgender Benefit: Actual Cost & Utilization (2001-2006)*, HUM. RTS. CAMPAIGN <http://www.hrc.org/resources/entry/san-francisco-transgender-benefit-actual-cost-utilization-2001-2006> (last visited Nov. 7, 2012).

128. The HRC notes that “[a]ccording to businesses reporting to the HRC Foundation, making these benefits accessible comes at an overall negligible cost to their overall health insurance plans.” HUM. RTS. CAMPAIGN, *CORPORATE EQUALITY INDEX 2013: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL AND TRANSGENDER EQUALITY* 28 (2012).

129. KOMESAR, *supra* note 63, at 60–61 (explaining minoritarian and majoritarian bias). *But see* Spade, *supra* note 78, at 230 (arguing that agendas determined by elite members of interest groups cannot achieve meaningful change for more vulnerable members, and advocating for increased self-determination).

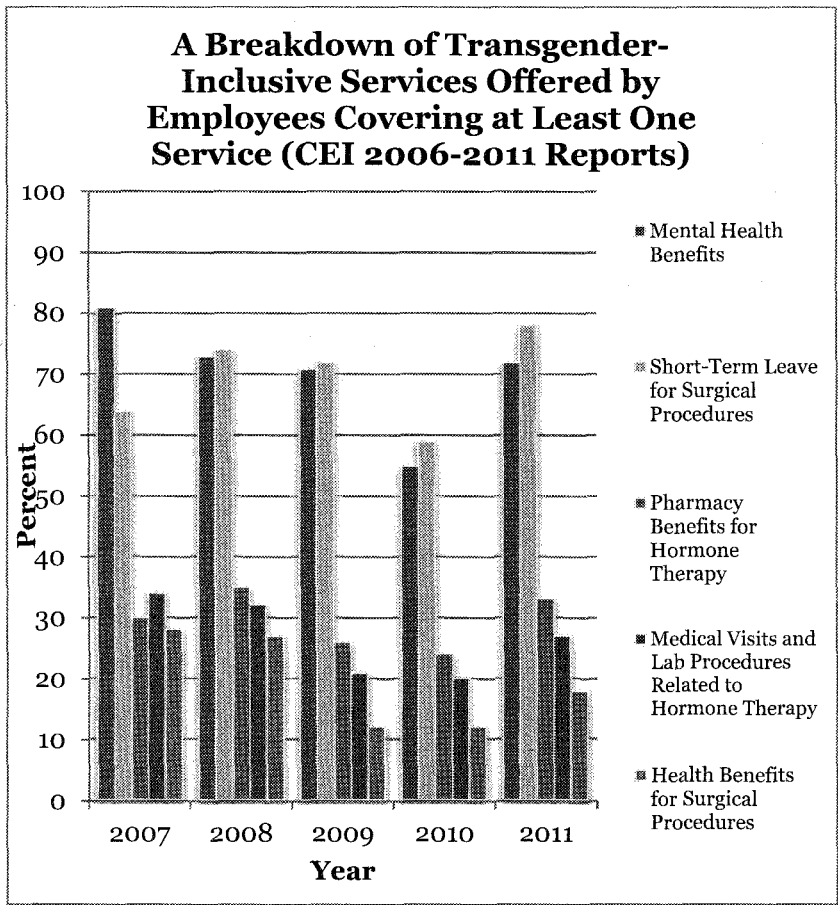
discussed above, the HRC began indexing data on transition-related benefits in the CEI 2006 report.¹³⁰ Under Criterion 2c, the new transgender health criterion, survey respondents received five points if they provided at least one transgender-inclusive health benefit—counseling, hormone therapy, hormone therapy monitoring, surgical sex reassignment procedures, or short-term disability leave for surgical sex-reassignment procedures—without exclusion.¹³¹ An employer could thus receive credit for offering “transgender-inclusive benefits” even if they retained exclusions for hormone therapy and surgical procedures.¹³² The chart below illustrates the breakdown of transgender-inclusive benefits provided by all employees who fulfilled Criterion 2c¹³³ in the criterion’s first five years:

130. *See supra* note 54 and accompanying text.

131. HUM. RTS. CAMPAIGN, CORPORATE EQUALITY INDEX 2006: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL AND TRANSGENDER EQUALITY 7–8 (2006).

132. Recall, as discussed above, that a mental health diagnosis of gender dysphoria is generally required to establish eligibility for hormone therapy or surgical procedures. *See supra* note 14 and accompanying text. While mental health benefits are important, it should be noted that this type of benefit would not actually cover any aspect of the medical transition itself. To be sure, this type of benefit would cover not only therapy for diagnosis, but also any further therapy for the treatment of gender dysphoria. Interestingly, covering mental health services for gender dysphoria without covering physical transition-related benefits may reflect a common, underlying belief that gender variance is exclusively a psychological issue and that physical transitions are medically unnecessary.

