

CONTENTS

Emily Prince, “RIN 3206-AM77, ‘Nondiscrimination Provisions.’” (June 19, 2014)

Office of Personnel Management, “Nondiscrimination Provisions,” 78 Fed. Reg. 54434 (Sept. 4 2013)

FEHB Program Carrier Letter No. 2014-17 (June 13, 2014)

42 U.S.C. § 18116

Macy v. Holder, Appeal No. 0120120821 (Apr. 20, 2012)

AMA Resolution 122 (A-08), “Removing Financial Barriers to Care for Transgender Patients” (Apr. 18, 2008)

American Foundation for Suicide Prevention and the Williams Institute, “Suicide Attempts among Transgender and Gender Non-Conforming Adults” (Jan. 2014)

The Williams Institute, “Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans” (Sept. 2013)

Human Rights Commission, City and County of San Francisco, “San Francisco City and County Transgender Health Benefit” (Aug. 10, 2007)

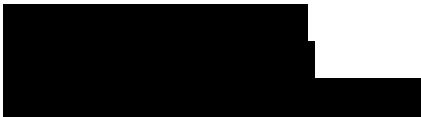
Department of Insurance, State of California, “Economic Impact Assessment: Gender Nondiscrimination in Health Insurance” (Apr. 13, 2012)

Office of the Secretary, Department of Health and Human Services, “Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities” (Aug. 1, 2013)

Prince, Emily, “Comment on Department of Health and Human Services: Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities” (Sept. 30, 2013)

Center for American Progress, Department of Health and Human Services, “Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities” (Sept. 30, 2013)

Whitman-Walker Health, “Response of Whitman-Walker Health to Request for Information on Regulations to Implement the Nondiscrimination Requirements in Section 1557 of the Affordable Care Act” (Sept. 30, 2013)



The Honorable Howard Shelanski
Administrator
Office of Information and Regulatory Affairs
Office of Management and Budget
Washington, D.C. 20503

Dear Administrator Shelanski:

Re: RIN 3206-AM77, "Nondiscrimination Provisions"

As a Federal employee and a transgender woman, I have grave concerns with the draft final rule "Nondiscrimination Provisions" submitted to the Office of Information and Regulatory Analysis from the Office of Personnel Management (OPM) on May 8, 2014. A review of the Notice of Proposed Rulemaking (NPRM), 78 Fed. Reg. 54434 (Sept. 4, 2013) indicates that the rule will prohibit employment practices that discriminate on the basis of sex "including pregnancy and gender identity." However, recent events have indicated that OPM plans to continue its discrimination with respect to its administration of the Federal Employees Health Benefits Program (FEHB or FEHBP).

On June 13, 2014, OPM issued FEHB Program Carrier Letter No. 2014-17, titled "Gender Identity Disorder / Gender Dysphoria." This letter referenced a prior letter, Carrier Letter No. 2011-12, which directed carriers to allow employees to "select their preferred gender designation" for health records, before stating that "OPM is removing the requirement that FEHB brochures exclude 'services, drugs, or supplies related to sex transformations' in Section 6 of the FEHB plan brochure effective with the 2015 plan year." OPM has never identified such a requirement, and prior statements by OPM officials indicate that such a ban does not exist, though OPM included the exclusion language in several draft templates of plan brochures provided to insurance carriers. The letter goes on to state that carriers will have the option of maintaining such general exclusion language for the 2015 plan year.

In light of this recent activity by OPM, additional review of the agency's nondiscrimination rulemaking is necessary. In the proposed rule, OPM notes that its updates to the agency's nondiscrimination provisions are being harmonized to existing statutory prohibitions on discrimination, including those grounded in Title VII of the Civil Rights Act of 1964 as amended (42 U.S.C. 2000e, *et seq.*), which includes discrimination on the basis of sex (including pregnancy and gender identity) as a prohibited practice. This is consistent with the decision of the Equal Employment Opportunity Commission in *Macy v. Holder*, EEOC Appeal No. 0120120821 (April 20, 2012), available at <http://www.eeoc.gov/decisions/0120120821%20Macy%20v%20DOJ%20ATF.txt>. In the decision, the EEOC explicitly held that discriminating against an individual for the "sheer

fact of transition” is unlawful discrimination on the basis of sex (quoting *Glenn v. Brumby*, 663 F.3d 1312, 1320-21 (11th. Cir. 2011)). OPM claims to seek conformity with Title VII, but Carrier Letter No. 2014-17 demonstrates that the agency, more than two years after the *Macy* decision, still views discrimination against the act of transition to be lawful, and has now expressly notified insurance carriers that OPM will tolerate such discrimination in its review of health insurance plans to be offered to Federal employees.

Exclusions of transition-related care are inhumane and have real human costs. As the American Medical Association states in its 2008 resolution, “Removing Financial Barriers to Care for Transgender Patients,” H-185.980, Resolution 122 A-08, “[Gender Identity Disorder], if left untreated, can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death.” A January 2014 report by the American Foundation for Suicide Prevention and the Williams Institute, “Suicide Attempts among Transgender and Gender Non-Conforming Adults,” found that transgender men and women have “an exceptionally high prevalence of lifetime suicide attempts . . . across all demographics and experiences” of 46% and 42% respectively. This rate increases more than 10%, exceeding 50%, for individuals who are unable to afford necessary health care. While costs can be prohibitive for individuals, studies have shown that providing transition-inclusive health insurance causes negligible to no increase in costs of insurance; see, for instance, The Williams Institute, “Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans,” (Sept. 2013).

In order to avoid the real harms created by OPM’s current policy of permitting FEHB plans to categorically exclude transition-related care, the final rule issued by OPM must be revised to ensure that OPM policy is consistent with Federal statutes concerning nondiscrimination, including not just Title VII but also 42 U.S.C. 18116, the nondiscrimination provision of the Affordable Care Act. I ask that you decline to approve the OPM nondiscrimination rule until such time as it is revised to make clear that actions in administering FEHBP are subject to the nondiscrimination provisions and that discrimination on the basis of sex (including gender identity), such as categorical exclusion of transition-related care, will not be tolerated in FEHBP plans.

I would be grateful for an opportunity to discuss this matter with you or your staff.

Sincerely,

A handwritten signature in black ink, appearing to read 'Emily T. Prince'.

Emily T. Prince, Esq.



the number of test subjects generally used, the distribution of the subjects within the panel cells, the sizing basis, and the representation of male and female test subjects. What pass/fail criteria are you currently using to approve proto-types for further development or production?

(a) As a manufacturer, do you use facepiece-to-face seal criteria to qualify a design for production? Please include details about the criteria in your answer.

(b) As a purchaser, what are the attributes you use to determine which brand(s) or model(s) of respirators to buy (e.g., price point, size, supplier, availability)?

3. Does your company use a panel or portion of a panel to develop respirators for a defined user group (e.g., users with smaller facial features, users with larger facial features)? If so, please define the user group, the panel used, the cells included, and the number of subjects generally needed.

(a) Could the LANL half-facepiece panel be used to test respirators for defined user groups? Please explain why or why not and include related implementation issues.

(b) What issues do you foresee in the implementation of fit testing standards for defined user groups?

4. Does your company use a panel or a portion of a panel to ensure the quality of a manufactured product line? If so, what test method and panel are used? How many subjects are included? Please explain how you maintain your pool of subjects.

5. NIOSH currently uses the LANL half-facepiece panel (lip length, which is actually the lip width, and face length) for categorizing human subjects to evaluate those half-mask respirators evaluated for fit. What are the advantages and/or disadvantages of using the LANL half-facepiece panel for an inward leakage requirement for half-mask air-purifying particulate respirators, approved under subpart K, which are currently not evaluated for fit?

6. What panel size would be sufficient for conducting a facepiece-to-face seal certification test?

(a) Given the recommended number of test subjects, should the pass/fail criteria be specific and include a minimum of one pass per member cell? More than one per cell?

(b) Given the recommended number of test subjects, should the pass/fail criteria be panel based (e.g., 20/25, 28/35) and not specific to panel cells?

(c) Should the pass/fail criteria require an overall high pass rate and allow for a percentage of failures or a

lower fit factor pass criteria and a 100 percent pass rate?

C. Future Utility of the NIOSH Bivariate Panel for All NIOSH-Approved Respirators

1. Based on your experience with the NIOSH bivariate panel, what implementation issues must NIOSH consider in order to use the NIOSH bivariate panel for certification testing of all classes of respirators?

2. Should NIOSH develop a second NIOSH bivariate panel based on face length and lip length? Please explain why or why not and any implementation concerns or specific recommendations concerning future implementation of a new panel utilizing subject lip length and face length.

D. Inter-Panel Variability

1. What is an appropriate pass/fail criterion? Assuming the CNC is used, should the subject pass with a fit factor of 20? 50? 75? 100?

2. If a corn oil chamber is used, what inward leakage pass/fail criteria should be used?

3. What other strategies do you suggest to address the inter-panel variability? Please provide specific information that supports your recommendation including experiences, data, analyses, studies, published articles, and standard professional practices.

Dated: August 27, 2013.

Kathleen Sebelius,
Secretary.

[FR Doc. 2013-21430 Filed 9-3-13; 8:45 am]

BILLING CODE P

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Parts 300, 315, 335, 410, 537, and 900

RIN 3206-AM77

Nondiscrimination Provisions

AGENCY: U.S. Office of Personnel Management.

ACTION: Proposed rule.

SUMMARY: The Office of Personnel Management (OPM) is proposing to update various nondiscrimination provisions appearing in title 5, Code of Federal Regulations, to provide greater consistency and reflect current law.

DATES: Comments must be received on or before November 4, 2013.

ADDRESSES: Send or deliver comments to U.S. Office of Personnel Management, Office of Diversity & Inclusion, 1900 E

Street NW., Washington, DC 20415; email to diversityandinclusion@opm.gov; or fax to (202) 606-6042. Comments may also be sent through the Federal eRulemaking Portal at <http://www.regulations.gov>. All submissions received through the Portal must include the agency name and docket number or the Regulation Identifier Number (RIN) for this rulemaking. Please specify the section number for each comment.

FOR FURTHER INFORMATION CONTACT:

Contact Sharon Wong by telephone at (202) 606-7140; by TTY at 1-800-877-8339; by fax at (202) 606-6042; or by email at diversityandinclusion@opm.gov.

SUPPLEMENTARY INFORMATION: Executive Order 13563 directs agencies to promote “retrospective analysis of rules that may be outmoded, ineffective, insufficient, or excessively burdensome, and to modify, streamline, expand, or repeal them in accordance with what has been learned.” Pursuant to that direction and OPM’s plan for conducting retrospective review (see <http://www.opm.gov/Open/Resources/RetrospectiveRegReview.pdf>), OPM has been reviewing a number of existing regulations to determine whether they should be changed or eliminated.

Among the regulations OPM has decided to review are those that contain nondiscrimination provisions. OPM chose these regulations for retrospective review to further respond to a separate instruction issued by President Obama in a June 17, 2009, Memorandum on Federal Benefits and Nondiscrimination. That memorandum directed OPM to issue guidance “regarding compliance with, and implementation of, the civil service laws, rules, and regulations, including 5 U.S.C. 2302(b)(10), which make it unlawful to discriminate against Federal employees or applicants for Federal employment on the basis of factors not related to job performance.” See <http://www.whitehouse.gov/the-press-office/memorandum-heads-executive-departments-and-agencies-federal-benefits-and-non-discri>.

Our review revealed that the nondiscrimination provisions are inconsistently worded and most have not been updated to reflect recent legal developments, including enactment of the Genetic Information Nondiscrimination Act of 2008 (GINA), Pub. L. 110-233, which prohibits discrimination on the basis of genetic information. Accordingly, we are issuing these proposed regulations to update the nondiscrimination provisions to reflect current law and to

make them consistent, to the greatest extent possible.

Some of the nondiscrimination provisions reflect statutory prohibitions on discrimination that arise out of the civil service laws codified at title 5, United States Code, and OPM's authority to enforce the merit system principles. Others were promulgated to reflect the provisions of Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000e, *et seq.*), the Rehabilitation Act of 1973, as amended (29 U.S.C. 701 *et seq.*), and the Age Discrimination in Employment Act of 1967, as amended (ADEA) (29 U.S.C. 621–634). As a result, we are adopting two formulations of the nondiscrimination language. For those grounded in Title VII of the Civil Rights Act, the Rehabilitation Act, the ADEA, and the GINA, the provisions will reflect the statutory prohibitions on discrimination on the basis of race, color, religion, sex (including pregnancy and gender identity), national origin, age (as defined by the Age Discrimination in Employment Act of 1967, as amended), disability, genetic information and retaliation for exercising rights under the statutes enumerated above, where retaliation rights are available. For those grounded in the civil service laws, the provisions will reflect the statutory prohibitions against discrimination on those bases (5 U.S.C. 2302(b)(1)(A)–(D)), as well as prohibitions against discrimination on the basis of marital status (5 U.S.C. 2302(b)(1)(E)); political affiliation (*id.*), and sexual orientation, labor organization affiliation or non-affiliation, status as a parent, or any other non-merit-based factor (E.O. 13087; E.O. 13152; 5 U.S.C. 2302(b)(10)); and retaliation for exercising rights under the statutes enumerated above, where retaliation rights are available. (5 U.S.C. 2302(b)(9)(A)–(B)).

Other provisions in our existing regulations are grounded in other specific legal authorities (such as our Federal Equal Opportunity Employment Program regulations at 5 CFR part 720 and our regulations implementing the Notification and Federal Employee Antidiscrimination and Retaliation Act of 2002 at 5 CFR part 724). We have concluded that the nondiscrimination provisions currently appearing in those regulations appropriately reflect the scope of the laws that they are implementing.

We believe that having uniform nondiscrimination provisions, to the extent permitted by law, will clarify the protections afforded to individuals under law and negate any confusion that might be caused by seemingly

conflicting provisions. Also, where appropriate, we are updating the authority citations for the regulations to reflect a complete list of the statutory provisions pursuant to which the regulations have been issued.

Executive Order 13563 and Executive Order 12866

The Office of Management and Budget has reviewed this rule in accordance with E.O. 13563 and 12866.

Regulatory Flexibility Act

I certify that these regulations would not have a significant economic impact on a substantial number of small entities because they would apply only to Federal agencies and employees.

List of Subjects in 5 CFR Parts 300, 315, 335, 410, 537, and 900

Administrative practice and procedure, Equal employment opportunity, Government employees, Individuals with disabilities, Intergovernmental relations.

U.S. Office of Personnel Management.

Elaine Kaplan,

Acting Director.

Accordingly, OPM is proposing to amend 5 CFR chapter I, as follows:

PART 300—EMPLOYMENT (GENERAL)

- 1. Revise the authority citation for part 300 to read as follows:

Authority: 5 U.S.C. 552, 2301, 2302, 3301, and 3302; E.O. 10577, 3 CFR 1954–1958 Comp., page 218, unless otherwise noted.

Secs. 300.101 through 300.104 also issued under 5 U.S.C. 7201, 7204, and 7701; E.O. 11478, 3 CFR 1966–1970 Comp., page 803, E.O. 13087; and E.O. 13152.

Secs. 300.401 through 300.408 also issued under 5 U.S.C. 1302(c).

Secs. 300.501 through 300.507 also issued under 5 U.S.C. 1103(a)(5).

Sec. 300.603 also issued under 5 U.S.C. 1104.

- 2. Revise § 300.102(c) to read as follows:

§ 300.102 Policy.

* * * * *

(c) Be developed and used without discrimination on the basis of race, color, religion, sex (including pregnancy and gender identity), national origin, age (as defined by the Age Discrimination in Employment Act of 1967, as amended), disability, genetic information, marital status, political affiliation, sexual orientation, labor organization affiliation or nonaffiliation, status as a parent, or any other non-merit-based factor, or retaliation for exercising rights with respect to the

categories enumerated above, where retaliation rights are available.

* * * * *

- 3. Revise § 300.103(c) to read as follows:

§ 300.103 Basic requirements.

* * * * *

(c) *Equal employment opportunity.*

An employment practice must not discriminate on the basis of race, color, religion, sex (including pregnancy and gender identity), national origin, age (as defined by the Age Discrimination in Employment Act of 1967, as amended), disability, genetic information, marital status, political affiliation, sexual orientation, labor organization affiliation or nonaffiliation, status as a parent, or any other non-merit-based factor, or retaliation for exercising rights with respect to the categories enumerated above, where retaliation rights are available. Employee selection procedures shall meet the standards established by the “Uniform Guidelines on Employee Selection Procedures.”

- 4. Revise § 300.104(c)(1) to read as follows:

§ 300.104 Appeals, grievances and complaints.

* * * * *

(c) *Complaints and grievances to an agency.* (1) A candidate may file a complaint with an agency when he or she believes that an employment practice that was applied to him or her and that is administered by the agency discriminates against him or her on the basis of race, color, religion, sex, national origin, or age (as defined by the Age Discrimination in Employment Act of 1967, as amended). The complaint must be filed and processed in accordance with the agency EEO or grievance procedures, as appropriate.

* * * * *

PART 315—CAREER AND CAREER-CONDITIONAL EMPLOYMENT

- 5. Revise the authority citation for part 315 to read as follows:

Authority: 5 U.S.C. 1302, 2301, 2302, 3301, and 3302; E.O. 10577, 3 CFR, 1954–1958 Comp. p. 218, unless otherwise noted; and E.O. 13162.

Secs. 315.601 and 315.609 also issued under 22 U.S.C. 3651 and 3652.

Secs. 315.602 and 315.604 also issued under 5 U.S.C. 1104.

Sec. 315.603 also issued under 5 U.S.C. 8151.

Sec. 315.605 also issued under E.O. 12034, 3 CFR, 1978 Comp. p.111.

Sec. 315.606 also issued under E.O. 11219, 3 CFR, 1964–1965 Comp. p. 303.

Sec. 315.607 also issued under 22 U.S.C. 2506.

Sec. 315.608 also issued under E.O. 12721, 3 CFR, 1990 Comp. p. 293.

Sec. 315.610 also issued under 5 U.S.C. 3304(c).

Sec. 315.611 also issued under 5 U.S.C. 3304(f).

Sec. 315.612 also issued under E.O. 13473.

Sec. 315.708 also issued under E.O. 13318, 3 CFR, 2004 Comp. p. 265.

Sec. 315.710 also issued under E.O. 12596, 3 CFR, 1987 Comp. p. 229.

Subpart I also issued under 5 U.S.C. 3321, E.O. 12107, 3 CFR, 1978 Comp. p. 264.

■ 6. Revise § 315.806(d) to read as follows:

§ 315.806 Appeal rights to the Merit Systems Protection Board.

* * * * *

(d) An employee may appeal to the Board under this section a termination that the employee alleges was based on discrimination because of race, color, religion, sex, national origin, age (as defined by the Age Discrimination in Employment Act of 1967, as amended), or disability. An appeal alleging a discriminatory termination may be filed under this subsection only if such discrimination is raised in addition to one of the issues stated in paragraph (b) or (c) of this section.

PART 335—PROMOTION AND INTERNAL PLACEMENT

■ 7. Revise the authority citation for part 335 to read as follows:

Authority: 5 U.S.C. 2301, 2302, 3301, 3302, 3330; E.O. 10577, E.O. 11478, 3 CFR 1966–1970 Comp., page 803, unless otherwise noted, E.O. 13087; and E.O. 13152, 3 CFR 1954–58 Comp., p. 218; 5 U.S.C. 3304(f), and Pub. L. 106–117.

■ 8. Revise § 335.103(b)(1) to read as follows:

§ 335.103 Agency promotion programs.

* * * * *

(b) *Merit promotion requirements*—(1) *Requirement 1.* Each agency must establish procedures for promoting employees that are based on merit and are available in writing to candidates. Agencies must list appropriate exceptions, including those required by paragraph (c) of this section. Actions under a promotion plan—whether identification, qualification, evaluation, or selection of candidates—must be made without regard to race, color, religion, sex (including pregnancy and gender identity), national origin, age (as defined by the Age Discrimination in Employment Act of 1967, as amended), disability, genetic information, marital status, political affiliation, sexual orientation, labor organization affiliation or nonaffiliation, status as a parent, or any other non-merit-based

factor, unless specifically designated by statute as a factor that must be taken into consideration when awarding such benefits, or retaliation for exercising rights with respect to the categories enumerated above, where retaliation rights are available, and must be based solely on job-related criteria.

* * * * *

PART 410—TRAINING

■ 9. Revise the authority citation for part 410 to read as follows:

Authority: 5 U.S.C. 1103(c), 2301, 2302, 4101, *et seq.*; E.O. 11348, 3 CFR, 1967 Comp., p. 275, E.O. 11478, 3 CFR 1966–1970 Comp., page 803, unless otherwise noted, E.O. 13087; and E.O. 13152.

■ 10. Revise § 410.302(a)(1) to read as follows:

§ 410.302 Responsibility of the head of an agency.

(a) *Specific responsibilities.* (1) The head of each agency must prescribe procedures as are necessary to ensure that the selection of employees for training is made without regard to race, color, religion, sex (including pregnancy and gender identity), national origin, age (as defined by the Age Discrimination in Employment Act of 1967, as amended), disability, genetic information, marital status, political affiliation, sexual orientation, labor organization affiliation or nonaffiliation, status as parent, or any other non-merit-based factor, unless specifically designated by statute as a factor that must be taken into consideration when awarding such benefits, or retaliation for exercising rights with respect to the categories enumerated above, where retaliation rights are available, and with proper regard for their privacy and constitutional rights as provided by merit system principles set forth in 5 U.S.C. 2301(b)(2).

* * * * *

PART 537—REPAYMENT OF STUDENT LOANS

■ 11. Revise the authority citation for part 537 to read as follows:

Authority: 5 U.S.C. 2301, 2302, and 5379(g); E.O. 11478, 3 CFR 1966–1970 Comp., page 803, unless otherwise noted, E.O. 13087; and E.O. 13152.

■ 12. Revise § 537.105(d) to read as follows:

§ 537.105 Criteria for payment.

* * * * *

(d) *Selection.* When selecting employees (or job candidates) to receive student loan repayment benefits, agencies must ensure that benefits are

awarded without regard to race, color, religion, sex (including pregnancy and gender identity), national origin, age (as defined by the Age Discrimination in Employment Act of 1967, as amended), disability, genetic information, marital status, political affiliation, sexual orientation, labor affiliation or nonaffiliation, status as a parent, or any other non-merit-based factor, unless specifically designated by statute as a factor that must be taken into consideration when awarding such benefits, or retaliation for exercising rights with respect to the categories enumerated above, where retaliation rights are available.

PART 900—INTERGOVERNMENTAL PERSONNEL ACT PROGRAMS

Subpart F—Standards for a Merit System of Personnel Administration

■ 13. Revise the authority citation for part 900, subpart F, to read as follows:

Authority: 42 U.S.C. 4728, 4763; E.O. 11589, 3 CFR part 557 (1971–75 Compilation); 5 U.S.C. 2301, 2302, E.O. 11478, 3 CFR 1966–1970 Comp., page 803, unless otherwise noted, E.O. 13087; and E.O. 13152.

■ 14. Revise § 900.603(e) to read as follows:

§ 900.603 Standards for a merit system of personnel administration.

* * * * *

(e) Assuring fair treatment of applicants and employees in all aspects of personnel administration without regard to race, color, religion, sex (including pregnancy and gender identity), national origin, age (as defined by the Age Discrimination in Employment Act of 1967, as amended), disability, genetic information, marital status, political affiliation, sexual orientation, status as parent, labor organization affiliation or nonaffiliation in accordance with Chapter 71 of Title V, or any other non-merit-based factor, or retaliation for exercising rights with respect to the categories enumerated above, where retaliation rights are available, and with proper regard for their privacy and constitutional rights as citizens. This “fair treatment” principle includes compliance with the Federal equal employment opportunity and nondiscrimination laws.

* * * * *

[FR Doc. 2013–21486 Filed 9–3–13; 8:45 am]

BILLING CODE 6325–39–P

FEHB Program Carrier Letter

All FEHB Carriers

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2014-17

Date: June 13, 2014

Fee-for-Service [14] Experience-rated HMO [14] Community-rated HMO [15]

SUBJECT: Gender Identity Disorder/Gender Dysphoria

This letter provides guidance for FEHB carriers regarding treatment of individuals who meet established criteria for a diagnosis of Gender Identity Disorder/Gender Dysphoria.

Carrier Letter 2011-12 directed carriers to allow individuals who identify as transgender to select their preferred gender designation for health records. It also reinforced the need to provide health benefits consistent with each person's individual medical status before and after gender transition.

There is an evolving professional consensus that treatment is considered medically necessary for certain individuals who meet established Diagnostic and Statistical Manual (DSM) criteria for a diagnosis of Gender Identity Disorder/Gender Dysphoria. Accordingly, OPM is removing the requirement that FEHB brochures exclude "services, drugs, or supplies related to sex transformations" in Section 6 of the FEHB plan brochure effective with the 2015 plan year.

Carriers will propose one of two options on coverage of services, drugs, and supplies regarding a diagnosis of Gender Identity Disorder/Gender Dysphoria:

- 1) Remove the **General Exclusion** language and provide to OPM the specific brochure text that describes the covered components and limitations of care for the diagnosis; or
- 2) Maintain the **General Exclusion** language for the 2015 plan year.

Let your contract specialist know by June 30, 2014 which option you are proposing and include the brochure text if applicable. Consistent with other benefit and rate negotiations, provide your contract specialist with all required information and necessary justification.

For questions or additional information, please contact your contract specialist.

Sincerely

John O'Brien
Director
Healthcare and Insurance

§ 18115. Freedom not to participate in Federal health insurance programs

No individual, company, business, nonprofit entity, or health insurance issuer offering group or individual health insurance coverage shall be required to participate in any Federal health insurance program created under this Act (or any amendments made by this Act), or in any Federal health insurance program expanded by this Act (or any such amendments), and there shall be no penalty or fine imposed upon any such issuer for choosing not to participate in such programs.

(Pub. L. 111-148, title I, §1555, Mar. 23, 2010, 124 Stat. 260.)

REFERENCES IN TEXT

This Act, referred to in text, is Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 119, known as the Patient Protection and Affordable Care Act. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

§ 18116. Nondiscrimination

(a) In general

Except as otherwise provided for in this title¹ (or an amendment made by this title),¹ an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title¹ (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) Continued application of laws

Nothing in this title¹ (or an amendment made by this title)¹ shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 794 of title 29, or the Age Discrimination Act of 1975 [42 U.S.C. 6101 et seq.], or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

(c) Regulations

The Secretary may promulgate regulations to implement this section.

(Pub. L. 111-148, title I, §1557, Mar. 23, 2010, 124 Stat. 260.)

REFERENCES IN TEXT

This title, referred to in subsecs. (a) and (b), is title I of Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 130, which

enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

The Civil Rights Act of 1964, referred to in subsecs. (a) and (b), is Pub. L. 88-352, July 2, 1964, 78 Stat. 241. Titles VI and VII of the Act are classified generally to subchapters V (§2000d et seq.) and VI (§2000e et seq.), respectively, of chapter 21 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 2000a of this title and Tables.

The Education Amendments of 1972, referred to in subsecs. (a) and (b), is Pub. L. 92-318, June 23, 1972, 86 Stat. 235. Title IX of the Act, known as the Patsy Takemoto Mink Equal Opportunity in Education Act, is classified principally to chapter 38 (§1681 et seq.) of Title 20, Education. For complete classification of title IX to the Code, see Short Title note set out under section 1681 of Title 20 and Tables.

The Age Discrimination Act of 1975, referred to in subsecs. (a) and (b), is title III of Pub. L. 94-135, Nov. 28, 1975, 89 Stat. 728, which is classified generally to chapter 76 (§6101 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 6101 of this title and Tables.

§ 18117. Oversight

The Inspector General of the Department of Health and Human Services shall have oversight authority with respect to the administration and implementation of this title¹ as it relates to such Department.

(Pub. L. 111-148, title I, §1559, Mar. 23, 2010, 124 Stat. 261.)

REFERENCES IN TEXT

This title, referred to in text, is title I of Pub. L. 111-148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

§ 18118. Rules of construction

(a) No effect on antitrust laws

Nothing in this title¹ (or an amendment made by this title)¹ shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For the purposes of this section, the term “antitrust laws” has the meaning given such term in subsection (a) of section 12 of title 15, except that such term includes section 45 of title 15 to the extent that such section 45 applies to unfair methods of competition.

(b) Rule of construction regarding Hawaii’s Prepaid Health Care Act

Nothing in this title¹ (or an amendment made by this title)¹ shall be construed to modify or limit the application of the exemption for Hawaii’s Prepaid Health Care Act (Haw. Rev. Stat. §§393-1 et seq.) as provided for under section 1144(b)(5) of title 29.

(c) Student health insurance plans

Nothing in this title¹ (or an amendment made by this title)¹ shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965 [20 U.S.C. 1001 et seq., 42 U.S.C. 2751 et seq.]) from offering a student health insurance plan, to the extent that such requirement is

¹ See References in Text note below.

¹ See References in Text note below.

¹ See References in Text note below.



U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION
Washington, DC 20507

Mia Macy,
Complainant,

v.

Eric Holder,
Attorney General,
Department of Justice,
(Bureau of Alcohol, Tobacco, Firearms and Explosives),
Agency.

Appeal No. 0120120821

Agency No. ATF-2011-00751

DECISION

On December 9, 2011, Complainant filed an appeal concerning her equal employment opportunity (EEO) complaint alleging employment discrimination in violation of Title VII of the Civil Rights Act of 1964 (Title VII), as amended, 42 U.S.C. § 2000e et seq. For the following reasons, the Commission finds that the Complainant's complaint of discrimination based on gender identity, change of sex, and/or transgender status is cognizable under Title VII and remands the complaint to the Agency for further processing.

BACKGROUND¹

Complainant, a transgender woman, was a police detective in Phoenix, Arizona. In December 2010 she decided to relocate to San Francisco for family reasons. According to her formal complaint, Complainant was still known as a male at that time, having not yet made the transition to being a female.

Complainant's supervisor in Phoenix told her that the Bureau of Alcohol, Tobacco, Firearms and Explosives (Agency) had a position open at its Walnut Creek crime laboratory for which the Complainant was qualified. Complainant is trained and certified as a National Integrated Ballistic Information Network (NIBIN) operator and a BrassTrax ballistics investigator.

Complainant discussed the position with the Director of the Walnut Creek lab by telephone, in either December 2010 or January 2011, while still presenting as a man. According to Complainant, the telephone conversation covered her experience, credentials, salary and

¹ The facts in this section are taken from the EEO Counselor's Report and the formal complaint of discrimination. Because this decision addresses a jurisdictional issue, we offer no position on the facts themselves and thus no position on whether unlawful discrimination occurred in this case.

benefits. Complainant further asserts that, following the conversation, the Director told her she would be able to have the position assuming no problems arose during her background check. The Director also told her that the position would be filled as a civilian contractor through an outside company.

Complainant states that she talked again with the Director in January 2011 and asked that he check on the status of the position. According to Complainant in her formal complaint, the Director did so and reasserted that the job was hers pending completion of the background check. Complainant asserts, as evidence of her impending hire, that Aspen of DC ("Aspen"),² the contractor responsible for filling the position, contacted her to begin the necessary paperwork and that an investigator from the Agency was assigned to do her background check.³

On March 29, 2011, Complainant informed Aspen via email that she was in the process of transitioning from male to female and she requested that Aspen inform the Director of the Walnut Creek lab of this change. According to Complainant, on April 3, 2011, Aspen informed Complainant that the Agency had been informed of her change in name and gender. Five days later, on April 8, 2011, Complainant received an email from the contractor's Director of Operations stating that, due to federal budget reductions, the position at Walnut Creek was no longer available.

According to Complainant, she was concerned about this quick change in events and on May 10, 2011,⁴ she contacted an agency EEO counselor to discuss her concerns. She states that the counselor told her that the position at Walnut Creek had not been cut but, rather, that someone

² It appears from the record that Aspen of DC may be considered a staffing firm. Under the Commission's Enforcement Guidance: Application of EEO Laws to Contingent Workers Placed by Temporary Employment Agencies and Other Staffing Firms, EEOC Notice No. 915.002 (December 3, 1997), we have recognized that a "joint employment" relationship may exist where both the Agency and the "staffing firm" may be deemed employers. The Commission makes no determination at this time as to whether or not a "joint employment" relationship exists in this case as this issue is not presently before us.

³ On March 28, 2011, Complainant received an e-mail from the contractor asking her to fill out an application packet for the position. It is unclear how far the background investigation had proceeded prior to Complainant notifying the contractor of her gender change, but e-mails included in the record indicate that the Agency's Personnel Security Branch had received Complainant's completed security package, that Complainant had been interviewed by a security investigator, and that the investigator had contacted Complainant on March 31, 2011 and had indicated that he "hope[d] to finish your investigation the first of next week."

⁴ In the narrative accompanying her formal complaint, Complainant asserts she contacted the Agency's EEO Counselor on May 5, 2011. However, the EEO Counselor's report indicates that the initial contact occurred on May 10, 2011.

else had been hired for the position. Complainant further states that the counselor told her that the Agency had decided to take the other individual because that person was farthest along in the background investigation.⁵ Complainant claims that this was a pretextual explanation because the background investigation had been proceeding on her as well. Complainant believes she was incorrectly informed that the position had been cut because the Agency did not want to hire her because she is transgender.

The EEO counselor's report indicates that Complainant alleged that she had been discriminated against based on sex, and had specifically described her claim of discrimination as "change in gender (from male to female)."

On June 13, 2011, Complainant filed her formal EEO complaint with the Agency. On her formal complaint form, Complainant checked off "sex" and the box "female," and then typed in "gender identity" and "sex stereotyping" as the basis of her complaint. In the narrative accompanying her complaint, Complainant stated that she was discriminated against on the basis of "my sex, gender identity (transgender woman) and on the basis of sex stereotyping."

On October 26, 2011, the Agency issued Complainant a Letter of Acceptance, stating that the "claim alleged and being accepted and referred for investigation is the following: Whether you were discriminated against based on your gender identity sex (female) stereotyping when on May 5, 2011, you learned that you were not hired as a Contractor for the position of [NIBIN] Ballistics Forensic Technician in the Walnut Creek Lab, San Francisco Field Office." The letter went on to state, however, that "since claims of discrimination on the basis of gender identity stereotyping cannot be adjudicated before the [EEOC], your claims will be processed according to Department of Justice policy." The letter provided that if Complainant did not agree with how the Agency had identified her claim, she should contact the EEO office within 15 days.

The Department of Justice has one system for adjudicating claims of sex discrimination under Title VII and a separate system for adjudicating complaints of sexual orientation and gender identity discrimination by its employees. This separate process does not include the same rights offered under Title VII and the EEOC regulations set forth under 29 C.F.R. Part 1614. See Department of Justice Order 1200.1, Chapter 4-1, B.7.j, found at <http://www.justice.gov/jmd/ps/chpt4-1.html> (last accessed on March 30, 2012). While such complaints are processed utilizing the same EEO complaint process and time frames – including an ADR program, an EEO investigation and issuance of a final Agency decision – the Department of Justice process allows for fewer remedies and does not include the right to request a hearing before an EEOC Administrative Judge or the right to appeal the final Agency decision to the Commission.

⁵ The Counselor's Report includes several email exchanges with various Agency officials who informed the counselor of the circumstances by which it was decided not to hire Complainant.

On November 8, 2011, Complainant's attorney contacted the Agency by letter to explain that the claims that Complainant had set forth in the formal complaint had not been correctly identified by the Agency. The letter explained that the claim as identified by the Agency was both incomplete and confusing. The letter noted that "[Complainant] is a transgender woman who was discriminated against during the hiring process for a job with [the Agency]," and that the discrimination against Complainant was based on "separate and related" factors, including on the basis of sex, sex stereotyping, sex due to gender transition/change of sex, and sex due to gender identity. Thus, Complainant disagreed with the Agency's contention that her claim in its entirety could not be adjudicated through the Title VII and EEOC process simply because of how she had stated the alleged bases of discrimination.

On November 18, 2011, the Agency issued a correction to its Letter of Acceptance in response to Complainant's November 8, 2011 letter. In this letter, the Agency stated that it was accepting the complaint "on the basis of sex (female) and gender identity stereotyping." However, the Agency again stated that it would process only her claim "based on sex (female)" under Title VII and the EEOC's Part 1614 regulations. Her claim based on "gender identity stereotyping" would be processed instead under the Agency's "policy and practice," including the issuance of a final Agency decision from the Agency's Complaint Adjudication Office.

CONTENTIONS ON APPEAL

On December 6, 2011, Complainant, through counsel, submitted a Notice of Appeal to the Commission asking that it adjudicate the claim that she was discriminated against on the basis of "sex stereotyping, sex discrimination based gender transition/change of sex, and sex discrimination based gender identity" when she was denied the position as an NIBIN ballistics technician.

Complainant argues that EEOC has jurisdiction over her entire claim. She further asserts that the Agency's "reclassification" of her claim of discrimination into two separate claims of discrimination -- one "based on sex (female) under Title VII" which the Agency will investigate under Title VII and the EEOC's Part 1614 regulations, and a separate claim of discrimination based on "gender identity stereotyping" which the Agency will investigate under a separate process designated for such claims -- is a "de facto dismissal" of her Title VII claim of discrimination based on gender identity and transgender status.

In response to Complainant's appeal, the Agency sent a letter to the Commission on January 11, 2012, arguing that Complainant's appeal was "premature" because the Agency had accepted a claim designated as discrimination "based on sex (female)."

In response to the Agency's January 11, 2012 letter, Complainant wrote to the Agency on February 8, 2012, stating that, in light of how the Agency was characterizing her claim, she wished to withdraw her claim of "discrimination based on sex (female)," as characterized by the Agency, and to pursue solely the Agency's dismissal of her complaint of discrimination

based on her gender identity, change of sex and/or transgender status. In a letter to the Commission dated February 9, 2012, Complainant explained that she had withdrawn the claim “based on sex (female)” as the Agency had characterized it, in order to remove any possible procedural claim that her appeal to the Commission was premature.

Complainant reiterates her contention that the Agency mischaracterized her claim and asks the Commission to rule on her appeal that the Agency should investigate, under Title VII and the EEOC’s Part 1614 regulations, her claim of discriminatory failure to hire based on her gender identity, change of sex, and/or transgender status.

ANALYSIS AND FINDINGS

The narrative accompanying Complainant’s complaint makes clear that she believes she was not hired for the position as a result of making her transgender status known. As already noted, Complainant stated that she was discriminated against on the basis of “my sex, gender identity (transgender woman) and on the basis of sex stereotyping.” In response to her complaint, the Agency stated that claims of gender identity discrimination “cannot be adjudicated before the [EEOC].” See Agency Letters of October 26, 2011 and November 18, 2011. Although it is possible that the Agency would have fully addressed her claims under that portion of her complaint accepted under the 1614 process, the Agency’s communications prompted in Complainant a reasonable belief that the Agency viewed the gender identity discrimination she alleged as outside the scope of Title VII’s sex discrimination prohibitions. Based on these communications, Complainant believed that her complaint would not be investigated effectively by the Agency, and she filed the instant appeal.

EEOC Regulation 29 C.F.R. §1614.107(b) provides that where an agency decides that some, but not all, of the claims in a complaint should be dismissed, it must notify the complainant of its determination. However, this determination is not appealable until final action is taken on the remainder of the complaint. In apparent recognition of the operation of §1614.107(b), Complainant withdrew the accepted portion of her complaint from the 1614 process so that the constructive dismissal of her gender identity discrimination claim would be a final decision and the matter ripe for appeal.