133. The information composing this graph is drawn from the HRC’s Corporate Equality Index Reports from 2007–2011. *See supra* note 55 and accompanying text. Refer to the chart in Part I to see the percentage of employers who offered transgender-inclusive healthcare. That chart does not reflect percentages of employers who simply fulfilled Criterion 2c. Rather, it reflects percentages of employers who offered transgender-inclusive healthcare benefits without exclusion.



Evidently, the majority of employers who fulfilled Criterion 2c did not cover any physical aspect of transition-related care. Beginning with the CEI 2012 report, however, the HRC tightened requirements for Criterion 2c.¹³⁴ Under these new requirements, employers received ten points for satisfying Criterion 2c only if they offered at least one health insurance plan that 1) covered all medically necessary transition-related care, and 2) conformed to current medical standards of care for eligibility determinations.¹³⁵ Although the HRC had been announcing these upcoming changes

134. HUM. RTS. CAMPAIGN, *CORPORATE EQUALITY INDEX 2012: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL AND TRANSGENDER EQUALITY* 13 (2012).

135. *Id.* at 13.

since 2009,¹³⁶ the heightened requirements resulted in a dramatic decrease in the number of survey participants who fulfilled Criterion 2c: seventy-nine percent¹³⁷ of respondents received credit in the 2011 report, but only thirty-three percent¹³⁸ received credit in the 2012 report. Despite this percentage drop, the actual number of employers offering transition-related benefits more than doubled, from 85 in 2011 to 207 in 2012.¹³⁹

These statistics reveal two important lessons about the power of group representation in the political process. The first is that when influential community groups like the HRC advocate on behalf of transgender populations within their ranks, they may successfully win material benefits that transgender populations, acting alone, could not.¹⁴⁰ By incorporating transgender-inclusive benefits into the CEI, the HRC communicated to large employers that these benefits constituted an integral part of LGBT workplace equality.¹⁴¹ The increasing number of employers who have elected to fulfill Criterion 2c in response to its inclusion indicates that some employers are willing to offer transgender-inclusive care to affirm their commitment to this vision of equality.¹⁴² Moreover,

136. *Id.* at 12.

137. HUM. RTS. CAMPAIGN, CORPORATE EQUALITY INDEX 2011: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL AND TRANSGENDER EQUALITY 26 (2011).

138. HUM. RTS. CAMPAIGN, CORPORATE EQUALITY INDEX 2012: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL AND TRANSGENDER EQUALITY 28 (2012). Tellingly, the HRC has dedicated a webpage to explaining (and, in part, justifying) its refusal to give credit for mental health services alone. *Corporate Equality Index: Does It Give Credit for Therapy*, HUM. RTS. CAMPAIGN, <http://www.hrc.org/resources/entry/corporate-equality-index-does-it-give-credit-for-therapy> (last visited Nov. 29, 2012).

139. HUM. RTS. CAMPAIGN, CORPORATE EQUALITY INDEX 2012: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL AND TRANSGENDER EQUALITY 28 (2012). For an important distinction, see *supra* note 133 and accompanying text.

140. See HUM. RTS. CAMPAIGN, TRANSGENDER-INCLUSIVE HEALTH CARE COVERAGE AND THE CORPORATE EQUALITY INDEX 3 (2012), available at http://www.hrc.org/files/assets/resources/Transgender_Healthcare_White_Paper_4.pdf (last visited Dec. 1, 2012) ("Up until the last few years, nearly all U.S. employer-based health insurance plans contained 'transgender exclusions' that limited insurance coverage for transition-related treatment and other care, but this is changing.").

141. *Id.* at 14 ("Transgender-inclusive health coverage is part of equal compensation, specifically equal benefits.").

142. For evidence that companies pride themselves on CEI scores, see, e.g., *Cigna Scores 100% on Human Rights Campaign's Corporate Equality Index*, DAILY FIN., Nov. 14, 2012, <http://newsroom.cigna.com/NewsReleases/cigna-scores-100-on-human-rights-campaign-s-corporate-equality-index.htm>; *Comcast Is One of America's Best Employers for Gay Workers*, PHILLY POST, Nov. 14, 2012, http://blogs.phillymag.com/the_philly_post/2012/11/14/comcast-americas-places-work-gay-people/; *Diageo Recognized by Human Rights Campaign as "Best Place to*

the fact that heightened requirements resulted in a significant percentage drop in the number of employers who received credit for Criterion 2c, but nevertheless produced a substantial increase in the number of employers who offered all transgender-inclusive benefits, illustrates the strength of political influence. Because companies can use high CEI scores to promote themselves as diverse, inclusive employers,¹⁴³ the HRC can effectively bargain for more transgender-inclusive benefits by raising the bar to Criterion 2c credit. When the HRC demands transgender-inclusive healthcare as part of its demand for broader LGBT equality, employers—especially those who have expressed their commitment to LGBT equality with perfect CEI scores in the past—have incentive to meet these demands.¹⁴⁴