In the interest of resolving the confusion regarding a recurring legal issue that is demonstrated by this complaint’s procedural history, as well as to ensure efficient use of resources, we accept this appeal for adjudication. Moreover, EEOC’s responsibilities under Executive Order 12067 for enforcing all Federal EEO laws and leading the Federal government’s efforts to eradicate workplace discrimination, require, among other things, that EEOC ensure that uniform standards be implemented defining the nature of employment discrimination under the statutes we enforce. Executive Order 12067, 43 F.R. 28967, § 1-301(a) (June 30, 1978). To that end, the Commission hereby clarifies that claims of discrimination based on transgender

status, also referred to as claims of discrimination based on gender identity, are cognizable under Title VII's sex discrimination prohibition, and may therefore be processed under Part 1614 of EEOC's federal sector EEO complaints process.

We find that the Agency mistakenly separated Complainant's complaint into separate claims: one described as discrimination based on "sex" (which the Agency accepted for processing under Title VII) and others that were alternatively described by Complainant as "sex stereotyping," "gender transition/change of sex," and "gender identity" (Complainant Letter of Nov. 8, 2011); by the Agency as "gender identity stereotyping" (Agency Letter Nov. 18, 2011); and finally by Complainant as "gender identity, change of sex and/or transgender status" (Complainant Letter Feb. 8, 2012). While Complainant could have chosen to avail herself of the Agency's administrative procedures for discrimination based on gender identity, she clearly expressed her desire to have her claims investigated through the 1614 process, and this desire should have been honored. Each of the formulations of Complainant's claims are simply different ways of stating the same claim of discrimination "based on . . . sex," a claim cognizable under Title VII.

Title VII states that, except as otherwise specifically provided, "[a]ll personnel actions affecting [federal] employees or applicants for employment . . . shall be made free from any discrimination *based on . . . sex . . .*" 42 U.S.C. § 2000e-16(a) (emphasis added). *Cf.* 42 U.S.C. §§ 2000e-2(a)(1), (2) (it is unlawful for a covered employer to "fail or refuse to hire or to discharge any individual, or otherwise to discriminate with respect to his compensation, terms, conditions, or privileges of employment," or to "limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, *because of such individual's . . . sex*") (emphasis added).

As used in Title VII, the term "sex" "encompasses both sex—that is, the biological differences between men and women—and gender." *See Schwenk v. Hartford*, 204 F.3d 1187, 1202 (9th Cir. 2000); *see also Smith v. City of Salem*, 378 F.3d 566, 572 (6th Cir. 2004) ("The Supreme Court made clear that in the context of Title VII, discrimination because of 'sex' includes gender discrimination."). As the Eleventh Circuit noted in *Glenn v. Brumby*, 663 F.3d 1312, 1316 (11th Cir. 2011), six members of the Supreme Court in *Price Waterhouse* agreed that Title VII barred "not just discrimination because of biological sex, but also gender stereotyping—failing to act and appear according to expectations defined by gender." As such, the terms "gender" and "sex" are often used interchangeably to describe the discrimination prohibited by Title VII. *See, e.g., Price Waterhouse v. Hopkins*, 490 U.S. 228, 239 (1989) (emphasis added) ("Congress' intent to forbid employers to take *gender* into account in making employment decisions appears on the face of the statute.").

That Title VII's prohibition on sex discrimination proscribes gender discrimination, and not just discrimination on the basis of biological sex, is important. If Title VII proscribed only discrimination on the basis of biological sex, the only prohibited gender-based disparate treatment would be when an employer prefers a man over a woman, or vice versa. But the

statute's protections sweep far broader than that, in part because the term "gender" encompasses not only a person's biological sex but also the cultural and social aspects associated with masculinity and femininity.

In Price Waterhouse, the employer refused to make a female senior manager, Hopkins, a partner at least in part because she did not act as some of the partners thought a woman should act. Id. at 230–31, 235. She was informed, for example, that to improve her chances for partnership she should "walk more femininely, talk more femininely, dress more femininely, wear make-up, have her hair styled, and wear jewelry." Id. at 235. The Court concluded that discrimination for failing to conform with gender-based expectations violates Title VII, holding that "[i]n the specific context of sex stereotyping, an employer who acts on the basis of a belief that a woman cannot be aggressive, or that she must not be, has acted on the basis of gender." Id. at 250.

Although the partners at Price Waterhouse discriminated against Ms. Hopkins for failing to conform to stereotypical gender norms, gender discrimination occurs any time an employer treats an employee differently for failing to conform to any gender-based expectations or norms. "What matters, for purposes of . . . the Price Waterhouse analysis, is that in the mind of the perpetrator the discrimination is related to the sex of the victim." Schwenk, 204 F.3d at 1201–02; see also Price Waterhouse, 490 U.S. at 254–55 (noting the illegitimacy of allowing "sex-linked evaluations to play a part in the [employer's] decision-making process").

"Title VII does identify one circumstance in which an employer may take gender into account in making an employment decision, namely, when gender is a 'bona fide occupational qualification [(BFOQ)] reasonably necessary to the normal operation of th[e] particular business or enterprise.'" Price Waterhouse, 490 U.S. at 242 (quoting 42 U.S.C. § 2000e-2(e)). Even then, "the [BFOQ] exception was in fact meant to be an extremely narrow exception to the general prohibition of discrimination on the basis of sex." See Phillips v. Martin Marietta Corp., 400 U.S. 542, 544 (1971) (Marshall, J., concurring). "The only plausible inference to draw from this provision is that, in all other circumstances, a person's gender may not be considered in making decisions that affect her." Price Waterhouse, 490 U.S. at 242.⁶

When an employer discriminates against someone because the person is transgender, the employer has engaged in disparate treatment "related to the sex of the victim." See Schwenk, 204 F.3d at 1202. This is true regardless of whether an employer discriminates against an employee because the individual has expressed his or her gender in a non-stereotypical fashion, because the employer is uncomfortable with the fact that the person has transitioned or is in the process of transitioning from one gender to another, or because the employer simply does not

⁶ There are other, limited instances in which gender may be taken into account, such as is in the context of a valid affirmative action plan, see Johnson v. Santa Clara County Transportation Agency, 480 U.S. 616 (1987), or relatedly, as part of a settlement of a pattern or practice claim.

like that the person is identifying as a transgender person. In each of these circumstances, the employer is making a gender-based evaluation, thus violating the Supreme Court's admonition that "an employer may not take gender into account in making an employment decision." Price Waterhouse, 490 U.S. at 244.

Since Price Waterhouse, courts have widely recognized the availability of the sex stereotyping theory as a valid method of establishing discrimination "on the basis of sex" in many scenarios involving individuals who act or appear in gender-nonconforming ways.⁷ And since Price Waterhouse, courts also have widely recognized the availability of the sex stereotyping theory as a valid method of establishing discrimination "on the basis of sex" in scenarios involving transgender individuals.

For example, in Schwenk v. Hartford, a prison guard had sexually assaulted a pre-operative male-to-female transgender prisoner, and the prisoner sued, alleging that the guard had

⁷ See, e.g., Lewis v. Heartland Inns of Am., L.L.C., 591 F.3d 1033, 1041 (8th Cir. 2010) (concluding that evidence that a female "tomboyish" plaintiff had been fired for not having the "Midwestern girl look" suggested "her employer found her unsuited for her job . . . because her appearance did not comport with its preferred feminine stereotype"); Prowel v. Wise Business Forms, Inc., 579 F.3d 285 (3rd Cir. 2009) (an effeminate gay man who did not conform to his employer's vision of how a man should look, speak, and act provided sufficient evidence of gender stereotyping harassment under Title VII); Medina v. Income Support Div., 413 F.3d 1131, 1135 (10th Cir. 2005) (involving a heterosexual female who alleged that her lesbian supervisor discriminated against her on the basis of sex, and finding that "a plaintiff may satisfy her evidentiary burden [under Title VII] by showing that the harasser was acting to punish the plaintiff's noncompliance with gender stereotypes"); Nichols v. Azteca Rest. Enters., 256 F.3d 864, 874-75 (9th Cir. 2001) (concluding that a male plaintiff stated a Title VII claim when he was discriminated against "for walking and carrying his tray 'like a woman' - i.e., for having feminine mannerisms"); Simonton v. Runyon, 232 F.3d 33, 37 (2d Cir. 2000) (indicating that a gay man would have a viable Title VII claim if "the abuse he suffered was discrimination based on sexual stereotypes, which may be cognizable as discrimination based on sex"); Higgins v. New Balance Athletic Shoe, Inc., 194 F.3d 252, 261 n.4 (1st Cir. 1999) (analyzing a gay plaintiff's claim that his co-workers harassed him by "mocking his supposedly effeminate characteristics" and acknowledging that "just as a woman can ground an action on a claim that men discriminated against her because she did not meet stereotyped expectations of femininity . . . a man can ground a claim on evidence that other men discriminated against him because he did not meet stereotypical expectations of masculinity"); Doe by Doe v. City of Belleville, 119 F.3d 563, 580-81 (7th Cir. 1997) (involving a heterosexual male who was harassed by other heterosexual males, and concluding that "a man who is harassed because his voice is soft, his physique is slight, his hair is long, or because in some other respect he . . . does not meet his coworkers' idea of how men are to appear and behave, is harassed 'because of' his sex"), vacated and remanded on other grounds, 523 U.S. 1001 (1998).

violated the Gender Motivated Violence Act (GMVA), 42 U.S.C. § 13981. 204 F.3d at 1201–02. The U.S. Court of Appeals for the Ninth Circuit found that the guard had known that the prisoner “considered herself a transsexual and that she planned to seek sex reassignment surgery in the future.” *Id.* at 1202. According to the court, the guard had targeted the transgender prisoner “only after he discovered that she considered herself female[,]” and the guard was “motivated, at least in part, by [her] gender”—that is, “by her assumption of a feminine rather than a typically masculine appearance or demeanor.” *Id.* On these facts, the Ninth Circuit readily concluded that the guard’s attack constituted discrimination because of gender within the meaning of both the GMVA and Title VII.

The court relied on Price Waterhouse, reasoning that it stood for the proposition that discrimination based on sex includes discrimination based on a failure “to conform to socially-constructed gender expectations.” *Id.* at 1201–02. Accordingly, the Ninth Circuit concluded, discrimination against transgender females – i.e., “as anatomical males whose *outward behavior and inward identity* [do] not meet social definitions of masculinity” – is actionable discrimination “because of sex.” *Id.* (emphasis added); cf. Rosa v. Park W. Bank & Trust Co., 214 F.3d 213, 215–16 (1st Cir. 2000) (finding that under Price Waterhouse, a bank’s refusal to give a loan application to a biologically-male plaintiff dressed in “traditionally feminine attire” because his “attire did not accord with his male gender” stated a claim of illegal sex discrimination in violation of the Equal Credit Opportunity Act, 15 U.S.C. §§ 1691–1691f).

Similarly, in Smith v. City of Salem, the plaintiff was “biologically and by birth male.” 378 F.3d at 568. However, Smith was diagnosed with Gender Identity Disorder (GID), and began to present at work as a female (in accordance with medical protocols for treatment of GID). *Id.* Smith’s co-workers began commenting that her appearance and mannerisms were “not masculine enough.” *Id.* Smith’s employer later subjected her to numerous psychological evaluations, and ultimately suspended her. *Id.* at 569–70. Smith filed suit under Title VII alleging that her employer had discriminated against her because of sex, “both because of [her] *gender non-conforming conduct* and, more generally, because of [her] *identification* as a transsexual.” *Id.* at 571 (emphasis added).

The district court rejected Smith’s efforts to prove her case using a sex-stereotyping theory, concluding that it was really an attempt to challenge discrimination based on “transsexuality.” *Id.* The U.S. Court of Appeals for the Sixth Circuit reversed, stating that the district court’s conclusion:

cannot be reconciled with Price Waterhouse, which does not make Title VII protection against sex stereotyping conditional or provide any reason to exclude Title VII coverage for non sex-stereotypical behavior simply because the person is a transsexual. As such, discrimination against a plaintiff who is a transsexual—and therefore fails to act and/or identify with his or her gender—is no different from the discrimination directed against [the plaintiff] in Price Waterhouse who, in sex-stereotypical terms, did not act like a woman. Sex

stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior; a label, such as "transsexual" is not fatal to a sex discrimination claim where the victim has suffered discrimination because of his or her gender non-conformity. Accordingly, we hold that Smith has stated a claim for relief pursuant to Title VII's prohibition of sex discrimination.

Id. at 574–75.⁸

Finally, as the Eleventh Circuit suggested in Glenn v. Brumby, 663 F.3d 1312 (11th Cir. 2011), consideration of gender stereotypes will inherently be part of what drives discrimination against a transgendered individual. In that case, the employer testified at his deposition that it had fired Vandiver Elizabeth Glenn, a transgender woman, because he considered it "inappropriate" for her to appear at work dressed as a woman and that he found it "unsettling" and "unnatural" that she would appear wearing women's clothing. Id. at 1320. The firing supervisor further testified that his decision to dismiss Glenn was based on his perception of Glenn as "a man dressed as a woman and made up as a woman," and admitted that his decision to fire her was based on "the sheer fact of the transition." Id. at 1320–21. According to the Eleventh Circuit, this testimony "provides ample direct evidence" to support the conclusion that the employer acted on the basis of the plaintiff's gender non-conformity and therefore granted summary judgment to her. Id. at 1321.

In setting forth its legal reasoning, the Eleventh Circuit explained:

A person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes. "[T]he very acts that define transgender people as transgender are those that contradict stereotypes of gender-appropriate appearance and behavior." Ilona M. Turner, *Sex Stereotyping Per Se: Transgender Employees and Title VII*, 95 Cal. L. Rev. 561, 563 (2007); see also Taylor Flynn, *Transforming the Debate: Why We Need to Include Transgender Rights in the Struggles for Sex and Sexual Orientation Equality*, 101 Colum. L.Rev. 392, 392 (2001) (defining transgender persons as those whose "appearance, behavior, or other personal characteristics differ from traditional gender norms"). There is thus a congruence between discriminating against transgender and transsexual individuals and discrimination on the basis of gender-based behavioral norms.

⁸ See also Barnes v. City of Cincinnati, 401 F.3d 729, 741 (6th Cir. 2005) (affirming a jury award in favor of a pre-operative transgender female, ruling that "a claim for sex discrimination under Title VII . . . can properly lie where the claim is based on 'sexual stereotypes'" and that the "district court therefore did not err when it instructed the jury that it could find discrimination based on 'sexual stereotypes'").

Accordingly, discrimination against a transgender individual because of her gender-nonconformity is sex discrimination, whether it's described as being on the basis of sex or gender.

Glenn v. Brumby, 663 F.3d 1312, 1316–17 (11th Cir. 2011).⁹

There has likewise been a steady stream of district court decisions recognizing that discrimination against transgender individuals on the basis of sex stereotyping constitutes discrimination because of sex. Most notably, in Schroer v. Billington, the Library of Congress rescinded an offer of employment it had extended to a transgender job applicant after the applicant informed the Library's hiring officials that she intended to undergo a gender transition. See 577 F. Supp. 2d 293 (D.D.C. 2008). The U.S. District Court for the District of Columbia entered judgment in favor of the plaintiff on her Title VII sex discrimination claim. According to the district court, it did not matter “for purposes of Title VII liability whether the Library withdrew its offer of employment because it perceived Schroer to be an insufficiently masculine man, an insufficiently feminine woman, or an inherently gender-nonconforming transsexual.” *Id.* at 305. In any case, Schroer was “entitled to judgment based on a Price-Waterhouse-type claim for sex stereotyping” *Id.*¹⁰

To be sure, the members of Congress that enacted Title VII in 1964 and amended it in 1972 were likely not considering the problems of discrimination that were faced by transgender individuals. But as the Supreme Court recognized in Oncale v. Sundowner Offshore Services, Inc.:

⁹ But see Etsitty v. Utah Trans. Auth., No. 2:04-CV-616, 2005 WL 1505610, at *4–5 (D. Utah June 24, 2005) (concluding that Price Waterhouse is inapplicable to transsexuals), aff'd on other grounds, 502 F.3d 1215 (10th Cir.2007).

¹⁰ The district court in Schroer also concluded that discrimination against a transgender individual on the basis of an intended, ongoing, or completed gender transition is “literally discrimination ‘because of . . . sex.’” Schroer, 577 F. Supp. 2d at 308; see also *id.* at 306–07 (analogizing to cases involving discrimination based on an employee’s religious conversion, which undeniably constitutes discrimination “because of . . . religion” under Title VII). For other district court cases using sex stereotyping as grounds for establishing coverage of transgender individuals under Title VII, see Michaels v. Akal Security, Inc., No. 09-cv-1300, 2010 WL 2573988, at * 4 (D. Colo. June 24, 2010); Lopez v. River Oaks Imaging & Diag. Group, Inc., 542 F. Supp. 2d 653, 660 (S.D. Tex. 2008); Mitchell v. Axcan Scandipharm, Inc., No. Vic. A. 05-243, 2006 WL 456173 (W.D. Pa. Feb. 17, 2006); Tronetti v. TLC HealthNet Lakeshore Hosp., No. 03-CV-0375E(SC), 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003); Doe v. United Consumer Fin. Servs., No. 1:01 CV 111, 2001 WL 34350174 (N.D. Ohio Nov. 9, 2001).

[S]tatutory prohibitions often go beyond the principal evil [they were passed to combat] to cover reasonably comparable evils, and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed. Title VII prohibits “discriminat[ion] . . . because of . . . sex” in . . . employment. [This] . . . must extend to [sex-based discrimination] of any kind that meets the statutory requirements.

523 U.S. at 79-80; see also Newport News, 462 U.S. at 679-81 (rejecting the argument that discrimination against men does not violate Title VII despite the fact that discrimination against women was plainly the principal problem that Title VII’s prohibition of sex discrimination was enacted to combat).

Although most courts have found protection for transgender people under Title VII under a theory of gender stereotyping, evidence of gender stereotyping is simply one means of proving sex discrimination. Title VII prohibits discrimination based on sex whether motivated by hostility,¹¹ by a desire to protect people of a certain gender,¹² by assumptions that disadvantage men,¹³ by gender stereotypes,¹⁴ or by the desire to accommodate other people’s prejudices or discomfort.¹⁵ While evidence that an employer has acted based on stereotypes about how men or women should act is certainly one means of demonstrating disparate treatment based on sex, “sex stereotyping” is not itself an independent cause of action. As the Price Waterhouse Court

¹¹ See Meritor Savings Bank, FSB v. Vinson, 477 U.S. 57, 64 (1986) (recognizing that sexual harassment is actionable discrimination “because of sex”); Oncale v. Sundowner Offshore Servs., Inc., 523 U.S. 75, 80 (1998) (“A trier of fact might reasonably find such discrimination, for example, if a female victim is harassed in such sex-specific and derogatory terms by another woman as to make it clear that the harasser is motivated by general hostility to the presence of women in the workplace.”).

¹² See Int’l Union v. Johnson Controls, 499 U.S. 187, 191 (1991) (policy barring all female employees except those who were infertile from working in jobs that exposed them to lead was facially discriminatory on the basis of sex).

¹³ See, e.g., Newport News, 462 U.S. at 679-81 (providing different insurance coverage to male and female employees violates Title VII even though women are treated better).

¹⁴ See, e.g., Price Waterhouse, 490 U.S. at 250-52.

¹⁵ See, e.g., Chaney v. Plainfield Healthcare Ctr., 612 F.3d 908, 912 (7th Cir. 2010) (concluding that “assignment sheet that unambiguously, and daily, reminded [the plaintiff, a black nurse,] and her co-workers that certain residents preferred no black” nurses created a hostile work environment); Fernandez v. Wynn Oil Co., 653 F.2d 1273, 1276-77 (9th Cir. 1981) (a female employee could not lawfully be fired because her employer’s foreign clients would only work with males); Diaz v. Pan American World Airways, Inc., 442 F.2d 385, 389 (5th Cir. 1971) (rejecting customer preference for female flight attendants as justification for discrimination against male applicants).

noted, while “stereotyped remarks can certainly be *evidence* that gender played a part” in an adverse employment action, the central question is always whether the “employer actually relied on [the employee’s] gender in making its decision.” *Id.* at 251 (emphasis in original).

Thus, a transgender person who has experienced discrimination based on his or her gender identity may establish a prima facie case of sex discrimination through any number of different formulations. These different formulations are not, however, different claims of discrimination that can be separated out and investigated within different systems. Rather, they are simply different ways of describing sex discrimination.

For example, Complainant could establish a case of sex discrimination under a theory of gender stereotyping by showing that she did not get the job as an NIBIN ballistics technician at Walnut Creek because the employer believed that biological men should consistently present as men and wear male clothing.

Alternatively, if Complainant can prove that the reason that she did not get the job at Walnut Creek is that the Director was willing to hire her when he thought she was a man, but was not willing to hire her once he found out that she was now a woman—she will have proven that the Director discriminated on the basis of sex. Under this theory, there would actually be no need, for purposes of establishing coverage under Title VII, for Complainant to compile any evidence that the Director was engaging in gender stereotyping.

In this respect, gender is no different from religion. Assume that an employee considers herself Christian and identifies as such. But assume that an employer finds out that the employee’s parents are Muslim, believes that the employee should therefore be Muslim, and terminates the employee on that basis. No one would doubt that such an employer discriminated on the basis of religion. There would be no need for the employee who experienced the adverse employment action to demonstrate that the employer acted on the basis of some religious stereotype—although, clearly, discomfort with the choice made by the employee with regard to religion would presumably be at the root of the employer’s actions. But for purposes of establishing a prima facie case that Title VII has been violated, the employee simply must demonstrate that the employer impermissibly used religion in making its employment decision.

The District Court in Schroer provided reasoning along similar lines:

Imagine that an employee is fired because she converts from Christianity to Judaism. Imagine too that her employer testifies that he harbors no bias toward either Christians or Jews but only ‘converts.’ That would be a clear case of discrimination ‘because of religion.’ No court would take seriously the notion that ‘converts’ are not covered by the statute. Discrimination “because of religion” easily encompasses discrimination because of a change of religion.

577 F. Supp. 2d at 306.

Applying Title VII in this manner does not create a new “class” of people covered under Title VII—for example, the “class” of people who have converted from Islam to Christianity or from Christianity to Judaism. Rather, it would simply be the result of applying the plain language of a statute prohibiting discrimination on the basis of religion to practical situations in which such characteristics are unlawfully taken into account. See Brumby, 663 F.3d at 1318–19 (noting that “all persons, whether transgender or not” are protected from discrimination and “[a]n individual cannot be punished because of his or her perceived gender non-conformity”).

Thus, we conclude that intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination “based on . . . sex,” and such discrimination therefore violates Title VII.¹⁶

CONCLUSION

Accordingly, the Agency's final decision declining to process Complainant's entire complaint within the Part 1614 EEO complaints process is **REVERSED**. The complaint is hereby **REMANDED** to the Agency for further processing in accordance with this decision and the Order below.

ORDER (E0610)

The Agency is ordered to process the remanded complaint in accordance with 29 C.F.R. § 1614.108 et seq. The Agency shall acknowledge to the Complainant that it has received the remanded claims **within thirty (30) calendar days** of the date this decision becomes final. The Agency shall issue to Complainant a copy of the investigative file and also shall notify Complainant of the appropriate rights **within one hundred fifty (150) calendar days** of the date this decision becomes final, unless the matter is otherwise resolved prior to that time. If the Complainant requests a final decision without a hearing, the Agency shall issue a final decision **within sixty (60) days** of receipt of Complainant's request. A copy of the Agency's letter of acknowledgment to Complainant and a copy of the notice that transmits the investigative file and notice of rights must be sent to the Compliance Officer as referenced below.

¹⁶ The Commission previously took this position in an amicus brief docketed with the district court in the Western District of Texas on Oct. 17, 2011, where it explained that “[i]t is the position of the EEOC that disparate treatment of an employee because he or she is transgender is discrimination “because of . . . sex” under Title VII.” EEOC Amicus Brief in *Pacheco v. Freedom Buick GMC Truck*, No. 07-116 (W.D. Tex. Oct. 17, 2011), Dkt. No. 30, at page 1, 2011 WL 5410751. With this decision, we expressly overturn, in light of the recent developments in the caselaw described above, any contrary earlier decisions from the Commission. See, e.g., Jennifer Casoni v. United States Postal Service, EEOC DOC 01840104 (Sept. 28, 1984); Campbell v. Dep't of Agriculture, EEOC Appeal No. 01931703 (July 21, 1994); Kowalczyk v. Dep't of Veterans Affairs, EEOC Appeal No. 01942053 (March 14, 1996).

IMPLEMENTATION OF THE COMMISSION'S DECISION (K0610)

Compliance with the Commission's corrective action is mandatory. The Agency shall submit its compliance report **within thirty (30) calendar days** of the completion of all ordered corrective action. The report shall be submitted to the Compliance Officer, Office of Federal Operations, Equal Employment Opportunity Commission, P.O. Box 77960, Washington, DC 20013. The Agency's report must contain supporting documentation, and the Agency must send a copy of all submissions to the Complainant. If the Agency does not comply with the Commission's order, the Complainant may petition the Commission for enforcement of the order. 29 C.F.R. § 1614.503(a). The Complainant also has the right to file a civil action to enforce compliance with the Commission's order prior to or following an administrative petition for enforcement. See 29 C.F.R. §§ 1614.407, 1614.408, and 29 C.F.R. § 1614.503(g). Alternatively, the Complainant has the right to file a civil action on the underlying complaint in accordance with the paragraph below entitled "Right to File a Civil Action." 29 C.F.R. §§ 1614.407 and 1614.408. A civil action for enforcement or a civil action on the underlying complaint is subject to the deadline stated in 42 U.S.C. 2000e-16(c) (1994 & Supp. IV 1999). If the Complainant files a civil action, the administrative processing of the complaint, including any petition for enforcement, will be terminated. See 29 C.F.R. § 1614.409.

STATEMENT OF RIGHTS - ON APPEAL

RECONSIDERATION (M0610)

The Commission may, in its discretion, reconsider the decision in this case if the Complainant or the Agency submits a written request containing arguments or evidence which tends to establish that:

1. The appellate decision involved a clearly erroneous interpretation of material fact or law; or
2. The appellate decision will have a substantial impact on the policies, practices, or operations of the Agency.

Requests to reconsider, with supporting statement or brief, must be filed with the Office of Federal Operations (OFO) **within thirty (30) calendar days** of receipt of this decision or **within twenty (20) calendar days** of receipt of another party's timely request for reconsideration. See 29 C.F.R. § 1614.405; Equal Employment Opportunity Management Directive for 29 C.F.R. Part 1614 (EEO MD-110), at 9-18 (Nov. 9, 1999). All requests and arguments must be submitted to the Director, Office of Federal Operations, Equal Employment Opportunity Commission, P.O. Box 77960, Washington, DC 20013. In the absence of a legible postmark, the request to reconsider shall be deemed timely filed if it is received by mail within five days of the expiration of the applicable filing period. See 29 C.F.R. § 1614.604. The request or opposition must also include proof of service on the other party.

Failure to file within the time period will result in dismissal of your request for reconsideration as untimely, unless extenuating circumstances prevented the timely filing of the request. Any supporting documentation must be submitted with your request for reconsideration. The Commission will consider requests for reconsideration filed after the deadline only in very limited circumstances. See 29 C.F.R. § 1614.604(c).

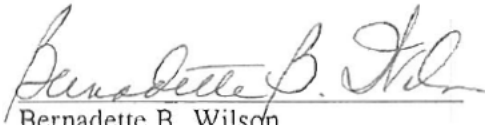
COMPLAINANT'S RIGHT TO FILE A CIVIL ACTION (R0610)

This is a decision requiring the Agency to continue its administrative processing of your complaint. However, if you wish to file a civil action, you have the right to file such action in an appropriate United States District Court **within ninety (90) calendar days** from the date that you receive this decision. In the alternative, you may file a civil action **after one hundred and eighty (180) calendar days** of the date you filed your complaint with the Agency, or filed your appeal with the Commission. If you file a civil action, you must name as the defendant in the complaint the person who is the official Agency head or department head, identifying that person by his or her full name and official title. Failure to do so may result in the dismissal of your case in court. "Agency" or "department" means the national organization, and not the local office, facility or department in which you work. **Filing a civil action will terminate the administrative processing of your complaint.**

RIGHT TO REQUEST COUNSEL (Z0610)

If you decide to file a civil action, and if you do not have or cannot afford the services of an attorney, you may request from the Court that the Court appoint an attorney to represent you and that the Court also permit you to file the action without payment of fees, costs, or other security. See Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000e et seq.; the Rehabilitation Act of 1973, as amended, 29 U.S.C. §§ 791, 794(c). **The grant or denial of the request is within the sole discretion of the Court.** Filing a request for an attorney with the Court does not extend your time in which to file a civil action. Both the request and the civil action must be filed within the time limits as stated in the paragraph above ("Right to File a Civil Action").

FOR THE COMMISSION:



Bernadette B. Wilson
Acting Executive Officer
Executive Secretariat

April 20 2012
Date

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(A-08)

Introduced by: Resident and Fellow Section
Massachusetts Delegation
California Delegation
New York Delegation

Subject: Removing Financial Barriers to Care for Transgender Patients

Referred to: Reference Committee A
(Linda B. Ford, MD, Chair)

Whereas, Our American Medical Association opposes discrimination on the basis of gender identityⁱ; and

Whereas, Gender Identity Disorder (GID) is a serious medical condition recognized as such in both the Diagnostic and Statistical Manual of Mental Disorders (4th Ed., Text Revision) (DSM-IV-TR) and the International Classification of Diseases (10th Revision)ⁱⁱ, and is characterized in the DSM-IV-TR as a persistent discomfort with one's assigned sex and with one's primary and secondary sex characteristics, which causes intense emotional pain and sufferingⁱⁱⁱ; and

Whereas, GID, if left untreated, can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death^{iv}; and

Whereas, The World Professional Association For Transgender Health, Inc. ("WPATH") is the leading international, interdisciplinary professional organization devoted to the understanding and treatment of gender identity disorders^v, and has established internationally accepted Standards of Care^{vi} for providing medical treatment for people with GID, including mental health care, hormone therapy and sex reassignment surgery, which are designed to promote the health and welfare of persons with GID and are recognized within the medical community to be the standard of care for treating people with GID; and

Whereas, An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID^{vii}; and

Whereas, Health experts in GID, including WPATH, have rejected the myth that such treatments are "cosmetic" or "experimental" and have recognized that these treatments can provide safe and effective treatment for a serious health condition^{vii}; and

Whereas, Physicians treating persons with GID must be able to provide the correct treatment necessary for a patient in order to achieve genuine and lasting comfort with his or her gender, based on the person's individual needs and medical history^{viii}; and

Whereas, Our AMA opposes limitations placed on patient care by third-party payers when such care is based upon sound scientific evidence and sound medical opinion^{ix,x}; and

Whereas, Many health insurance plans categorically exclude coverage of mental health, medical, and surgical treatments for GID, even though many of these same treatments, such as psychotherapy, hormone therapy, breast augmentation and removal, hysterectomy, oophorectomy, orchiectomy, and salpingectomy, are often covered for other medical conditions; and

Whereas, The denial of these otherwise covered benefits for patients suffering from GID represents discrimination based solely on a patient's gender identity; and

Whereas, Delaying treatment for GID can cause and/or aggravate additional serious and expensive health problems, such as stress-related physical illnesses, depression, and substance abuse problems, which further endanger patients' health and strain the health care system; therefore be it

RESOLVED, That our American Medical Association support public and private health insurance coverage for treatment of gender identity disorder (New HOD Policy); and be it further

RESOLVED, That our AMA oppose categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than \$500 to implement.

Received: 04/18/08

RELEVANT AMA POLICY

H-65.983 Nondiscrimination Policy

H-65.992 Continued Support of Human Rights and Freedom

H-180.980 Sexual Orientation and/or Gender Identity as Health Insurance Criteria

H-120.988 Patient Access to Treatments Prescribed by Their Physicians

ⁱ AMA Policy H-65.983, H-65.992, and H-180.980

ⁱⁱ Diagnostic and Statistical Manual of Mental Disorders (4th ed.. Text revision) (2000) ("DSM-IV-TR"), 576-82, American Psychiatric Association; International Classification of Diseases (10th Revision) ("ICD-10"), F64, World Health Organization. The ICD further defines transsexualism as "[a] desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex." ICD-10, F64.0.

ⁱⁱⁱ DSM-IV-TR, 575-79

^{iv} Id. at 578-79.

^v World Professional Association for Transgender Health: <http://www.wpath.org>. Formerly known as The Harry Benjamin International Gender Dysphoria Association.

^{vi} The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version (February, 2001). Available at <http://wpath.org/Documents2/socv6.pdf>.

^{vii} Brown G R: A review of clinical approaches to gender dysphoria. *J Clin Psychiatry*. 51(2):57-64, 1990. Newfield E, Hart S, Dibble S, Kohler L. Female-to-male transgender quality of life. *Qual Life Res*. 15(9):1447-57, 2006. Best L, and Stein K. (1998) "Surgical gender reassignment for male to female transsexual people." Wessex Institute DEC report 88; Blanchard R, et al. "Gender dysphoria, gender reorientation, and the clinical management of transsexualism." *J Consulting and Clinical Psychology*. 53(3):295-304. 1985; Cole C, et al. "Treatment of gender dysphoria (transsexualism)." *Texas Medicine*. 90(5):68-72. 1994; Gordon E. "Transsexual healing: Medicaid funding of sex reassignment surgery." *Archives of Sexual Behavior*. 20(1):61-74. 1991; Hunt D, and Hampton J. "Follow-up of 17 biologic male transsexuals after sex-reassignment surgery." *Am J Psychiatry*. 137(4):432-428. 1980; Kockett G, and Fahrner E. "Transsexuals who have not undergone surgery: A follow-up study." *Arch of Sexual Behav*. 16(6):511-522. 1987; Pfafflin F and Junge A. "Sex Reassignment. Thirty Years of International Follow-Up Studies after Sex Reassignment Surgery: A Comprehensive Review, 1961-1991." IJT Electronic Books, available at <http://www.symposion.com/ijt/pfaefflin/1000.htm>; Selvaggi G, et al. "Gender Identity Disorder: General Overview and Surgical Treatment for Vaginoplasty in Male-to-Female Transsexuals." *Plast Reconstr Surg*. 2005 Nov;116(6):135e-145e; Smith Y, et al. "Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals." *Psychol Med*. 2005 Jan; 35(1):89-99; Tangpricha V, et al. "Endocrinologic treatment of gender identity disorders." *Endocr Pract*. 9(1):12-21. 2003; Tsoi W. "Follow-up study of transsexuals after sex reassignment surgery." *Singapore Med J*. 34:515-517. 1993; van Kesteren P, et al. "Mortality and morbidity in transsexual subjects treated with cross-sex hormones." *Clin Endocrinol (Oxf)*. 1997 Sep;47(3):337-42; World Professionals Association for Transgender Health Standards of Care for the Treatment of Gender Identity Disorders v.6 (2001).

^{viii} The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, at 18.

^{ix} Id.

^x AMA Policy H-120.988



AMERICAN FOUNDATION FOR
Suicide Prevention



the
Williams
INSTITUTE

Suicide Attempts among Transgender and Gender Non-Conforming Adults

**FINDINGS OF THE
NATIONAL TRANSGENDER
DISCRIMINATION SURVEY**

Ann P. Haas, Ph.D. and Philip L. Rodgers, Ph.D.,
American Foundation for Suicide Prevention

Jody L. Herman, Ph.D.
Williams Institute, UCLA School of Law
January 2014

EXECUTIVE SUMMARY

The prevalence of suicide attempts among respondents to the National Transgender Discrimination Survey (NTDS), conducted by the National Gay and Lesbian Task Force and National Center for Transgender Equality, is 41 percent, which vastly exceeds the 4.6 percent of the overall U.S. population who report a lifetime suicide attempt, and is also higher than the 10-20 percent of lesbian, gay and bisexual adults who report ever attempting suicide. Much remains to be learned about underlying factors and which groups within the diverse population of transgender and gender non-conforming people are most at risk.

In the present study, we sought to increase understanding of suicidal behavior among transgender and gender non-conforming people through an in-depth analysis of NTDS data. The specific aims of our analysis were to identify the key characteristics and experiences associated with lifetime suicide attempts in the NTDS sample as a whole, and to examine how lifetime suicide attempts vary among different groups of transgender and gender non-conforming people.

Key findings of this report include the following:

- Suicide attempts among trans men (46%) and trans women (42%) were slightly higher than the full sample (41%). Cross-dressers assigned male at birth have the lowest reported prevalence of suicide attempts among gender identity groups (21%).
- Analysis of other demographic variables found prevalence of suicide attempts was highest among those who are younger (18 to 24: 45%), multiracial (54%) and American Indian or Alaska Native (56%), have lower levels of educational attainment (high school or less: 48-49%), and have lower annual household income (less than \$10,000: 54%).
- Prevalence of suicide attempts is elevated among those who disclose to everyone that they are transgender or gender-non-conforming (50%) and among those that report others can tell always (42%) or most of the time (45%) that they are transgender or gender non-conforming even if they don't tell them.
- Respondents who are HIV-positive (51%) and respondents with disabilities (55-65%) also have elevated prevalence of suicide attempts. In particular, 65 percent of those with a mental health condition that substantially affects a major life activity reported attempting suicide.

- Respondents who experienced rejection by family and friends, discrimination, victimization, or violence had elevated prevalence of suicide attempts, such as those who experienced the following:
 - Family chose not to speak/spend time with them: 57%
 - Discrimination, victimization, or violence at school, at work, and when accessing health care
 - Harassed or bullied at school (any level): 50-54%
 - Experienced discrimination or harassment at work: 50-59%
 - Doctor or health care provider refused to treat them: 60%
 - Suffered physical or sexual violence:
 - At work: 64-65%
 - At school (any level): 63-78%
 - Discrimination, victimization, or violence by law enforcement
 - Disrespected or harassed by law enforcement officers: 57-61%
 - Suffered physical or sexual violence: By law enforcement officers: 60-70
 - Experienced homelessness: 69%

“Overall, the most striking finding of our analysis was the exceptionally high prevalence of lifetime suicide attempts reported by NTDS respondents across all demographics and experiences.”

Overall, the most striking finding of our analysis was the exceptionally high prevalence of lifetime suicide attempts reported by NTDS respondents across all demographics and experiences. Based on prior research and the findings of this report, we find that mental health factors and experiences of harassment, discrimination, violence and rejection may interact to produce a marked vulnerability to suicidal behavior in transgender and gender non-conforming individuals. More research on suicidal behavior among transgender and gender non-conforming people is needed.

INTRODUCTION

Since 2001, over a dozen separate surveys of transgender adults in the United States and other countries have found lifetime suicide attempts to be reported by 25-43 percent of respondents (Clements-Nolle et al., 2001; Clements-Nolle et al., 2006; Grant et al., 2011; Kenagy, 2005; Maguen & Shipherd, 2010; Transgender Equality Network Ireland, 2012; Trans PULSE, 2010; Whittle et al., 2007; Whittle et al., 2008; Xavier et al., 2005; Xavier et al., 2007). These figures vastly exceed the 4.6 percent of the overall U.S. population who report a lifetime suicide attempt (Kessler, Borges and Walters, 1999; Nock & Kessler, 2006), and are also higher than the 10-20 percent of lesbian, gay and bisexual adults who report ever attempting suicide (Paul et al., 2002).

While these surveys suggest an unparalleled level of suicidal behavior among transgender adults, much remains to be learned about underlying factors and which groups within this diverse population are most at risk. In

the present study, we sought to increase understanding of suicidal behavior among transgender and gender non-conforming people through an in-depth analysis of data from the U.S. National Transgender Discrimination Survey (NTDS), conducted by the National Gay and Lesbian Task Force and the National Center for Transgender Equality. With over 6,000 respondents, the NTDS is the largest survey of transgender and gender non-conforming adults to date. In that sample, 41 percent of respondents reported ever attempting suicide (Grant et al., 2011).