The second lesson is that because community groups like the HRC have a sizeable audience, the HRC can use its influence to counter social myths about the “elective” or “cosmetic” nature of transition-related care.¹⁴⁵ By requiring that eligibility determinations for transition-related care comport with Standard of Care standards of medical necessity,¹⁴⁶ the HRC legitimizes such

Work” for Fifth Year in a Row, PRNEWSWIRE, Nov. 14, 2012, <http://www.prnewswire.com/news-releases/diageo-recognized-by-human-rights-campaign-as-best-place-to-work-for-fifth-year-in-a-row-179296891.html>; *DTCC Named a “Best Place to Work” by Human Rights Campaign*, BUS. WIRE, Nov. 14, 2012, <http://finance.yahoo.com/news/dtcc-named-best-place-human-150500389.html>.

143. Each year, the HRC produces a list of “Best Places to Work” based on CEI data. *Best Places to Work 2012*, HUM. RTS. CAMPAIGN, <http://www.hrc.org/resources/entry/best-places-to-work-2012> (last visited Apr. 21, 2013).

144. See, e.g., *Aetna Makes “Best Place to Work” List for LGBTs Eleventh Year in a Row*, AETNA NEWS HUB, Nov. 29, 2012, <http://newshub.aetna.com/press-release/corporate-and-financial/aetna-makes-best-places-work-list-lgbts-eleventh-year-row> (reporting that executives are “proud of the accomplishments Aetna has made as an organization to advance diversity in its broadest sense and serve the LGBT community as an employer and business partner”); *PepsiCo Receives perfect score on HRC’s Corporate Equality Index for LGBT Employees and Their Families*, PEPSICO.COM, Nov. 27, 2012, <http://www.pepsico.com/Story/PepsiCo-receives-perfect-score-on-HRCs-Corporate-Equality-Index-for-LGBT-employee11272012797.html> (referring to the CEI as the “gold standard” for LGBT employment policies).

145. *Transgender Medical Treatment: Medically Necessary and Not Cosmetic*, HUM. RTS. CAMPAIGN (Apr. 28, 2012), <http://www.hrc.org/resources/entry/transgender-medical-treatment-medically-necessary-and-not-cosmetic>.

146. *Ending Stigma & Achieving Inclusion: HRC’s Task Force to Address Insurance Industry Practices*, HUM. RTS. CAMPAIGN, <http://www.hrc.org/resources/entry/ending-stigma-achieving-full-inclusion-hrcs-task-force-to-address-insurance> (last visited Apr. 21, 2013) (endorsing WPATH

care and precludes employers seeking Criterion 2c credit from using different, possibly biased standards of medical necessity review to deny coverage.

Finally, transgender-inclusive healthcare coverage won through political processes has the potential to frame inclusive coverage as the morally “right” choice. Compared to transition-related benefits that materialize as a result of judicial intervention, benefits that emerge electively in response to political advocacy may have the beneficial effect of signaling broader social acceptance.¹⁴⁷ If political processes can convince employers that public opinion about the importance of transgender-inclusive care is shifting, employers may feel increasingly compelled to follow these trends.¹⁴⁸ Indeed, companies that have publically adopted transgender-inclusive health benefits tend to frame these decisions as evidence of their participation in the next step for LGBT progress.¹⁴⁹ Because demands for transgender-inclusive healthcare made through the political process leave room for employers to reiterate their commitment to equality by electing coverage, the political process may offer a positive, popular framework that other institutional choices do not.

2. The Structural Costs of the Political Process

Despite the benefits discussed above, the political process works severe institutional costs on the struggle for transgender healthcare equality. The biggest cost is that political processes ultimately leave coverage for transition-related benefits up to the goodwill of employers. This is so for several reasons. First, as a matter of rhetoric, demands in the political process focus on explaining inclusion as “important and economically attainable,”

standards). See SOC, *supra* note 5, at 34, 58–60 (detailing best practices).

147. See Diskin, *supra* note 17, at 161 (presenting political victories like San Francisco's as a “double victory” for encouraging employers to think about transition-related care as “good for business”).

148. See *id.* at 161–62.

149. See, e.g., *Chubb Offers Medical Benefits to Transgender Employees*, CHUBB GROUP OF INS. COMPANIES (Nov. 15, 2011), <http://www.chubb.com/corporate/chubb14684.html>; *Google Announces Health Benefits for Transgender US Employees*, GLAAD (Nov. 22, 2011, 4:53 PM), <http://www.glaad.org/blog/google-announces-health-benefits-us-transgender-employees>; *SEIU Passes Resolution Calling for Transgender-Inclusive Health Insurance*, NAT'L GAY & LESBIAN TASK FORCE BLOG (May 30, 2012), <http://thetaskforceblog.org/2012/05/30/seiu-passes-resolution-calling-for-transgender-inclusive-health-insurance-coverage/>.

not on threatening exclusion as socially or fiscally unwise.¹⁵⁰ Second, as a matter of strategy, these demands seem more like suggestions because the LGBT community has not historically advocated for transgender rights. Since gay groups have tended to view transgender people as outsiders, leaders have distanced themselves from transgender-inclusive struggles out of fear that “the sudden emergence of a transgender constituency demanding inclusion in the gay movement might well appear to be a destabilizing and potentially threatening element.”¹⁵¹ Thus, transgender-inclusive advocacy in these groups has been difficult to achieve and, when it occurs, may appear strategically less attractive.¹⁵² In turn, employers may feel less compelled to act.