The specific aims of our analysis were to identify the key characteristics and experiences associated with lifetime suicide attempts in the NTDS sample as a whole, and to examine how lifetime suicide attempts vary among different groups of transgender and gender non-conforming people. In this report, we present our findings, discuss their implications, and conclude by describing considerations and needs for future research.

METHODS AND LIMITATIONS

The NTDS was launched in fall 2008 and was distributed online and on paper through over 900 organizations that were known venues for contact with the transgender community throughout the United States. Details of the survey instrument, methods and procedures have previously been described (Grant et al., 2011). In brief, responses were obtained from 6,456 self-identified transgender and gender non-conforming adults aged 18 and over. History of lifetime suicide attempt was among the many outcomes covered in the 70-item survey. The analysis of the NTDS data presented in this paper is mainly descriptive. Where appropriate, Pearson's chi-square tests of independence were conducted to assess whether lifetime suicide attempts were related to a variety of characteristics and experiences of survey respondents.

While the NTDS provides a wealth of information about the experiences of transgender and gender non-conforming people, the survey instrument and methodology posed some limitations for this study. First, the NTDS questionnaire included only a single item about suicidal behavior that asked, "Have you ever attempted suicide?" with dichotomized responses of Yes/No. Researchers have found that using this question alone in surveys can inflate the percentage of affirmative responses, since some respondents may use it to communicate self-harm behavior that is not a "suicide attempt," such as seriously considering suicide, planning

for suicide, or engaging in self-harm behavior without the intent to die (Bongiovi-Garcia et al., 2009). The National Comorbidity Survey, a nationally representative survey, found that probing for intent to die through in-person interviews reduced the prevalence of lifetime suicide attempts from 4.6 percent to 2.7 percent of the adult sample (Kessler et al., 1999; Nock & Kessler, 2006). Without such probes, we were unable to determine the extent to which the 41 percent of NTDS participants who reported ever attempting suicide may overestimate the actual prevalence of attempts in the sample. In addition, the analysis was limited due to a lack of follow-up questions asked of respondents who reported having attempted suicide about such things as age and transgender/gender non-conforming status at the time of the attempt.

Second, the survey did not directly explore mental health status and history, which have been identified as important risk factors for both attempted and completed suicide in the general population (Lasage, Boyer, Grunberg, Vanier, Morissett et al., 1994; Suominen, Henrikssen, Suokas, Isometsa, Ostamo, et al., 1996; Harris & Barraclough, 1997; Bertolote & Fleischmann, 2002; Nock, Hwang, Sampson, & Kessler, 2010). Further, research has shown that the impact of adverse life events, such as being attacked or raped, is most severe among people with co-existing mood, anxiety and other mental disorders (Breslau, Davis, Andreski, & Peterson,

1991; Kendler, Kardowski, & Presco, 1999). The lack of systematic mental health information in the NTDS data significantly limited our ability to identify the pathways to suicidal behavior among the respondents.

Third, since the NTDS utilized convenience sampling, it is unclear how representative the respondents are of the overall U.S. transgender/gender non-conforming adult population. Further, the survey's focus on discrimination may have resulted in wider participation by persons who had suffered negative life experiences due to anti-transgender bias.¹ As the relationship between minority stress and mental health would suggest (Meyer, 2003), this may have contributed to a higher prevalence of negative outcomes, including lifetime suicide attempts, in the sample. These limitations should be kept in mind in interpreting the findings of our analyses.

Finally, it should be emphasized that the NTDS, like all similar surveys, captured information about suicide attempts, not completed suicide. Lacking any information about completed suicide among transgender people (due primarily to decedents not being identified by gender identity or transgender status), it may be tempting to consider suicide attempt

data to be the best available proxy measure of suicide death. Data from the U.S. population at large, however, show clear demographic differences between suicide attempters and those who die by suicide. While almost 80 percent of all suicide deaths occur among males, about 75 percent of suicide attempts are made by females. Adolescents, who overall have a relatively low suicide rate of about 7 per 100,000 people, account for a substantial proportion of suicide attempts, making perhaps 100 or more attempts for every suicide death. By contrast, the elderly have a much higher suicide rate of about 15 per 100,000, but make only four attempts for every completed suicide. Although making a suicide attempt generally increases the risk of subsequent suicidal behavior, six separate studies that have followed suicide attempters for periods of five to 37 years found death by suicide to occur in 7 to 13 percent of the samples (Tidemalm et al., 2008). We do not know whether these general population patterns hold true for transgender people but in the absence of supporting data, we should be especially careful not to extrapolate findings about suicide attempts among transgender adults to imply conclusions about completed suicide in this population.

1. For the purposes of this paper, "anti-transgender bias" means bias or prejudice that is directed toward people who are transgender or gender non-conforming

DEMOGRAPHICS

The age of NTDS respondents ranged from 18 to 98 years, with an average of 37 years. Frequency distributions for other demographic characteristics are provided in Table 1; gender-related characteristics are summarized in Table 2.

Table 1: Demographic characteristics of NTDS respondents

	Mean	sd	Range	n	Employment Status	Percent	n
Age	37.0	13.1	18-98	5885	Full-time	46%	2970
					Part-time	16%	1012
Age Categories					More than one job	8%	490
18-24		19%		1099	Self-employed (own your business)	8%	541
25-44		52%		3051	Self-employed (contract worker)	4%	282
45-54		17%		973	Unemployed but looking	11%	700
55-64		11%		648	Unemployed and stopped looking	3%	210
65+		2%		114	On disability	8%	502
Race/Ethnicity					Student	20%	1292
American Indian or Alaska Native Alone		1%		75	Retired	7%	450
Asian or Pacific Islander Alone		2%		137	Homemaker/full-time parent	2%	111
Black or African American Alone		5%		290	Other	7%	434
Hispanic or Latino Alone		5%		294	Workforce Participation Recode ³		
White Alone		76%		4872	In workforce	70%	4498
Multiracial or Mixed Race/Ethnicity ²		11%		736	Out of the workforce, unemployed	11%	710
Education					Out of the workforce, not looking	19%	1203
Did not graduate from high school		4%		266	Relationship Status		
High school graduate		8%		540	Single	36%	2286
Some college (incl. AA, AS, tech, other)		40%		2585	Partnered	27%	1706
College degree (incl. BA, BS, other)		27%		1745	Married	22%	1394
Graduate degree (incl. PhD, MD, other)		20%		1281	Divorced	11%	690
Household Income					Separated	3%	185
< \$10,000		15%		944	Widowed	2%	94
\$10,000 - \$19,999		12%		754	Civil Union	1%	72
\$20,000 - \$49,999		32%		1982	Sexual Orientation		
\$50,000 - \$99,999		28%		1718	Gay/Lesbian/Same-Gender Attraction	21%	1326
> \$100,000		14%		860	Bisexual	23%	1473
					Queer	20%	1270
					Heterosexual	21%	1341
					Asexual	4%	260
					Other	11%	698

² Multiracial or Mixed Race includes survey respondents who selected "Multiracial or Mixed Race" as their race/ethnicity on the survey plus those who selected two or more races/ethnicities

³ NTDS researchers utilized the survey question on employment status to create this three-level current workforce participation recode for survey respondents. The original variable contained the following twelve categories: full-time, part-time, more than one job, self-employed (own your business), self-employed (contract worker), unemployed but looking, unemployed and stopped looking, on disability, student, retired, homemaker or full-time parent, and other. The recoded variable collapsed the twelve categories into three: in workforce, out of the workforce - unemployed, and out of the workforce - not looking. PLEASE NOTE: the rate of those who are out of the workforce and unemployed should not be used as the unemployment rate for the NTDS sample. Unemployment rates calculated by the U.S. Bureau of Labor Statistics do not include those who are out of the workforce and not looking for employment. For more information on how the U.S. Bureau of Labor Statistics measures unemployment, please visit <http://www.bls.gov/cps/cps.htm>. The unemployment rate for the NTDS sample is 14%.

Table 2: Gender-related characteristics of NTDS respondents

Sex Assigned at Birth	Percent	n	Strength of Identification with Listed Identities				
Male	60%	3870	Listed Identity	Strongly	Somewhat	Not at all	n
Female	40%	2566	Transgender	65%	26%	10%	6258
Primary Gender Identity Today ⁴			Transsexual	46%	27%	27%	6154
Male/Man	26%	1687	FTM (female to male)	26%	13%	62%	5835
Female/Woman	41%	2608	MTF (male to female)	46%	10%	44%	6066
Part time one gender/ part time another	20%	1275	Intersex	6%	16%	79%	5801
A gender not listed	13%	864	GNC or gender variant	32%	34%	34%	5903
Gender Identity Recode ⁵			Genderqueer	22%	25%	53%	5865
Trans Women / MTF	47%	3005	Androgynous	14%	30%	56%	5856
Trans Men / FTM	28%	1776	Feminine Male	10%	25%	65%	5837
Cross-dresser (male-assigned)	11%	702	Masculine Female/Butch	8%	19%	73%	5823
Cross-dresser (female-assigned)	3%	192	A.G. or Aggressive	2%	8%	90%	5798
GNC ⁶ / Genderqueer (male-assigned)	3%	169	Third gender	10%	21%	69%	5814
GNC / Genderqueer (female-assigned)	9%	597	Cross-dresser	15%	16%	69%	5882
			Drag Performer	3%	8%	89%	5795
			Two spirit	15%	23%	63%	5851
			Other	17%	2%	81%	2552

SUICIDE ATTEMPTS AND DEMOGRAPHIC CHARACTERISTICS

As shown in Table 3, reported lifetime suicide attempts decreased with age, from a high of 45 percent for 18-44 year-olds to 33 percent for 55-64 year-olds and 16 percent for those over 65 years.⁷ Respondents who indicated "white" race/ethnicity had the lowest prevalence of lifetime suicide attempts at 38 percent, while American Indians and Alaska Natives reported the highest at 56 percent. Generally, those with greater educational achievement were less likely to

report having attempted suicide, with 31 percent of respondents with a graduate degree, compared to 49 percent of those with a high school diploma, reporting a lifetime suicide attempt. Like education, those with higher household income had a lower prevalence of lifetime suicide attempts, with 26 percent of those with income exceeding \$100,000 saying they had ever attempted suicide, compared to 54 percent of those with income less than \$10,000.

⁴ Gender identities listed here are as they appeared on the NTDS survey. "Part time one gender/part time another" was listed to include those respondents who are not yet living full-time in their gender identity, such as those who only express their gender identity in certain circumstances (e.g. at home but not at work) and/or those who do not wish to live full-time in a gender different than the one assigned at birth (e.g. part time cross-dressers).

⁵ NTDS researchers utilized the three questions in the survey related to gender identity and sex assigned at birth (shown in Table 2) to create this six-level gender identity recode for survey respondents. Respondents were first categorized by cross-tabulating sex assigned at birth and primary gender today. Next, respondents' answers to strength of identification with listed terms were taken into consideration. For instance, those who were assigned male at birth and today identify as female would generally be categorized as trans women/ MTF. However, if they did not at all identify with terms indicating a trans identity (transgender, transsexual, MTF) and strongly identified with another identity, such as cross-dresser, they were categorized according to the identity with which they strongly identified. For more information on how the gender identity recode was constructed, see *Injustice at Every Turn*, available at <http://www.thetaskforce.org/reports-and-research/ntds>.

⁶ "GNC" stands for Gender Non-Conforming.

⁷ Lower percentages of older respondents reporting lifetime suicide attempts has also been observed in some general population surveys, including the National Comorbidity Survey (Nock & Kessler, 2006). Possible reasons include older respondents' selective recall, reinterpretation of past suicidal behavior in light of more recent life events, and cohort effects.

Lifetime suicide attempts were less frequently reported by respondents who were in the workforce (37%) than those who were out of the workforce and not looking for work (46%) and those who were unemployed (50%). Among all categories of current participation in the workforce, respondents who were retired reported the lowest prevalence of lifetime suicide attempts (29%), which is consistent with findings related to age. The highest prevalence of lifetime suicide attempts (65%) was found among those on disability.⁸

In regard to relationship status, those who were married or widowed reported lower prevalence of lifetime suicide attempts at 33 percent and 31 percent, respectively, while those who were single reported the highest prevalence at 45 percent. The prevalence of lifetime suicide attempts varied across sexual orientation categories with 35 percent of those who described themselves as heterosexual saying they had ever attempted suicide, compared to 40 percent of those who were gay/lesbian, 40 percent of those who were bisexual, and 46 percent of those who said they were asexual or another orientation.

Table 3: Lifetime suicide attempts by demographic characteristics

Have Attempted Suicide			Have Attempted Suicide		
Frequency Row %			Frequency Row %		
Age			Household Income		
18-24	488	45%	< \$10,000	504	54%
25-44	1348	45%	\$10,000 - \$19,999	397	53%
45-54	373	39%	\$20,000 - \$49,999	826	42%
55-64	210	33%	\$50,000 - \$99,999	563	33%
65+	18	16%	> \$100,000	222	26%
$\chi^2 = 70.6^*$			$\chi^2 = 240.0^*$		
Race/Ethnicity			Workforce Participation Recode		
American Indian or Alaska Native Alone	39	56%	In workforce	1673	37%
Asian or Pacific Islander Alone	52	39%	Out of the workforce, unemployed	352	50%
Black or African American Alone	118	45%	Out of the workforce, not looking	547	46%
Hispanic or Latino Alone	125	44%	$\chi^2 = 59.9^*$		
White Alone	1829	38%	Relationship Status		
Multiracial or Mixed Race/Ethnicity	395	54%	Single	1009	45%
$\chi^2 = 81.2^*$			Partnered	715	42%
Education			Married	452	33%
Did not graduate from high school	125	48%	Divorced	272	40%
High school graduate	258	49%	Separated	67	37%
Some college (incl. AA, AS, tech, other)	1228	48%	Widowed	29	31%
College degree (incl. BA, BS, other)	566	33%	Civil Union	32	44%
Graduate degree (incl. PhD, MD, other)	394	31%	$\chi^2 = 60.7^*$		
$\chi^2 = 171.7^*$			Sexual Orientation		
			Gay/Lesbian	528	40%
			Bisexual	583	40%
			Queer	544	43%
			Heterosexual	466	35%
			Asexual	119	46%
			Other	318	46%
			$\chi^2 = 32.3^*$		

*p < .001

⁸ The workforce participation question in the NTDS was a "check all" item with twelve workforce categories listed, meaning respondents could choose more than one response from the list of twelve. Therefore, a chi-square test was only performed with the workforce recode variable, as shown in Table 3. Findings for those on disability and those who are retired are provided here due to their notable rates of lifetime suicide attempts.

SUICIDE ATTEMPTS AND GENDER IDENTITY

As shown in Table 4, among respondents who were assigned female at birth, 44 percent reported making a lifetime suicide attempt, compared to 38 percent of those who were assigned male at birth.

Table 4: Lifetime suicide attempts by gender-related characteristics

	Have Attempted Suicide	
	Frequency	Row %
Sex Assigned at Birth		
Male	1457	38%
Female	1120	44%
$\chi^2 = 19.3^*$		
Primary Gender Identity Today		
Male/Man	699	42%
Female/Woman	1106	43%
Part time one gender/ part time another	406	32%
A gender not listed	367	43%
$\chi^2 = 45.1^*$		
Gender Identity Recode		
Trans Women / MTF	1251	42%
Trans Men / FTM	822	46%
Cross-dresser (male-assigned)	477	21%
Cross-dresser (female-assigned)	84	44%
GNC / Genderqueer (male-assigned)	61	38%
GNC / Genderqueer (female-assigned)	212	36%
$\chi^2 = 145.2^*$		

*p < .001

The percentage of respondents who reported a lifetime suicide attempt overall showed little variability by current gender identity, as defined by respondents' answers to the question "What is your primary gender identity today?" The one exception was seen among those who described themselves as "part time as one gender/part time as another." These respondents, who constituted 20 percent of the NTDS sample, were less likely than others to report having ever attempted suicide. Using the gender identity recode which categorized respondents into one of six gender identities, trans women (MTF), trans men (FTM), and female-assigned cross-dressers had the highest prevalence of lifetime suicide attempts (42%, 46% and 44% respectively).

Additional insight into the relationship between gender identity and lifetime suicide attempts was provided by respondents' answers to a survey question that inquired about mental health care services and medical treatments and procedures related to gender transition. As shown in

Table 5, respondents who said they had received transition-related health care or wanted to have it someday were more likely to report having attempted suicide than those who said they did not want it. This pattern was observed across all transition-related services and procedures that were explored in the NTDS. The survey did not provide information about the timing of reported suicide attempts in relation to receiving transition-related health care, which precluded investigation of transition-related explanations for these patterns.

Table 5: Lifetime suicide attempts by responses about transition-related health care

Transition-related Health Care	Do Not Want It	Want It Someday	Have Had It	χ^2 *
Counseling	190 (29%)	327 (39%)	1963 (44%)	53.2
Hormone Treatment	272 (31%)	540 (40%)	1608 (45%)	60.6
Top/chest/breast surgery	500 (34%)	1222 (45%)	563 (44%)	46.3
Male-to-female removal of testes	327 (31%)	800 (43%)	286 (43%)	47.3
Male-to-female genital surgery	340 (31%)	834 (43%)	265 (43%)	49.7
Female-to-male hysterectomy	344 (36%)	564 (49%)	182 (48%)	40.4
Female-to-male genital surgery	570 (40%)	464 (49%)	38 (49%)	21.0
Female-to-male phalloplasty	757 (40%)	268 (56%)	21 (46%)	39.9

*p < .001

Perceived recognition by others as transgender/gender non-conforming was also examined as possibly contributing to variation in lifetime suicide attempt rates among NTDS respondents. For this analysis, we looked at responses to the questionnaire item, "People can tell I'm transgender/gender non-conforming even if I don't tell them." This item measured respondents' perceptions of how often others recognize the respondent as transgender or gender non-conforming. As can be seen in Table 6, lifetime suicide attempts were found to be lowest (36%) among respondents who said people can "never" tell they are transgender or gender non-conforming. Suicide attempts were reported by higher percentages of those who said people can "always" (42%) or "most of the time" (45%) tell they are transgender or gender non-conforming.

To better understand the impact of perceived recognition as transgender or gender non-conforming on suicidality, we looked separately at respondents in each of the six major gender identity categories (see Table 7). In three of the gender identity categories:

Table 6: Lifetime suicide attempts by perceived recognition by others

People can tell I'm transgender/GNC	Have Attempted Suicide	
	Frequency	Row %
Always	167	42%
Most of the time	457	45%
Sometimes	693	41%
Occasionally	765	41%
Never	487	36%
$\chi^2 = 20.6, p < .001$		

trans women (MTF), male-assigned cross-dressers, and gender non-conforming/genderqueer people assigned male at birth, lifetime suicide attempt rates were found to be lower among those who perceived others as only “occasionally” or “never” being able to tell they are transgender or gender non-conforming, compared to those who thought that others could “always,” “most of the time,” or “sometimes” tell. Trans men (FTM) were found to have the same prevalence of lifetime suicide attempts (46%) regardless of whether they thought others can tell they are transgender. However, for respondents in the last two gender identity categories – female-assigned cross-dressers and gender non-conforming/genderqueer people assigned female at birth – the prevalence of lifetime suicide attempts was found to be higher among those who said other people “occasionally” or “never” can tell they are transgender or gender non-conforming, compared to those who said that other people “always,” “most of the time,” or “sometimes” can tell. Cross-dressers assigned female at birth who perceived that they were generally not recognized as transgender or gender non-conforming were found in this analysis to have the highest prevalence of lifetime suicide attempts (47%). In summary, the patterns in Table 7 are most striking among those who said that people can occasionally or never tell they are transgender/gender non-conforming in that those on the trans-feminine spectrum had lower prevalence of lifetime suicide attempts than those on the trans-masculine spectrum.

Related to these analyses, we also examined respondents' disclosure of transgender/gender non-conforming status and whether or not they were “out” in various settings. As shown in Table 8, the prevalence of lifetime suicide attempts was found to be highest (50%) among those who said they “tell everyone” about their transgender/gender non-conforming status and lowest (33%) among those who said they “never” tell people their status.

Table 8: Lifetime suicide attempts by disclosure of transgender/gender non-conforming status

I tell people that I'm transgender/GNC	Have Attempted Suicide	
	Frequency	Row %
Never	242	33%
Tell people who are close friends	1755	40%
Tell people who are casual friends	692	41%
Tell work colleagues	565	40%
Tell family	1091	41%
Tell everyone	468	50%

Similarly, suicide attempts were more frequently reported by respondents who were “out” to others as transgender or gender non-conforming in various settings (see Table 9).⁹

Table 9: Lifetime suicide attempts by being “out” in various settings

Setting	Have Attempted Suicide	
	Not Out	Out
At home	193 (34%)	2233 (41%)
On the job	526 (33%)	1590 (42%)
At school	385 (35%)	886 (45%)
In private social settings	226 (37%)	2274 (41%)
In public social settings	603 (38%)	1909 (41%)
When seeking medical care	395 (31%)	2092 (43%)

Table 7: Lifetime suicide attempts by gender identity and perceived recognition by others

People can tell I'm transgender/GNC	Trans Women / MTF	Trans Men / FTM	Cross-dresser (male assigned)	Cross-dresser (female assigned)	GNC / Genderqueer (male assigned)	GNC / Genderqueer (female assigned)
Always, most of the time, sometimes	652 (45%)	342 (46%)	67 (27%)	63 (43%)	40 (43%)	152 (34%)
Occasionally, never	590 (40%)	480 (46%)	76 (17%)	20 (47%)	21 (31%)	60 (42%)

⁹ Respondents were classified as being “Out” if they answered “a few,” “some,” “most” or “all” to the question, “How many people know or believe you are transgender/gender non-conforming in each of the following settings?” Respondents who answered “none” for each setting found in this question were classified as “Not out.” Those who responded “Not Applicable” to any of the settings were excluded from the analysis. Respondents who are “Out” are more likely to report that people can tell they are transgender or gender non-conforming.

SUICIDE ATTEMPTS AND HIV

The prevalence of lifetime suicide attempts was higher among respondents who indicated being HIV positive (see Table 10).

Table 10: Lifetime suicide attempts by HIV status

HIV Status	Have Attempted Suicide	
	Frequency	Row %
Positive	84	51%
Negative	2260	40%
Don't know	217	41%
$\chi^2 = 7.7, p < .021$		

SUICIDE ATTEMPTS AND DISABILITIES

Respondents who indicated having a disability (physical, learning, mental health) that substantially affects a major life activity reported a higher prevalence of lifetime suicide attempts than those without a disability (57% v.33%, $\chi^2 = 320.8, p < .001$). As seen in Table 11, the highest prevalence of suicide attempts (65%) was reported by those who described their disability as related to a mental health condition. *It should be noted that this was the only item on the NTDS that specifically asked about mental health, and was answered only by respondents who indicated in the previous question that they had a disability that substantially affects a major life activity.*

Table 11: Lifetime suicide attempts by type of disability

Disability	Have Attempted Suicide	
	Frequency	Row %
Physical condition	984	56%
Learning disability	493	55%
Mental health condition	1220	65%

As shown in Table 12, among respondents who indicated having a mental health disability, at least 54 percent of respondents in each of the six main gender identity categories reported a lifetime suicide attempt. In all gender identity categories, respondents who did not indicate having a mental health disability were found to have significantly lower prevalence of lifetime suicide attempts than those in the same category who had such a disability.¹⁰ Among those who did not indicate having a mental health disability, the prevalence of suicide attempts ranged from a high of 40 percent among trans men (FTM) and female-assigned cross-dressers, to a low of 17 percent among male-assigned cross-dressers.

Table 12: Lifetime suicide attempts by gender identity and mental health disability

Gender Identity	Have Attempted Suicide	
	MH Disability	No MH Disability
Trans Women / MTF	360 (67%)	891 (37%)
Trans Men / FTM	263 (67%)	559 (40%)
Cross-dresser (male-assigned)	39 (54%)	108 (17%)
Cross-dresser (female-assigned)	27 (56%)	57 (40%)
GNC / Genderqueer (male-assigned)	18 (62%)	43 (33%)
GNC / Genderqueer (female-assigned)	82 (59%)	130 (29%)

Among respondents who reported having a disability due to a mental health condition, the prevalence of lifetime suicide attempts was not substantially affected by whether they could be recognized by others as transgender/gender non-conforming (see Table 13).

Table 13: Lifetime suicide attempts by perceived recognition by others and mental health disability

People can tell I'm transgender/GNC:	Have Attempted Suicide	
	MH Disability	No MH Disability
Always, most of the time, sometimes	431 (64%)	886 (36%)
Occasionally, never	356 (66%)	896 (33%)

¹⁰ Respondents who did not indicate having a mental health disability included those who reported no disability of any kind and those who reported a disability related to conditions other than mental health

SUICIDE ATTEMPTS AND STRESSORS RELATED TO ANTI-TRANSGENDER BIAS

In a series of analyses, we looked at the relationship between suicide attempts and a range of stressful life experiences that NTDS respondents described as occurring due to anti-transgender bias, which we refer to collectively as “stressors related to anti-transgender bias.” These included experiences of rejection, discrimination, victimization, and violence that occurred within a number of specific contexts, as described below.

Table 14: Lifetime suicide attempts by experiences of housing discrimination and other housing-related problems

Housing experience	Have Attempted Suicide	
	Frequency	Row %
I moved into less expensive home/apartment	849	54%
I became homeless	487	69%
I was evicted	254	63%
I was denied home/apartment	449	62%
I had to move back with family/friends	614	62%
I had to find a temporary place to sleep	652	64%
I had sex to stay with people/pay rent	281	64%

Housing

Relative to the prevalence of lifetime suicide attempts reported by NTDS respondents as a whole (41%), those who reported experiencing housing discrimination or other housing-related problems because of anti-transgender bias were found to have an elevated prevalence of lifetime suicide attempts (see Table 14). The highest suicide attempt prevalence (69%) was found among those who became homeless due to anti-transgender bias.

School

A higher than average prevalence of lifetime suicide attempts was consistently found among NTDS respondents who reported that they had been harassed, bullied, or assaulted in school by other students and/or teachers due to anti-transgender bias (see Table 15). Among such respondents, suicide attempt prevalence varied little according to the level of school at which the victimization occurred. Consistently, suicide attempts were most frequently reported by those who had experienced school-based violence in the form of physical or sexual assault.

Work

As shown in Table 16, an elevated prevalence of lifetime suicide attempts was consistently found among respondents who reported negative work experiences related to anti-transgender bias. Prevalence was found

Table 15: Lifetime suicide attempts by experiences of school victimization

	Have Attempted Suicide	
	Frequency	Row %
Elementary School		
Harassed or Bullied	360	50%
Physically Assaulted	191	63%
Sexually Assaulted	46	73%
Jr. High/Middle School		
Harassed or Bullied	477	50%
Physically Assaulted	255	64%
Sexually Assaulted	80	73%
High School		
Harassed or Bullied	659	52%
Physically Assaulted	292	68%
Sexually Assaulted	104	69%
College		
Harassed or Bullied	424	54%
Physically Assaulted	71	68%
Sexually Assaulted	45	78%

Table 16: Lifetime suicide attempts by negative work experiences

Work experience	Have Attempted Suicide	
	Frequency	Row %
I did not get a job I applied for	987	53%
I am or have been under-employed	977	50%
I was removed from direct contact with clients, customers or patients	491	57%
I was denied a promotion	553	56%
I lost my job	660	55%
I was harassed by someone at work	1259	51%
I was the victim of physical violence by someone at work	209	65%
I was the victim of sexual assault by someone at work	176	64%
I was forced to present in the wrong gender to keep my job	806	54%
I was not able to work out a suitable bathroom situation with my employer	500	58%
I was denied access to appropriate bathrooms	546	59%
I was asked inappropriate questions about my transgender or surgical status	1019	55%
I was referred to by the wrong pronoun, repeatedly and on purpose	1155	56%
Supervisors or coworkers shared information about me that they should not have	1193	54%

to be especially high among those who said they had experienced work-based physical violence (65%) or sexual assault (64%).

In addition, respondents who indicated having engaged in sex work reported a high prevalence of lifetime suicide attempts. A separate question on the NTDS identified 694 respondents who had engaged in sex work for income. Among those in this group who answered the question on ever attempting suicide (n = 674), 407 or 60 percent reported a lifetime suicide attempt.

Family and Friends

A lower than average prevalence of lifetime suicide attempts (33%) was found among respondents who said their family relationships had remained strong after coming out (see Table 17). In contrast, the prevalence of suicide attempts was elevated among respondents who reported experiencing rejection, disruption, or abuse by family members or close friends because of anti-transgender bias. Again, lifetime suicide attempts were reported most frequently by those who were victims of violence by a family member, with 65 percent of such respondents indicating having attempted suicide.

Table 17: Lifetime suicide attempts by experiences with family and friends

Experience with family and friends	Have Attempted Suicide	
	Frequency	Row %
Family is as strong today as when I came out	747	33%
Family relationships are improving after coming out	1171	42%
Relationship with my spouse or partner ended	894	49%
Ex limited or stopped relationship with children	257	55%
Court/judge limited/stopped relationship with children	108	58%
Children chose not to speak/spend time with me	272	50%
Parents/family chose not to speak/spend time with me	994	57%
Victim of domestic violence by a family member	490	65%
Lost close friends	1552	52%

Medical Care

Respondents who reported having negative experiences related to obtaining medical care as a transgender or gender non-conforming person also reported an elevated prevalence of lifetime suicide attempts (see Table 18). Sixty percent of respondents who said they had been refused medical care because of anti-transgender bias reported a lifetime suicide attempt.

Table 18: Lifetime suicide attempts by experiences with medical care

Experience with medical care	Have Attempted Suicide	
	Frequency	Row %
I have postponed or not tried to get needed medical care when I was sick or injured because I could not afford it	1354	53%
I have postponed or not tried to get checkups or other preventive medical care because I could not afford it	1371	51%
I have postponed or not tried to get needed medical care when I was sick or injured because of disrespect or discrimination from doctors or other healthcare providers	827	56%
I have postponed or not tried to get checkups or other preventive medical care because of disrespect or discrimination from doctors or other healthcare providers	927	54%
A doctor or other provider refused to treat me because I am transgender/gender nonconforming	582	60%
I had to teach my doctor or other provider about transgender/gender non-conforming people in order to get appropriate care	1275	51%

Law Enforcement

Respondents who reported having negative experiences with law enforcement officers commonly reported having attempted suicide (see Table 19). An especially high prevalence of lifetime suicide attempts was found among those who had experienced police violence in the form of physical or sexual assault.

Lifetime suicide attempts were less prevalent among respondents who said they had been generally treated with respect by law enforcement personnel. As seen in Table 20, decreasing level of comfort in seeking help from the police was found to be significantly related to higher prevalence of lifetime suicide attempts.

Table 19: Lifetime suicide attempts by experiences with law enforcement

Experience with law enforcement	Have Attempted Suicide	
	Frequency	Row %
Officers have generally treated me with respect	963	41%
Officers have generally treated me with disrespect	593	57%
Officers have harassed me	466	61%
Officers have physically assaulted me	122	60%
Officers have sexually assaulted me	60	70%

Table 20: Lifetime suicide attempts by comfort level seeking help from police

Comfort level seeking help from police	Have Attempted Suicide	
	Frequency	Row %
Very comfortable	356	33%
Somewhat comfortable	416	36%
Neutral	466	38%
Somewhat uncomfortable	670	41%
Very uncomfortable	666	52%
$\chi^2 = 108.4, p < .001$		

Nature of the Relationship between Stressors and Suicide Attempts

The survey data did not allow us to determine a direct causal relationship between experiencing rejection, discrimination, victimization, or violence, and lifetime suicide attempts. Drawing on minority stress theory (Meyer, 2003) and recent research on the development of suicidal thinking and behavior following victimization (Espelage & Holt, 2013; Klomek et al., 2011), we hypothesized that mental health factors may be an important factor in helping to explain the strong and consistent relationship observed between stressors related to anti-transgender bias and lifetime suicide attempts among NTDS respondents. Although the limited NTDS data related to mental health precluded a full testing of this hypothesis, many specific experiences of rejection, discrimination, victimization, and violence were found to be significantly related to having a disabling mental health condition (see Table 21). Examples included a weakening of family relationships after coming out as transgender, being a victim of violence by a family member, becoming homeless after coming out, being harassed at work, and being refused medical care because of anti-transgender bias. The significant relationship between such stressors and mental health disability, coupled with our earlier findings of the relationship between mental health disability and lifetime suicide attempts (Tables 11-13), suggests that mental health factors and stressors interact to produce a marked vulnerability to suicidal behavior in transgender and gender non-conforming individuals.

Table 21: Relationship between specific stressors related to gender identity and mental health disability

Experience	MH Disability	No MH Disability	χ^2*
Family is not as strong as before I came out	614 (61%)	2218 (54%)	17.25
Victim of violence by a family member	235 (30%)	523 (17%)	72.98
Became homeless after coming out	236 (28%)	485 (16%)	67.88
Harassed at work	593 (62%)	1873 (47%)	70.89
Was refused medical treatment	252 (24%)	721 (18%)	23.86

* $p < .001$

QUALITY OF LIFE

The prevalence of lifetime suicide attempts was lowest (31%) among respondents who felt that being transgender or gender non-conforming had not markedly affected the quality of their lives (see Table 22). Those who felt that their life was “much worse” because they were transgender or gender non-conforming had a much higher prevalence of suicide attempts (56%).

Table 22: Lifetime suicide attempts by perceived impact of transgender/gender non-conforming status on quality of life

Because I am Trans/GNC, life in general is...	Have Attempted Suicide	
	Frequency	Row %
Much improved	570	39%
Somewhat improved	379	37%
The same	255	31%
Somewhat worse	316	42%
Much worse	135	56%
Some ways better, some ways worse	918	45%
$\chi^2 = 75.6, p < .001$		

DISCUSSION

The most striking finding of our analysis was the exceptionally high prevalence of lifetime suicide attempts reported by NTDS respondents. In looking at the percentages reporting a lifetime attempt within various subgroups of the overall sample, we repeatedly found “lows” in the range of 30 to 40 percent, while the “highs” exceeded 50 or even 60 percent. Even taking into consideration that some degree of over-reporting likely occurred in the survey, the results suggest these transgender and gender non-conforming respondents have experienced exceptionally high levels of suicidality. Notwithstanding the several significant limitations of the NTDS data that we noted at the outset of this report, our analysis suggests some tentative findings related to risk and protective factors for suicide attempts among transgender and gender non-conforming adults. Two interrelated risk factors appear to be most strongly related to suicidal behavior among transgender and gender non-conforming adults: rejection, discrimination, victimization, and violence related to anti-transgender bias and serious mental health conditions. In this study, we found a markedly high prevalence of lifetime suicide attempts among respondents who reported experiencing stressors related to anti-transgender bias, and among those who reported having a mental health condition that substantially affects a major life activity. In addition, our analyses suggest that these two sets of risk factors are closely related.

Significantly higher prevalence of lifetime suicide attempts was found among respondents who were classified as trans women (MTF) and trans men (FTM), based on their primary self-identifications. Since trans women and trans men are the groups within the overall transgender population most likely to need surgical care for transition, this may help to explain the high prevalence of lifetime suicide attempts we found among respondents who said they have had transition-related surgical procedures, compared to those who said they did not want transition-related surgery. Comparably high, or higher, prevalence of suicide attempts were found among respondents who said that they

“In looking at the percentages reporting a lifetime attempt within various subgroups of the overall sample, we repeatedly found “lows” in the range of 30 to 40 percent, while the “highs” exceeded 50 or even 60 percent.”

someday wanted FTM genital surgery, hysterectomy, or phalloplasty, suggesting that desiring transition-related health care services and procedures but not yet having them may exacerbate respondents’ distress at the incongruence between their gender identity and physical appearance. It is also possible that elevated prevalence of lifetime suicide attempts may be due

to distress related to barriers to obtaining transition-related health care, such as a lack of insurance coverage, inability to afford the procedures, or lack of access to providers. These findings may also be related to the higher rates of reported lifetime suicide attempts among those who have undergone transition-related surgery. As has been noted, the NTDS instrument did not include questions about the timing of suicide attempts relative to transition, and thus we were unable to determine whether suicidal behavior is significantly reduced following transition-related surgeries, as some clinical studies have suggested (Dixen et al., 1984; De Cuypere et al., 2006).

Respondents' perceptions that people can always or sometimes tell they are transgender or gender non-conforming were likewise found to be associated with high prevalence of lifetime suicide attempts. Similarly, higher suicide attempt prevalence was found among respondents who said they tell "everyone" they are transgender or gender non-conforming. In this analysis, we were not able to precisely identify how perceived recognition by others or disclosure of one's transgender status contributes to suicide risk, although our overall results suggest that recognition by others as transgender or gender non-conforming, whether actual or perceived, significantly increases the likelihood of rejection and discrimination, which are clearly related to increased risk of suicidal behavior.

In contrast, prevalence of lifetime suicide attempts was found to be significantly lower among respondents, who described their gender identity as "part time as one gender and part time as another," which may

suggest more selective disclosure and/or more limited perceived recognition by others of transgender or gender non-conforming status. This would be consistent with the findings of significantly lower prevalence of suicide attempts among respondents who said people can "never" tell they are transgender or gender non-conforming, and those who "never" tell anyone they are transgender or gender non-conforming. Collectively, these findings suggest that not being recognized by others as transgender or gender non-conforming may function as a protective factor for suicidal behavior. Conversely, one's *inability* to *not* be recognized as transgender or gender non-conforming may create added risk.

"Collectively, these findings suggest that not being recognized by others as transgender or gender non-conforming may function as a protective factor for suicidal behavior."

Importantly, our analyses suggest that the protective effect of non-recognition is especially significant for those on the trans feminine spectrum. For people on the trans masculine spectrum, however, our data suggest that this protective effect may not exist or, in some cases, may work in the opposite direction. Clearly, more research is needed to illuminate the mechanisms through which not being recognized by others as transgender or gender non-conforming, whether by not disclosing to others or not being perceived as such by others, reduces suicidal behavior among transgender and gender non-conforming people.

NEED FOR FUTURE STUDIES

Transgender people are estimated to constitute 0.3 percent of the U.S. population (Gates, 2011). Federally-sponsored population-based surveys are increasingly including measures of sexual orientation and gender identity, and the data from these surveys will certainly help to increase understanding of the characteristics and needs of the transgender population. It is unlikely, however, that population-based surveys will be able to explore the full range of issues that uniquely impact the well-being of transgender people, such as barriers to transition-related health care and the impact of discrimination due to anti-transgender bias. Thus, well-designed studies that specifically engage the transgender community will continue to be needed to identify and illuminate the health and mental health needs of transgender people, including access to appropriate health care services. In light of the clarity with which the NTDS data have identified suicidal behavior as a significant threat to the well-being of transgender and gender non-conforming people, it is recommended that future surveys that include these populations devote particular attention to careful measurement of suicidal behavior and suicide risk.

This study has identified several areas that are in particular need of further research. First, more research is needed into the timing of suicide attempts in relation to age and gender transition status. In regard to timing of suicide attempts and gender transition, some surveys and clinical studies have found that transgender people are at an elevated risk for suicide attempt during gender transition, while rates of suicide attempts decrease after gender transition (Whittle et al., 2007; DeCuypere et al., 2006; Transgender Equality Network Ireland, 2012). Further research is clearly needed on the occurrence of all aspects of self-harm behavior, including suicidal ideation, suicide attempts and non-suicidal self-injury, in relation to gender transition and barriers to transition. Such research would provide better insight into the factors that underlie suicidal thinking and behavior among transgender people, especially those who want to transition from one gender to another, and could serve as the basis for designing better interventions and suicide prevention services for this population.

Second, further research is needed to examine the interrelationship of rejection, discrimination, victimization, and violence related to anti-transgender bias and serious mental health conditions. In-depth studies using in-person interviews and clinical measures are also needed to determine the independent and combined effects of these two factors in creating a pathway to suicidal behavior in transgender and gender non-conforming populations. Such studies could not only provide the basis for better interventions, but could also underscore the need to address through public policy the high levels of rejection, discrimination, victimization, and violence experienced by transgender and gender non-conforming people.

Finally, prior studies have suggested that lack of disclosure and attempts to conceal sexual orientation contributes to lower levels of mental health for lesbian, gay and bisexual individuals (Meyer, 2003; Pachankis, 2007; Hatzenbuehler, 2009; Schrimshaw, Siegel, Downing & Parsons, 2013). Explanatory mechanisms that have been posited include the stress of constant vigilance and concern about being “outed,” internalized homophobia, and loss of potential emotional support from others. Our findings suggest that non-disclosure may function differently for transgender and gender non-conforming people. As we have noted, one possible explanation is that limiting disclosure of transgender or gender non-conforming status reduces the likelihood of experiencing bias-related rejection, discrimination, victimization, and violence, which in turn, reduces the likelihood suicidal behavior. This appears to be an additional important area for future research.

References

- Bertolote, J.M., & Fleischmann A. (2002). Suicide and psychiatric diagnosis: A worldwide perspective. *World Psychiatry*, 1(3): 181 5.
- Bongiovi Garcia, M.E., Merville, J., Almeida, M.G., Burke, A., Ellis, S., Stanley, B.H., et al. (2009). Comparison of clinical and research assessments of diagnosis, suicide attempt history and suicidal ideation in major depression. *Journal of Affective Disorders*, 115(1 2), 185 188.
- Breslau, N., Davis, G.C., Andreski, P., & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry*, 48(3), 216 222.
- Clements Nolle, K., Marx, R., Guzman, R., & Katz M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health*, 91(6), 915 921.
- Clements Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender based discrimination and victimization. *Journal of Homosexuality*, 51(3), 53 69.
- DeCuypere, G., Elaut, E., Heylens, G., Van Maele, G., Selvaggi, G., T'Sjoen, G., Rubens, R., Hoebeke, P., Monstrey, S. (2006). Long term follow up: psychosocial outcome of Belgian transsexuals after sex reassignment surgery. *Sexologies*, 15, 126 133.
- Dixen, J. M., Maddever, H., van Maasdam, J., & Edwards, P. W. (1984). Psychosocial characteristics of applicants evaluated for surgical gender reassignment. *Archives of Sexual Behavior*, 13(3), 269 276.
- Espelage, D.L. & Holt M.K. (2013). Suicidal ideation and school bullying after controlling for depression and delinquency. *Journal of Adolescent Health*, 53, 527 531.
- Gates, G. (2011). *How many people are lesbian, gay, bisexual, and transgender?* Williams Institute, UCLA School of Law, April 2011.
- Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., & Keisling, M. (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force. Retrieved July 15, 2013, from http://www.thetaskforce.org/reports_and_research/ntds.
- Grossman, A. H., & D'Augelli, A. R. (2007). Transgender youth and life threatening behaviors. *Suicide and Life Threatening Behavior*, 37(5), 527 537.
- Harris, E.C., & Barraclough, B. (1997). Suicide as an outcome for mental disorders: A meta analysis. *British Journal of Psychiatry*, 170, 205 228.
- Hatzenbuehler, M.L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin*, 135, 707 730.
- Kenagy, G. P. (2005). Transgender health: Findings from two needs assessment studies in Philadelphia. *Health & Social Work*, 30(1), 19 26.
- Kendler, K.S., Karkowski, L.M., & Prescott, C.A. (1999). Causal relationships between stressful life events and the onset of major depression. *American Journal of Psychiatry*, 156, 837 841.
- Kessler, R. C., Borges, G., & Walters, E. E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Archives of General Psychiatry*, 56, 617 626.
- Klomek, A.B., Kleinman, M., Altschuler, E., Marrocco, F., Amakawa, L., & Gould, M.S. (2011). High school bullying as a risk factor for later depression and suicidality. *Suicide and Life Threatening Behavior*, 41, 501 516.
- Lesage, A.D., Boyer, R., Grunberg, F., Vanier, C., Morrisette, R., Menardbuteau, C., et al. (1994). Suicide and mental disorders: A case control study of young men. *American Journal of Psychiatry*, 151, 1063 1068.
- Maguen, S., & Shipherd, J. (2010) Suicide risk among transgender individuals. *Psychology & Sexuality* 1(1), 34 43.
- Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674 697.
- Nock, M.K., Hwang, I., Sampson, N.A., & Kessler, R.C. (2010). Mental disorders, comorbidity and suicidal behavior: Results from the National Comorbidity Survey Replication. *Molecular Psychiatry*, 15, 868 876.
- Nock, M.K., & Kessler, R.C. (2006). Prevalence of and risk factors for suicide attempts versus suicide gestures: Analysis of the National Comorbidity Survey. *Journal of Abnormal Psychology*, 115(3), 616 623.
- Pachankis, J.E. (2007). The psychological implications of concealing a stigma: A cognitive affective behavioral model. *Psychological Bulletin*, 133, 328 345.
- Paul, J. P., Cantania, J., Pollack, L., Moskowitz, J., Canchola, J., Mills, T., et al. (2002). Suicide attempts among gay and bisexual men: Lifetime prevalence and antecedents. *American Journal of Public Health*, 92(8), 1338 1345.
- Ploderl, M., Wagenmakers, E.J., Tremblay, P., Ramsay, R., Kralovec, K., Fartacek, C., et al. (2013). Suicide risk and sexual orientation: A critical review. *Archives of Sexual Behavior*, 42(5), 715 727.
- Schrimshaw, E.W., Siegel, K., Downing, M.J., & Parsons, J.T. (2013). Disclosure and concealment of sexual orientation and the mental health of non gay identified behaviorally bisexual men. *Journal of Consulting and Clinical Psychology*, 81, 141 153.
- Suominen, K., Henriksson, M., Suokas, J., Isometsa, E., Ostamo, A., & Lonnqvist, J. (1996). Mental disorders and comorbidity in attempted suicide. *Acta Psychiatrica Scandinavica*, 94, 234 240.
- Tidemalm, D., Langstrom, M., Lichtenstein, P., & Runeson, B. (2008, November 18). Risk of suicide after suicide attempt according to coexisting psychiatric disorder: Swedish cohort study with long term follow up. *British Medical Journal*, 337, a2205, DOI: <http://dx.doi.org/10.1136/bmj.a2205>
- Transgender Equality Network Ireland. (2012). *Ireland's Trans Mental Health and Well being Survey*. Dublin: Transgender Equality Network Ireland. Retrieved July 15, 2013, from http://www.teni.ie/suicide_in_trans_communities_new_data_from_the_mental_health_well_being_survey.
- TransPULSE. (2010). Ontario's Trans Communities and Suicide: Transphobia is Bad for Our Health. *TransPULSE E Bulletin*, 1(2): np. Retrieved July 15, 2013, from http://transpulseproject.ca/research/ontarios_trans_communities_and_suicide/
- Whittle, S., Turner, L., & Al Alami, M. (2007). *Endangered penalties: Transgender and transsexual people's experiences of inequality and discrimination*. The Equalities Review. Retrieved July 15, 2013, from <http://www.pfc.org.uk/pdf/EngenderedPenalties.pdf>.
- Whittle, S., Turner, L., Combs, R., & Rhodes, S. (2008). *Transgender EuroStudy: Legal Survey and Focus on the Transgender Experience of Health Care*. Brussels, Belgium and Berlin, Germany: ILGA Europe and TransGender Europe. Retrieved July 15, 2013, from <http://tgeu.org/sites/default/files/eurostudy.pdf>.
- Xavier, J.M., Bobbin, M., Singer, B., & Budd, E. (2005). A Needs Assessment of Transgendered People of Color Living in Washington, DC. *International Journal of Transgenderism*, 8, (2 3), 31 47.
- Xavier, J., Honnold, J. A., & Bradford, J. (2007). *The health, health related needs, and lifecourse experiences of transgender Virginians*. Richmond: Virginia Department of Health.

About the authors

Ann P. Haas is Senior Director of Education and Prevention at the American Foundation for Suicide Prevention, where she studies suicide in high-risk populations and develops intervention and prevention initiatives. She received a Ph.D. in Sociology with an emphasis in health behavior from Fordham University.

Philip L. Rodgers is an Evaluation Scientist with the American Foundation for Suicide Prevention and manages the Best Practices Registry for Suicide Prevention in collaboration with the Suicide Prevention Resource Center. He holds a Ph.D. in Research and Evaluation Methodology from Utah State University.

Jody L. Herman is the Peter J. Cooper Public Policy Fellow and Manager of Transgender Research at the Williams Institute, UCLA School of Law. She holds a Ph.D. in Public Policy and Public Administration from The George Washington University.

Acknowledgements

The authors gratefully acknowledge Andrew Lane, Chair of the National Action Alliance for Suicide Prevention Task Force on LGBT Populations (2011-13), for initiating this project and providing ongoing leadership, support, and critical input. We thank Kellan Baker, Jack Harrison-Quintana, Mara Keisling, Ilan Meyer, Brad Sears, and Jill Harkavy-Friedman for their thoughtful reviews of the report. We also thank Erin Fitzgerald, Sheila Nezhad, and Becky Mengel Freund for their assistance with the final report. We also thank the National Gay and Lesbian Task Force and the National Center for Transgender Equality for the use of the NTDS dataset.

For more information, contact:

American Foundation for Suicide Prevention

120 Wall Street
29th Floor
New York, NY 10005-0056
T (212)363-3500
pr@afsp.org
www.afsp.org

The Williams Institute

UCLA School of Law
Box 951476
Los Angeles, CA 90095-1476
T (310)267-4382
F (310)825-7270
williamsinstitute@law.ucla.edu
<http://williamsinstitute.law.ucla.edu>



the
Williams
INSTITUTE

Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans

**FINDINGS FROM A
SURVEY OF EMPLOYERS**

Jody L. Herman, Ph.D.

Manager of Transgender Research
Peter J. Cooper Public Policy Fellow

September 2013

EXECUTIVE SUMMARY

A growing number of employers, both public and private, are providing coverage in employee health benefits plans for transition-related health care to treat gender dysphoria. In order to inform employer-based decisions and current policy debates regarding provision of this coverage, this study describes the experiences of 34 employers who provide transition-related coverage in their health benefits plans. Overall, we find that transition-related health care benefits have zero or very low costs, have low utilization by employees, and yet can provide benefits for employers and employees alike.

Employers report very low costs, if any, from adding transition-related coverage to their health benefits plans or from actual utilization of the benefit after it has been added – with many employers reporting no costs at all.

Based on data collected in this study, costs of providing transition-related health care coverage are very low, including for employers that cover a wider range of medical treatments or surgical procedures for transition.

Overall, we find that transition-related health care benefits have zero or very low costs, have low utilization by employees, and yet can provide benefits for employers and employees alike.

Twenty-six of the 34 employers in this study provided information about the cost of adding transition-related coverage to existing health care plans.

- Eighty-five percent (85%) of these 26 employers reported no costs associated with adding the coverage, such as increases in premiums in the first year.
- Four employers (15%) reported costs due to adding the coverage. Three employers provided information about the costs they incurred from adding the coverage based on projections of utilization. These costs based on projections seem high in light of the findings from prior research and this study regarding actual costs and utilization rates. These projections may reflect actuarial overestimates of the utilization of these benefits and subsequent cost of claims. For instance, two employers reported a 1 percent increase in total cost to their transition-inclusive plans, based on projected benefit utilization, whereas two similarly-sized employers reported lower costs due to actual benefit utilization.

Twenty-one of the 34 employers in the study provided information about the actual costs from employees utilizing the transition-related health care coverage.

- Two-thirds (14 employers) reported no actual costs resulting from employees utilizing the coverage.
- One-third (7 employers) reported some actual costs related to utilization by employees.
- However only three of the seven employers reported the actual costs with any degree of specificity. All three of these employers reported that their actual costs from utilization are very low:
 - In one case, actual cost over two years was only \$5500, which comprised only 0.004 percent of total health care expenditures. The other two employers characterized the costs as “negligible” and “minimal” at less than 1 percent of total costs or total claims paid.

Few people will utilize transition-related health care benefits when they are provided.

When an employee utilizes transition-related health care benefits, their claims may result in costs to their employer. The type, number and cost of services accessed by individuals will vary, yet as described above, the costs of these benefits, if any, are very low, as is the utilization of the benefit. While utilization rates depend on the size of the employer, estimates based on the best data gathered in the survey result in annual utilization rates of approximately:

- 1 out of 10,000 employees for employers with 1,000 to 10,000 employees, and
- 1 out of 20,000 employees for employers with 10,000 to 50,000 employees.

More specifically:

- Two employers with less than 1,000 employees reported zero transition-related claims over a combined six years of providing this type of coverage in their health benefits plans.
- For employers with 1,000 to 9,999 employees, average annualized utilization was 0.107, with a lower bound of 0.027 and an upper bound of 0.214 claimants per 1,000 employees.
- For employers with 10,000 to 49,999 employees, average annualized utilization was 0.044, with an upper bound of 0.054 claimants per thousand employees.

Employers reported that providing transition-related health care coverage benefits them in a variety of ways. Employers reported that they

provide the coverage in order to:

- Make them competitive as an employer within their industries and help them with recruitment and retention of employees (60%);
- Reflect their corporate values, including equality and fairness (60%);
- Provide for the health care needs of their employees and improve employee satisfaction and morale (48%); and
- Demonstrate their commitments to inclusion and diversity (44%).

Not surprisingly, then, a majority of employers also reported that they would encourage other employers to add the coverage, and none would advise against adding the coverage.

With regard to the scope of transition-related health care coverage that employers are providing, while many transition-related claims would be covered under these employers' plans, some do not provide coverage for many medical treatments or surgical procedures that the WPATH *Standards of Care* describe as medically necessary when clinically indicated for an individual.

- Employers provide coverage in their health benefits plans that cover many medical treatments and surgeries that an individual may need for treatment of gender dysphoria. For most of the hormone therapies and genital surgeries asked about in the survey, 100 percent of transition-related benefits plans provide coverage.
- Plans are less likely to cover certain reconstructive procedures such as breast/chest surgeries, electrolysis, facial surgeries and related procedures, and voice-related care.
- Only 59 percent of employers cover breast or chest reconstruction, with only a quarter covering electrolysis, certain facial procedures, and voice-related procedures.
- Plans also have other specified limitations in coverage:
 - Forty-eight percent (48%) of transition-inclusive plans have some type of restriction on access to transition-related healthcare provided out-of-network, including restrictions of services provided outside of the United States. These restrictions may limit access to transition-related care since providers in the United States may not participate in certain health benefits plans. In this case, employees may seek services outside of their plan,

elsewhere in the U.S., or in another country.

- However, twenty-five employers (74%) offer transition-related benefits with no dollar limit. Almost all employers with a limit reported a \$75,000 lifetime limit or higher (21%).
- In this sample, there was no relationship between the scope of the coverage provided and reported costs of adding the coverage, meaning providing broader coverage did not result in higher costs for surveyed employers.

In one case, actual cost over two years was only \$5500, which comprised only 0.004 percent of total health care expenditures. The other two employers characterized the costs as “negligible” and “minimal” at less than 1 percent of total costs or total claims paid.

Of the 33 employers responding to questions about the process of adding transition-related health care benefits, 94 percent (31 employers) reported that there were no significant barriers to adding the coverage. Employers also provided practical guidance to other employers to aid them in adding the coverage for their employees. Employers recommended that other employers:

- Work with their insurers and Third Party Administrators to discuss the coverage they can offer and to address any shortcomings in their medical guidelines.
- Conduct research and consult with other employers that provide the coverage to better understand costs they may incur and to be better informed to negotiate with their insurers.
- Work with benefits administrators to make sure they are providing competent customer service to employees who inquire about transition-related health care benefits.

Overall, we find that transition-related health care benefits have very low costs, have low utilization rates by employees, and yet can provide benefits for employers and employees alike. Future research regarding transition-related health care coverage should consider the negative impact on employees, and therefore on employers, of not providing medically necessary care for treatment of gender dysphoria. Future research should also consider the cost savings to employers over time that result from providing the health care that their employees need.

INTRODUCTION

A growing number of employers, both public and private, are providing coverage in employee health benefits plans for transition-related health care to treat gender dysphoria. Since 2008, the Human Rights Campaign has collected data for its Corporate Equality Index (CEI) on the provision of transition-related health care benefits by the largest U.S. employers (Fortune 1000 and AmLaw 200).¹ A total of 49 employers reported providing this coverage in 2009. That number has grown to 287 as of the 2013 CEI, a nearly 600 percent increase over four years. Growing numbers of cities and universities are providing coverage for employees as well. Currently nine cities, three counties, and fourteen universities are known to provide this benefit to employees.² California, Colorado, Oregon, Vermont, and the District of Columbia have also issued insurance regulations, directives, or bulletins informing private insurers and managed care plans that discrimination against transgender people in health care is not permissible.³

The increasing number of employers providing transition-related health care coverage as part of their benefit suite may be related to new requirements for earning points in the CEI's rating system. Beginning with the 2012 CEI, the Human Rights Campaign has required participating employers to make available to employees at least one transition-inclusive health benefits plan in order to receive full credit, and a possible score of 100, in the CEI.⁴ In addition to the CEI requirements, recent statements by professional associations, such as the American Medical Association (AMA) and the American Psychological Association (APA), explain that care for the treatment of gender dysphoria is a medical necessity and coverage should be included in health benefits plans.⁵

Despite these statements and the increasing number of employers providing this coverage, treatment for gender dysphoria is still rarely covered by health benefits plans, including both public plans and employer-based plans. Surgeries and other medical treatments to treat gender dysphoria are often explicitly excluded from health benefits plans or are determined to be cosmetic and, therefore, not medically necessary.⁶ While coverage for transition-related health care remains rare in health benefits plans, employers are being encouraged to provide it. In order to come into compliance with the determinations of the AMA, APA, and other professional associations and to meet the requirements of the CEI, employers must remove existing exclusions to transition-related health care from health benefits plans. In most cases, employers will also need to provide a defined benefit for transition-related care that

meets current medical standards of care.⁷ A "defined benefit" means that the scope and limitations of this coverage are described in plan documentation.

Since 1979, the World Professional Association for Transgender Health (WPATH), formerly the Harry Benjamin International Gender Dysphoria Association, has established standards for appropriate and medically necessary care for the treatment of gender dysphoria.⁸ The most recent edition of the *Standards of Care*, the 7th edition, describes an individualized program of treatment based on a person's particular mental health and medical needs in consultation with their health care providers. The *Standards of Care* describe the individual treatments and procedures that may be considered medically necessary in an individualized treatment program, including hormone therapies, chest/breast surgeries, genital surgeries, and other surgeries, such as facial feminization surgeries. These medically necessary treatments and procedures alleviate gender dysphoria by bringing one's physical characteristics into alignment with one's internal sense of gender.⁹ For purposes of this report, these medical treatments and procedures are referred to as "transition-related health care."

In order to inform employer-based decisions regarding this type of health care coverage and current policy debates regarding provision of this coverage in public health insurance plans, this study describes the experiences of employers who have chosen to provide transition-related health care coverage for their employees through their health benefits plans. In this report, we review findings from an original survey of 34 employers who provide this health benefit to their employees.¹⁰ First, we present prior research on cost and utilization of transition-related health care benefits and recent research on the benefits to employers of adopting lesbian, gay, bisexual, and transgender (LGBT)-inclusive workplace policies. Next, we will describe the survey methods we employed in the current study. We then describe the findings from the survey. In particular, we examine the scope of the transition-related benefit employers are providing, the cost to the employer to provide the benefit, and the utilization of the benefit. Afterward, we describe why and how employers began providing the coverage, what benefits, if any, employers report they receive as a result of providing this coverage for their employees, and what advice they would give to other employers considering adding this coverage. We conclude by discussing our findings as compared to prior research findings, the limitations of this study, and considerations for future research.

PRIOR RESEARCH

Employers who are considering adding transition-related health care benefits may be interested in understanding how much adding this benefit will cost in dollars. Prior research shows that data on costs to employers are not widely available, especially in terms of the actual cost in dollars of transition-related claims that have been paid. Data that do exist on actual costs incurred are sometimes expressed as a percentage of total health care expenditures or as a percentage of premiums per member per year or per month. Costs to employers based on actuarial projections are expressed in similar terms. In all cases, data on costs to employers are scarce. In lieu of information about the actual dollar cost of transition-related claims, we look to data on benefit utilization in terms of the number of claims and number of claimants. While data on utilization does not allow us to determine the cost of the services utilized, it can provide a description of the demand for these services. Existing data on cost and utilization together can assist in predicting what an employer can expect in terms of the cost of providing transition-related health care coverage for employees. Research also can assist employers in understanding the positive or negative impact on their business and their employees of providing LGBT-inclusive workplace policies.

Cost

The best available data on cost to employers to provide transition-related health care benefits for employees come from the City and County of San Francisco. The University of California and the cities of Seattle, Portland, and Berkeley have also released data on the costs they incurred for providing the benefit.

A 2007 memo from the City and County of San Francisco and the San Francisco Human Rights Commission describes the costs over time associated with adding transition-related health care benefits for employees as of 2001.¹¹ Initially, actuaries assumed that out of 100,000 enrolled members, 35 members would make claims each year under the transition-related health care benefit at a total cost of \$1.75 million per year, or \$50,000 per claimant. To cover the projected cost, \$1.70 per month from each enrolled member's premium was allocated for this benefit.¹² Over the first three years, a total of \$4.3 million was collected for this benefit from employee premiums, yet only a total of \$156,000 was spent on claims under the benefit. Because actual costs of transition-related claims were so small relative to projections, these benefits were provided at no

additional cost to employees as of July 1, 2006. Over five years from 2001 through 2006, \$5.6 million was collected from enrolled employees to cover the cost of the benefit and a total of \$386,417 was spent, or about \$77,000 on average per year.

The University of California began providing transition-related health care coverage to employees in 2005.¹³ The University, which has a mix of self-insured, fully insured, and managed care/HMO plans, was not charged any additional premium by insurers for adding the coverage.¹⁴ Actual cost data provided to the Department of Insurance for the State of California reveal that claims paid under the transition-related health care benefit for one health plan represented a cost of \$0.20 per member per month, or 0.05 percent of the total premium.¹⁵ The cost of individual claims ranged from \$67 to \$86,800, with an average cost per claimant of \$29,929.¹⁶

The cities of Berkeley, Seattle, and Portland, however, have absorbed premium increases of 0.2 percent, 0.19 percent, and 0.08 percent of their total health care budgets, respectively.¹⁷ Given the experiences of the City and County of San Francisco and the University of California, these premium increases based on insurer projections may be high in relation to actual costs that will occur. Since these cities have added coverage only recently, within the past two years, actual cost data were not available at the time of the California Department of Insurance report.

Utilization

Studies of the utilization of transition-related health care benefits have analyzed data from the City and County of San Francisco, the University of California (one health plan only), and from several private employers. Findings from these studies have expressed utilization of the benefit by providing the number of individual claimants per thousand employees in the health benefits plan. A summary of the findings of this research, presenting the maximum and minimum reported utilization per year, is shown in Table 1.¹⁸ The lowest utilization rate per 1000 employees per year (0.0015) was found in a sample of private employers in a 2009 HRC Foundation (HRCF) study conducted by Jamison Green & Associates.¹⁹ The same study also found the highest reported utilization rate per year of 0.22 claimants per thousand employees.

To better understand the employer-level context for findings regarding utilization of the transition-

Table 1: Summary of Utilization Findings from Prior Research

Utilization Rates per 1,000 employees per year

Case	City and County of San Francisco	University of California	Sample of Private Employers
Minimum	0.074	0.022	0.0015
Maximum	0.200	0.187	0.22

Sources: State of California, Department of Insurance, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, April 13, 2012; Jamison Green & Associates, *Transgender-Inclusive Health Benefits: Data for Cost Calculation*, March 2012.

related health care benefit, the Jamison Green & Associates report gives utilization data by employer size for the 2009 HRCF study. Table 2 provides the findings from their 2009 sample of private employers who provided utilization data, along with data from the City and County of San Francisco and the University of California (UC). Data from private employers were adjusted to provide the average annual number of claimants per thousand employees for all employers of that size (lower bound) and for only those employers of that size reporting the benefit had been utilized (upper bound). Lower and upper bound utilization for the City and County of San Francisco are based on the average annual number of claimants divided by the lowest estimate of the number of employees over the time period (25,000) versus the largest estimate of the number of employees over the period of time (35,000).²⁰ An overall average utilization rate is also provided for the City and County of San Francisco, based on average annual utilization for 30,000 employees. Lower and upper bound utilization for the University of California are the lowest and highest utilization rates per thousand employees enrolled in this plan per year observed in years 2006 through 2011.²¹ The overall average annual utilization is also provided for the University of California.

To provide better understanding of the practical implications of these utilization findings, André Wilson explained, "For firms with 1000-9999 employees, an upper bound or worst case is 0.22 per thousand per year. Using this data to forecast utilization, an employer with 2000 employees might expect to see about two insured persons access transition-related surgeries every five years."²² Given that Wilson's projection presents a "worst case," he noted that the projected utilization is actually unlikely to occur. He also noted that the survey sample for the 2009 HRCF

study was small and further research is needed to understand if these findings are representative of other employers' experiences.

One can see from the findings presented in Table 2, as employer size increases, utilization rates decrease. Of the private employers, utilization is highest for smaller employers, ranging from 0.074 to 0.220 claimants per thousand employees, and is lowest for the largest employers, ranging from 0.0015 to 0.0023 claimants per thousand employees. These particular employers' data suggests that projected risk decreases as employer size increases. Data from the City and County of San Francisco show they have relatively high utilization compared to similarly-sized private employers (10,000 to 49,999 employees), with average annual utilization of 0.127 per thousand employees compared to a range of 0.016 to 0.060 for the private employers. The University of California also seems to have relatively high utilization in this one health plan compared to private employers with similar numbers of employees, with an average annual 0.124 claimants per thousand employees. However, it should be noted that in order to understand the total demand for transition-related health care at the University of California, we would need to have similar data from all of the UC employee plans.²³

Table 2: Annualized Utilization Per Thousand Employees by Employer Size

	1,000 to 9,999	(San Francisco) 25,000 to 35,000	(Univ. of CA) 43,000 to 61,000 ²⁴	10,000 to 49,999	50,000 +
# Employers	4	1	1	7	2
Adjusted rate (lower bound)	0.074	0.074	0.022	0.016	0.0015
Average rate	—	0.127	0.124	—	—
# Employers	2	1	1	3	1
Adjusted rate (upper bound)	0.208 - 0.220	0.200	0.187	0.016 - 0.060	0.0023

Sources: State of California, Department of Insurance, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, April 13, 2012; Jamison Green & Associates, *Transgender-Inclusive Health Benefits: Data for Cost Calculation*, March 2012. NOTE: No data were available for employers with less than 1,000 employees. Average annual utilization rate for the City and County of San Francisco calculated by the author.

The California Department of Insurance also provided utilization data based on the estimated total number of covered lives in this health benefit plan for the University of California. In contrast to the number of enrolled employees, the total number of "covered lives" in transition-inclusive plans is a more accurate measure of the demand for transition-related health care because this number includes all individuals who would be eligible to make transition-related claims (i.e., employees and retirees plus covered dependents). Data on the number of claimants for transition-related health care, both in prior research and the current study, could include claims from employees' and employees' dependents as well.

For this University of California plan from 2006 through 2011, the average annual number of claimants per thousand covered lives is 0.062.²⁵ This means that in a plan with 100,000 covered lives, an employer could expect to see about 6 covered individuals make transition-related claims each year. However, as noted above, we would need to have similar data from all of the UC employee plans in order to assess total demand for transition-related health care at the University of California.

Benefits to Employers

Existing research shows that workplace policies that benefit LGBT employees are connected to positive outcomes for businesses.²⁶ Positive outcomes for businesses include increased job

satisfaction and productivity for employees, improved health outcomes among LGBT employees, improved workplace relationships, and improving employers' bottom lines.²⁷ In addition to the generally positive impact of LGBT-inclusive workplace policies, research conducted by the California Department of Insurance found potential cost savings to employers that provide transition-related health care benefits for employees.²⁸ The California Department of Insurance describes cost savings that may result by reducing costs associated with not providing medically necessary care for people who experience gender dysphoria. These cost savings include a reduction in suicide ideation and attempts, an improvement in mental health, reduction in rates of substance abuse, and an increase in socioeconomic status for those who receive the medically necessary care needed to treat their gender dysphoria.

METHOD

Survey participants for this study were all employers known to provide transition-related health care coverage for employees through their health benefits plans. To identify these target participants, we relied on the 2013 CEI and existing knowledge networks to identify city, county, and university employers. The survey was announced via email in December 2012 to a total of 243 employers, utilizing personal contacts and LGBT employee resource groups. For employers not responding to the initial survey announcement, follow-up emails were sent in January 2013. Outreach efforts resulted in completed survey responses from 34 employers, both public and private, including corporations, law firms, universities, and cities. These employers represent 900,000 full-time employees, 2 million covered lives in their health benefits plans, 122 years of combined transition-related health care coverage experience, 191 total health benefits plans for active employees, and 150 total retiree-only plans, including Medicare supplements. These employers are headquartered in 16 U.S. states and the District of Columbia, representing all regions of the U.S., and all but five (85%) have significant operations in other U.S. locations. Table 3 provides a breakdown of participating employers by number of full-time active employees and the number of health benefits plans provided.

The survey was designed to capture details about the employers and the health benefits plans they provide. It asked for details about the transition-

related health care coverage provided, such as procedures covered, limits to the coverage, and the total number of covered lives in the transition-inclusive plans. Employers were asked about the costs related to providing the coverage, including costs based on actual utilization of the benefit or costs based on insurer projections which may have resulted in premium increases, and any utilization of the benefit. Employers were also asked why they decided to provide the benefit, any barriers they experienced to adding the benefit, what benefits they receive by providing the coverage, and what advice they would give to other employers who are considering adding transition-related health care benefits for their employees. In order to protect the privacy and identities of any individual employer or employee, all data are presented in the aggregate, with few exceptions in regard to costs, and are not attributed to any particular employer.

Table 3: Participating Employers, by size and number of health benefits plans

Utilization Rates per 1,000 employees per year		
Full-Time Active Employees	Number of Employers	Number of Health Benefits Plans
Less than 1,000	4	13
1,000 to 9,999	15	56
10,000 to 49,999	11	89
50,000 or more	4	33
TOTAL	34	191

TRANSITION-RELATED HEALTH INSURANCE BENEFITS POLICIES

Of the 191 health plans for active employees offered by surveyed employers, 68 percent cover transition-related health care. All benefits-eligible employees for 28 employers (82%) have access to a transition-inclusive plan. Six employers reported they had some employees without access to transition-related plans for one or more of the following reasons:

- They have HMO plans that do not include the benefit (3 employers).
- Union-negotiated plans did not provide coverage (4 employers).
- Some of their plans were subject to medical guidelines that did not include transition-related health care (1 employer).

Access to transition-related health care coverage is less common for non-Medicare retirees than for active employees. Twenty-one employers (62%) reported that non-Medicare retirees have access to transition-inclusive plans.

Employers provide transition-related health care benefits through one or more plan types: self-insured plans, fully insured plans, and/or managed care/HMO plans. Most employers (72%) provide transition-related health care benefits through self-insured plans, either alone or in addition to transition-inclusive fully insured or managed care/HMO plans. Table 4 provides the type of transition-inclusive plans participating employers offered by employer size. The most commonly used Third Party Administrator (TPA) for transition-inclusive self-insured plans is UnitedHealthcare (11 employers), followed by Anthem (including Anthem Blue Cross and Blue Shield) (6 employers), Cigna (4 employers), and Aetna (4 employers).

Table 4: Type of Transition-Inclusive Plan by Employer Size

Type of transition-inclusive plan	Number of Employers by Size			
	Less than 1,000	1,000 to 9,999	10,000 to 49,999	50,000 +
Self-insured only	—	11	8	2
Fully Insured only	3	1	—	—
HMO/Managed care only	—	1	—	—
More than one plan type	1	2	3	2

According to WPATH's *Standards of Care*, treatment of gender dysphoria should be an individualized program that meets the specific needs of those individuals seeking care.²⁹ Individuals and their health care providers have a range of medical treatments and surgical procedures they can consider to alleviate gender dysphoria.³⁰ When mental health and medical providers, in consultation

with the individual seeking care, determine that particular medical treatments or procedures are needed to address an individual's gender dysphoria, these interventions are considered medically necessary care for that individual.³¹ An individual in need of treatment for gender dysphoria will not need every available medical treatment or procedure for purposes of gender transition. If the medical treatments or procedures an individual needs as part of their medically necessary care are not covered by their health benefits plan, it will be up to the individual to cover any expenses incurred through their own means.

To assess whether transition-inclusive health plans would meet the range of treatment that could be deemed medically necessary for a covered individual, the survey for this study asked employers to describe the transition-related health care coverage they provide. Survey respondents were asked whether their plan(s) cover specific hormone therapies, surgeries, and other procedures that the WPATH *Standards of Care* describe as medically necessary care if clinically indicated for an individual. The survey asked for coverage limitations, including eligibility, maximum dollar limits, coverage outside of the network, and other limitations and restrictions related to travel expenses. It should be noted that the CEI requires that employers provide transition-related health care coverage consistent with the WPATH *Standards of Care* with no less than a \$75,000 lifetime cap on transition-related claims. Tables 5 and 6 provide the list of specific hormone therapies, surgeries, and other procedures the survey inquired about and the percentage of employers who provide coverage for each one listed. Not all employers were able to provide an answer or adequate plan documentation to determine an answer for each item listed. Therefore, the sample size is indicated for each item.

Of employers providing answers to all listed items, only two provide coverage for all transition-related care inquired about in the survey. For most of the hormone therapies and genital surgeries listed, 100 percent of transition-related benefits plans provide coverage. However, plans are less likely to cover certain reconstructive procedures such as breast/chest surgeries, electrolysis, facial surgeries and related procedures, and voice-related care. For instance, only 59 percent of employers cover breast or chest reconstruction.

It is clear that many employers in this sample do not provide health benefits for their employees for medical treatments or procedures that the WPATH

Table 5: Hormone Therapies Covered by Employer Health Benefits Plans

Therapies	Percent Providing Coverage	Number of Companies Responding
Cross Sex Hormonal Therapies:		
Estrogen	100	25
Progesterone	100	24
Spironolactone (anti-androgen)	100	22
Testosterone	100	25
GnRH analogs (puberty suppression)	94	18

Standards of Care describe as medically necessary when clinically indicated for an individual. There may be several reasons for the limited scope of the coverage. It is possible that some of the listed procedures were not available as part of the insurance products that fully-insured employers could purchase. It is also possible that coverage is limited to standardized internal medical or clinical guidelines, which insurance carriers and TPAs develop to determine coverage and guide claims decisions, many of which exclude certain medical treatments or procedures. For instance, CIGNA's Medical Coverage Policy describes covered and excluded medical treatments and procedures for "gender reassignment surgery."³² While CIGNA covers a number of surgical procedures under their Policy, such as mastectomy and hysterectomy for trans men and orchiectomy and vaginoplasty for trans women, there are a number of exclusions, such as breast surgeries, electrolysis, tracheal shave, facial surgeries, and voice modification surgery for trans women and certain chest reconstruction procedures for trans men, among other exclusions. Those employers with health benefits plans purchased from or administered through CIGNA may be subject to CIGNA's Medical Coverage Policy and, therefore, these exclusions.

The survey also assessed lifetime dollar limits for transition-related health care coverage. Twenty-five employers (74%) offer transition-related benefits with no dollar limit. Two employers reported a lifetime limit of \$100,000, while others reported a \$75,000 lifetime limit (5 employers) and a \$50,000 lifetime limit (1 employer). One employer did not report a dollar limit. Since most of the employers who participated in this study received the trans-inclusive benefits points in their CEI score, it is not surprising to find that nearly all of those instituting caps established a lifetime cap at \$75,000 or greater, with the vast majority providing coverage with no lifetime dollar limit.

Table 6: Surgical and Body Procedures Covered by Employer Health Benefits Plans

Procedures	Percent Providing Coverage	Number of Companies Responding
Electrolysis (hair removal):		
Feminizing (Facial/Neck)	24	25
Pre-surgical MTF genital epilation	39	23
Pre-surgical FTM free flap preparation	39	23
Breast/Chest surgeries:		
MTF Breast augmentation (implants)	59	27
FTM Bi-lateral mastectomy	92	25
FTM chest reconstruction	59	22
FTM nipple areolar reconstruction	70	20
MTF Gonadectomy and Genital Surgeries:		
Orchiectomy	100	26
Vaginoplasty	100	27
Labiaplasty	100	27
Clitoroplasty	100	27
FTM Gonadectomy and Genital Surgeries :		
Hysterectomy/Oophorectomy	100	27
Metoidioplasty	100	26
Phalloplasty	100	26
Penile/erectile implants	74	23
Urethroplasty	100	26
Vaginectomy	100	26
Scrotoplasty	88	26
Testicular implants	84	23
"Facial Feminization" and related procedures:		
Orthognathic surgeries (reshaping of bony structures of brow/cheek/jaw)	26	27
Rhytidectomy (hairline advancement)	22	23
Rhinoplasty	28	25
Reduction Thyroid Chondroplasty (tracheal shave)	58	24
Voice:		
Voice retraining	9	23
Vocal chord surgery	20	25

Thirty-seven percent (37%) of transition-inclusive plans are limited to “initial surgery only” or “one transition.” Forty-eight percent (48%) of transition-inclusive plans have some type of restriction on access to transition-related healthcare provided out-of-network, including restrictions of services provided outside of the United States. Of these 48 percent, only two employers noted that no out-of-network services are covered under the plan and nine reported that no services, except for emergency care in most cases, were covered outside the United States. Four employers indicated that services rendered outside the United

States could be covered, but would be subject to the same reimbursement rates and limitations that would apply for care provided out-of-network. Seventeen percent (17%) of transition-inclusive plans will reimburse claimants for travel and lodging expenses for transition services. Restrictions on out of network services may impact those in need of transition-related care since providers for certain transition-related services in the United States may not participate in certain health benefits plans’ networks. In this case, U.S.-based employees may seek services outside of their plan networks and/or in another country.³³

COST OF TRANSITION-RELATED HEALTH CARE BENEFITS

Costs to an employer and/or employees of providing transition-related health care benefits are based on utilization of the benefit. Some employers, particularly self-insured employers, will see no costs until actual utilization of the benefit results in the payment of claims. Other employers may see premium increases when adding the benefit based on projected utilization. Increased costs based on projections are based on actuarial estimates by the employer’s insurance provider, TPA, or, in the case of some self-insured employers, by their own actuaries of predicted benefit utilization and the costs of these predicted claims. Employers that are faced with cost increases to their plans based on projections, such as a premium increase for a fully-insured plan, can choose whether to pass along the cost increase to employees in full, in part, or to cover the full cost increase themselves. The accuracy of actuarial predictions can only be assessed in subsequent years when the actual costs of transition-related claims, or the impact of the addition of the benefit on total health care expenditures, can be known. Future premiums may be adjusted based on the actual known cost of these benefits in subsequent years or, more commonly, based on the overall impact on the total cost of the health benefits plan.