Relatedly, the second cost is that political processes may not exert the same influence over all employers, leaving some transgender employees without protection. While political pressures cannot compel any employers to elect coverage, the rhetoric of LGBT equality that has been somewhat successful in gaining coverage from large corporations has not influenced, or at least has not been documented to influence, smaller employers in a similar manner.¹⁵³ Arguably, smaller companies may eventually follow the lead of larger, big-name corporations. But because small- and medium-size employers face different health insurance constraints than large employers do,¹⁵⁴ it is also possible that political pressures will do little to compel smaller employers to act. For instance, smaller employers may remain unresponsive to political demands if they feel financially unable to offer more benefits than the law requires, or if they do not feel that a commitment to transgender-inclusive healthcare gives them any particular edge over their competitors.¹⁵⁵ Even if leaving coverage to the goodwill of employers constitutes an unfortunate but

150. HRC COVERAGE, *supra* note 120, at 3.

151. Shannon Minter, *Do Transsexuals Dream of Gay Rights?*, in *TRANSGENDER RIGHTS*, *supra* note 14, at 153.

152. “Although usually unspoken, I believe some gay leaders also feel resentment and fear that transgender people will co-opt or derail the hard-won resources and political power that gay people have worked so long to achieve.” *Id.*

153. Tellingly, the HRC states, “[T]he more successful a business is in the United States, the more likely it is to embrace equality.” HUM. RTS. CAMPAIGN, *CORPORATE EQUALITY INDEX 2013: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL AND TRANSGENDER EQUALITY 3* (2012), available at http://asp.hrc.org/documents/CorporateEqualityIndex_2012.pdf.

154. For instance, most employers who offer coverage are self-insured, and the option to self-insure is much more cost effective for large employers than it is for small employers. Diskin, *supra* note 17, at 139.

155. See HRC COVERAGE, *supra* note 120, at 14.

acceptable cost, the fact that the efficacy of inciting this goodwill may diminish with employer size is cause for concern. Because the right to affordable transition-related care does not depend on an individual's employer size, strategies for securing this care should not reflect this imbalance.

Even if one insists on the power of political influence at all levels and accepts the institutional cost of waiting longer for transition-related coverage from smaller employers,¹⁵⁶ problematic variations at legislative levels of the political process exacerbate the advocacy imbalances discussed above. In particular, under the ACA, small and large group employers face different regulatory schemes with regard to health insurance exchanges.¹⁵⁷ Exchanges, which must be operational in each state by 2014, are state-run entities that "organiz[e] the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality."¹⁵⁸ Beginning in 2014, all small employers with 100 or fewer employees must have the option of purchasing affordable health insurance through an exchange.¹⁵⁹ These exchanges will remain closed to large employers with 100 or more employees until 2017, when states will have the option to include them.¹⁶⁰ This differential treatment based on size is relevant to transgender health for two reasons. First, health insurance policies offered through exchanges must cover "essential health benefits."¹⁶¹ The Department of Health and Human Services (HHS) will allow each state to select its own definition of "essential health benefits" from a variety of the largest federal and in-state plans in operation, which will allow states to select a "definition that incorporates all existing state mandates."¹⁶² Because no state mandates coverage for all transition-related care,¹⁶³ states are unlikely to consider these health benefits

156. Cf. Spade et al., *supra* note 78, at 232 ("[W]e need to strategize beyond a notion that if we win rights for the most sympathetic and normal of our lot first, the others will be protected in time. Instead, we should be concerned that the breadth of our vision will determine the victories we obtain.").

157. Monahan, *supra* note 75, at 83–84.

158. *Initial Guidance to States on Exchanges*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges.html> (last visited Nov. 15, 2012).

159. See Monahan, *supra* note 75, at 88–89.

160. *Id.*

161. Patient Protection and Affordable Care Act, 42 U.S.C. § 300 gg-6 (2010).

162. Monahan, *supra* note 75, at 97.

163. Spade, *supra* note 13, at 500.

“essential.”