The survey asked employers about whether they incurred costs for adding transition-related health care coverage to their employee health benefits plans, and if so, what those costs were. Table 7 shows the costs employers reported by employer size; more specific information about those reporting costs is provided below. All employers that reported costs due to utilization or

projections provide their transition-related health care benefits through self-insured plans, except for one employer with costs due to utilization that provides several different transition-inclusive plan types and one employer with costs based on projections that provides a fully-insured plan.

Overall, 26 employers were able to provide information about costs related to adding their transition-related health care benefit. Twenty-one employers provided information about the actual costs from employee utilization of the transition-related health care benefit. Eight employers did not know if there were costs associated with the benefit because several plan changes were made at the same time and specific costs for transition-related coverage were not separated out.

Twenty-two (85%) of the 26 employers reported no costs associated with adding the benefit, such as in premium increases in the first year. Ten of these 22 employers stated that there was no cost specifically

Table 7: Costs of Transition-related Health Care Coverage, number of employers by plan type and employer size				
	Less than 1,000	1,000 to 9,999	10,000 to 49,999	50,000 +
No costs to add coverage, no subsequent costs	2	6	2	—
No costs to add coverage, unknown subsequent costs	1	3	1	—
Do not know cost, several plan changes made	—	2	3	3
Known costs due to utilization	—	2	4	1
Known costs based on projections	1	2	1	—

attached to adding the benefit and there have been no subsequent costs due to utilization of the benefit. Five of these 22 employers stated that there was no cost to add the coverage, but they did not know if there had been subsequent costs due to utilization of the benefit. Seven of these 22 employers reported no costs to adding the benefit, but did report subsequent costs due to utilization.

Of the 21 employers that provided information about the actual costs from employees utilizing the transition-related health care coverage, 14 employers (67%) reported no actual costs resulting from employees utilizing the coverage. Seven employers (33%) reported some actual costs related to benefit utilization by employees. More information about these seven employers is provided below.

No Reported Costs for Adding Transition-related Health Care Coverage (n=22)

Of the 22 employers (85%) who reported that there was no cost to adding transition-related health care coverage, six provided additional explanation as to why there were no costs to adding the benefit. One fully-insured employer remarked that their insurance provider initially stated that there would be an additional charge for adding this coverage to their plan, but after further review added the coverage at no additional cost. Two of the 22 employers reported their plans have always covered transition-related care, so there was no cost to add the benefit. One of these two employers stated their plan (a managed care/HMO plan) has been in place since the mid 1990s. Their coverage for transition-related health care has been in place since plan inception and is explicitly described in the health plan documents. The other employer's plan (self-insured) has been in place for at least 30 years and has no exclusion on transition-related care. Though coverage is not explicitly described in the plan documentation they provided for this study, they reported that certain transition-related health care benefits have been covered through this plan since the mid 1980s. Three of the 22 employers who reported no costs to adding the coverage (all three self-insured) stated the projected cost of adding the benefit was too small to justify an increase. One of these employers (~26,000 employees) explained, "Our analysis indicated that the cost would be quite small. We price based on past year costs with adjustments for estimated increases. This was too small to adjust for." Another employer (~1,500 employees) similarly explained, "The actuarial impact of adding this benefit was

deemed negligible enough not to warrant a budget adjustment." The third employer (~1,600 employees) explained, "We looked at projected cost based on aggregate of total claims projected - increase was de minimis - .2% or \$26,000."

"The actuarial impact of adding this benefit was deemed negligible enough not to warrant a budget adjustment."

Reported Actual Costs Based on Utilization (n=7)

Seven employers reported they incurred costs directly related to employee utilization of the transition-related health care benefit. Six of these seven employers provide transition-related health care coverage through self-insured plans and chose to absorb any costs associated with the benefit. One of the seven provides the coverage through several plan types. Three of these seven employers (each self-insured) offered more specific information on the actual costs they incurred. Only one of these employers was able to provide actual cost in dollars of transition-related claims under their health benefits plan. This employer (~10,000 employees) reported that transition-related claims cost just under \$5500, or 0.004 percent of total health care expenditures, over two years. This employer's plan covers just over 21,000 individuals (employees and dependents) and total health care expenditures over the same two years were \$144 million.

Two other employers gave a general impression of the costs they have incurred for transition-related claims, but did not provide enough information about their costs and their total health care expenditures in order to calculate the actual total cost in dollars. One employer (~5,000 employees) reported that the cost of the benefit was "negligible" and less than 1 percent of total health care expenditures over one year. Another employer (~2,000 employees) reported that claims paid on the benefit were "minimal" and represented less than 1 percent of total claims paid under the plan over one year.

Reported Actual Costs to Add Coverage Based on Projections (n=4)

Costs based on projections are the result of actuarial predictions of the utilization of transition-related health care benefits and what the actual cost of those claims will be. Four employers reported increased costs based on projected

utilization of the benefit. Three of these four employers cover transition-related health care through self-insured plans. The remaining employer provides a fully-insured plan. The three employers with self-insured plans provided some information about their cost increases. One of these three employers (~38,500 enrolled employees) reported a total projected increase to the plan of \$100,000 per year for providing the benefit, which is substantially less than 1 percent of total health care expenditures. To date, this employer has not verified the actual expenditures for this benefit. Any actual utilization will be included in future plan costs, and, therefore, reflected in premium rates.

One employer (-1,600 employees) reported that the total premium cost per member per month of \$485 was increased \$5 due to adding transition-

related coverage; an increase of about 1 percent. This increase occurred in the first year and will be included in future premiums as well. At a rate of \$5 per employee per month, this would be a total annual increase of about \$94,000 each year. This employer chose to absorb the cost of this increase, meaning employee premiums were not increased to cover the cost, and believes the benefit has not been utilized.

The remaining employer (-1,300 employees) did not provide dollar amounts in regard to the increase, but reported that their one transition-inclusive plan, their high deductible health plan, increased in cost by 1 percent as a result of adding the coverage. The employer absorbed the cost of this initial premium increase and believes the benefit has not been utilized. Future premiums will be adjusted based on review of actual health plan costs.

UTILIZATION OF TRANSITION-RELATED HEALTH CARE BENEFITS

Eighteen employers were able to provide answers to survey questions about utilization of their transition-related health benefits. Of these eighteen, three reported they had confirmed with their insurer or TPA that the benefit had not been utilized. These three employers represent over 28,000 full-time active employees, nearly 128,000 covered lives, and five and a half combined years of transition-related health care coverage experience. Five employers reported they believed the benefit had not been utilized, but were unable to confirm with their insurer or TPA. Six employers reported the benefit had been utilized and were able to provide utilization data. Four reported utilization but were not able to provide any data about the utilization. In addition to those employers that provided information about utilization, four employers reported that employees had inquired about the benefit. The remaining employers in the sample did not provide any information regarding utilization about the benefit or benefit inquiries.

Table 8 provides the average annual utilization per thousand employees for three sets of employers, using calculations similar to the 2009 HRCF study.³⁴ The number of employers included in the calculations for Table 8 differs slightly than the numbers of employers described in the prior paragraph. One of the six employers that provided utilization data is not included in Table 8, since that employer expressed their utilization as a percentage

of all claims instead of a number of claims/claimants. Therefore, the employer did not provide data that could be compared to the other employers. Two of the five employers who reported that they believed there had been no utilization had the benefits in place for less than one year at the time of the survey. Due to the short timeframe for their transition-related coverage, these two employers were not included in the calculations for Table 8.

The top two rows of Table 8 provide “lower bound” average annual utilization rates, which includes employers who reported the benefit had been utilized and provided actual utilization data (5 employers), employers who confirmed with their insurer or TPA there had been no utilization (3 employers), and employers who believed the benefit had not been utilized without confirming with their insurer or TPA (3 employers). The middle two rows of Table 8 provide the “preferred” average annual utilization rates, which includes the three employers that confirmed they had no utilization and the five employers that provided actual utilization data. These rates are considered the “preferred” rates because they reflect all confirmed utilization data from our surveyed employers. The bottom two rows of the table include only those five employers that provided actual utilization data, which comprises the “upper bound” average annual utilization rates. One employer of less than 1,000 employees confirmed they had no utilization of the benefit.

Unfortunately, that is the only confirmed data point we have for employers of that size. We had no data points for our four largest employers, those with 50,000 or more employees.

Table 8: Average Annual Utilization Per Thousand Employees, by employer size

	Less than 1,000	1,000 to 9,999	10,000 to 49,999	50,000 +
# Employers with or without utilization (incl. unconfirmed)	2	4	5	—
Adjusted rate (lower bound)	0.000	0.027	0.044	—
# Employers with or without utilization (confirmed only)	1	2	5	—
Adjusted rate (preferred rate)	0.000	0.107	0.044	—
# Employers with utilization only	—	1	4	—
Adjusted rate (upper bound)	—	0.214	0.054	—

For employers with 1,000 to 9,999 employees, average annualized utilization was 0.107 claimants per thousand employees, with a lower bound of 0.027 and an upper bound of 0.214. For employers with 10,000 to 49,999 employees, average annualized utilization was 0.044 claimants per thousand employees, with an upper bound of 0.054. As an example of future projections based on these findings, using the preferred utilization of 0.044, an employer with 20,000 employees would see, on average, one claimant utilizing the transition-related health care benefit every 14 months. This projection is based on the “preferred” rate for similarly-sized employers, so this projection may not apply to much larger or much smaller employers, as Tables 2 and 8 suggest.

One employer was able to provide annualized transition-related surgical claims data for one of their transition-inclusive health benefits plans. For this one plan, the employer provided the number of surgical claims for gender transition that were completed in a given plan year and the number of enrolled employees for each plan year. These data are presented in Table 9. On average over five years, just over 47,000 employees enrolled in this plan and 0.06 surgical claims related to gender transition were completed per thousand enrolled employees each year. In other words, on average, there were three transition-related surgical claims per year in this plan. Notably, the highest annual utilization is found in the fourth year (2010) and

the second-highest in the fifth year (2011). Due to limitations in data available to this employer, enrollment figures do not include employees’ dependents that were enrolled in the plan, though surgical claims included here could have been for covered dependents. Furthermore, the employer noted that these data are for individual surgical procedures and one person could have had more than one transition-related surgical procedure. Therefore, these data should be understood as individual claims, but not individual claimants.

It is also important to note that these utilization figures are not comparable to utilization experienced by an employer with a similar number of employees (~47,000). This employer provides other transition-inclusive plans in which other employees elected to enroll. When viewed in the aggregate (if complete data were available), it is likely that the total utilization rate for all plans would resolve to a lower number. Partial data provided on the employer’s other transition-inclusive plans suggest that this plan, for which we have data, may have the highest utilization of transition-related benefits of all plans, and, therefore, likely represents a “worst case” in terms of the number of claims. Average annual utilization based on partial data for the plan with the second-highest reported utilization was 0.03 surgical claims per thousand enrolled employees.³⁵

Table 9: Surgical Claims, one employer plan by year

	2007	2008	2009	2010	2011	Annual Average
Total enrolled employees (dependents not included)	50,267	49,210	47,370	45,262	44,557	47,333
Surgical claims per thousand enrolled employees	0.06	0.06	0.04	0.09	0.07	0.06

Of the six employers who provided information about the utilization of the transition-related health care benefit, three provided data on how many individual claimants had utilized the benefit and the total number of covered lives (employees and dependents) in their transition-inclusive plans. This data provides the most accurate denominator to assess demand for transition-related health care benefits because it includes all individuals who are eligible to submit transition-related claims. Table 10 shows the average annual utilization for these three employers. These employers range in size from 10,000 to 15,000 full-time active employees, have only fully-insured plans, range from 22,000 to 45,000 total covered lives in their transition-inclusive plans, and have a combined 15 years of transition-inclusive health benefits coverage experience. Based on the highest utilization

rate found in Table 10, an employer with 25,000 covered lives in transition-inclusive plan could expect, on average, one claimant per year to utilize the transition-related health care benefit.

Table 10: Average Annual Individual Claimants per Thousand Covered Lives, Transition-Inclusive Plans

Employer	Average Annual Utilization
Employer 1	0.04
Employer 2	0.02
Employer 3	0.01

Four employers reported that there have been recent inquiries about the benefit, but none have yet resulted in utilization of the benefit. These inquiries represent 2 total inquiries per thousand

full-time active employees for the smallest employer (less than 1,000 employees) to 0.019 for the largest employer (greater than 50,000 employees). It should be emphasized that inquiries may or may not result in actual utilization of the benefit in the future and cannot be used as reliable predictors of future utilization.

Table 11: Current Inquiries Per Thousand Employees by Employer Size

	Less than 1,000	1,000 to 9,999	10,000 to 49,999	50,000 +
# Employers	1	1	1	1
Current Inquiries	2.000	0.248	0.133	0.019

EMPLOYER-REPORTED EXPERIENCES WITH TRANSITION-RELATED COVERAGE

Employers were asked in the survey why they decided to provide the benefit, any barriers they experienced to adding the benefit, what benefits they receive by providing the coverage, and what advice they would give to other employers who are considering adding transition-related health care coverage to their employees' health benefits plans.

Reasons for Adding Coverage

Thirty-two employers responded to the survey question which asked why their business decided to provide transition-related health care for their employees. These employers provided a variety of responses. The most frequent response, with 47 percent of responses, was that employers provide the coverage to reflect their values. One employer remarked, "As a firm that highly values diversity, this was an essential step for us to take to demonstrate complete support for our LGBT population." Another explained, "Inclusion and diversity is very important to our business."

Eleven employers (34%) reported that they added the benefit to meet the needs of current and future employees. A few employers explained:

- "It is important to [us] to offer a benefits package to our employees that is competitive with the market and that is inclusive in addressing the needs of our diverse employee population. We felt that including a transition related health care provision was key to achieving this."³⁶
- "[Our firm] strives to provide high value, wide

ranging benefit opportunities that are relevant to our [employees]."

- Finally, one employer said they added the benefit to "provide an important healthcare benefit to current and prospective employees."

Employers provided a variety of other reasons for adding transition-related health care coverage. Eight employers (25%) said they added the benefit to remain competitive within their industry. Six employers (19%) added the benefit because employees had requested the benefit be added. Six employers (19%) responded that they added to benefit to maintain a 100 percent rating in the Corporate Equality Index, which was described as an important indicator of an employer's

support for the LGBT community. Other employers responded that they wished to provide high value, current benefits (6%), they wanted to show support for the LGBT community and diversity (9%), a desire to meet WPATH standards (3%), and one employer said they took a cue from other employers in their industry that had added the benefit. One employer simply stated, "It was the right thing to do."

"It was the right thing to do."

Barriers to Adding Coverage

The survey asked employers to respond to the following question: “Were there significant barriers (either internally, for example by benefits providers/administrators, or externally, for example by regulators or insurance boards) to adding transition-related health care coverage to your business’s health benefits?” Of the 33 employers responding to this question, 31 employers (94%) reported that there were no significant barriers to adding the coverage. One of the two employers who did report barriers explained:

“Some of the [executives] did not agree with adding this coverage. It is difficult to educate people about gender dysphoria. In addition, we are self-insured for [our] medical plans and use [our medical claims administrator’s] Medical Policies to govern covered procedures. When reviewing [the] medical policy on gender reassignment surgery, we found that the policy did not cover certain...

procedures required by the WPATH guidelines. [We] instructed [them] to augment the Medical Policy...to include all...

surgery services and supplies that the patient’s doctor determines to be medically necessary.”

The other employer reported they had to make repeated requests to their health insurance provider over several years to finally get them to provide the coverage.

The survey asked employers how they overcame the significant barriers to adding the coverage. The first employer described above noted, “This proposal was bundled with other changes related to our LGBT employees. It may not have been possible to get it approved as a stand-alone proposal because people don’t understand the nature of gender dysphoria. But the costs are so minimal...it was hard for [them] to argue against it.” Two other employers, who did not report significant barriers, offered their responses on how they were able to add the coverage. One remarked, “This was supported at the highest levels of the organization, so no barriers there. [We] worked with our health care provider to understand implications.” The other said they were able to add the benefit “by making a strong business case and researching what our peer firms were offering in terms of transition-related health care.”

Benefits of Adding Coverage

The survey asked employers to describe any benefits they receive for providing transition-related health care benefits for their employees. Like prior research on LGBT workplace policies, these

responses also reveal positive benefits to employers for providing transition-inclusive health benefits. Twenty-five employers described benefits they receive from providing transition-inclusive health benefits plans. Fifteen employers (60%) stated that providing the benefits made them more competitive as an employer and would improve recruitment and retention. One employer explained:

“[Our firm] seeks to be an employer of choice in [our] profession and coverage for transition-related health care may help us to retain and/or recruit the best available talent in the industry. We are broadening our search for talent to include more diverse perspectives, which in turn, will contribute to the diversity of the knowledge capital we provide our clients. This deliberate search for diverse talent must be met with an equally compelling effort to be the best employer we can for our talented pool of...professionals, which includes offering relevant benefits.

One employer explained, “It is in keeping with our philosophy of being all inclusive, non-discriminatory, and ‘leading edge’.”

Other employers echoed similar perceived benefits to recruitment and retention. Others added that providing the benefit allows them to be competitive as an employer. One employer remarked, “We also believe this keeps us competitive with other firms that have similar values.”

Equally important to employers, fifteen (60%) stated that providing the benefit is a matter of equality or fairness, which reflects their values. One employer listed three ways providing this benefit reflects their values: “Supporting fairness through our actions. Communicating commitment to broad diversity values. Inclusive view of supporting the health and well-being of our employees.”

Twelve employers (48%) stated the benefit provides for the needs of their employees and improves employee satisfaction and morale. One employer explained that “although a relatively small population would take advantage of the benefits, we felt it was a quality of life issue for them.” Another employer highlighted the need to provide medically necessary care for employees and allay worries about costs:

The most important benefits of providing coverage for transition-related health care in our benefits plans include:

- 1. provides necessary medical benefits for transitioning employees;*
- 2. allows employees and managers, etc. to work collaboratively through the process; and*
- 3. reduces employee concerns about medical costs.*

Eleven employers (44%) stated that the benefit supports their commitment to diversity, supports a diverse workforce, and/or attracts diverse employees. Four employers (16%) believe providing the benefit signals to LGBT people and the general public that the employer supports the LGBT community and wants to attract talent and/or consumers from the LGBT community. Two employers (8%) said providing the benefit puts them on the “leading edge” among employers. One employer explained, “It is in keeping with our philosophy of being all inclusive, non-discriminatory, and ‘leading edge’.”

“Provide the coverage as it not only is minimal in cost but does provide employee satisfaction, morale and is becoming covered more often in certain industries.”

Advice to other Employers Considering Adding Coverage

Finally, employers were asked to respond to the following question: “If another business asked your business for advice on whether to begin providing coverage for transition-related health care for their employees, what advice would you give them?” Twenty-five employers responded to this question. Some offered simple encouragement to provide the benefit, while others offered practical advice to other employers. Notably, no employer advised against providing transition-related health benefits for employees.

Thirteen employers (52%) said they would encourage the business to add the benefit. Employers provided encouragement for a variety of reasons, such as:

- “[T]hey should pursue this. The costs are nominal and their reputation in the LGBT community and with LGBT employees will be enhanced.”
- “Provide the coverage as it not only is minimal in cost but does provide employee satisfaction, morale and is becoming covered more often in certain industries.”
- “It seems to have been a non-issue for us; advise going ahead with implementation.”
- “Providing coverage for transition-related health care has tremendous benefits for employees and the business.”

One employer described five reasons why businesses should provide this coverage for their employees. They explained:

Yes, add this benefit because it is a low cost, high value proposition for employees.

1. *This benefit is low cost because it is aimed at a small population who will access the benefits.*
2. *Generally, when the benefit is utilized the cost is much less than treatment for diabetes, asthma...and the like.*
3. *Cost of coverage will not impact your benefit budget either because the utilization is low.*
4. *Makes many positive statements to existing and prospective clients, employees, industry and community.*
5. *Adding this benefit says: We are socially responsible. We have vision. We are ahead of the curve. We can help you make a difference. We embrace diversity in our employees. Come work for us.*

Fifteen employers (60%) offered practical advice to other employers considering adding this coverage, ranging from how to handle internal communications to strategies for negotiations with insurance providers. First, five employers (20%) suggested businesses assess whether adding the coverage is consistent with their values and practices of their competition. One employer suggested that the business “consider their philosophy regarding the value of a diverse workforce, being an employer of choice, and of delivering a comprehensive health care plan.” Four employers (16%) suggested getting the support of employees and employee resources groups to help argue for the change internally. Three employers (12%) suggested working to get the support of management and executives and that promoting the business case for adding the coverage could be a part of these communications. Two employers (8%) stressed the importance of doing education and communication about the importance of providing the benefit. To the contrary, one employer suggested working internally in a quiet, “low key” manner, so as not to provoke any opposition from employees. Having faced some internal opposition, two employers (8%) advised to ignore “squeaky wheels” or those who try to thwart the inclusion of the benefit. As one employer put it, “Move forward with conviction. Find allies at the executive level, as well as within the employee population. Don’t let squeaky wheels derail.”

Eleven employers (44%) offered their advice on how to negotiate with insurers and TPAs to add the benefit. Five employers (25%) suggested working with insurers and TPAs to discuss the coverage they can offer and to address shortcomings in their medical guidelines, if necessary. Two employers offered the following advice:

- “They have to read their provider’s medical policy closely to assure it is compliant with WPATH standards, or as we did, create an exception to their policy for these diagnoses.”

- “Do your research and talk with employers who have the benefit. Look within your own industry and see who else offers the benefit. Look at different options for the plan design and follow the WPATH guidelines.”

Employers also advised the business to understand the costs of adding the coverage (12%). Understanding costs would assist in negotiating with the benefits provider to add the transition-related coverage at no cost, as one employer advised. Two employers (8%) advised

working with health benefits providers to provide competent customer service for their members:

- “Stress to the carrier they must have well-trained customer service staff to handle the questions from members.”
- “Have your carrier provide an informational sheet to provide to employees that inquire about the benefit, who they can call with questions, etc.”

Advice surrounding customer service may point to a need among health benefits providers to train staff on transition-related health care benefits.

CONCLUSION

This study provides notable findings about the transition-related benefits that employers are providing for their employees, the utilization and cost of these benefits, and what benefits employers report of providing this type of coverage. Overall, we find that transition-related health care benefits are low in cost due to low utilization yet can provide benefits for employers and employees alike.

In regard to the health benefits employers are providing, we found that many employers do not provide their employees with coverage for medical treatments or procedures that the WPATH *Standards of Care* describe as medically necessary if clinically indicated for an individual. As noted earlier, it is possible that some of the listed procedures were not available as part of the insurance products fully insured employers could purchase. It is also possible that coverage is limited to standardized insurance industry internal medical or clinical guidelines, upon which particular health benefits plan administrators rely to determine coverage. These guidelines may not include certain medical treatments or procedures. However, based on employer statements regarding negotiations with TPAs, self-insured employers may argue for the changes necessary to bring their plans into alignment with the WPATH *Standards of Care*. Fully-insured employers can request that their health insurance providers add this coverage to their plans. Clearly, as indicated in employer statements, the WPATH standards have been helpful for some employers when crafting their plans.

Costs of providing transition-related health care coverage seem very low, including for employers that cover a wider range of treatments or procedures for transition. Twenty-two surveyed employers (85%) reported no costs associated with adding the benefit, with 10 of those 22 saying there have been no subsequent costs due to utilization. For three employers reporting actual costs due to utilization, they report that the costs are very low:

- In one case, actual costs over two years comprised only 0.004 percent of total health care expenditures.

- The other two employers characterized the costs as “negligible” and “minimal” at less than 1 percent of total costs or claims paid.

In this sample, there is no relationship between the scope of the transition-related health care benefit and the cost of the coverage and there is no difference in reported costs between plans with broader coverage and plans with more limited coverage.³⁷

When employers reported cost increases based on projected utilization, these projections seem high in comparison to costs reported from other employers and findings related to cost from prior research and may reflect an actuarial overestimate of the utilization of these benefits and the subsequent cost of claims. Two employers reported a 1 percent increase in total cost to their transition-inclusive plans, based on projected costs. This 1 percent increase seems high in comparison to the two similarly-sized firms that reported “minimal” and “negligible” actual costs that were less than 1 percent of total health plan costs or claims paid. In prior research, larger employers reported premium increases due to projected costs that ranged from 0.08% to 0.20% of total health plan costs.³⁸ Therefore, a full 1 percent increase in total cost to the plan does seem high in comparison to similarly-situated employers in this survey and those described in prior research.

Examining these increases based on what we know about utilization also reveals that these increases seem high. In the case of one of these employers, the 1 percent increase amounts to \$94,000 annually. However, based on this employer’s size (~1,600 employees) and using the highest observed

utilization rate for employers of that size (0.214), we would predict, in a “worst case,” this employer would have one claimant for transition-related health benefits every three years. If the \$94,000 increase is carried over annually, they would have predicted a cost of \$282,000 for one claimant over three years. Based on prior research, the highest transition-related claim that occurred at the University of California was \$86,800, with an average cost per claimant of \$29,929.³⁹ Therefore, this 1 percent increase also seems high when we consider predicted utilization.

Another employer reported a projected cost increase of \$100,000 annually for adding transition-related health care coverage to their plan, which is substantially less than 1 percent of their total health care expenditures. This employer (a private employer) has about 38,500 employees enrolled in the plan and, based on the “worst case” utilization rate for similarly-sized employers (0.054), could expect two claimants for transition-related benefits every year. According to prior research, the City and County of San Francisco paid \$386,417 over five years for transition-related claims for about 100,000 covered lives in their plan.⁴⁰ This means, on average, San Francisco spent about \$77,000 annually on transition-related claims. For the fiscal year ending June 2012, San Francisco reported about \$620 million in health care expenditures.⁴¹ The lowest possible annual utilization found in prior research on San Francisco is 0.074 per thousand employees, which is higher than the 0.054 observed “worst case” for similarly-sized private employers in this study. The employer with the projected \$100,000 cost is of a similar size to San Francisco, in terms of total covered lives in their plan. Their annual increase of \$100,000, therefore, may be slightly high given the experience of San Francisco, which we would predict would have higher benefit utilization than a similarly-sized private employer. However, future premium adjustments based on reviews of actual costs may be able to correct for any overestimate. In any case, the relative cost of transition-related health care benefits is quite low relative to total health plan expenditures.

In terms of utilization, very few people will access transition-related health care benefits when they are provided. Our findings in regard to utilization generally fit with the ranges of utilization found in prior research, though our lower bound rate was lower for one set of employers. Our study found that for employers with 1,000 to 9,999 employees, average annual utilization was 0.107, with a lower bound of 0.027 and an upper bound of 0.214 claimants per thousand employees. Prior research of private employers with 1,000 to 9,999 employees ranged from 0.074 to 0.220 claimants per thousand

employees. All of the employers in this size category in our study were also private employers.

For employers with 10,000 to 49,999 employees, we found the average annual utilization rate was 0.044, with an upper bound of 0.054 claimants per thousand employees. These findings include both public and private employers and fit within the utilization ranges found in prior research on both types of employers. Prior research found utilization for private employers of this size to be 0.016 to 0.060 claimants per thousand employees and for public employers of this size to be from 0.022 to 0.200 claimants per thousand employees. Our findings fit well within these ranges. Therefore, our study appears to provide further confirmation of prior research on utilization, which can serve as a useful guide to employers who are considering adding transition-related health care coverage.

Overall, we find that transition-related health care benefits are low in cost due to low utilization yet can provide benefits for employers and employees alike.

Prior research shows employers generally benefit from providing LGBT-inclusive workplace policies. Studies found increased job satisfaction and productivity for employees, improved health outcomes among LGBT employees, improved workplace relationships, and employers improved bottom lines by providing LGBT-inclusive workplace policies.⁴² Our findings from this study suggest that employers that provide transition-related health care coverage may benefit in similar ways. Employers reported that they provide the coverage to help them with recruitment and retention of employees, make them competitive as an employer within their industries, provide for the health care needs of their employees, and demonstrate their commitments to inclusion and diversity, among other reported benefits. It is notable that a majority of employers would encourage other employers to add the coverage and none would advise against adding the coverage.

Employers also provided practical guidance to other employers to aid them in adding the coverage for their employees. First, employers recommended that employers work with their insurers and TPAs to discuss the coverage they can offer and to address any shortcomings in their medical guidelines. Second, employers suggested doing research and consulting with other employers that provide the coverage to better understand costs they may incur and to be better informed when negotiating with their insurers. Finally, employers recommended working with benefits administrators to make sure they are providing competent customer service to employees who inquire about the benefits.

LIMITATIONS

This study has limitations that should be noted. Because this study is based on a survey, it has similar limitations to all survey research in that the data are self-reported and subject to respondent recall. The sample size for the survey was 34 employers, which is roughly 11 percent of the employers known to provide transition-related health care benefits for employees. Therefore, these findings may not be representative of the experiences of other employers that provide this coverage. Additionally, respondents to this survey were limited by the information or documentation available to the respondent at the time of the survey. For instance, many respondents were unable to provide specific answers about the utilization of the transition-related health care benefit due to a lack of available data. Several respondents were not able to describe the health benefit plan provisions or provide plan documentation. Employers that were able to provide information about utilization and costs did not do so in a uniform manner, which makes comparisons difficult. For instance, one employer was able to provide actual costs in dollar amount along with the total health plan costs over the same period of time the costs were incurred. However, other employers expressed costs as a vague percentage of total claims paid or total health care expenditures ("less than 1%"). These responses did not allow for comparison to other employers where actual costs were known.

In terms of utilization, all employers provided the number of full-time employees but many did not provide the total number of covered lives in their plans. While the latter would have provided a more accurate denominator to assess demand for transition-related health care, we were only able consistently to use full-time employees as a denominator since that was the only data point all employers provided. When possible, comparisons were presented above to provide context for our findings, but on occasion we were only able to describe the particular situation of a single employer.

This study also is limited by the number of years that employers have provided transition-related health care benefits. Since the benefit is relatively new among most employers, some employers had only a year or two of experience to draw on to answer the survey. In some cases, this short time frame helped in providing useful data on how this policy change came about and the cost to add the benefit for that particular employer, since these changes happened recently and the same staff members involved in adding the benefit were still on staff at the time of the survey. However, a short time frame does not allow the respondent to be able to discuss changes in plan structure, cost, utilization, and negative or positive impacts to the business over time. Furthermore, this study wasn't able to look at the cost savings in the long run of providing medically necessary care for employees in need of care for gender dysphoria.

CONSIDERATIONS FOR FUTURE RESEARCH

Findings from this report also point to considerations for future research on experiences providing this benefit and what impact providing the benefit may have on employees and employers. Researchers may want to consider the impact on employees, and by extension their employers, of not providing coverage for certain transition-related health care that may be deemed medically necessary when clinically indicated for an individual, according to the *WPATH Standards of Care*. For instance, according to the *WPATH Standards of Care*, facial hair removal through electrolysis or laser may be deemed medically necessary for some individuals as part of their individualized treatment plan for gender dysphoria. Facial hair removal for a person transitioning from male to female may be medically necessary to treat the skin of the face and neck to eliminate masculine secondary sex characteristics and bring this person's body into alignment with her gender identity, which is the

goal of treatment for gender dysphoria. Seventy-six percent (76%) of employers that participated in this survey exclude coverage for facial hair removal in their health benefits plans. Not only does this mean that an employee may not be able to receive medically-necessary care, unless they are able to pay out of pocket, but the exclusion also may have related negative impacts for that employee, and by extension, her employer. For instance, a recent study found that transgender women who have had electrolysis or laser hair removal were less likely to experience harassment in public spaces than those who had not had electrolysis or laser hair removal.⁴³ Experiencing harassment may have a negative impact on an employee's productivity and workplace relationships, but it may also have a negative impact on the success of a person's treatment for gender dysphoria. More research on the impact on employees of not providing certain coverage can provide valuable information for

employers when considering the scope of their health benefits plans by describing the full range of costs that may be associated with exclusions.

Related to the above suggestion for future research, researchers should examine the long-term cost savings to employers that result from providing medically-necessary care for their employees. Prior research suggests that there are positive impacts on mental and physical health that result from individuals receiving the care they need for gender dysphoria.⁴⁴ To the extent that these positive impacts result in reduced need for health care related to untreated gender dysphoria, cost savings can accrue over time. For instance, if an individual experiences improved mental health as a result of receiving medically necessary care for gender dysphoria, this may result in reduced costs related to mental health services for that individual. Research on these long-term cost savings would provide helpful information to employers on the true costs and benefits of providing transition-related health care coverage.

Finally, more research is needed with employers who have a long history of providing transition-

related health care benefits to employees. These employers are uniquely positioned to provide an understanding of the long term costs and benefits of providing this coverage and may help refine actuarial estimates of utilization and cost. Not only may they have better, longitudinal data on the utilization and cost of the benefit, they may also provide insight on measureable positive and negative impacts on their business, including the impact on employee job satisfaction, workplace climate and relationships, productivity, and the impact on their business's bottom line. Research conducted with these employers would help provide a better forecast for companies who have recently added the benefit or are considering adding it in the future. However, because employers may have limited access to data from their TPAs or health insurance providers, or may not be willing to share that data if they have it, future research should also focus on accessing larger claims databases that would contain data from multiple employers. Since the number of employers providing transition-related health care coverage is increasing, databases of major insurers and administrators may have compiled sufficient data for analyses in the near future.

About the author

Jody L. Herman is the Peter J. Cooper Public Policy Fellow and Manager of Transgender Research at the Williams Institute, UCLA School of Law. She holds a PhD. in Public Policy and Public Administration from The George Washington University.

Acknowledgements

The author would like to thank **Jamison Green, PhD**, and **André Wilson, MS**, of **Jamison Green & Associates**, who served as consultants and invaluable advisors on this project. Their ingenuity, creativity, dedication, and persistence have – among numerous other accomplishments – defined and developed this area of research and provided the foundations upon which this report is built. The author would also like to thank Brad Sears, M.V. Lee Badgett, Christy Mallory, Erin Fitzgerald, Becky Mengel Freund, Matt Strieker, and Hamid Jahangard for their contributions to this project, and Anonymous, who provided funding to support this research.