Secondly, Section 1557 of the ACA prohibits discrimination on the basis of sex by any federally-assisted health program, any health program administered by an executive agency, or any entity established under Title I of the ACA.¹⁶⁴ In a promising response to LGBT activist organizations urging¹⁶⁵ HHS to adopt a definition of sex discrimination consistent with the holding in *Macy*, the Department announced that “Section 1557’s sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity.”¹⁶⁶ When HHS subsequently published this clarification on its website, however, the Department explicitly stated without elaboration that it did not consider exclusions for transition-related surgical procedures to constitute discrimination on the basis of gender identity or sex stereotyping.¹⁶⁷ Although further guidance from the Department is forthcoming,¹⁶⁸ this unequivocal decision to separate transition-related benefits from the concept of sex discrimination is unlikely to change. Thus, state-run health exchanges—entities established under Title I—have clear authority to offer policies that exclude transition-related surgical procedures under Section 1557. In sum, the regulatory differences between small- and large-group insurance policies under the ACA have the potential to perpetuate existing imbalances in political advocacy. Because small employers may be least likely to elect coverage for socially progressive reasons and because the ACA explicitly permits small employers to elect exclusionary plans, political processes will likely result in unbalanced efforts to secure transgender-inclusive healthcare.

Lastly, political processes may fail to communicate the

164. § 1557, 42 U.S.C. § 18116 (2010).

165. Letter from LGBT Rts. Orgs. to Kathleen Sebelius, Sec’y, Dep’t of Health & Hum. Servs. (Jun. 5, 2012), *available at* <http://files.www.cmhnetwork.org/news/transgender-activists-hail-obamacare-protections/102169763-June-6-LGBT-1557-Letter-to-HHS.pdf>.

166. Letter from Leon Rodriguez, Dir., Dep’t of Health & Hum. Servs., to Maya Rupert, Fed. Policy Dir., Nat’l Ctr. for Lesbian Rts. (July 12, 2012), *available at* <http://www.scribd.com/doc/101981113/Response-on-LGBT-People-in-Sec-1557-in-the-Affordable-Care-Act-from-the-U-S-Dept-of-Health-and-Human-Services>.

167. *Questions and Answers on Section 1557 of the Affordable Care Act*, U.S. DEP’T OF HEALTH & HUM. SERVS., http://www.hhs.gov/ocr/civilrights/resources/laws/section1557_questions_answers.html (last visited Apr. 1, 2013) [hereinafter *Questions and Answers*].

168. *Id.*

complexities and nuances of transgender-inclusive healthcare. In their letter to the HHS, LGBT advocacy organizations stressed that “LGBT people face high levels of discrimination in the provision of health services that has a substantial impact on individual and public health.”¹⁶⁹ The letter did not enumerate forms of healthcare discrimination, but the Department seems to have sketched a rough line between what it will consider to be discriminatory and what it will not. On its website dedicated to Section 1557 clarifications, the Department refers to two particular examples.¹⁷⁰ The first is an instance of actionable discrimination: individuals who are “not getting health care because of how they look”¹⁷¹ can file a claim for discrimination for failure to conform to stereotypical notions of masculinity or femininity. The second is an instance of non-actionable discrimination: a health insurer’s refusal to cover transition-related surgery, as mentioned above. This determination is difficult to critique without further guidance. Suffice it to say that political advocacy may successfully convey to legislators and agencies how refusing to treat a transgender woman’s broken arm simply because of her transgender status is discriminatory.¹⁷² Conveying how excluding coverage for transition-related care is discriminatory, on the other hand—which might require explanations of medical necessity, rates of usage, individual and employer costs, and much more—might prove too complex a message for the political process.¹⁷³

3. The Costs and Benefits of Political Participation

For transgender healthcare coverage, the costs and benefits of political participation generally mirror those in the market. Employers interested in avoiding claim payments do not have to invest significant resources in justifying their exclusions because transgender individuals lack popular support and because most people do not understand the medical necessity of transition-

169. Letter from LGBT Rts. Orgs., *supra* note 165.

170. *Questions and Answers*, *supra* note 167.

171. *Id.*

172. See NTDS, *supra* note 3, at 73.

173. Some transgender activist groups have focused on educating the public about various forms of transgender discrimination by encouraging transgender individuals to make their voices heard in the political process. See, e.g., NAT’L CTR. FOR TRANSGENDER EQUAL., MAKE YOUR VOICE HEARD: A TRANSGENDER GUIDE TO EDUCATING CONGRESS (2009), available at <http://transequality.org/Resources/VoiceHeard.pdf>.

related care.¹⁷⁴ On the other hand, employees interested in coverage have difficulty gaining political representation for similar reasons.¹⁷⁵ However, in limited cases, political processes may equalize participation by increasing benefits to employers and decreasing costs to transgender employees. When political pressures convince employers that they stand to gain more from the social benefits of inclusion than the financial benefits of exclusion,¹⁷⁶ employers may be incentivized to elect coverage. Similarly, when powerful actors in the political process act on behalf of transgender employees, this advocacy may diminish the costs of representing diffuse interests.¹⁷⁷ In this way, when employers are sensitive to political demands and political groups are sensitive to transgender interests, the political process may equalize institutional participation. Under these conditions, comparative institutional analysis predicts that political processes will produce better outcomes for transgender health than the market.

C. The Courts: The Potential Future Model

1. Structural Benefits of the Judicial System

The principal institutional benefit of pursuing transgender-inclusive healthcare through the courts is that transgender individuals now have a clear statutory basis for alleging claims of discrimination.¹⁷⁸ Because *Macy* held transgender discrimination constituted unlawful discrimination on the basis of sex,¹⁷⁹ transgender individuals who have suffered discrimination in employment may sue their employer under Title VII of the Civil

174. See Hong, *supra* note 8, at 100.

175. *Id.*

176. DeCleene, *supra* note 77, at 141.

177. The informational costs are great.

Through the intensive educational and consultative efforts to address health care and insurance disparities for the transgender population and their families, including: outreach to leading health insurance companies, direct consultation with both fully and self-insured employers to modify their health care plans, and collection and dissemination of cost and utilization data from leading businesses, the HRC Foundation led a five-fold increase in the number of major U.S. employers affording transgender-inclusive health care coverage, from 49 in the 2009 CEI to more than 200 in the 2012 CEI.

HRC COVERAGE, *supra* note 140, at 3.

178. Pub. L. No. 88-352, tit. VII, 78 Stat. 241, 253–66 (codified as amended at 42 U.S.C. §§2000e to 2000e-17); *Macy v. Holder*, 2012 WL 1435995 E.E.O.C. (2012).

179. *Macy*, 2012 WL 1435995 E.E.O.C. at *11 (2012).

Rights Act of 1964. Given this recent development, transgender employees who have been denied transition-related benefits under exclusionary ESI plans may now have a viable path to legal remedies. If successful, a legal challenge to an employer's exclusion of transition-related coverage could help secure transgender-inclusive benefits.

To illustrate what such a suit might look like, I will briefly sketch out a claim of sex discrimination that a transgender plaintiff might bring against an employer for excluding transition-related coverage. Proceeding under a theory of disparate treatment,¹⁸⁰ the plaintiff would first allege membership in a protected class (sex) as per the holding in *Macy*. Next, the plaintiff must allege his or her disqualification to receive benefits under an ESI plan; this might involve, for instance, a showing of full-time status. Third, the plaintiff must allege that he or she suffered an adverse employment action from his or her employer. To satisfy this element, the plaintiff might argue that he or she sought coverage for a transition-related procedure, that his or her employer denied coverage under an exclusion clause in the relevant ESI plan, and that this denial of health insurance benefits constituted an adverse employment action.¹⁸¹ Finally, the plaintiff must allege circumstances that give rise to an inference of discriminatory intent. To this end, the plaintiff might produce evidence demonstrating that only transgender individuals receive diagnoses of gender dysphoria or receive transition-related care for the purposes of treating diagnosed gender dysphoria. The plaintiff might also produce evidence demonstrating that the type of care transgender individuals receive for the treatment of gender dysphoria is, in fact, regularly prescribed to cisgender individuals for other diagnoses.¹⁸² Considering that the exclusion clause in the ESI plan bars coverage for gender dysphoria (or some other transgender-specific phrasing), the plaintiff would argue that these circumstances demonstrate the employer's intent to discriminate against plaintiff on the basis of transgender status.

180. *McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973) (laying out elements of a plaintiff's prima facie case of disparate treatment within a burden-shifting framework).

181. Denials of health insurance benefits have been held to constitute adverse employment actions. *See, e.g., Lewis v. K2 Industrial Servs., Inc.*, 2007 WL 3442189, at *6 (M.D. Ala. 2007); *Sherman v. Dallas County Community College Dist.*, 2010 WL 2293165, at *5 (N.D. Tex. 2010); *Velasquez v. Frontier Medical Inc.* 275 F. Supp. 2d 1253, 1281 (D.N.M. 2005).

182. *See Khan, supra* note 26, at 404–05.

There are certainly numerous legal challenges to asserting such a case. First, although statistical evidence is not required for every type of employment discrimination claim, the lack thereof, or the small size of the relevant data pool, may influence skeptical members of a court.¹⁸³ Any statistical evidence on the number of private insurance denials, for instance, may be difficult to obtain.¹⁸⁴ Even if this data were available, it might not evince discrimination to a court if only a small number of transgender employees from a company had actually sought coverage; a lack of statistical evidence would likely preclude a class action lawsuit. Second, a court might find that although some procedures provided for gender dysphoria are provided to cisgender individuals without exclusion, the fact that services for the purpose of transition-related coverage are equally denied to transgender and cisgender employees thwarts a finding of discriminatory intent. An argument against medical necessity would certainly arise as well, as I will discuss in further detail below.