Without the 34 employers who participated in our survey, this study would not have been possible. We express our thanks and gratitude to all 34 employers, including the following:

- Alcoa, Inc.
- AOL Inc.
- Baker & McKenzie LLP
- Best Buy
- CA Technologies
- Choice Hotels International
- Chrysler Group LLC
- Chubb Group of Insurance Companies
- City of Seattle
- GlaxoSmithKline
- O'Melveny & Myers LLP
- Patterson Belknap Webb & Tyler LLP
- Paul Hastings LLP
- Paul, Weiss, Rifkind, Wharton & Garrison LLP
- The University of California

For more information, contact:

The Williams Institute

UCLA School of Law
Box 951476
Los Angeles, CA 90095-1476
T (310)267-4382
F (310)825-7270
williamsinstitute@law.ucla.edu
<http://williamsinstitute.law.ucla.edu>

Notes

- 1 Human Rights Campaign. 2013. *Corporate Equality Index 2013*. Washington, DC: Human Rights Campaign, available at http://www.hrc.org/files/assets/resources/CorporateEqualityIndex_2013.pdf (last accessed July 10, 2013).
- 2 Based on a review conducted for this study of cities, counties, and universities that are known to provide coverage for transition related health care benefits for their employees, the following list of employers was compiled: the City and County of San Francisco; the cities of Berkeley, Long Beach, Minneapolis, New York, Philadelphia, Portland, Seattle, and St. Paul; Multnomah County, OR, and Macomb County, MI; American University, City University of New York, Cornell University, Harvard University, Massachusetts Institute of Technology (MIT), Northwestern University, Princeton University, Syracuse University, University of California (all campuses), University of Michigan, University of Minnesota, University of Pennsylvania, University of Vermont, and Yale University. Notably, HRC has begun rating municipal employers in a similar manner to the Corporate Equality Index. HRC's Municipal Equality Index is available at http://www.hrc.org/municipal_equality_index#.Ui_eAMasiVY (last accessed September 9, 2013).
- 3 Cal. Code Regs. tit. 10, §§ 2561.2, 2561.2 (2013); Brent A. Barnhart, Director, Cal. Dep't of Managed Health Care, Letter No. 12 K, Gender Nondiscrimination Requirements (Apr. 9, 2013), available at <http://transgenderlawcenter.org/wp-content/uploads/2013/04/DMHC-Director-Letter-re-Gender-NonDiscrimination-Requirements.pdf> (last accessed August 15, 2013); Williams P. White, Comm'r, Colo. Dep't of Reg. Agencies, Bulletin No. B 4.49, Insurance Unfair Practices Act Prohibitions on Discrimination Based on Sexual Orientation (Mar. 18, 2013), available at http://www.one.colorado.org/wp-content/uploads/2013/03/B_4.49.pdf (last accessed August 15, 2013); D.C. Dep't of Ins., Bulletin No. 13 IB 01 30/15, Prohibition of Discrimination in Health Insurance (Mar. 15, 2013), available at http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/Bulletin13_IB_01_30_15.pdf (last accessed August 15, 2013); Louis D. Savage, Ins. Comm'r, Or. Ins. Div., Bulletin No. INS 2012 01, Applications of Senate Bill 2 (2007 Legislative Session) to Gender Identity Issues in the Transaction and Regulation of Insurance in Oregon (Dec. 19, 2012), available at http://www.cbs.state.or.us/ins/bulletins/bulletin2012_01.html (last accessed August 15, 2013); Susan L. Donegan, Comm'r, Dep't of Fin. Reg., Bulletin No. 174, Guidance Regarding Discrimination on the Basis of Gender Identity Including Medically Necessary Gender Dysphoria Surgery and Related Health Care; Withdrawing and Superseding Insurance Division Bulletin No. 153, Banking Division Bulletin No. 30, and Health Care Division Bulletin No. HCA 124 (Apr. 22, 2013), available at http://www.dfr.vermont.gov/sites/default/files/Bulletin_174.pdf (last accessed August 15, 2013).
- 4 Change to Human Rights Campaign, see note #1.
- 5 GLMA: Health Professionals Advancing LGBT Equality. 2013. *Compendium of Health Profession Association LGBT Policy & Position Statements*, available at http://www.glma.org/data/n_0001/resources/live/GLMA%20Compendium%20of%20Health%20Profession%20Association%20LGBT%20Policy%20and%20Position%20Statements.pdf (last accessed July 10, 2013).
- 6 American Psychiatric Association. 2012. *Position Statement on Access to Care for Transgender and Gender Variant Individuals*, available at http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2012_TransgenderCare.pdf (last accessed July 10, 2013).
- 7 Some employers do not provide a defined benefit for transition related care, but rather have no exclusion for this care and coverage is provided in the same manner as all other health care that is deemed medically necessary.
- 8 Coleman, E., Bockting, W., Botzer, M., Cohen Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., Lev, A. I., Mayer, G., Meyer Bahlburg, H., Hall, B. P., Pfaefflin, F., Rachlin, K., Robinson, B., Schechter, L. S., Tangpricha, V., van Trotsenburg, M., Vitale, A., Winter, S., Whittle, S., Wylie, K. R., & Zucker, K.. 2011. "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7." *International Journal of Transgenderism*, 13: 165-232.
- 9 *Id.*
- 10 The ULCA North General Institutional Review Board (NGIRB) determined this study is not human subject research and, therefore, not subject to IRB review.
- 11 City and County of San Francisco and San Francisco Human Rights Commission. 2007. *San Francisco City and County Transgender Health Benefit*, available at http://www.hrc.org/files/assets/resources/San_Francisco_City_and_County_Transgender_Health_Benefit_2007_08_10.pdf (last accessed August 1, 2013).
- 12 According to Jamison Green & Associates, when the Transgender Health Benefit was added to the San Francisco City and County plan in 2001, other unrelated changes in the plan resulted in a reduction of \$5.95 in monthly premium charges to employees, and even greater reductions for retirees with and without Medicare.
- 13 Department of Insurance, State of California. 2012. *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, available at http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic_Impact_Assessment_Gender_Nondiscrimination_In_Health_Insurance.pdf (last accessed August 1, 2013).
- 14 *Id.*
- 15 *Id.*
- 16 *Id.*
- 17 *Id.*
- 18 Department of Insurance, State of California, see note #13; Jamison Green & Associates. 2012. *Transgender Inclusive Health Benefits: Data for Cost Calculation*. Presented by Andre Wilson of Jamison Green & Associates to the Department of Insurance, State of California, February 2012. For Table 1, for the City and County of San Francisco and the University of California, the maximum and minimum reported utilization per year means the utilization in the year in which the highest utilization per thousand employees was observed and the utilization in the year in which the lowest utilization per thousand employees was observed. For private employers, the maximum and minimum utilization per year means the highest observed annual utilization and the lowest utilization out of the sample of individual employers. Figures for the City and County of San Francisco are taken from Jamison Green & Associates, February 2012. The Department of Insurance incorrectly cited 0.325 as the maximum utilization for private employers. The correct utilization figure, 0.22, is reported here, per Jamison Green & Associates, February 2012.
- 19 Jamison Green & Associates, see note #18.
- 20 *Id.*
- 21 Department of Insurance, State of California, see note #13. For the University of California, the lowest utilization per thousand employees per year (0.022) was observed in 2006. The highest utilization per thousand employees per year (0.187) was observed in 2009.
- 22 Jamison Green & Associates, see note #18.
- 23 The University of California (UC) currently offers five health benefits plans. All five plans include coverage for transition related health care, including surgical claims. The health benefits plan included here currently covers 38 percent of enrolled employees in all plans. The Department of Insurance for the State of California report (see note #13) does not provide information to assess utilization in other UC plans. Therefore, we cannot assess whether utilization in the plan reported here is higher or lower than other UC plans. It is possible, therefore, that this plan may represent a disproportionately higher or lower number of claims within the UC system.
- 24 Number of employees shown is the number of enrolled employees for one of the University of California's health benefits plans.
- 25 Department of Insurance, State of California, see note #13.
- 26 Sears, B. and Mallory, C. 2011. *Economic Motives for Adopting LGBT Related Workplace Policies (Updated)*. Los Angeles: The Williams Institute, available at http://williamsinstitute.law.ucla.edu/research/workplace/economic_motives_for_adopting_lgbt_related_workplace_policies/ (last accessed July 10, 2013); Badgett, M.V.L., Durso, L., Kastanis, A., and Mallory, C. 2013. *The Business Impact of LGBT Supportive Workplace Policies*. Los Angeles: The Williams Institute, available at http://williamsinstitute.law.ucla.edu/research/workplace/business_impact_of_lgbt_policies_may_2013/ (last accessed July 10, 2013).
- 27 *Id.*

Notes

- 28** Department of Insurance, State of California, see note #13.
- 29** Coleman, et al., see note #8.
- 30** *Id.*
- 31** *Id.*
- 32** CIGNA Medical Coverage Policy, Gender Reassignment Surgery, effective Jan. 15, 2013, available at https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0266_coveragepositioncriteria_gender_reassignment_surgery.pdf (last accessed August 15, 2013).
- 33** Travel outside of the United States for transition related surgical procedures is not uncommon. See, for instance, Aizura, A. (2010). "Feminine Transformations: Gender Reassignment Surgical Tourism in Thailand." *Medical Anthropology: Cross Cultural Studies in Health and Illness*, 29(4), 424-443.
- 34** Utilization rates in this table are the average of each individual employer's average annual utilization for employers of that particular size category for each grouping by row. For instance, annual average utilization was calculated for the four employers for the 10,000 to 49,000 size range in the upper bound row. The four individual employers' average annual utilization rates were added and divided by four to get the average annual utilization rate for that group. If one pools the number of employees, the number of claimants, and the total years of coverage across the employers of interest and then calculates the average annual utilization using those pooled figures, the results consistently reflect lower utilization than the calculations used here. All employers described in the prior paragraph are not included in these calculations.
- All employers had to have their benefits in place for at least one full plan year prior to the survey. Two of the five employers who reported that they believed there had been no utilization had the benefits in place for less than one year at the time of the survey. These two employers were not included in the calculation. One of the six employers that provided utilization data is not included here since that employer expressed their utilization as a percentage of all claims instead of a number of claims/claimants. This employer (between 1,000 and 9,999 employees, fully insured plan only) reported that utilization of the transition related health care benefit represented less than 1 percent of total health benefits claims over one year. Since this employer did not report the actual number of claims or claimants, the data they provided did not allow that employer's utilization rate to be averaged among the other five employers that reported utilization. One of the five employers that provided comparable utilization data provided the number of surgical claims per year. In order to include this employer's data in the calculations for this table, we make the conservative assumption that each surgical claim represents one unique claimant. In other words, we assume an individual claimant made one surgical claim only. This employer also has other transition inclusive health benefits plans. Partial data provided on this employer's other transition inclusive plans suggest that this plan may have the highest utilization of these benefits of all plans, and, therefore, may represent a "worst case" in terms of utilization. All employers in the 10,000 to 49,999 size range in this table either reported actual utilization or confirmed no utilization, therefore the lower bound figure is the same as the mid range figure.
- 35** Two years of data were missing for this plan, so the number of surgical claims for this plan in those two missing years were set equal to the number of surgeries approved to be performed in that year. In all cases, the number of approved surgeries each year in each plan for which there were data in a particular year were less than the number of surgical claims, meaning not all approved surgeries were actually performed. Therefore, the average annual utilization of 0.03 surgical claims per thousand enrolled employees is likely an overestimate of actual surgical claims.
- 36** This and other quotes have been redacted to maintain the anonymity of the employer and for clarity. Changes to quotes are indicated by brackets and ellipses.
- 37** Chi square test of independence testing relationship between having a broad coverage plan and any reported costs: $\chi^2=0.9593$, d.f.=2, $p=0.619$. T test for mean difference in any reported cost by scope of coverage (broad or limited): $t=0.6814$, d.f.=26, $p=0.5017$.
- 38** City and County of San Francisco, see note #11; Department of Insurance, State of California, see note #13.
- 39** Department of Insurance, State of California, see note #13.
- 40** City and County of San Francisco, see note #11.
- 41** City and County of San Francisco. 2012. *Health Service System 2011 2012 Annual Report*, available at http://www.myhss.org/downloads/finance/HSS_AR_2011_2012.pdf (last accessed September 10, 2013).
- 42** Sears and Mallory; Badgett et al., see note #26.
- 43** Herman, J. 2013. "Gendered Restrooms and Minority Stress: The Public Regulation of Gender and its Impact on Transgender People's Lives." *Journal of Public Management and Social Policy*, 19(1), 65-80.
- 44** Department of Insurance, State of California, see note #13.



San Francisco City and County Transgender Health Benefit

History:

In 2001, The City and County of San Francisco made history by becoming the first US municipality to remove transgender access exclusions in its employee health plans. Since that time, other entities have used the success of San Francisco's program as a model for their own. And, despite actuarial fears of over-utilization and a potentially expensive benefit, the Transgender Health Benefit Program has proven to be appropriately accessed and undeniably more affordable than other, often routinely covered, procedures.

Starting in 1996, the San Francisco Human Rights Commission began work on the Transgender Health Benefit Project. Working with Commissioners, staff, experts, and community members, the goal of the project was to remove exclusions from City health insurance policies so that transgender employees, retirees, and their dependents would have access to procedures that were routinely covered by health insurance plans for people who are not transsexual. Due to fiscal constraints, the project stalled, lacking adequate support from the Health Service System (HSS) Board, which is the entity responsible for overseeing the administration of City employee health benefits.

Some Board Members expressed certain fears. They wondered why the City should pay for cosmetic surgery, or why the City should subsidize a spurious alternative lifestyle choice. If the exclusions were to be removed and transgender benefits were available, it might encourage large numbers of employees, retirees, and their dependents to have "sex changes." Some people might flock to the City to get municipal employment so they could access the benefits, and other people might marry or domestically partner with City employees so they could have their transition covered.

Commission staff met with HSS staff and Board members to address key issues: Most of the procedures that are denied coverage for transgender people are routinely covered in people who are not transgender, such as mastectomy, hysterectomy, genital surgery, hormone replacement therapy, etc. Furthermore, the positive outcome for the treatment of transsexualism stipulates psychotherapy, hormone treatment, and surgery as the standard of care to achieve maximum therapeutic value for the patient, and this lengthy process is designed to cull out any potential spurious intent. Under the standard of care, hormonal and surgical interventions for the treatment of transsexualism are considered medically necessary.

Plan Design:

In 2001, with support from key HSS Board Members and staff and nine City Supervisors, the City removed transsexual exclusions from its self-insured City Plan, with a one-year pilot program to collect actuarial data. The benefit provided surgical coverage through the self-insured plan, and the HMOs joined the City Plan by covering hormone treatments and transition-related psychotherapy. Procedures such as electrolysis, facial surgery, and tracheal shaves were not included in the plan design. The HSS Board plan had some flaws – a one-year enrollment requirement and a \$50,000



surgical cap. In 2004, as result of Commission advocacy, several changes happened: the one year waiting period was dropped, the surgical cap was increased to \$75,000, and the benefit became available through the HMOs: Blue Shield, Kaiser Permanente, and Health Net.

Actuarial Information:

The actuaries created estimates of plan costs, basing their formula on similar coverage provided by the Canadian province of British Columbia (a population of approximately 1 million people). In BC, the Province paid for about 50 procedures per year. The City's actuaries estimated that in a member population of approximately 100,000, 35 eligible members per year would spend \$50,000.

2001-2004: Employees, retirees, and their enrolled dependents were charged \$1.70 per month to meet that cost projection. It should be noted that, from 2001 through 2004, the HSS Board kept the transgender benefit limited to the self-insured City Plan despite the agreement to move it into the HMOs after one year. From July 2001 to July 2004, the HSS collected approximately \$4.3 million from its members specifically to cover the transgender benefit, while paying out approximately \$156,000 on seven claims for surgery.

In 2004-2005, even after rolling the benefit into the HMOs, the City's surplus monies increased slightly. After negotiating with the HMOs, the cost charged to members was dropped to \$1.16 per month for the benefit. The City Plan reduced its surcharge to .50 cents per member per month. Accumulatively, as of August 2005, the HSS had collected \$5.6 million and had paid out \$183,000 on 11 claims through the City Plan. Kaiser and Blue Shield reported no surgical claims for 2004-2005. Health Net reported that from 2004-2005, they have paid out \$3,300 on behalf of 14 members for hormonal treatments and transition-related psychological services.

Unlike the fears expressed, none of the concerns came to pass. A preliminary analysis indicates that there has been appropriate utilization (the number of claims compared to the number of eligible members) and the growing surplus indicates that the benefit costs much less to provide than the rates that have been charged to cover this specific benefit.

2005-2006: The rates collected for this period have not been reported yet. The total spent was \$44,117.51. The City Plan (administered by United HealthCare) paid \$5,038.50 on 13 of 17 claims submitted by two individuals. Health Net paid \$5,055.41 on 4 claims by an estimated two individuals. Kaiser paid \$34,023.60 on 2 claims submitted by two individuals, and Blue Shield has not reported for this period.

2006-2007: Due to its obvious affordability, as of July 1, 2006, the pricing for the benefit changed. While the benefit design remained the same, beneficial cost data led Kaiser and Blue Shield to no longer separately rate and price the transgender benefit - in other words, to treat the benefit the same as other medical procedures such as gall bladder removal or heart surgery. The HSS failed to negotiate the same change with Health Net. In July 2007, Health Net was replaced by PacifiCare as one of the available HMO carriers for the City.

From July 2001 through July 2006, the grand total of reported monies collected is \$5.6 million. The grand total of reported monies expended is \$386, 417.

**STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
300 South Spring Street
12th Floor, South Tower
Los Angeles, CA 90013**

ECONOMIC IMPACT ASSESSMENT

GENDER NONDISCRIMINATION IN HEALTH INSURANCE

REGULATION FILE NUMBER: REG-2011-00023

Dated April 13, 2012

ACTUARIES: Ali Zaker-Shahrak, Lai Weng (Carol) Chio

ECONOMIST: Rani Isaac

HEALTH PROGRAM SPECIALIST: Jason Tescher

Description of Proposal

The proposed regulation clarifies the prohibition against discrimination on the basis of gender or sex. AB 1586 (2005) prohibits plans and insurers from denying an individual a plan contract or policy, or coverage for a benefit included in the contract or policy, based on the person's sex, defined as "includ[ing] a person's gender identity and gender related appearance and behavior whether or not stereotypically associated with a person's assigned sex at birth."

The proposed regulation specifies forms of gender discrimination that are a violation of the discrimination prohibition in California Insurance Code (Ins. Code) section 10140 including:

- Denying or cancelling an insurance policy on the basis of gender identity;
- Using gender identity as a basis for determining premium;
- Considering gender identity as a pre-existing condition; or
- Denying coverage or claims for health care services to transgender people when coverage is provided to non-transgender people for the same services.

The California Department of Insurance (the "Department") has determined that denying claims as listed in the bullet points above is a violation of the discrimination prohibition in Ins. Code section 10140. The proposed regulation clarifies the obligation of insurers to refrain from discriminatory practices and results in a prohibition on the denial of claims solely due to an individual's transgender status. Furthermore, the proposed is consistent with recently enacted legislation, AB 887 (Atkins, 2011), which specifically prohibited discrimination based on gender identity and gender expression. This document constitutes the Department's Economic Impact Assessment (EIA), which considers the economic impact of this prohibition and assesses whether and to what extent the proposed regulation affects the criteria set forth in Government Code Section 11346.3(b)(1).

Economic Impact Findings

The Department has determined that the adoption of the proposed regulation would have an insignificant and immaterial economic impact on the creation or elimination of jobs, the creation or elimination of new businesses, and the expansion of businesses in the State of California.

Prohibiting the four types of discrimination listed in the bullets above will be of significant benefit for transgender people and should thereby potentially improve their health and welfare since they have been targets of discrimination and violence.¹ The regulation may also have a positive impact on transgender worker safety. Since these workers will have improved access to health care coverage, under the proposed regulation, they should be in better health and more productive at work. However, while the proposed regulation may have a positive impact on the health, welfare and worker safety of the transgender population, which is a very small subset of California residents, the aggregate cost to the state population as a whole will be very insignificant (see “Prevalence of the Transgender Population” section).

The Department finds that nothing in the proposed regulation prohibits an insurer from using objective, valid, and up-to-date statistical and actuarial data or sound underwriting practices. While insurers may use someone’s health status to determine their premium, analysis of the potential increase in claim costs from the proposed regulation shows that any such costs are immaterial and insignificant.

To arrive at these conclusions, Department staff conducted a thorough literature review, analyzed existing data, and obtained cost and premium data from employers. Department staff used a variety of data sources to reach these conclusions, including actuarial and utilization data related to potential increased claim costs resulting from the prohibition of the four types of discrimination listed in the bullets, above.

Impact on Employment and Business

Based on the very small size of the population that may be impacted by the proposed regulation, the Department has concluded that the proposed regulation will have an insignificant and immaterial impact on the creation or elimination of jobs, the creation of new business or the elimination of existing business, and the expansion of business currently doing business in California (see “Prevalence of the Transgender Population” section below).

Department staff have determined that the adoption of the proposed regulation will have an immaterial impact on extra demands for treatments, because of the low prevalence of the impacted population. Consequently, there will be immaterial changes in the labor force.

In addition, the proposed regulation requires equality of treatment. If a medically necessary treatment is not available to any insured, the insurer is not obligated to provide that treatment to transgender individuals. Because no new treatments are required, there is no impact on the creation or elimination of existing businesses, nor the expansion of established businesses in California.

Prevalence of the Transgender Population

Because the proposed regulation will give transgender Californians access to the same treatments offered to non-transgender Californians, the Department’s analysis included a review of the number of the individuals in the California population that could contribute to increased claim

¹ See the “Impact on Health and Welfare” section.

costs. The transgender population is much smaller than the overall lesbian, gay, and bisexual population and is more difficult to track and follow due to the significant disenfranchisement and discrimination that transgender individuals face.² The Department has published a range of estimates (see table below).

The classic estimate for prevalence of transgender individuals (using gender identity disorder as a measurement) comes from the 1994 Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), which reported 1:30,000 natal males and 1:100,000 natal females.³ More recently, a 2009 review by Zucker and Lawrence concluded that the prevalence may be 3 to 8 times the numbers reported in the DSM-IV, based mostly on reports from Western European clinics.^{4, 5}

In 2007, De Cuypere, et al., reviewed ten studies from eight countries; plus, they conducted their own study. “The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals and from 1:30,400 to 1:200,000 for female-to-male individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used.”⁶

Department staff utilized data from these studies, and estimates of the uninsured population, to arrive at a range of estimates for the insured transgender population in California based upon 2010 Census figures.⁷

Out of the 37.3 million California residents, transgender people make up between 0.0065 and 0.0173 percent of the total population in California, using the two highest estimates in order to be conservative (see the last two columns of the table below). When the rate of uninsured Californians (19 percent) is factored in, only 0.0052 to 0.014 percent of the state population would be impacted by the proposed regulation — or between 1,955 and 5,214 people.⁸

Total California Population	Source	Estimated Number of Transgender Individuals				
		DSM-IV	De Cuypere - Low End	De Cuypere - High End	Zucker and Lawrence - 3 times DSM-IV	Zucker and Lawrence - 8 times DSM-IV
18,517,830	Male	617	412	1,556	1,852	4,938
18,736,126	Female	187	94	616	562	1,499
37,253,956	Total	805	505	2,172	2,414	6,437
100%	Percentage of Total California Population	0.0022%	0.0014%	0.0058%	0.0065%	0.0173%
	Total Insured* (Total X .81)	652	409	1,760	1,955	5,214
	Percentage of Total California Population	0.0017%	0.0011%	0.0047%	0.0052%	0.0140%

² (Baker, Kesteren, Gooren, & Bezemer, 1993)

³ (American Psychiatric Association, 1994)

⁴ (Zucker & Lawrence, 2009)

⁵ (Olson, Forbes, & Belzer, 2001)

⁶ (The World Professional Association for Transgender Health, 2011)

⁷ (U.S. Census Bureau, 2010)

⁸ (The Kaiser Family Foundation, 2009)

Since the number of transgender people in the general population is so small, the subpopulation of insured individuals is even less significant. The following estimates by the Department of costs and utilization are conservative, considering that the transgender population has higher than average rates of poverty and unemployment and lower rates of insurance coverage. A 2008 survey conducted by the Transgender Law Center indicates that transgender people are twice as likely to live below the poverty line.⁹ Because transgender people have less access to insurance coverage than average Californians, they are more likely to be covered by a public program and would not contribute to increased claims against private insurers.

Utilization and Impact on Claim Costs and Premiums

While there is limited actuarial data publically available on the impact that the Department's proposed regulation would have on claim costs and premiums, the Department has identified enough existing data to make conclusions about the economic impact of the regulation.

Department staff reviewed data from five employers that have internal policies prohibiting discrimination in health care coverage and reviewed their related cost studies. For reasons discussed in the following section, the Department has concluded the impact on costs, due to the adoption of the proposed regulation, would be immaterial.

Utilization

Utilization data is important because it is used by insurers to calculate expected claim costs and then premiums. As utilization increases, the expected claim costs increase and in general the increase will be reflected in setting premiums. In this section, the Department presents data that indicates extremely low utilization resulting from elimination of gender discrimination, as would be expected with such a small population.

Once again, the proposed regulation requires that treatments available to non-transgender insureds not be denied based on an insureds actual or perceived gender identity or transgender status, as defined. If a medically necessary treatment is not available to any insured, the insurer is not obligated to provide that treatment to transgender individuals. Department staff used utilization data from employers that offer transgender employees equal health care benefits as a proxy for increased utilization that we may expect to see as a result of implementing the proposed regulations. Department staff determined that this data most closely represents the kind of increased utilization that we can expect based on prohibition of the four types of discrimination listed in the first section of this assessment.

While the move to eliminate this type of gender discrimination in health policies was rare among employers ten years ago, many more employers are adopting internal policies offering equal access to health care services for their transgender employees. The number of Fortune 500 companies that have eliminated discrimination in health care benefits offered to their transgender employees has increased from 49 in 2009 to 207 in 2012.¹⁰ Presenters at the Out & Equal Workplace Summit 2011 indicated that the utilization, and thus costs, for prohibiting discrimination are very low. "[M]any employers around the country have eliminated the

⁹ (Transgender Law Center, 2008)

¹⁰ (Human Rights Campaign, 2012)

exclusions in their health plans...Utilization is very low and there has been little or no impact to premiums.”¹¹

Existing utilization data is limited due to extremely low utilization coupled with the concern that releasing this data could be traced back to individuals and violate health privacy laws. However, Department staff obtained and reviewed three sources of utilization data: (1) The City and County of San Francisco; (2) The University of California; and (3) Jamison Green and Associates report on utilization and costs to private companies with voluntary internal nondiscrimination policies similar to the proposed regulation.

The City and County of San Francisco (San Francisco) prohibited gender-based discrimination in 2001 for all City and County employees and their dependents. In the following five years, there were only 37 claims. A report by Jamison Green and Associates estimated that utilization rates (claimants per employee) ranged from 0.0325 to 0.104 claimants per thousand employees per year.¹²

In March 2012, the University of California (UC) released utilization and cost data from one of its health plan insurers, for the 6.5 years since UC first prohibited discrimination against transgender employees in its health care plans.¹³ The utilization rates, as summarized in the table below, ranged from 0.011 to 0.093 claimants per thousand covered lives per year.¹⁴ In order to make comparisons with other utilization data, the Department converted the UC data to utilization rates per 1,000 covered employees. Using a member-to-employee ratio of 2:1, Department staff arrived at utilization rates per 1,000 employees, from a minimum of 0.022 in CY 2006 to a maximum of 0.187 in CY 2009 (see far right column in table below).

Coverage Period	Number of Claimants	Average Covered Lives	Est. Average Number of Employees*	Utilization Rates per 1,000 covered lives	Utilization Rates per 1,000 employees*
Jul - Dec 2005	-	92,470	46,235	-	-
CY 2006	1	91,705	45,853	0.011	0.022
CY 2007	3	86,868	43,434	0.035	0.069
CY 2008	9	120,905	60,453	0.074	0.149
CY 2009	11	117,945	58,973	0.093	0.187
CY 2010	10	115,087	57,544	0.087	0.174
CY 2011	8	111,571	55,785	0.072	0.143
Total	42				
		Average utilization rates (excl. 2005 data)		0.062	0.124
		Min utilization rates (excl. 2005 data)		0.011	0.022
		Max utilization rates (excl. 2005 data)		0.093	0.187
*Estimated number of employees based on a member-to-employee ratio of 2:1					

¹¹ (Green, Wilson, & Fidas, 2011). Slide #5.

¹² (Wilson, 2012); Slide # 11

¹³ (Manning, 2012)

¹⁴ *ibid.*

Further underscoring evidence of extremely low utilization, the insurer reported that only 27 individuals sought treatments, some with multiple claims, over the period of 6.5 years.¹⁵ Using the number of (distinct) members, rather than the number of distinct claims, Department staff obtained an average utilization rate of 0.039 per thousand covered lives per year. Department staff made the conversion because utilization data relying on covered lives is a more accurate representation of actual utilization. As expected, the average utilization rate per thousand covered lives (0.062 per thousand) is significantly lower than the utilization per thousand employees (0.124) because the rate per covered lives represents utilization spread across all insureds.

In addition, a report issued by Jamison Green and Associates estimated utilization rates in the range of 0.0015 to 0.325 per thousand employees per year, based on interviews with fifteen Fortune 500 companies who have eliminated the discriminatory policies.¹⁶ Their broader estimates discussed below included the experience of San Francisco.

The table below summarizes the utilization rates from all three sources mentioned above.

	Utilization Rates per 1,000 employees per year		
Case	City and County of San Francisco	University of California	Sample of Private Employers
Minimum	0.0325	0.022	0.0015
Maximum	0.104	0.187	0.325

The utilization rates for San Francisco and UC fall within the range of utilization estimates of Jamison Green and Associates discussed above.

Claim Costs and Premium History

The Department augmented the limited claim cost and utilization data available by reviewing premium data from several employers to determine the additional amount their insurers have been charging to extend equal coverage to transgender employees and dependents.

For San Francisco, the initial cost per employee was \$1.70 per member per month (PMPM) in 2001. Due to low utilization, San Francisco reduced the PMPM to \$1.16 in 2004-2005 and the city's self-insured plan reduced its charge to \$0.50 PMPM. As of July 1, 2006, the cost data demonstrated that no separate rate was required, so the charge was removed entirely. Initial claims were first subject to a lifetime maximum of \$50,000 then increased to \$75,000 in 2004.¹⁷

¹⁵ There were 27 unduplicated individuals who received treatment during this time period. There were 42 claimants because some procedures for the same individual occurred over more than one year.

¹⁶ (Wilson, 2012) Slide #13

¹⁷ (The City and County of San Francisco Human Rights Commission, 2007)

The University of California eliminated transgender discrimination in 2005 without being charged an additional premium.¹⁸ Claim cost data from the UC health plan with the largest enrollment shows that the claim costs PMPM attributed to the elimination were very low. The maximum of claim costs during the 6.5 years was \$0.20 PMPM, or 0.05 percent of the total premium.

As of January 1, 2012, the City of Berkeley removed discriminatory provisions within its health plans. Berkeley's insurers charged a premium of 0.2 percent of the total annual budget for healthcare benefits. The total projected monthly increase was 0.25 percent (223 covered lives in one plan) and 0.19 percent (938 covered lives in another plan) as of March 2012.¹⁹

Two other cities have had experiences similar to Berkeley's. The City of Portland removed discriminatory policies beginning July 1, 2011. The cost projection for Portland was \$32,302 out of a total \$41,615,000 health care budget – a 0.08 percent increase.²⁰ The City of Seattle absorbed a premium increase of \$200,000 per year of a total \$105 million health care budget – just 0.19 percent of total health costs based on insurer estimates of increased utilization.²¹

It is a standard practice for insurers to charge a premium to cover expected claim costs of the proposed regulation, administrative expenses, taxes, profit and any provisions for adverse deviation. When credible cost and utilization data is absent or limited for new benefits, insurers tend to be conservative by including a larger provision for adverse deviation. This is evidenced by San Francisco's experience, where "[f]rom July 2001 through July 2006, the grand total of reported monies collected (for this purpose) is \$5.6 million. The grand total of reported monies expended is \$386,417."²² Since cost assumptions were nearly 15 times higher than actual claims, the city eventually eliminated the additional premium.

Using the impact on premiums as a proxy for anticipated increased claim costs, the range of the impact on costs for the proposed regulation would be a minimum of no increase (the case of San Francisco and the University of California), to a maximum increase of 0.2 percent in expected claim costs (the cases of Berkeley and Seattle). However, changes to policies in Berkeley and Seattle were recent, limiting data availability. As stated before, the 0.2 percent estimate may very likely include a large provision for adverse deviation. The Department's conclusion is supported by the actual claims data collected for the UC system, which shows the claims costs accounted for only 0.05 percent of premiums.

In addition to the employer information, Department staff also reviewed the Sylvia Rivera Law Project white paper discussing the impact of a similar prohibition for Medicaid in the State of New York. "A preliminary estimate by the New York State Department of Health in 2010 approximated that it would cost about \$1.7 million to cover gender-confirming care through

¹⁸ (Manning, 2012)

¹⁹ (Hodgkins, 2012)

²⁰ (The City of Portland, Oregon, 2011)

²¹ (Freiboth, 2012)

²² (The City and County of San Francisco Human Rights Commission, 2007)

Medicaid. As the state Medicaid budget totals \$52 billion, this represents only 0.003 percent of the total budget.”²³

Based on evidence of low utilization and prevalence rates shown above, the Department has determined that the impact on costs or increases in premiums due to the adoption of the proposed regulation would be immaterial.

Utilization Assumptions

There are a number of assumptions that contribute to lower-than-expected utilization seen in San Francisco. Like any other condition, treatment options for GID vary greatly and not all transgender people with the diagnosis will undergo surgical intervention. It appears that utilization projections are made with:

...the belief that all transgender people undergo genital surgery as the primary medical treatment for changing gender. In fact, gender-confirming healthcare is an individualized treatment that differs according to the needs and pre-existing conditions of individual transgender people. Some transgender people undergo no medical care related to their expression of a gender identity that differs from their birth-assigned sex. Others undergo only hormone therapy treatment or any number of surgical procedures.²⁴

The assumption that treatment utilization and costs are the same for each transgender person is reflected in the significant difference between premium charges by insurers and actual utilization costs and evidenced in the wide range of claims costs reported by the University of California. The claims varied from \$67 to \$86,800 with an average cost of \$29,929 per transgender person requiring treatment.

Additional factors that impact utilization and cost include, but are not limited to:

- Transgender insureds may have already undergone treatment;
- Surgical treatment for gender identity disorder (GID) is usually a once-in-a-lifetime event, and many costs are spread over a lifetime, and do not occur in just a single year;
- Transgender people do not always have a diagnosis of GID and thus have no medically necessary indication for treatment;
- Almost all surgical treatments for treatment of GID are treatments that are provided to non-transgender insureds for other indications; and
- Other health factors can contraindicate treatment.

²³ (The Sylvia Rivera Law Project, 2011)

²⁴ (Spade, 2010)

A detailed analysis of the impact of each of these assumptions on utilization is beyond the scope of this assessment, but is illustrative of what may be the reasons for the apparent gap between premiums charged to employers for prohibiting health care discrimination against transgender insureds and the actual reported utilization and cost.

In addition, the Department believes that there may be a possible spike in demand for such services in the first few years after the adoption of the proposed regulation due to the possible existence of some current unmet demand. This may lead to higher costs, in the near-term, following the adoption of the proposed regulation. While this is possible, this was not the experience of the University of California or San Francisco. In any case, the small size of the impacted population will likely make the magnitude of such an increase insignificant and immaterial.

Impact on Health and Welfare

As discussed in the *Prevalence* and the *Utilization and Claims* sections, prohibiting the four types of discrimination listed in the bullets on page one will be of significant benefit for a very small class of California residents who are directly impacted. The proposed regulation should thereby potentially improve their health and welfare since transgender people have been targets of discrimination and violence.²⁵ The proposed regulation may also improve worker safety, as explained above. However, while the Department found that the proposed regulation may have a significant beneficial impact on the health, welfare and safety of the transgender population, the aggregate costs will be very insignificant. The Department has determined that the benefits of eliminating discrimination far exceed the insignificant costs associated with implementation of the proposed regulation. Based on this assessment, the Department has determined that there are no significant adverse impacts of the regulation to the health and welfare of California residents, nor will it impact overall worker safety, and the state's environment.

Further, the Department's evidence suggests that benefits will accrue to insurance carriers and employers as costs decline for the treatment of complications arising from denial of coverage for treatments. The evidence suggests that there may be potential cost savings resulting from the adoption of the proposed regulation in the medium to long term, such as lower costs associated with the high cost of suicide and attempts at suicide, overall improvements in mental health and lower rates of substance abuse, as discussed in the following section.

The Benefit and Cost Savings of Suicide Reduction²⁶

One of the most severe results of denying coverage of treatments to transgender insureds that are available to non-transgender insureds is suicidal ideation and attempts. The Centers for Disease Control and Prevention estimate the average acute medical costs of a single suicide completion or attempt in the United States is \$2,596 and \$7,234 respectively.²⁷ This only includes acute care and hospitalization costs. While there are studies that provide higher estimated costs per suicide attempt and completion, we choose to conservatively use the lower bound cost to keep estimates

²⁵ (Tannis, Grant, & Mottat, 2010)

²⁶ (Gorton, 2011)

²⁷ (The Centers for Disease Control, 2010)

as relevant to health insurers as possible.^{28,29} A more in-depth analysis might include the costs of mental health treatment or other medical costs following a suicide attempt.

A meta-analysis published in 2010 by Murad, et al., of patients who received currently excluded treatments demonstrated that there was a significant decrease in suicidality post-treatment. The average reduction was from 30 percent pretreatment to 8 percent post treatment.³⁰

De Cuyper, et al., reported that the rate of suicide attempts dropped dramatically from 29.3 percent to 5.1 percent after receiving medical and surgical treatment among Dutch patients treated from 1986-2001.³¹

According to Dr. Ryan Gorton, “In a cross-sectional study of 141 transgender patients, Kuiper and Cohen-Kittens found that after medical intervention and treatments, suicide fell from 19 percent to zero percent in transgender men and from 24 percent to 6 percent in transgender women.”^{32,33}

Clements-Nolle, et al., studied the predictors of suicide among over 500 transgender men and women in a sample from San Francisco and found a prevalence of suicide attempts of 32 percent.³⁴ In this study, the strongest predictor associated with the risk of suicide was gender based discrimination which included “problems getting health or medical services due to their gender identity or presentation.”³⁵ According to Gorton, “Notably, this gender-based discrimination was a more reliable predictor of suicide than depression, history of alcohol/drug abuse treatment, physical victimization, or sexual assault.”³⁶

A recent systematic review of largely American samples gives a suicide attempt rate of approximately one in every three individuals with higher rates found among adolescents and young adults.³⁷ According to Dr. R. Nicholas Gorton, MD, who treats transgender people at a San Francisco Health Clinic, “The same review also noted that while mental health problems predispose to suicidality, a significant proportion of the drivers of suicide in the LGBT population as a whole is minority stress.” He continues to conclude that, “[f]or transgender people such stress is tremendous especially if they are unable to 'pass' in society. Surgical and hormonal treatments — that are [also] covered for non-transgender insureds — are specifically aimed at correcting the body so that it more closely resembles that of the target gender, so providing care significantly improves patients' ability to pass and thus lessens minority stress.”³⁸

These studies provide overwhelming evidence that removing discriminatory barriers to treatment results in significantly lower suicide rates. These lower rates, taken together with the estimated

²⁸ (Yang & D.Lester, 2007)

²⁹ (Corso P, 2007)

³⁰ (Murad M, 2010)

³¹ (DeCuyper, 2006)

³² (Kuiper M, 1988)

³³ (Gorton, 2011)

³⁴ (Clements-Nolle K, 2006)

³⁵ (Clements-Nolle, Marx, & and Katz, 2006)

³⁶ (Gorton, 2011)

³⁷ (Haas, 2011)

³⁸ (Gorton, 2011)

costs of a suicide attempt and completion, demonstrate that the proposed regulation will not only save insurers from the costs associated with suicide, but prevent significant numbers of transgender insureds from losing their lives.

Additional Benefits

Overall improvements in mental health. Transgender insureds who have access to treatment see rates of depression drop and anxiety decrease. Evidence supporting this conclusion comes from a meta-analysis of 28 studies showing that 78 percent of transgender people had improved psychological functioning after treatment.³⁹ In another recent study, transgender women who had had any relevant surgeries had mental health scores comparable to women in general, while those who were not able to access care scored much lower on mental health measures.⁴⁰ In another study, participants improved on 13 out of 14 mental health measures after receiving treatments.⁴¹ This overall improvement in mental health and reduction in utilization of mental health services could be a source of cost savings for employers, insurers, and insureds.

Substance abuse rates decline. There are numerous studies that provide evidence that substance abuse rates decline including one where participants, “describe how substance use was a coping mechanism for their gender dysphoria before they had access to treatment.”^{42, 43} Another study found an overall reduction in substance use after receiving treatment.⁴⁴

Further, the Sylvia Rivera Law Project suggests that treatment for GID could combat other types of substance abuse since it is well known that “[i]ncreased smoking and drug and alcohol use correlates with increased rates of lung cancer, heart disease, stroke, and liver disease.”⁴⁵

HIV Rates and Care. Transgender people have significantly higher rates of HIV than the general population (28 percent in a meta-analysis⁴⁶ as compared to a general population rate of 0.6 percent).⁴⁷ It is also significant that studies show “high rates of adherence to HIV care for trans people when combined with hormonal treatment.”^{48, 49} This is particularly relevant to insurers because it provides evidence that offering treatment may reduce the long-term costs of treatment for HIV/AIDS. It is particularly relevant for the welfare of all Californians because, “[w]hen compliant with care, HIV-positive people stay healthier longer and are far less likely to transmit the virus to others.”⁵⁰

Other Benefits. Transgender people who are denied access to treatment and suffer from dysphoria associated with gender identity disorder sometimes turn to self-medication for relief.

³⁹ (Murad M, 2010)

⁴⁰ (Ainsworth & Spiegel, 2010).

⁴¹ (Smith Y, 2005)

⁴² (The Sylvia Rivera Law Project, 2011)

⁴³ (Cole, 1997)

⁴⁴ (Rehman, 1999)

⁴⁵ (The Sylvia Rivera Law Project, 2011)

⁴⁶ (Operario D., 2010)

⁴⁷ (United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO), 2007)

⁴⁸ (The Sylvia Rivera Law Project, 2011)

⁴⁹ Grimaldi J; Jacobs J. (1998.) “The HIV/Hormone Bridge, *Int Conf AIDS*; 12: 981, abstract no. 571/44225.

⁵⁰ (The Sylvia Rivera Law Project, 2011)

Silicone injections, for example, are sometimes used in lieu of medically available treatments. Prevalence of this has been documented in needs assessments in Washington D.C., Chicago, and Los Angeles, where respondents reported having injected silicone into their bodies at a rate of 25, 30, and 33 percent of the time, respectively.^{51, 52, 53} Construction-grade silicone is used to alter body shape sometimes resulting in deadly consequences.⁵⁴ Several researchers suggest that lack of early access to GID treatments and care costs more.

Increased socioeconomic status for transgender insureds. Lack of access to treatment due to coverage denials also results in a greater likelihood of adverse socioeconomic consequences for the insured. A single group pre- and post-study demonstrated improvements in socioeconomic status or employment status in transgender patients after hormonal and surgical treatment.⁵⁵ Additional studies conclude that transgender persons have higher employment rates after they have access to treatments.⁵⁶

For the reasons cited above, Department staff concluded that ending these four types of discrimination will cost little or nothing in the short run and may produce longer-term cost savings and improved health benefits for transgender people.

⁵¹ (Xavier, 2000)

⁵² (Bostwick, 2001)

⁵³ (Reback, Simon, Bemis, & Gatson, 2001)

⁵⁴ (Komenaka, 2004); (Fox, 2004); (Hage, 2001).

⁵⁵ (Bodlund O, 1996)

⁵⁶ (Grant, 2010); (Murad M, 2010); (Rakic, 1996).

Works Cited

- Ainsworth, T., & Spiegel, J. (2010). Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. *Quality of Life Research*, 19, 1019–1024.
- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*. Washington, D.C.: American Psychiatric Association.
- Baker, A., Kesteren, P. V., Gooren, L., & Bezemer, P. (1993). The prevalence of transsexualism in the Netherlands. *Acta Psychiatrica Scandinavica*(87), 237-238.
- Bodlund, O., & Gunnar, K. (1996). Transsexualism – General outcome and prognostic factors: A 5 year follow-up study of 19 TSs in the process of changing sex. *Arch. Sexual Behavior*, 25, 303-316.
- Bostwick, W., & Kenagy, G. (2001). *Health and social service needs of transgendered people in Chicago*. Chicago: Jane Addams College of Social Work, University of Illinois at Chicago.
- Census Bureau. (2010). *Profile of General Demographic Characteristics, California*. Retrieved from Table DP-1: www.census.gov
- Centers for Disease Control. (2010). *Fact Sheet: The Medical Cost Associated with Suicide in the United States*. Retrieved 2012, from http://www.cdc.gov/ncipc/factsheets/images/Medical_Costs.pdf;
- City and County of San Francisco Human Rights Commission, The. (2007). *Report on San Francisco City and County Transgender Health Benefit*. San Francisco: The City and County of San Francisco.
- City of Portland, Oregon. (2011). *Mayor Sam Adams*. Retrieved from <http://www.portlandonline.com/mayor/?a=351892&c=49278>
- Clements-Nolle, K., Marx, R., & and Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of Homosexuality*, 53(3), 53-69.
- Cole, C., O'Boyle, M., Emory, L., & Meyer, W. (1997). Co-morbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses. *Archives of Sexual Behavior*, 26(1), 13-19.
- Corso, P., Mercy, J., Simon, T., Finkelstein, E., & Miller, T. (2007). Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States 32(6) : 474-482. *Am J Prev Med*, 32(6), 474-482.
- De Cuypere, G. E. (2006). Long-term follow-up: psychosocial outcome of Belgian transsexuals after sex reassignment surgery. *Sexologies*, 15, 126–133.
- Fox, L., Geyer, A., Husain, S., Della-Latta, P., & Grossman, M. (2004). Mycobacterium abscessus cellulitis and multifocal abscesses of the breasts in A transsexual from illicit intramammary injections of silicone. *Journal of the American Academy of Dermatology*, 50, 450.
- Freiboth, R. (2012, March 6). Transgender Benefit Insurance Premium Increase Data. (email communication). (C. o. Manager, Ed.) Seattle, WA.
- Gorton, R. N. (2011). *The Costs and Benefits of Access to Treatment for Transgender People*. Prepared for the San Francisco Department of Public Health, San Francisco.
- Green, J., Wilson, A., & Fidas, D. (2011). *Transgender Inclusive Health Benefits: Costs, Medical Models & Best practices*. Dallas.

- Haas, A., Eliason, M., Mays, V., Mathy, R., Cochran, S., D'Augelli, A., . . . Diamond, G. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality*, 58(1), 10-51.
- Hage, J. (2001). The devastating Outcome of Massive Subcutaneous Injection of Highly Viscous Fluids In Male to Female Transsexuals. *Plastic and Reconstructive Surgery*, 734.
- Hodgkins, D. (2012, March 15). Transgender Benefit Insurance Premium Increase Data. (email communication). Berkeley, CA: City of Berkeley, Department of Human Resources.
- Human Rights Campaign. (2012). *Corporate Equality Index 2012*. Washington, D.C.: Human Rights Campaign.
- Institute of Medicine of the National Academies. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. National Academies, Board on the Health of Select Populations. Washington, D.C.: The National Academies Press.
- Kaiser Family Foundation, The. (2009). *State Health Facts*. Retrieved 2011, from <http://www.statehealthfacts.org/profileglance.jsp?rgn=6>
- Komenaka, I. (2004). Free silicone injection causing polyarthropathy and septic shock. *The Breast Journal*, 10(2), 160.
- Kuiper, M., & Cohen-Kittenis, P. (1988). Sex reassignment surgery: A study of 141 Dutch transsexuals. *Arch Sex Behav*, 5, 439-457.
- Manning, J. (2012, April). University of California Transgender Benefit Cost and Utilization Letter. *University of California Transgender Benefit Review 2012*(email communication). Oakland, CA, United States: University of California, Office of the President.
- Murad, M., Elamin, M., Garcia, M., Mullan, R., Murad, A., Erwin, P., & Montori, V. (2010). Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology*, 72, 214-231.
- Olson, J., Forbes, C., & Belzer, M. (2001, February). Management of the Transgender Adolescent. *Archives of Pediatrics and Adolescent Medicine*, 165(2), 171-176. Retrieved from <http://archpedi.ama-assn.org/cgi/content/full/165/2/171>
- Operario, D., & Nemoto, T. (2010). HIV in Transgender Communities: Syndemic Dynamics and a Need for Multicomponent Interventions. *Journal of Acquired Immune Deficiency Syndrome*, 55(2), S91-S93.
- Rakic, Z., Starcevic, V., Maric, J., & Kelin, K. (1996). The Outcome of Sex Reassignment Surgery in Belgrade: 32 Patients of Both Sexes. *Archives of Sexual Behavior*, 25, 515.
- Reback, C., Simon, P., Bemis, K., & Gatson, B. (2001). *Los Angeles Transgender Health Study: Community Report*. Los Angeles.
- Rehman, J., Lazar, S., Benet, A., Schaefer, L., & Melman, A. (1999). The Reported Sex and Surgery Satisfaction of 28 Postoperative Male to-Female Transsexual Patients. *Archives of Sexual Behavior*, 71.
- Smith, Y., Van Goozen, S., Kuiper, A., & Cohen-Kettenis, P. (2005). Sex Reassignment: Outcomes and Predictors of Treatment for Adult and Adolescent Transsexuals. *Psychological Medicine*, 35, 89-99.
- Spade, D., Arkles, G., Duran, P., Gehi, P., & Nguyen, H. (2010). Medicaid Policy & Gender-Confirming Helathcare for Trans Prople: An Interview with Advocates. *Seattle Journal for Social Justice*, 8(2), 497-514.

- Sylvia Rivera Law Project, The. (2011). *Eliminating the Medicaid Exclusion for Transition-Related Care in NYS: Good Public Health, the Right Thing to Do and Ultimately a Cost-Saving Measure*. New York: Sylvia Rivera Law Project.
- Tannis, J., Grant, J., & Mottat, L. (2010). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington, D.C.: National Center for Transgender Equality and National Gay and Lesbian Task Force.
- Transgender Law Center. (2008). *The State of Transgender California: A report on the 2008 California Transgender Economic Health Survey*. San Francisco: The Transgender Law Center.
- United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO). (2007). *AIDS Epidemic Update*. Retrieved from http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.
- Wilson, A. (2012). *Transgender-Inclusive Health Benefits: Costs, Data for Cost Calculation*. Jamison Green and Associates.
- World Professional Association for Transgender Health, The. (2011). *Standards of Care for the Health of Transexual, Transgender, and Gender Nonconforming People, 7th ed.* The World Professional Association for Transgender Health.
- Xavier, J. (2000). *The Washington Transgender Needs Assessment Survey*. Washington, D.C.: The Administration for HIV and AIDS of the District of Columbia Government.
- Yang, B., & Lester, D. (2007). Recalculating the Economic Cost of Suicide. *Death Studies*, 31, 351–361.
- Zucker, K., & Lawrence, A. (2009). Epidemiology of Gender Identity Disorder. *International Journal of Transgenderism*, 11(1), 8-18.

12. Clarity of This Regulation

We are required by Executive Order 12866 and 12988, the Plain Writing Act of 2010 (H.R. 946), and the Presidential Memorandum of June 1, 1998, to write all rulemaking in plain language. This means each rule we publish must:

- Be logically organized;
- Use the active voice to address readers directly;
- Use clear language rather than jargon;
- Be divided into short sections and sentences; and
- Use lists and tables wherever possible.

List of Subjects in 43 CFR Part 2

Administrative practice and procedure, Classified information, Courts, Freedom of information, Government employees, Privacy.

Dated: July 18, 2013.

Rhea Suh,

Assistant Secretary for Policy, Management and Budget.

For the reasons stated in the preamble, the Department of the Interior proposes to amend 43 CFR part 2 as follows:

PART 2—FREEDOM OF INFORMATION ACT; RECORDS AND TESTIMONY

- 1. The authority citation for part 2 continues to read as follows:

Authority: 5 U.S.C. 301, 552, 552a, 553; 31 U.S.C. 3717; 43 U.S.C. 1460, 1461.

- 2. Revise § 2.254 to read as follows:

§ 2.254 Exemptions.

(a) *Criminal law enforcement records exempt under 5 U.S.C. 552a(j)(2).* Pursuant to 5 U.S.C. 552a(j)(2) the following systems of records have been exempted from all of the provisions of 5 U.S.C. 552a and the regulations in the subpart except paragraphs (b), (c)(1) and (2), (e)(4)(A) through (F), (e)(6), (7), (9), (10), and (11), and (i) of 5 U.S.C. 552a and the portions of the regulations in this subpart implementing these paragraphs:

(1) Investigative Records, Interior/Office of Inspector General—2.

(2) Incident Management, Analysis and Reporting System, DOI—10.

(b) *Law enforcement records exempt under 5 U.S.C. 552a(k)(2).* Pursuant to 5 U.S.C. 552a(k)(2), the following systems of records have been exempted from paragraphs (c)(3), (d), (e)(1), (e)(4) (G), (H), and (I), and (f) of 5 U.S.C. 552a and the provisions of the regulations in this subpart implementing these paragraphs:

(1) Investigative Records, Interior/Office of Inspector General—2.

(2) Permits System, Interior/FWS—21.

(3) Civil Trespass Case Investigations, Interior/BLM—19.

(4) Employee Conduct Investigations, Interior/BLM—20.

(5) [Reserved]

(6) [Reserved]

(7) Employee Financial Irregularities, Interior/NPS—17.

(8) Trespass Cases, Interior/Reclamation—37.

(9) Litigation, Appeal and Case Files System, Interior/Office of the Solicitor—1 to the extent that it consists of investigatory material compiled for law enforcement purposes.

(10) Endangered Species Licenses System, Interior/FWS—19.

(11) Timber Cutting and Trespass Claims Files, Interior/BIA—24.

(12) Incident Management, Analysis and Reporting System, DOI—10.

(c) Investigatory records exempt under 5 U.S.C. 552a(k)(5), the following systems of records have been exempted from subsections (c)(3), (d), (e)(1), (e)(4) (G), (H), and (I) and (f) of 5 U.S.C. 552a and the provisions of the regulations in this subpart implementing these subsections:

(1) [Reserved]

(2) National Research Council Grants Program, Interior/GS—9

(3) Committee Management Files, Interior/Office of the Secretary—68.

[FR Doc. 2013-18223 Filed 7-31-13; 8:45 am]

BILLING CODE 4310-RK-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Subtitle A

RIN 0945-ZA01

Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities

AGENCY: Office for Civil Rights (OCR), HHS.

ACTION: Request for Information.

SUMMARY: Section 1557 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) (42 U.S.C. 18116) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Section 1557(c) of the Affordable Care Act authorizes the Secretary of the Department of Health and Human Services (Department) to promulgate regulations to implement the nondiscrimination requirements in Section 1557. This notice is a request for information (RFI)

to inform the Department's rulemaking for Section 1557. This RFI seeks information on a variety of issues to better understand individuals' experiences with discrimination in health programs or activities and covered entities' experiences in complying with Federal civil rights laws.

DATES: Comments must be received at one of the addresses provided below, no later than 5p.m. on September 30, 2013.

ADDRESSES: Written comments may be submitted through any of the methods specified below. Please do not submit duplicate comments.

• *Federal eRulemaking Portal:* You may submit electronic comments at <http://www.regulations.gov>. Follow the instructions for submitting electronic comments. Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.

• *Regular, Express, or Overnight Mail:* You may mail written comments (one original and two copies) to the following address only: U.S. Department of Health and Human Services, Office for Civil Rights, Attention: 1557 RFI (RIN 0945-AA02), Hubert H. Humphrey Building, Room 509F, 200 Independence Avenue SW., Washington, DC 20201. Mailed comments may be subject to delivery delays due to security procedures. Please allow sufficient time for mailed comments to be timely received in the event of delivery delays.

• *Hand Delivery or Courier:* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) to the following address only: Office for Civil Rights, Attention: 1557 RFI (RIN 0945-AA02), Hubert H. Humphrey Building, Room 509F, 200 Independence Avenue SW., Washington, DC 20201. (Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the mail drop slots located in the main lobby of the building.)

• *Inspection of Public Comments:* All comments received before the close of the comment period will be available for public inspection, including any personally identifiable or confidential business information that is included in a comment. We will post all comments received before the close of the comment period at <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT: Carole Brown, 202-619-0805.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1557 is consistent with and promotes several of the Administration's and Department's key initiatives that promote health and equal access to health care. In 2011, the Department adopted the Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities (HHS Disparities Action Plan). With the HHS Disparities Action Plan, the Department commits to continuously assessing the impact of all policies and programs on health disparities and promoting integrated approaches, evidence-based programs and best practices to reduce these disparities. The HHS Action Plan builds on the strong foundation of the Affordable Care Act and is aligned with programs and initiatives such as Healthy People 2020, the First Lady's Let's Move initiative and the President's National HIV/AIDS Strategy. In addition, Exchanges or Health Insurance Marketplaces established under the Affordable Care Act must also comply with all applicable Federal laws prohibiting discrimination.

Section 1557 provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (Title VI), 42 U.S.C. 2000d et seq. (race, color, national origin), Title IX of the Education Amendments of 1972 (Title IX), 20 U.S.C. 1681 et seq. (sex), the Age Discrimination Act of 1975 (Age Act), 42 U.S.C. 6101 et seq. (age), or Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794 (disability), under any health program or activity, any part of which is receiving Federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act or its amendments. Section 1557 states that the "enforcement mechanisms provided for and available under" Title VI, Title IX, Section 504, or the Age Act shall apply for purposes of violations of Section 1557. The Department is responsible for developing regulations to implement Section 1557.

In developing a regulation to implement Section 1557, the Department recognizes that Section 1557 builds on a landscape of existing civil rights laws. For example, the prohibitions against discrimination on the grounds of race, color, national origin, age, and disability in Title VI, the Age Act, and Section 504, respectively, apply to all programs and activities

covered by those statutes, including those related to health; however, the prohibition of sex discrimination in Title IX applies only to education programs and activities of covered entities. Section 1557 is the first Federal civil rights statute that prohibits sex discrimination in health programs and activities of covered entities. Section 1557 also applies to entities created under Title I of the Affordable Care Act, such as the Health Insurance Marketplaces.

Additionally, Section 1557 is the first broad based Federal civil rights statute incorporating the grounds prohibited by four distinct civil rights statutes. Although Title VI, Title IX, the Age Act, and Section 504 have similarities in their purpose, structure, requirements, and enforcement mechanisms, they also have notable differences.

Moreover, almost 50 years have passed since Title VI was enacted and roughly 40 years have passed since Title IX, Section 504, and the Age Act were enacted. Since the enactment of these civil rights laws, the demographics of the United States have increasingly diversified, major advances in electronic and information technology have occurred, and the health care landscape has changed, particularly with the enactment of the Affordable Care Act.

Recognizing the significant issues implicated by the development of a regulation to implement Section 1557, the Department is requesting information through this notice from stakeholders on a range of issues to better inform our rulemaking. The Department welcomes comments from all interested stakeholders, including individuals potentially protected from discrimination under Section 1557, organizations serving or representing the interests of such individuals, the legal community, State, Tribal, and local health agencies, health care providers, health insurers, and other health programs.

II. Solicitation of Comments

The Department is requesting information regarding the following issues. In responding, please indicate in your response the corresponding question number and provide the basis or reasoning for your answers with as much specificity and detail as possible, as well as any supporting documentation, including research or analyses, to ensure we have the most helpful information for our rulemaking.

Understanding the Current Landscape

1. The Department is interested in experiences with, and examples of, discrimination in health programs and

activities. Please describe experiences that you have had, or examples of which you are aware, with respect to the following types of discrimination in health programs and activities: (a) Race, color, or national origin discrimination; (b) Sex discrimination (including discrimination on the basis of gender identity, sex stereotyping, or pregnancy); (c) Disability discrimination; (d) Age discrimination; or (e) discrimination on one or more bases, where those bases intersect.

2. There are different types of health programs and activities. These include health insurance coverage, medical care in a physician's office or hospital, or home health care, for example. What are examples of the types of programs and activities that should be considered health programs or activities under Section 1557 and why?

3. What are the impacts of discrimination? What studies or other evidence documents the costs of discrimination and/or the benefits of equal access to health programs and activities for various populations? For example, what information is available regarding possible consequences of unequal access to health programs and services, such as delays in diagnosis or treatment, or receipt of an incorrect diagnosis or treatment? We are particularly interested in information relevant to areas in which Section 1557 confers new jurisdiction.

Ensuring Access to Health Programs and Activities

4. In the interest of ensuring access to health programs and activities for individuals with limited English proficiency (LEP):

(a) What are examples of recommended or best practice standards for the following topics: (1) Translation services, including thresholds for the translation of documents into non-English languages and the determination of the service area relevant for the application of the thresholds; (2) oral interpretation services, including in-person and telephonic communications, as well as interpretation services provided via telemedicine or telehealth communications; and (3) competence (including certification and skill levels) of oral interpretation and written translation providers and bilingual staff?

(b) What are examples of effective and cost-efficient practices for providing language assistance services, including translation, oral interpretation, and taglines? What cost-benefit data are available on providing language assistance services?

(c) What are the experiences of individuals seeking access to, or participating in, health programs and activities who have LEP, especially persons who speak less common non-English languages, including languages spoken or understood by American Indians or Alaska Natives?

(d) What are the experiences of covered entities in providing language assistance services with respect to: (1) Costs of services, (2) cost management, budgeting and planning, (3) current state of language assistance services technology, (4) providing services for individuals who speak less common non-English languages, and (5) barriers covered entities may face based on their types or sizes?

(e) What experiences have you had developing a language access plan? What are the benefits or burdens of developing such a plan?

(f) What documents used in health programs and activities are particularly important to provide in the primary language of an individual with LEP and why? What factors should we consider in determining whether a document should be translated? Are there common health care forms or health-related documents that lend themselves to shared translations?

5. Title IX, which is referenced in Section 1557, prohibits sex discrimination in federally assisted education programs and activities, with certain exceptions. Section 1557 prohibits sex discrimination in health programs and activities of covered entities. What unique issues, burdens, or barriers for individuals or covered entities should we consider and address in developing a regulation that applies a prohibition of sex discrimination in the context of health programs and activities? What exceptions, if any, should apply in the context of sex discrimination in health programs and activities? What are the implications and considerations for individuals and covered entities with respect to health programs and activities that serve individuals of only one sex? What other issues should be considered in this area?

6. The Department has been engaged in an unprecedented effort to expand access to information technology to improve health care and health coverage. As we consider Section 1557's requirement for nondiscrimination in health programs and activities, what are the benefits and barriers encountered by people with disabilities in accessing electronic and information technology in health programs and activities? What are examples of innovative or effective and efficient methods of making

electronic and information technology accessible? What specific standards, if any, should the Department consider applying as it considers access to electronic and information technology in these programs? What, if any, burden or barriers would be encountered by covered entities in implementing accessible electronic and information technology in areas such as web-based health coverage applications, electronic health records, pharmacy kiosks, and others? If specific accessibility standards were to be applied, should there be a phased-in implementation schedule, and if so, please describe it.

Compliance and Enforcement Approaches

7. Section 1557 incorporates the enforcement mechanisms of Title VI, Title IX, Section 504 and the Age Act. These civil rights laws may be enforced in different ways. Title VI, Title IX, and Section 504 have one set of established administrative procedures for investigation of entities that receive Federal financial assistance from the Department. The Age Act has a separate administrative procedure that is similar, but requires mediation before an investigation. There is also a separate administrative procedure under Section 504 that applies to programs conducted by the Department. Under all these laws, parties also may file private litigation in Federal court, subject to some restrictions.

(a) How effective have these different processes been in addressing discrimination? What are ways in which we could strengthen these enforcement processes?

(b) The regulations that implement Section 504, Title IX, and the Age Act also require that covered entities conduct a self-evaluation of their compliance with the regulation. What experience, if any, do you have with self-evaluations? What are the benefits and burdens of conducting them?

(c) What lessons or experiences may be gleaned from complaint and grievance procedures already in place at many hospitals, clinics, and other covered entities?

8. Are there any other issues important to the implementation of Section 1557 that we should consider? Please be as specific as possible.

III. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and

time specified in the **DATES** section of this preamble.

Dated: June 5, 2013.

Leon Rodriguez,

Director, Office for Civil Rights.

[FR Doc. 2013-18707 Filed 7-31-13; 8:45 am]

BILLING CODE 4153-01-P

DEPARTMENT OF TRANSPORTATION

Pipeline and Hazardous Materials Safety Administration

49 CFR Part 192

[Docket ID PHMSA-2013-0161]

Pipeline Safety: Class Location Requirements

AGENCY: Pipeline and Hazardous Materials Safety Administration (PHMSA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: PHMSA is seeking public comment on whether applying the integrity management program (IMP) requirements, or elements of IMP, to areas beyond current high consequence areas (HCAs) would mitigate the need for class location requirements for gas transmission pipelines.

Section 5 of the Pipeline Safety, Regulatory Certainty, and Job Creation Act of 2011 requires the Secretary of Transportation to evaluate and issue a report on whether IMP requirements should be expanded beyond HCAs and whether such expansion would mitigate the need for class location requirements.

DATES: The public comment period for this notice ends September 30, 2013.


ADDRESSES: You may submit comments identified by the Docket ID PHMSA-2013-0161 by any of the following methods:

- *E-Gov Web site:* <http://www.regulations.gov>. This site allows the public to enter comments on any **Federal Register** notice issued by any agency. Follow the instructions for submitting comments.
- *Fax:* 1-202-493-2251.
- *Mail:* Docket Management System, U.S. Department of Transportation (DOT), 1200 New Jersey Avenue SE, Room W12-140, Washington, DC 20590.
- *Hand Delivery:* DOT Docket Management System, Room W12-140, on the ground floor of the West Building, 1200 New Jersey Avenue SE., Washington, DC between 9:00 a.m. and 5:00 p.m., Monday through Friday, except Federal holidays.

Instructions: Identify the Docket ID at the beginning of your comments. If you submit your comments by mail, submit

Comment on FR Doc # 2013-18707

This is a Comment on the **Department of Health and Human Services (HHS) Proposed Rule: Requests for Information: Nondiscrimination in Certain Health Programs or Activities**

For related information, [Open Docket Folder](#) 

Comment Period Closed
Sep 30 2013, at 11:59 PM ET

ID: HHS-OCR-2013-0007-0060
Tracking Number: 1jx-87wi-xx8t

Document Information

Date Posted:
Sep 30, 2013

[Show More Details](#) 

Submitter Information

Submitter Name:
Anonymous Anonymous

Comment

As a Federal employee, I participate in the Federal Employees Health Benefits Program (FEHBP) program for my health insurance, a program which receives Federal funds and is administered by a Federal agency, and is therefore covered by Federal anti-discrimination laws such as Section 1557. I have several options of insurers, but each insurance brochure contains this or similar language:

"We do not cover the following:

- Services, drugs, or supplies related to sex transformations;"

This policy is clear discrimination on the basis of sex and must not be tolerated in Medicare, Medicaid, FEHBP, insurance on the exchanges, or any other government-funded healthcare. The Equal Employment Opportunity Commission has held that discrimination on the basis of gender identity is necessarily discrimination on the basis of sex. *Macy v. Holder*, EEOC Appeal No. 0120120821. The EEOC concluded "that intentional discrimination against a transgender individual because that individual is transgender is, by definition, discrimination "based on . . . sex," and such discrimination therefore violates Title VII. The Commission noted in its decision that it "expressly overturn[ed] . . . any contrary earlier decisions from the Commission." The EEOC states, "When an employer discriminates against someone because the person is transgender, the employer has engaged in disparate treatment 'related to the sex of the victim.' This is true regardless of whether the individual has expressed his or her gender in a non-stereotypical fashion, because the employer is uncomfortable with the fact that the person has transitioned or is in the process of transitioning from one gender to another, or because the employer simply does not like that the person is identifying as a transgender person. In each of these circumstances, the employer is making a gender-based evaluation." (internal citations omitted).

In the case of exclusions for transgender-related care, insurers are discriminating against the act of transition, which, as the EEOC makes clear, is necessarily and definitionally discrimination on the basis of sex and therefore illegal under Title VII and Section 1557.

Prominent medical organizations such as the American Medical Association, the American Psychiatric Association, the American

Psychological Association, the American Academy of Family Physicians, the American Public Health Association, and the American College of Obstetricians and Gynecologists have all weighed in, making clear that treatments such as mental health care, hormone therapy, and sex reassignment surgery are medically necessary treatments for many transgender individuals. See, e.g., Professional Organization Statements Supporting Transgender People in Health Care, Lambda Legal, available at http://www.lambdalegal.org/sites/default/files/publications/downloads/fs_professional-org-statements-supporting-trans-health_4.pdf.

While the costs to the Federal government for covering such care would be low - in San Francisco, insurers found the costs to be so low as to no longer separately rate and price coverage for transition-related care (See San Francisco Transgender Benefit, Human Rights Campaign, available at <http://www.hrc.org/resources/entry/san-francisco-transgender-benefit>) - the costs to transgender individuals for failing to remedy this discrimination are high. Not only are the costs for mental health care, hormone replacement therapy, and sex reassignment surgery significant, ranging into the tens of thousands of dollars, but covering such procedures will improve overall health. As the Center for American Progress noted in a recent report, "The California Department of Insurance assessment [Economic Impact Assessment: Gender Nondiscrimination in Health Insurance, State of California Department of Insurance, April 13, 2012, available at <http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf>] found improved outcomes for some of the most significant health problems facing the transgender population, including reduced suicide risk, lower rates of substance abuse, improved mental health outcomes, and increased adherence to HIV treatment regimens." FAQ: Health Insurance Needs for Transgender Americans, Center for American Progress, October 3, 2012, available at <http://www.americanprogress.org/wp-content/uploads/2012/10/TransgenderHealth.pdf>.

The Office for Civil Rights should immediately make clear to all Federal agencies, States, and private medical insurers that exclusions for transgender care are inconsistent with present law, must not be enforced in response to current claims, and must be removed from future plan brochures.

U.S. Department of Health and Human Services
 Office for Civil Rights
 Attention: 1557 RFI (RIN 0945-ZA01)
 Hubert H. Humphrey Building
 Room 509F
 200 Independence Avenue, SW
 Washington, DC 20201

To whom it may concern:

The Center for American Progress is pleased to have the opportunity to comment on the request for information published by the Department of Health and Human Services (HHS) regarding health care discrimination in health programs and activities in the context of Section 1557 of the Affordable Care Act. We join the Department of Health and Human Services in strongly supporting efforts to promote health and equal access to health care, with the eventual goal of ensuring that no individual will be unfairly denied the care and coverage they need.

A population that has faced significant barriers across healthcare systems in our country is the lesbian, gay, bisexual, and transgender (LGBT) population. Sources such as the Institute of Medicine,ⁱ Healthy People 2020,ⁱⁱ the Substance Abuse and Mental Health Services Administration,ⁱⁱⁱ and the *National Healthcare Disparities Report*^{iv} indicate that LGBT individuals and their families are disproportionately likely to live in poverty, to be uninsured, and to face substantial barriers to quality health care, including refusals of care, substandard care, inequitable policies and practices, and exclusion from health outreach or education efforts.^v As a result, the LGBT population experiences significant disparities in health indicators such as smoking,^{vi} obesity,^{vii} experiences of abuse and violence,^{viii} mental and behavioral health concerns,^{ix} and HIV infection.^x These inequities may be even more pronounced for LGBT people who are also members of other groups that are disadvantaged on the basis of factors such as race, ethnicity, geography, or disability.

These comments provide information regarding the experiences of LGBT people in health care and coverage systems, and details the reasoning – based both in practical and legal foundations – for including and addressing gender identity and sexual orientation-based discrimination under the sex-based nondiscrimination protections included in Section 1557. In these comments, we address several of the questions posed by HHS with regard to experiences of discrimination and the scope and breadth of Section 1557's applicability. This includes:

- Experiences of discrimination against LGBT people in health programs and activities
- Programs and activities that should be considered health programs and activities under Section 1557
- The impact of discrimination against LGBT people in health programs and activities
- Considerations in the applicability of Title IX sex-based nondiscrimination protections
- Enforcement mechanisms provided by Section 1557

Below, we discuss each of these issues in turn.

Question 1: Experiences of discrimination against LGBT people in health programs and activities

Discrimination in healthcare has adversely and disproportionately impacted the LGBT community.

Lesbian, gay, bisexual, and transgender Americans have too often faced health care and coverage systems that have provided inequitable and sometimes hostile treatment on the basis of their sexual orientation or gender identity. Discrimination has touched the lives of many LGBT people at all points in the health care system – from being unable to access insurance coverage, to outright refusals to provide care, to verbal and physical abuse at the hands of medical professionals.

Discrimination in Insurance Coverage

Prior to passage of the Affordable Care Act, few nondiscrimination protections applied to insurance, and these laws and regulations had only a limited effect in ensuring fair coverage for all consumers.^{xi} Exclusions on the basis of preexisting conditions, variations in rates and charges based on personal characteristics, and arbitrary revocation of coverage were among the discriminatory practices that persisted in private insurance markets, but are being ended by the reforms introduced by the Affordable Care Act.

However, discrimination in benefits design has also been pervasive in both public and private systems of health coverage, and eradicating such discrimination has historically been a challenging process for both consumers and regulators.^{xii} For example, in the private insurance market, breast reconstruction following mastectomy was widely considered cosmetic and routinely excluded from coverage until the passage of the Women’s Cancer Recovery Act of 1998. Similarly, private market carriers continue to argue that exclusions for services or drugs commonly provided for the treatment of conditions such as HIV/AIDS are not discriminatory because they apply to all plan enrollees, regardless of their specific negative effect on people with these conditions. As a result, these discriminatory exclusions persist – and an estimated 30 percent of Americans living with HIV are unable to access coverage – despite nondiscrimination laws such as the Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act (HIPAA).^{xiii} These exclusions have disproportionately impacted the LGBT community, in that lesbian and bisexual women have higher rates of breast cancer than heterosexual women, and HIV infection rates are elevated among gay and bisexual men, as well as transgender women.^{xiv}

Transgender people have also experienced discrimination in the form of exclusions for otherwise-covered services when provided for the purpose of treating Gender Identity Disorder, gender dysphoria, or related conditions. Like anyone else, transgender people need acute care when they are sick and preventive care to keep from becoming sick, including services that are traditionally considered to be gender-specific, such as pap smears, prostate exams, and mammograms. In addition, transgender people need access to medically necessary care related to gender transition, and access to these transition-related services is integral to the meaning of gender identity nondiscrimination. For transgender people, their identity – the essence of who they are – is closely connected with a medical condition.^{xv} The medical diagnosis that correlates with a transgender identity is most frequently referred to as gender identity disorder, or GID, which the American Medical Association,^{xvi} the American Psychiatric Association,^{xvii} and the World Health Organization^{xviii} all recognize as a serious medical condition. To fail to provide equal coverage for services when provided to transgender people for the purpose of gender transition is to engage in discrimination on the basis of gender identity.

In the private market, carriers have often excluded benefits from coverage in a manner that discriminates on the basis of gender identity. Examples of such discriminatory designs include exclusions for “any procedure or treatment, including hormone therapy, designed to change your physical

characteristics from your biologically determined sex to those of the opposite sex,” or for “all services related to gender dysphoria or gender identity disorder.”^{xxix} In public or government-provided health benefits programs, these discriminatory exclusions also frequently block coverage for medically necessary care provided to transgender people. For example, Medicaid programs have adopted exclusions for “treatment of gender dysphoria including gender reassignment surgeries”^{xxx} among others. Health plans offered to federal government employees through the FEHB program have contained exclusions targeting transgender enrollees,^{xxxi} as have benefits offered through the VA^{xxii} and Medicare.^{xxiii}

These exclusions arbitrarily target transgender people for discrimination by forcing them to pay out-of-pocket for the same medically necessary services provided to non-transgender people. Moreover, coverage determinations based on these exclusions are sometimes used in practice to deny transgender people coverage for basic services that are unrelated to gender transition. For example, a transgender woman in New Jersey who was denied coverage for a mammogram on the basis that it fell under her plan’s sweeping exclusion for all treatments “related to changing sex.” It took a two-year appeal process and intervention from the Transgender Legal Defense and Education Fund before the insurer agreed that the exclusion had unfairly prevented her from receiving medically necessary care and reimbursed her for the mammogram.

These transgender-specific exclusions contradict the consensus of leading professional medical associations regarding the medical necessity of these treatments for many patients, and they unacceptably limit access to otherwise covered benefits on the basis of gender identity. Major expert associations also agree that transition-related medical services, including mental health services, hormone therapy, and surgery, are medically necessary for many transgender people. The American Medical Association; the American Psychological Association; the American Psychiatric Association; the American Academy of Family Physicians; the American Congress of Obstetricians and Gynecologists; the Endocrine Society; the National Association of Social Workers; and the World Professional Association for Transgender Health have all issued public statements to this effect. According to these expert associations, determination of the medical necessity of any particular transition-related service for an individual patient properly rests with medical providers, not insurance companies. Additionally, according to the American Medical Association, “GID, if left untreated, can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death.”^{xxxiv}

People living with HIV, a population that disproportionately includes gay and bisexual men and transgender women, also face significant barriers in accessing health care and treatment due to discriminatory benefits designs in public and private health insurance plans. Examples of these designs include: monthly limits on prescription drugs or the exclusion of drugs recognized as the standard of care for HIV and utilization management techniques used primarily to deny or restrict access to care for people with chronic and complex health conditions. In addition to discriminatory plan designs, people living with HIV are also more likely to experience adverse coverage decisions, including service denials and rescission of coverage.

Discrimination in the provision of health care

For LGBT people who have been able to access health care despite barriers in coverage and benefits programs, many experiences have been colored by discriminatory experiences in the provision of that care.

A 2009 survey conducted by Lambda Legal provides data illustrating the gravity of discrimination in health care settings. Among lesbian, gay, and bisexual respondents, 56 percent reported experiencing discrimination ranging from health care workers being physically or verbally abusive to outright refusals of treatment.^{xxv} Among these experiences were harsh or abusive language (10 percent), refusal to touch (11 percent), or being blamed for their health status (12 percent). 8 percent of LGB respondents were denied healthcare as a result of their sexual orientation.^{xxvi} Transgender respondents to the Lambda Legal survey experienced even higher rates of discrimination in health care settings. Overall, 70 percent of transgender or gender non-conforming respondents reported experiencing discrimination while receiving care – nearly a quarter reported being subjected to abusive language, over 20 percent were blamed for their own health conditions, and almost 8 percent reported experiencing physically rough or abusive treatment from a health care professional.^{xxvii} One-third of these respondents were refused care altogether because of their gender identity.^{xxviii}

A second national survey of transgender people conducted by the National Gay and Lesbian Task Force and National Center for Transgender Equality details the experiences of discrimination among transgender Americans to an even greater degree. Transgender and gender nonconforming people seeking health care were denied equal treatment in doctor's offices and hospitals (24 percent), emergency rooms (13 percent), mental health clinics (11 percent), by EMTs (5 percent) and in drug treatment programs (3 percent).^{xxix} Discrimination reported among transgender people of color is especially high. Nearly one in five African American respondents reported being refused treatment, and 6 percent reported being physical attacked in doctor's office.^{xxx} Nearly one in three Latino/a respondents reported unequal treatment by a doctor or hospital.^{xxxi} 36 percent American Indian respondents were refused medical care.^{xxxii} These figures are only some of the findings regarding discrimination in health care settings reported in the survey.

In addition, stigma associated both with the LGBT community and HIV status serves as a significant barrier to care for people living with HIV or AIDS. People living with HIV report provider refusal to treat them as well as excessive provider precautions with regard to treatment of people living with HIV that do not comport with federal HIV treatment or health professional safety guidelines.^{xxxiii} HIV providers also report challenges with linking their patients to other specialty services.^{xxxiv} Provider refusal to treat as well as excessive precautions when treating people living with HIV has occurred across provider types, including private physicians, dentists, and community health centers.^{xxxv} Some services providers have gone so far as to put in place blanket policies refusing to provide services to people living with HIV.^{xxxvi} Black gay men and other men who have sex with men (MSM) also report high rates of stigma when accessing health care. In 2011, the National Alliance of State and Territorial AIDS Directors (NASTAD) and the National Coalition of STD Directors (NCSD) designed and implemented a survey to explore how community- and institution-level stigma within public health practice negatively affects HIV- and STD-related outcomes.^{xxxvii} The survey was completed by more than 1,300 health department and community-based organization (CBO) staff, health providers, and community members representing 54 different states and territories.^{xxxviii} Survey results showed high levels of perceived community-level and institutional stigma directed at Black and Latino gay men and other MSM.^{xxxix}

Individual stories of health care discrimination lay bare the results of these extraordinarily high rates of discrimination against LGBT patients – and transgender patients in particular. The tragic reality is that discrimination against LGBT people and people living with HIV, solely because of their sexual orientation, gender identity, and/or HIV status, has resulted in deaths and undue hardships that were likely preventable:

In August 1995, Tyra Hunter, a transgender woman, was injured in a serious car accident. The paramedics arrived and began treatment. In the course of that treatment, paramedics discovered that Tyra was transgender, and withdrew care. As she laid in the street, the paramedics who had been charged with saving Tyra's life laughed and directed slurs at her. Tyra died later that evening in the emergency room at DC General Hospital.^{xi} At trial, medical experts testified that if Tyra had been properly treated, she would have had "an 84-86 percent change of surviving."^{xli}

Robert Eads, a transgender man and parent of two children, was rushed to the hospital in 1996 while experiencing severe abdominal pain. While in the hospital, he was diagnosed with ovarian cancer. As he desperately sought treatment for his cancer, he was repeatedly turned away by medical providers. Over a dozen doctors refused to treat Eads' cancer, fearing that treating a transgender patient would damage their reputations. Finally, after a year of being diagnosed, Eads found that would treat him. But it was too late – his cancer has metasized to other parts of his body, and Eads died two years later.^{xlii}

Jay Kallio, a New Yorker and transgender man in his 50's, had biopsy that returned results indicating he was living with breast cancer. However, Kallio's attending physician had moral objections to Jay's gender identity, and was so taken aback by the results that he did not inform him about his diagnosis. Jay eventually learned that he had cancer when a he was accidentally informed by a lab technician inquiring about his diagnosis. By this time, Jay's cancer had progressed to where he could not benefit from chemotherapy. Jay later encountered an oncologist who refused to provide treatment advice, and was left to wonder whether his cancer was in remission. Kallio himself said, "I am medically savvy with a medical background, [am] white and speak English...if I have every advantage [and was still discriminated against], it doesn't bode well for other people."^{xliii}

Donald Ford went to the dentist because of severe tooth pain. Although his tooth needed to be removed, the dentist refused to do so without proof of his HIV diagnosis. Once the doctor received proof of Ford's status he refused to extract the tooth, claiming that Ford's viral load was too high, and sent him home. Ford was in extreme pain, and eventually became so desperate that he tried to remove the tooth himself.^{xliv}

Lupita Benitez, a lesbian who wanted to have a child, was denied access to the full range of infertility treatment by her medical doctor because of her sexual orientation. Her doctors were conservative Christians who claimed their religious beliefs gave them a right to withhold routine care from Benitez. Benitez was denied effective treatment for nearly a year. She subsequently was forced to abandon her course of treatment and seek out a doctor who would provide her with the treatment she needed.^{xlv}

At age 75, Dr. Robert Franke, a retired university provost and minister, moved into an assisted living facility. He only lived in the facility for one day before his HIV status was discovered. His daughter was told that she had to remove Dr. Franke from the facility immediately or he would be turned over to Adult Protective Services. For seven weeks, Dr. Franke was forced to sleep on a small bed in his daughter's kitchen and was deprived of human companionship during the day while his daughter was at work.

These stories are reflective of the type of discrimination faced by LGBT patients when trying to access healthcare and related services, but unfortunately, they represent only a small fraction of the cases in which such discrimination is present.

Question 2: Programs and activities that should be considered health programs and activities under Section 1557

Section 1557 Applies to Health Programs or Activities of Recipients of Federal Financial Assistance; Programs or Activities Administered by an Executive Agency; and Entities Established Under Title I of the ACA.

Section 1557 protects individuals from discrimination “on the ground[s] prohibited under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973” in “any health program or activity, any part of which is receiving Federal financial assistance, or under any program or activity that is administered by an Executive Agency,” or any entity established under Title I of the ACA. As is discussed more fully below, these health programs include public and private entities and activities in virtually all aspects of the health care system.