A second institutional benefit of pursuing coverage through the courts is that, unlike the political process, the judicial system theoretically has the skilled reasoning necessary to discern subtler, more complex forms of discrimination.¹⁸⁵ Instead of limiting its vision of anti-transgender discrimination to an explicit refusal of healthcare for non-transition-related services, a court might grasp the nuanced ways in which denial of certain benefits wreaks discriminatory impact upon a group. Relatedly, a part of this judicial competency theory is a commitment to political neutrality. Although this commitment appears questionable against a history of “confused hostility”¹⁸⁶ to transgender populations, courts would at the very least face the professional responsibility of justifying exclusions with some semblance of logic.

Finally, securing coverage through the courts would probably constitute a two-step process: a prohibition of discriminatory

183. *Teamsters v. United States*, 431 U.S. 324, 339–40 (clarifying the importance of statistical evidence in employment discrimination cases).

184. Hong, *supra* note 8, at 94–95 (“There is no ‘paper trail’ of alleged denials because privately insured transsexuals are precluded from seeking remedies from the courts.”).

185. For instance, the legal system recognizes that both disparate treatment and disparate impact constitute forms of illegal discrimination. *Teamsters*, 413 U.S. at 324.

186. Hong, *supra* note 8, at 93.

exclusions at first and affirmative protections later on. While this might in some ways reflect a limitation or cost, I believe that this two-step process has several benefits. For one, the first step is significantly easier than the second. Although a ban on exclusions may prove inadequate in the long run, eliminating complete employer immunity by refusing to protect these clauses as bargained-for terms would be a huge step in the right direction. In addition, because courts will understand that a prohibition of exclusion does not constitute a mandate for coverage, judges wary of overburdening employers with insurance liabilities may show more willingness to see these practices as discriminatory.

2. Structural Costs of the Legal System

The most critical institutional cost of the judicial system is the risk of an adverse ruling.¹⁸⁷ If courts hold that exclusions for transition-related care under ESI plans do not constitute sex discrimination under Title VII, employers who remain unsympathetic to political pressures could continue to deny coverage. Though unlikely, employers who have elected to offer coverage could also rely on these holdings to rescind their previous decisions. Although determinations upholding insurance exclusions would not prohibit special interest groups from continuing to advocate for elective coverage, adverse rulings would severely undermine the future efficacy of these efforts.

Courts may uphold discriminatory exclusions on any number of grounds, but judicial opposition to medical necessity and deference to HHS's Section 1557 determination are two possible sources of concern. Despite statements from the World Professional Association for Transgender Health and determinations by other courts, some courts have nevertheless rejected transition-related care as medically unnecessary.¹⁸⁸ While future courts may continue to reiterate these myths, any court that chooses to do so would have to confront and directly contradict the authority of the American Medical Association (AMA). In 2008, the AMA endorsed transition-related care as medically necessary, effective care for the treatment of gender

187. Diskin, *supra* note 17, at 160 (“[A] judge might end up narrowly interpreting the law and limiting access for the majority of transgender people in need of basic care.”).

188. *See, e.g.,* Smith v. Rasmussen, 249 F.3d 755 (8th Cir. 2001); Mario v. P & C Food Mkts., Inc., 313 F.3d 758 (2d Cir. 2002).

dysphoria.¹⁸⁹ Moreover, the AMA resolved its support for public and private insurance coverage of transition-related benefits, and stated that denial of these benefits “represents discrimination based solely on a patient’s gender identity.”¹⁹⁰ Arguably, even if courts expressed willingness to accept the AMA’s position, they might nevertheless hesitate to prohibit insurance exclusions when HHS has determined that such exclusions do not constitute sex discrimination.¹⁹¹ HHS’s judgment on this issue, however, would not likely constrain a court. First, the agency’s determination about sex reassignment benefits only precludes a finding of discrimination under Section 1557 of the ACA, so a finding of sex discrimination under Title VII would not contradict this determination. Second, even if courts looked to the Section 1557 stance for guidance, the fact that HHS has not yet provided any rationale¹⁹² for its interpretation gives courts ample room to disagree. Regardless, the concerns discussed here are not exhaustive. Especially considering the limited but positive developments in the political process, the cost of an unfavorable ruling may be too high to risk.

A second cost of turning to the judicial system for transgender-inclusive healthcare relates the ideological concerns expressed at the beginning of this Note. As mentioned, some critics contend that the medical community’s psychological diagnosis requirement to transition-related care pathologizes transgender populations.¹⁹³ Additionally, critics have pointed out that this pathologization tends to frame physical reassignments as the exclusive treatment for a mental illness that all transgender individuals are assumed to have.¹⁹⁴ As a result, transgender identities under the law have become “medicalized”¹⁹⁵ insofar as courts have conditioned legitimacy upon the receipt of transition-related care. The extent to which transgender individuals have successfully obtained irreversible, biological changes to sex

189. Am. Med. Ass’n House of Delegates, *supra* note 6, at 1.

190. *Id.*

191. See *Questions and Answers*, *supra* note 167.

192. Literally, the website just says “No.” *Id.*

193. See Butler, *supra* note 14, at 275.

194. Khan, *supra* note 4, at 386.

195. *Id.* at 408 (“Cases involving insurance privileges for transition-related services all recount an almost identical and medically focused narrative.”); Spade et al., *supra* note 13, at 497 (“Trans people live at a complex crossroads—the law defines us through medical norms by requiring medical evidence of our gender at every turn, yet many laws and policies deny that our medical needs are real or that the care we seek is legitimate.”).

characteristics is more likely to persuade courts about the validity of transgender status than non-biological or biologically reversible forms of transitioning. Courts have employed this discourse to define—and, more frequently, to limit—the legal rights of transgender individuals in various contexts, from marriage¹⁹⁶ to parenting.¹⁹⁷ Because courts are not likely to abandon this history of medicalized obsession, the choice to seek transgender-inclusive healthcare through litigation may come at the cost of perpetuating problematic conceptions of gender variance.¹⁹⁸ Indeed, this rhetoric is not only inaccurate and invasive, but also in many ways antithetical to broader visions of transgender autonomy and equality.

3. The Costs and Benefits of Legal Participation

It is difficult to project the participation costs for employers because very few employers have had to defend their exclusionary policies in court. Under the protective shadow of private contract law, the financial benefit of denying coverage for transgender-specific claims will probably justify the costs of defending exclusionary policies for employers. Similarly, the high costs of litigation will probably outweigh the benefit of coverage for individual employees if legal precedents are unfavorable. If courts extend Title VII protections to transgender employees, however, the cost of defending a policy as nondiscriminatory might exceed the benefits retained from denying infrequent claims. Alternatively, employers might reason that the risk of avoiding a “flood” of transition-related claims justifies one-time litigation costs. For transgender employees, the cost of educating judges under favorable legal precedent will likely be worth the benefit of winning coverage. Moreover, for some individual employees and civil rights groups, social justice goals of eliminating facially discriminatory workplace policies may easily justify litigation

196. In the Matter of the Estate of Gardiner, 42 P.3d 120 (Kan. 2002); Littleton v. Prange, 9 S.W.3d 222, 224 (Tx. App. 1999), Kantaras v. Kantaras, 884 So. 2d 155 (Fla. Cir. Ct. 2004); cf. M.T. v. J.T., 355 A.2d 204, 206 (N.J. Sup. Ct. 1976) (upholding a transgender woman’s marriage on the grounds that “her vagina had a ‘good cosmetic appearance’” and had “a vagina and a labia which were ‘adequate for sexual intercourse’”).

197. J.L.S. v. D.K.S., 943 S.W.2d 766 (Mo. Ct. App. 1997); Cisek v. Cisek, 1982 LEXIS 13335, at *4 (Ohio App. July 20, 1982); Daly v. Daly, 715 P.2d 56 (Nev. 1986); cf. Christian v. Randall, 516 P.2d 132 (Colo. App. 1973).

198. Then again, “[m]edicine clearly shapes the legal rights available to transgender individuals, but legal assumptions about sex can influence medical protocol for transgender patients too.” Khan, *supra* note 4, at 394.

costs.

Conclusion

This Note examined the structural and agency costs of pursuing transgender-inclusive healthcare through the market, the political process, and the courts. Although the market has clearly failed to remedy the exclusion of transition-related coverage, the relative costs and benefits of political and legal action may be more difficult to reconcile.¹⁹⁹ Careful consideration of these alternatives remains crucial to effectuating systemic changes. Ultimately, the present goal in applying a comparative institutional analysis to this issue is not to conclusively decide which course of action is best; rather, the point is that both acting and not acting, or acting in certain ways as opposed to others implicates a choice with distinct consequences. It is not enough, for instance, to argue against bringing a legal suit to enforce nondiscriminatory coverage out of fear of an adverse ruling without also considering the current and continuing sacrifices borne by transgender employees in the absence of litigation.

As evidenced by recent public health legislation, “health insurance plans . . . have evolved from functioning primarily as risk spreading devices to operating mainly as cost spreading vehicles.”²⁰⁰ The question of insurability thus depends not only on the risk of illness, “but also on whether treating the condition serves a socially beneficial purpose important enough to mandate insurance coverage of the treatment.”²⁰¹ Ultimately, the struggle for transgender rights hinges on communicating as “socially beneficial” the right “of all people to determine and express our gender, sexuality, and reproduction.”²⁰² The institutional capacity to allow and honor gender transgressions is integral to individual transgender rights, and critical to expanding our rigid conceptions of gender that operate to police all members of our society.²⁰³ At this juncture, a comparative institutional analysis may shed light on the most effective way to achieve these goals.

199. See Hong, *supra* note 8.

200. Khan, *supra* note 4, at 390.

201. *Id.*

202. Spade, *supra* note 78, at 218.

203. Spade, *supra* note 101.