Prior to the enactment of Section 1557, the four laws that it references (Title VI, Title IX, Section 504 of the Rehabilitation Act (“Section 504”), and the Age Discrimination Act (“the Age Act”)) provided some protection against discrimination in health care. It is essential that Section 1557 be interpreted consistent with these existing protections in health programs as generally described under the CRRA. In addition, Section 1557’s nondiscrimination mandate may overlap with existing protections under Title VI, Title IX, Section 504, and the Age Act. Other federal antidiscrimination laws, like Title VII, apply to aspects of health programs as well.

Section 1557 applies to any health program or activity, any part of which receives federal financial assistance, which for purposes of Section 1557 specifically includes credits, subsidies, and contracts of insurance.

Congress, in drafting Section 1557, used the same language – “program or activity” – as used in the four civil rights statutes Section 1557 references to indicate the entities covered by it.^{xlvi} “Program or activity” under Section 1557 thus has the same meaning as it does under those statutes, as defined by the CRRA. A covered “program or activity” thus includes public or private entities, as well as departments or agencies of a state or local government that receive federal financial assistance.

Furthermore, Congress structured Section 1557 similarly to the way it structured Title IX. Like Title IX, Section 1557 is written with a term that modifies the phrase “program or activity” (“education” in Title IX, “health” in Section 1557). The term “education” in Title IX does not limit the range of recipients of federal financial assistance that fall under Title IX’s jurisdiction; rather, the term indicates which portions of a covered program or activity cannot discriminate. Congress confirmed this interpretation when it enacted the CRRA.^{xlvii} Because Section 1557 is structured like Title IX, the analysis used to determine jurisdiction under Title IX should be used to determine jurisdiction under Section 1557.

In the Title IX context, if the entity has education as its primary purpose, like a public or private university, Title IX prohibits sex discrimination in all of its programs or activities.^{xlvi} If the entity does not have education as its primary purpose, Title IX bars discrimination in the education portions of the entity, any part of which receives federal financial assistance for any purpose.^{xlix} Likewise, Section 1557 should be interpreted to prohibit discrimination in all the operations of a covered entity that has health as its primary purpose.ⁱ These include entities such as state and local health departments, hospitals and hospital systems, health clinics, nursing homes, home care agencies, health insurance companies, health or medical research centers, and medical, dental, or other schools that focus on training individuals to enter careers in the health field.

Section 1557 also applies to entities that do not have health as a primary purpose. For a covered entity that does not have health as its primary purpose, Section 1557 prohibits discrimination in that entity's health programs or activities, regardless of whether those health programs or activities receive federal financial assistance as long as the entity itself does. This includes, for example, health insurance plans offered by institutions that receive federal financial assistance and health education programs at schools or other entities.ⁱⁱ

Whether a particular entity or program should be considered “health” related for purposes of Section 1557, like the question of whether a program is educational under Title IX, is a fact-specific question. To effectuate Section 1557's nondiscrimination principle, the determination of whether a program is a “health” program or activity should be consistent with existing interpretations of the term “health” offered by the World Health Organization (WHO). WHO defines health to include not just the absence of disease but also “physical, mental, and social well-being.”ⁱⁱⁱ Based on this widely accepted definition of health, a health program or activity includes any program or activity that is designed to promote, maintain, or prevent the decline of the health of the physical, mental, or social well-being of an individual or population's health.

Section 1557 applies to credits, subsidies, and contracts of insurance as federal financial assistance.

Section 1557 differs from the civil rights laws to which it refers by expressly identifying “credits, subsidies, [and] contracts of insurance” as federal financial assistance to make clear that each trigger its application. For example, Section 1557's inclusion of “contracts of insurance” as federal financial assistance means that it could have broader application than the other civil rights laws it references. Unlike Section 1557, Title VI, Title IX, and the Rehabilitation Act either explicitly exclude or have been interpreted in some circumstances to exclude contracts of insurance as a form of federal financial assistance.^{liii} A contract of insurance that is federal financial assistance is any contract of insurance that is funded, entered into, administered, or guaranteed by the federal government. Thus, for example, an insurance company in an Exchange that receives federally-subsidized payments such as through premium tax credits is covered by Section 1557. In addition, contracts for health insurance entered into by the federal government to provide coverage for federal employees are also federal financial assistance to the contracting insurance company. Because contracts of insurance are explicitly included in Section 1557, its regulations must recognize this fact and ensure that these federal funds are not used to finance discrimination.

Furthermore, the term “contracts of insurance” includes all aspects of such insurance contracts and administration of those contracts, including benefits design. Prior to the Affordable Care Act, few nondiscrimination protections applied to insurance, which had only a limited effect in ensuring fair coverage for all consumers. But several provisions of the ACA, including Section 1557, are designed to

address this gap by prohibiting practices previously viewed as permissible in many insurance markets.^{liv} Among these practices is discrimination in benefits design, which has been pervasive in the insurance industry.^{lv} For example, carriers have often excluded benefits from coverage in a manner that discriminates on the basis of gender identity. Examples of such discriminatory designs include exclusions for “any procedure or treatment, including hormone therapy, designed to change your physical characteristics from your biologically determined sex to those of the opposite sex,” or for “all services related to gender dysphoria or gender identity disorder.”^{lvi} These exclusions directly target transgender consumers, contradict the consensus of leading professional medical associations,^{lvii} and limit access to otherwise covered benefits on the basis of gender identity. Section 1557 should be interpreted to prohibit benefit designs that discriminate in this manner in programs administered by the federal government and in coverage programs or plans that receive federal funds.

Section 1557 applies to programs or activities administered by an Executive Agency.

Section 1557 protects individuals from discrimination “under any program or activity that is administered by an Executive Agency.” Section 504, too, applies to any program or activity, “conducted by any Executive agency.”^{lviii} The phrases “administered by” and “conducted by” are generally synonymous.^{lix} Federally-conducted programs or activities have typically been defined to include “anything a federal agency does.”^{lx} Simply put, “any program or activity that is administered by an Executive Agency” means that “anything a federal agency does” is subject to the nondiscrimination requirements of Section 1557.

More specifically, Section 1557 applies to HHS-administered health programs such as Medicare as well as jointly-administered federal and state programs such as Medicaid and the Children’s Health Insurance Program (CHIP).^{lxi} HHS is not the only federal agency that must comply with Section 1557; indeed, all federal agencies must conduct their programs and activities in a nondiscriminatory way to comply with Section 1557. This includes, for example, the agencies involved in implementing the ACA such as the Department of Labor and the Department of the Treasury. Likewise, Section 1557 applies to the Federal Employee Health Benefits Program (FEHBP), which is administered by the Office of Personnel Management, an executive agency.

Section 1557 applies to entities established under Title I of the ACA.

The third category of entities in which Section 1557 protects individuals from discrimination are entities established under Title I of the ACA. The health insurance Exchanges and Consumer-Oriented and Operated Plans (CO-OPs) are examples of entities that were or will be created pursuant to Title I of the ACA and that are, therefore, subject to Section 1557.^{lxii} As under other civil rights laws, a covered entity itself can neither discriminate, nor can it provide assistance—monetary or otherwise—to entities that discriminate.^{lxiii}

Question 3: The impact of discrimination against LGBT people in health programs and activities

Discrimination in healthcare programs and activities compounds with institutional and interpersonal discrimination to contribute to negative health outcomes for LGBT people. The Institute of Medicine has recognized that the stigma and discrimination experienced by LGBT people contributes to minority stress, which in turn can cause negative mental health outcomes.^{lxiv} Studies have documented such disparities among subpopulations of the LGBT community, including elevated rates of depression, anxiety, and substance use.^{lxv} For example, in a 2011 report presented to the American Psychology

Association, researchers found that lesbian, gay, and bisexual people who had experienced prejudice-related events were three times more likely to have suffered a serious physical health problem over a one-year follow-up period than those who had not experienced such events.^{lxvi} Also, in a recent study of Latina transgender women, respondents reported high levels of discrimination in various aspects of everyday life, and those who reported higher levels of discrimination were more likely to be identified with moderately severe to severe levels of depression.^{lxvii} And while data from the National Transgender Discrimination Survey, conducted by the National Gay and Lesbian Task Force and National Center For Transgender Equality, on the relationship between discrimination in health care and suicidality was not reported, the high lifetime suicide attempt rate among the sample (41 percent) was dramatically higher among those who had experienced bias-motivated victimization in other forms, such as bullying in school (51 percent), loss of a job (55 percent), and physical assault in any setting (61 percent).^{lxviii} Ultimately, internalized stigma, experiences of victimization, and fear of accessing health services were all significantly associated with poorer physical health, higher likelihood of disability, and higher degrees of depressive symptoms and perceived stress.^{lxix}

In addition to the institutional drivers of health disparities among the LGBT population, discrimination in the health care context can result in more direct negative health outcomes. While in severe instances, acts of discrimination by healthcare providers have resulted in serious injury, disease progression, and death,^{lxx} denial of care and delivery of inadequate care can also lead to mistrust and reluctance to seek care on the part of LGBT patients.^{lxxi} For example, according to a national survey of transgender adults, 28 percent of respondents reported postponing or not seeking care when sick or injured and 33 percent reported postponing or not seeking preventive care out of fear of discrimination or disrespect from providers. Failure to obtain preventative health care screenings out of fear of discrimination can lead to a delay in diagnosing and treating general health issues and to higher rates of hospitalization.^{lxxii}

Discriminatory barriers to health care coverage for LGBT people may also have an impact on health outcomes. For example, a California Department of Insurance studying the impact of removing discriminatory coverage exclusions that target the transgender population found improved outcomes for some of the most significant health problems facing the transgender population, including reduced suicide risk, lower rates of substance abuse, improved mental health outcomes, and increased adherence to HIV treatment regimens.^{lxxiii} Thus, while discrimination in health care programs and activities may drive some negative health outcomes for LGBT individuals, *removing* such discrimination may also *improve* the health of the LGBT population.

Question 5: Considerations in the applicability of Title IX sex-based nondiscrimination protections

Section 1557 bars discrimination “on the ground prohibited under . . . title IX of the Education Amendments of 1972,” which is sex.^{lxxiv} It is critical that regulations issued pursuant to this new statute reflect the long-established jurisprudence of strong protections against sex discrimination in federal law. Regulations, guidance, and case law under Title VII of the Civil Rights Act of 1964, the Pregnancy Discrimination Act (PDA), and Title IX of the Education Amendments of 1972 should inform what constitutes sex discrimination in health care under Section 1557. In addition, Section 1557 may not be misinterpreted to narrow existing interpretations of and protections against sex discrimination.

Section 1557’s prohibition of sex discrimination necessarily includes discrimination based on pregnancy, gender identity, and sex stereotypes—as the RFI rightly notes.^{lxxv}

Discrimination on the basis of actual or potential parental, family or marital status also violates Section 1557 if this behavior treats women and men differently or is based on sex stereotypes. Title IX's prohibition on sex discrimination encompasses these grounds.^{lxxxvi} Title IX further prohibits actions based on head of household or principal wage earner status.^{lxxxvii} Section 1557 regulations should likewise prohibit discrimination on these bases.

Further, Title IX has consistently been interpreted to bar discrimination based on sex stereotyping—including discrimination based on the assumption that someone conforms to a sex stereotype and discrimination against an individual because he or she departs from a sex stereotype—and Section 1557 must be understood to ban such discrimination.^{lxxxviii} Similarly, the E.E.O.C. has also concluded that discrimination based on gender identity or transgender status is a form of sex discrimination under Title VII,^{lxxxix} as has the Department of Housing and Urban Development with regard to the Fair Housing Act.^{lxxx} Indeed, HHS has already recognized the importance of addressing discrimination against LGBT people in health care when it included explicit prohibitions against sex, gender identity, and sexual orientation discrimination in final rules for health insurance Exchanges, QHPs, and the EHB.^{lxxxi}

In addition, HHS should clarify that sexual orientation falls within the sex stereotyping protections under Section 1557. Discrimination on the basis of sexual orientation is itself inherently rooted in sex stereotypes: that men are supposed to be attracted to women, and women are supposed to be attracted to men. Therefore, discrimination against gay, lesbian, and bisexual men and women is also discrimination for failing to conform to stereotypical gender roles.^{lxxxii} This reasoning has been accepted by several federal, state, and international courts and furthers HHS's goal to combat discrimination based on sex-stereotyping.^{lxxxiii} Given this inextricable link between discrimination based on sexual orientation and nonconformity with sex stereotypes, 1557's prohibition on sex discrimination should be interpreted to include discrimination on the basis of sexual orientation.

Clarification from HHS is also needed to ensure that LGB people are not excluded from bringing traditional sex discrimination claims under Section 1557. In Title VII discrimination cases, many sex discrimination claims made by lesbian, gay, and bisexual plaintiffs who have faced sex based discrimination unrelated to their sexual orientation have been rejected because of a perception that these plaintiffs are trying to "bootstrap" sexual orientation claims into Title VII.^{lxxxiv} Like heterosexual individuals, lesbian, gay, and bisexual individuals can and do face sex based discrimination aside from their sexual orientation and should be afforded the same protections under Section 1557. To avoid this misinterpretation and unequal enforcement, Section 1557 regulations should provide clear guidance on the permissibility of traditional sex discrimination claims made by people who may also have lesbian, gay, or bisexual sexual orientations.

The only exceptions to Section 1557's broad nondiscrimination mandate are specifically and explicitly contained in Title I of the ACA.

The Section 1557 ban against discrimination in health programs includes a single exception – that it applies "[e]xcept as otherwise provided" in Title I of the ACA.^{lxxxv} Thus, the only exceptions to Section 1557 are those expressly stated in that title. The plain language of the statute bars any interpretation that would suggest any other exceptions apply. In fact, exceptions to general rules like Section 1557's antidiscrimination provision must be read strictly and narrowly.^{lxxxvi}

Nothing in Section 1557, its language or legislative history, allows for any other limitations or exceptions regarding its application. Question (5) of the RFI notes that Title IX^{lxxxvii} contains limited exceptions to its

protection in certain circumstances. These exceptions, however, are not incorporated into Section 1557. First, because those limited exceptions are not explicitly stated in Section 1557, they cannot be read to apply to it. Second, Section 1557 does not import any exceptions from Title IX. Section 1557 references Title IX solely for the ground on which it prohibits discrimination, which is sex.

Sex-specific health programs or activities do not violate Section 1557 when they are necessary to accomplish an essential health purpose.

Because the RFI specifically asks how Section 1557 should apply to health programs and activities that serve only one sex, we address that issue here. Like Title IX and other civil rights laws, the circumstances under which sex-specific programs and activities are permissible and thus nondiscriminatory must be narrow. Consistent with Section 1557's broad nondiscrimination purpose, sex-specific health programs or activities should be permissible under Section 1557 when they are necessary to serve the disadvantaged sex – most usually women – or to comply with constitutionally protected rights to privacy. At heart, single-sex programs must be narrowly tailored and *necessary to accomplish an essential health purpose*. For example, clinical trials that aim to determine whether sex differences exist in certain diseases or responses to treatment do not violate Section 1557 when they establish sex-specific studies because the very purpose of the study is about sex difference and its impact on medical treatments. Further, Section 1557's protection against sex discrimination still applies in single-sex environments. So, where sex-specific programs or activities exist, they must be nondiscriminatory for each sex.

To the extent that Section 1557 makes narrow allowances for single-sex programs or activities, participation in these programs is determined by an individual's self-identified gender. As noted above, Section 1557 protects against gender identity discrimination, which means that the law protects an individual's ability to live in his or her community *as a man or a woman*.^{lxxxviii} So too Section 1557 protects an individual's access to health programs and activities in accordance with their self-identified gender and free from sex stereotypes.

Question 7: Enforcement mechanisms provided by Section 1557

Section 1557 Includes the Enforcement Mechanisms Provided For and Available Under Title VI, Title IX, Section 504, and the Age Discrimination Act.

It is critical that OCR create and administer a strong enforcement system for this new statute. The success of Title IX in combatting sex discrimination demonstrates the importance of strong agency enforcement.

The compliance and enforcement procedures used under Title IX and the three other civil rights laws referenced by Section 1557 provide a starting point for establishing procedures under Section 1557. The regulations adopted for Section 1557 must reflect the entire wide range of equitable relief and enforcement mechanisms established and available under those statutes, including agency enforcement as well as the private right of action for monetary damages.

Because the statutes listed in Section 1557 contain a private right of action for a full range of relief, including equitable relief and monetary damages, Section 1557 does as well.^{lxxxix} Likewise, Section 1557 provides for the full range of agency enforcement and Department of Justice enforcement in court.

The enforcement procedures provided under the laws referenced by Section 1557 are a starting point for developing procedures under Section 1557. Like those laws, Section 1557 must be interpreted to provide for complaints brought on behalf of an individual, a class, or by a third party. Each of these vehicles for agency enforcement is crucial and a hallmark of civil rights enforcement under the laws Section 1557 references. Class complaints and third party complaints in particular allow OCR to resolve systemic problems of discrimination, rather than proceeding piecemeal only on behalf of individual complainants. They are especially important in the health care area because of the consequences of allowing system-wide patterns of discrimination to continue. Individual victims of discrimination may be hesitant to file complaints themselves because, for example, they fear retaliation from individuals or entities on which they rely for health care or insurance coverage. This creates a strong disincentive for some to file complaints and reinforces the importance of class and third party complaints.

Compliance reviews, outreach, and education will assist in enforcement of the protections provided by Section 1557

Section 1557 is a powerful proactive tool in OCR's work to combat discrimination in health programs and activities. OCR's authority is not limited to responding to complaints under Section 1557. It can—and should—also address discriminatory policies and practices at covered entities through technical assistance, systemic investigations, and compliance reviews of selected entities. OCR has conducted these reviews pursuant to its authority under other civil rights laws.^{xc} Because Section 1557 is a new law, it is especially important that OCR complete compliance reviews to both identify discrimination and set precedents under this new law. Without knowledge of Section 1557's protection or how to file a complaint, individuals remain vulnerable to discrimination in health care settings and covered entities may well continue discriminatory practices.^{xci} The results of compliance reviews should also be made public. The reports from such reviews can serve as guidance for other covered entities as to what it means to comply with Section 1557.

The communities protected by Section 1557 will also require education as to their rights and the enforcement mechanisms available to them under the statute and implementing regulations. Previous experience dictates that those who have gone without nondiscrimination protections previously may be uncertain regarding their rights when these protections are introduced. In a survey conducted by the Transgender Law Center on the impact of the California's LGBT nondiscrimination laws on the transgender community, research showed that 30 percent of survey respondents did not know about the law, and 27 percent did not know how to file a complaint.^{xcii} Therefore, when promulgating rules regarding enforcement processes and mechanisms for Section 1557, HHS should craft effective measures to encourage minorities, including the LGBT community, to seek out resources that are created to assist them. HHS must proactively (1) educate communities about new protections, (2) require information about Section 1557 patient rights to be posted in health care facilities, (3) provide clear information, resources, and assistance for people to file complaints, and (4) provide training for health administrators, legal professionals, and Marketplace consumer assistance entities about new duties under Section 1557.

We commend HHS for taking the important step of issuing this RFI and urge the Department to move forward with the rulemaking necessary to implement this crucial new civil rights protection. We urge HHS to administer this statute through robust implementation and enforcement mechanisms, and this must be reflected in the final regulations that HHS promulgates. This is essential if Section 1557's guarantee of protection from discrimination in health care is to be fulfilled.

Sincerely,

Andrew Cray

Policy Analyst, Center for American Progress

ⁱ Institute of Medicine. 2011. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Available from <http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx>

ⁱⁱ Department of Health and Human Services. 2010. “Lesbian, Gay, Bisexual, and Transgender Health.” Available from <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25>

ⁱⁱⁱ Substance Abuse and Mental Health Services Administration. 2012. “Top Health Issues for LGBT Populations.” Available from <http://store.samhsa.gov/product/Top-Health-Issues-for-LGBT-Populations/SMA12-4684>

^{iv} Agency for Healthcare Research and Quality. 2012. *National Healthcare Disparities Report*. Available from <http://www.ahrq.gov/qual/nhdr11/nhdr11.pdf>

^v The Joint Commission. 2011. “Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBT Community: A Field Guide.” Available from <http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf>

^{vi} Institute of Medicine. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

^{vii} Ibid.

^{viii} Ibid.

^{ix} Substance Abuse and Mental Health Services Administration. “Top Health Issues for LGBT Populations.”

^x See e.g. Centers for Disease Control and Prevention. 2005. “HIV/AIDS and Transgender Persons.” Available from <http://www.cdc.gov/lgbthealth/transgender.htm>.

^{xi} See e.g. Katie Keith and others, “Nondiscrimination Under the Affordable Care Act” (Washington DC: Georgetown University Health Policy Institute 2013) available at http://chir.georgetown.edu/pdfs/NondiscriminationUndertheACA_GeorgetownCHIR.pdf

^{xii} Ibid.

^{xiii} AIDS.gov. 2012. “The Affordable Care Act Helps People Living with HIV/AIDS.” Available from <http://aids.gov/federal-resources/policies/health-care-reform/>

^{xiv} Institute of Medicine. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

^{xv} See, e.g., *South v. Gomez*, 211 F.3d 1275, *1 (9th Cir. 2000) (noting that “gender dysphoria [is] more commonly known as transsexualism”); *Schwenk v. Hartford*, 204 F.3d 1187, 1193 (9th Cir. WA 2000) (referring to “gender dysphoria [as] the technical diagnosis for transsexuality.”); *Farmer v. Haas*, 990 F.2d 319, 320 (7th Cir. 1993) (using “transsexualism” and “gender dysphoria” as interchangeable); *Glenn v. Brumby*, 724 F. Supp. 2d 1284, 1304, n.5 (N.D. Ga. 2010) *aff’d*, 663 F.3d 1312 (11th Cir. 2011) (stating that “GID and transsexualism are closely related and are sometimes used as synonyms, with transsexuals characterized by an intention to undergo medical treatments to align their bodies with their gender identities”).

^{xvi} American Medical Association House of Delegates, “Removing Financial Barriers to Care for Transgender Patients” (2008), available at http://www.tgender.net/taw/ama_resolutions.pdf

^{xvii} American Psychiatric Association, “Transgender, Gender Identity, & Gender Expression Non-Discrimination” (2008), available at <http://www.apa.org/about/policy/transgender.aspx>

^{xviii} The World Health Organization’s International Statistical Classification of Diseases and Related Health Problems, version 10 (ICD-10) includes “gender identity disorder.” See <http://apps.who.int/classifications/icd10/browse/2010/en#/F64>

^{xix} Kellan Baker and Andrew Cray “Ensuring Benefits Parity and Gender Identity Nondiscrimination in Essential Health Benefits” (Washington: Center for American Progress, 2013) available at <http://www.americanprogress.org/wp-content/uploads/2012/11/BakerHealthBenefits-2.pdf>

^{xx} Ariz. Admin Code § R9-27-203

^{xxi} See e.g. Government Employees Health Association, Inc. Benefit Plan (2013) Available from: <http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2013/brochures/71-006.pdf> (excluding coverage for “Services, drugs, or supplies related to sex transformations”).

^{xxii} See 38 C.F.R. § 17.38(c)(4) (Excluding coverage for “gender alterations”).

^{xxiii} National Center for Transgender Equality, “Medicare Benefits and Transgender People (2011) available at http://transequality.org/Resources/MedicareBenefitsAndTransPeople_Aug2011_FINAL.pdf

^{xxiv} American Medical Association House of Delegates, “Removing Financial Barriers to Care for Transgender Patients” (2008), available at http://www.tgender.net/taw/ama_resolutions.pdf

^{xxv} Lambda Legal, “When Healthcare Isn’t Caring” (2010) available at http://data.lambdalegal.org/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf at 9-10.

^{xxvi} Lambda Legal, “When Healthcare Isn’t Caring.”

^{xxvii} Ibid.

^{xxviii} Ibid.

^{xxix} Jaime M. Grant et al., Injustice at Every Turn: A Report of the National Transgender Discrimination Survey 73 (2011), available at http://transequality.org/PDFs/NTDS_Report.pdf.

^{xxx} Ibid.

^{xxxi} Ibid.

^{xxxii} Ibid.

^{xxxiii} National Women’s Law Center, Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS (2013), available at

http://www.nwlc.org/sites/default/files/pdfs/lgbt_refusals_factsheet_8-6-13.pdf.

^{xxxiv} Ibid.

^{xxxv} Ibid.

^{xxxvi} Brad Sears and Deborah Ho, The Williams Institute, UCLA School of Law, HIV Discrimination in Health Care Services in Los Angeles County: The Results of Three Testing Studies (2006), available at <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Sears-Ho-Discrimination-Health-Care-LA-County-Dec-2006.pdf>.

^{xxxvii} NASTAD/NCSD Stigma Survey Findings Presentation, United States Conference on AIDS (2012), available at http://www.nastad.org/Docs/042244_Slides-NASTAD-Stigma%20Seminar-and-Public-Health-USCA-2012-09-24-12-FINAL.pdf.

^{xxxviii} Ibid.

^{xxxix} Ibid.

^{xl} <http://www.glaa.org/archive/1998/margiehunter1211.shtml>

^{xli} <http://www.glaa.org/archive/1999/silber0325.shtml>

^{xlii} <http://www.ghjjournal.org/jgh-online/the-story-about-robert-eads/>

^{xliii} <http://www.queerty.com/in-the-face-of-discrimination-transgendered-man-denied-care-for-breast-cancer-20120809/>

^{xliv} <http://www.hivlawandpolicy.org/resources/view/297>

^{xlv} *N. Coast Women's Care Med. Grp., Inc. v. San Diego Cnty.* Superior Court, 44 Cal. 4th 1145 (2008).

^{xlvi} Civil Rights Restoration Act of 1987, Pub. L. 100-259, 102 Stat. 28 (1988), (codified as amended in scattered sections of 20, 29, and 42 U.S.C.).

^{xlvii} See, e.g., *O'Connor v. Davis*, 126 F.3d 112, 118 (2d Cir. 1997); Dep’t of Justice, *Title IX Legal Manual* (2001), available at <http://www.justice.gov/crt/about/cor/coord/ixlegal.php> (stating that the scope of Title coverage “will depend upon which portions of a covered program or activity are educational in nature.”).

^{xlviii} 20 U.S.C. § 1687(2) (2012). See also *O'Connor v. Davis*, 126 F.3d 112, 117 (2d Cir. 1997) (“[C]ourts have consistently interpreted Title IX to mean that if one arm of a university or state agency receives federal funds, the entire entity is subject to Title IX’s proscription against sex discrimination.”).

^{xlix} See, e.g., *Jeldness v. Pearce*, 30 F.3d 1220, 1226 (9th Cir. 1994) (recognizing that the recipient of federal financial assistance need not be educational in nature for an education program or activity operated by the non-educational entity to be covered by Title IX); Dep’t of Justice, *Title IX Legal Manual* (2001), available at <http://www.justice.gov/crt/about/cor/coord/ixlegal.php>.

¹ See Civil Rights Restoration Act of 1987, § 3 (codified as amended at 20 U.S.C. 1687(2)). See also *id.* at § 3 (codified as amended at 20 U.S.C. 1687(3)(A)(ii)).

^{li} Some entities are directly bound by Section 1557 in addition to other antidiscrimination laws, such as Title IX or Title VII. Section 1557, however, may provide additional protections to individuals not covered by those laws. *See, e.g., Nat'l Women's Law Ctr., NWLC Section 1557 Complaint: Sex Discrimination Complaints Against Five Institutions*, <http://www.nwlc.org/resource/nwlc-section-1557-complaint-sex-discrimination-complaints-against-five-institutions> (last visited Sept. 17, 2013).

^{lii} Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 8 April 1948.

^{liii} Because “contracts of insurance” are not excluded in the statutory text of Section 504 but in its regulations, there are conflicting decisions about whether the regulations properly exclude it. *Compare Moore v. Sun Bank of North Florida*, 923 F.2d 1423, 1429-32 (11th Cir. 1991) (finding that because Section 504 did not expressly exclude contracts of insurance or guaranty, the regulations containing the exclusion were invalid as inconsistent with congressional intent and that the contract at issue did in fact constitute federal financial assistance) *with Gallagher v. Croghan Colonial Bank*, 89 F.3d 275 (6th Cir. 1996) (holding that based on the Section 504 regulation’s exclusion of contracts of insurance or guaranty as federal financial assistance, a bank’s receipt of reimbursement for default loans was not federal financial assistance and thus the bank was not subject to the Rehabilitation Act).

^{liv} *See e.g.* http://chir.georgetown.edu/pdfs/NondiscriminationUndertheACA_GeorgetownCHIR.pdf

^{lv} *Ibid.*

^{lvi} <http://www.americanprogress.org/wp-content/uploads/2012/11/BakerHealthBenefits-2.pdf>

^{lvii} http://www.lambdalegal.org/sites/default/files/publications/downloads/fs_professional-org-statements-supporting-trans-health_1.pdf

^{lviii} 29 U.S.C. § 794 (2012). *See also* Exec. Order 13,160 3 C.F.R. 279 (2000).

^{lix} “Conduct” means “to direct or take part in the operation or management of.” Conduct - Definition from the Merriam-Webster Dictionary, <http://www.merriam-webster.com/dictionary/conduct> (last visited Sept. 17, 2013). “Administer” means “to manage or supervise the execution, use, or conduct of.” Administer - Definition from the Merriam-Webster Dictionary, <http://www.merriam-webster.com/dictionary/administer> (last visited Sept. 17, 2013).

^{lx} *E.g., Enforcement of Nondiscrimination on the Basis of Handicap in Programs or Activities Conducted by the Central Intelligence Agency*, 57 Fed. Reg. 39,605 (Sept. 1, 1992); Gen. Servs. Admin., Office of Civil Rights, *The Key To Accessing Federally Conducted Programs and Activities 4*, available at http://www.gsa.gov/graphics/staffoffices/Interim_Key_to_Accessing_FCPA_Handbook_R2-yY5K_0Z5RDZ-i34K-pR.pdf; *Commonly Asked Questions and Answers Regarding Executive Order 13166*, <http://www.lep.gov/13166/lepqa.htm> (last visited Sept. 17, 2013).

^{lxi} Medicaid and CHIP are jointly administered by HHS and state agencies; nonetheless, because HHS participates in the administration of these programs, Section 1557 applies to them. Section 1557 also applies to the state agencies that receive and distribute federal funds to operate these programs, as “health programs or activities, any part of which receive federal financial assistance.”

^{lxii} The Pre-existing Condition Insurance Program and the Early Retiree Reinsurance Program are also examples of entities that were brought into existence pursuant to Title I of the ACA that are subject to Section 1557. These programs expire January 1, 2014. 42 U.S.C. §§ 18001, 18002 (2012).

^{lxiii} *See, e.g.,* 34 C.F.R. § 106.31(b)(6) (2012) (prohibiting covered programs or activities from aiding or perpetuating discrimination on the basis of sex by providing aid or assistance to any entity that discriminates on the basis of sex).

^{lxiv} Institute of Medicine. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

^{lxv} *Ibid.*

^{lxvi} Ian Meyer, *et al., Minority Stress and Physical Health Among Sexual Minorities* (2011).

^{lxvii} M. Bazargan, & F. Galvan, *Perceived Discrimination and Depression among Low-Income Latina Male-to-Female Transgender Women* 12 BMC Public Health 663 (2012).

^{lxviii} Grant *et al.*, “Injustice at Every Turn”

^{lxix} K.I. Fredriksen-Goldsen *et al., Physical and Mental Health of Transgender Older Adults: An At-Risk and Underserved Population*, Epub ahead of print, *Gerontologist* (2013).

^{lxx} *See* section one above.

^{lxxi} Institute of Medicine. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*.

^{lxxii} See, e.g., A.B. Bindman, K. Grumbach, D. Osmond, et al., *Preventable Hospitalization and Access to Care*, 274 *Journal of the American Medical Association* 305 (1995).

^{lxxiii} State of California Department of Insurance, “Economic Impact Assessment: Gender Nondiscrimination in Health Insurance.”

^{lxxiv} 20 U.S.C. § 1681(a) (2012).

^{lxxv} Dep’t of Health & Human Servs., Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities, 78 Fed. Reg. 46,558, 46,559 (proposed Aug. 1, 2013) (“Sex discrimination (including discrimination on the basis of gender identity, sex stereotyping, or pregnancy”).

^{lxxvi} E.g. 34 C.F.R. § 106.40(a) (2012); 34 C.F.R. § 106.57(a).

^{lxxvii} E.g. 34 C.F.R. § 106.57(a) (2012).

^{lxxviii} See Dep’t of Educ., Office of Civil Rights, *Revised Sexual Harassment Guidance: Harassment of Students by School Employees, Other Students, or Third Parties: Title IX* (January 19, 2001), available at <http://www2.ed.gov/about/offices/list/ocr/docs/shguide.html>; Dep’t of Educ., “Dear Colleague,” 7-8 (October 26, 2010), available at http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010_pg8.html. See also *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989); *Lewis v. Heartland Inns of America, L.L.C.*, 591 F.3d 1033 (8th Cir. 2010); *Bibby v. Phila Coca Cola Bottling Co.*, 260 F.3d 257, 2652-63 (3rd Cir. 2001); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004). See also *Doe v. Brimfield Grade School*, 552 F. Supp. 2d 816, 823 (C.D. Ill. 2008); *Theno v. Tonganoxi Unified School District*, 377 F. Supp. 3d 952 (D. Kansas 2005); *Schroeder v. Maumee Bd. Of Educ.*, 296 F. Supp. 2d 869, 880 (N.D. Ohio 2003); *Montgomery v. Indep. Sch. Dist. No. 709*, 109 F. Supp. 2d 1081, 1090-91 (D. Minn. 2000).

^{lxxix} *Macy v. Holder*, E.E.O.C. Appeal No. 0120120821, *7 (Apr. 23, 2012) (interpreting Title VII’s prohibition against sex discrimination to include discrimination based on a person’s transgender status).

^{lxxx} Memorandum from John Trasviña to FHEO Regional Directors, *Assessing Complaints that Involve Sexual Orientation, Gender Identity, and Gender Expression* (June 2010), available at <http://www.fairhousingnc.org/wp-content/uploads/2012/03/HUD-Memo-re-Sexual-Orientation-Discrimination-6-15-2010.pdf> (announcing that the Department would treat “gender identity discrimination most often faced by transgender persons as gender discrimination under the Fair Housing Act”).

^{lxxxi} See, e.g., 45 C.F.R. §§ 155.120(c) (nondiscrimination rule for Exchanges); 156.200(e) (for QHPs); Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13,406, 13,438 (Feb. 27, 2013) (to be codified at 45 C.F.R. § 147.104(e)) (for marketing and benefit design); Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,867 (Feb. 25, 2013) (to be codified at 45 C.F.R. § 156.125) (for the EHB).

^{lxxxii} “[Studies] have consistently found correlations between conventional expectations about gender roles and hostility toward homosexuals.” Andrew Koppelman, *Why Discrimination Against Lesbians and Gay Men is Sex Discrimination*, 69 N.Y.U. L. REV. 197, 238 (citations omitted).

^{lxxxiii} See e.g. Zachary Kramer, *Heterosexuality and Title VII*, 103 NW. U. L. REV. 205, 232 (2009).

^{lxxxiv} See, e.g., *Simonton v. Runyon*, 232 F.3d 33, 38 (2d Cir. 2000). See also, Zachary Kramer, *Heterosexuality and Title VII*, 103 NW. U. L. REV. 205, 232 (2009).

^{lxxxv} Patient Protection and Affordable Care Act § 1557, codified at 42 U.S.C. § 18116 (2012).

^{lxxxvi} *Nussle v. Willette*, 224 F.3d 95, 99 (2d Cir. 2000) (quoting *Commissioner v. Clark*, 489 U.S. 726, 739 (1989), *overruled on other grounds by Porter v. Nussle*, 534 U.S. 516 (2002)); *Detroit Edison Co. V. SEC*, 119 F.2d 730, 739 (6th Cir. 1941) (holding that “[e]xceptions in statutes must be strictly construed and limited to objects fairly within their terms, since they are intended to restrain or except that which would otherwise be within the scope of the general language.”). See also *McNely v. Ocala Star-Banner Corp.*, 99 F.3d 1068, 1074 (11th Cir. 1996) (limiting language of “except as otherwise provided” precluded the ADA from importing more restrictive language from the Rehabilitation Act); *New York v. Bloomberg*, 524 F.3d 384, 402 (2d Cir. 2008).

^{lxxxvii} 20 U.S.C. 1681(a)(1)-(9) (2012).

^{lxxxviii} See, e.g., *Macy v. Holder*, E.E.O.C. Appeal No. 0120120821 (Apr. 23, 2012) (employer violated Title VII when job offer revoked because plaintiff sought to work as a woman); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.C.C. 2008) (same).

^{lxxxix} In *Cannon v. University of Chicago*, the Supreme Court emphasized the importance of the private right of action to enforcing antidiscrimination statutes. 441 U.S. 677, 704-05 (1979). The Court later determined that money damages are available for intentional discrimination, relying on the longstanding principle that all remedies are presumed to be available to accompany a federal right of action “unless Congress has expressly indicated otherwise.” *Franklin v. Gwinnett County Public Schs.*, 503 U.S. 60, 66 (1992). There, the Court stated “Congress surely did not intend for federal monies to be expended to support the intentional actions it sought by statute to

proscribe.” *Id.* at 74. *See also Guardians Assn. v. Civil Service Comm’n of New York City*, 463 U.S. 582 (1983) (damages available under Title VI for intentional violations); *Consolidated Rail Corporation v. Darrone*, 465 U.S. 624 (1984) (awarding backpay for violation of Section 504 of Rehabilitation Act).

^{xc} *See, e.g.,* Dep’t of Health & Human Servs., Office for Civ. Rts., *Compliance Review Initiative: Advancing Effective Communication in Critical Access Hospitals* (Apr. 2013), available at http://www.hhs.gov/ocr/civilrights/activities/agreements/compliancereview_initiative.pdf

^{xcⁱ} For instance, staff for the California Health and Human Services Agency, which oversees California’s Medicaid program, indicated a lack of complaints to the agency on language access issues in 2011 and 2012. Linda Bennett interview with Amanda Ream, Organizing Director, Interpreting for California (August 2013). The absence of complaints, however, is not an indication that discrimination does not exist; to the contrary, it suggests that individuals may not know their rights or about the complaint process.

^{xcⁱⁱ} Masen Davis & Kristina Wertz, When Laws Are Not Enough: A Study of the Economic Health of Transgender People and the Need for A Multidisciplinary Approach to Economic Justice, 8 *Seattle J. for Soc. Just.* 467, 479 (2010).

BEFORE THE UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS

Request for Information Regarding Nondiscrimination) RIN 0945-ZA01
in Certain Health Programs or Activities)

RESPONSE OF WHITMAN-WALKER HEALTH TO REQUEST FOR INFORMATION ON
REGULATIONS TO IMPLEMENT THE NONDISCRIMINATION REQUIREMENTS IN
SECTION 1557 OF THE AFFORDABLE CARE ACT

TABLE OF CONTENTS

Expertise and Interest of Whitman-Walker Health	3
Summary of Comments	5
Responses to Specific Questions in the Request for Information	8
Question 1	8
Discrimination Against LGBT Persons	8
Discrimination by health care providers and institutions	8
Discrimination by health insurers	13
Discrimination Against Persons Living With HIV	15
Question 2	16
Question 3	17
Question 4	22
Question 5	25
I. Title VII and Title IX broadly prohibit discrimination based on the sex of the individual, including the individual's nonconformity with a gender stereotype	28
A. Sex discrimination prohibited by Title VII includes any discrimination based on sex, including nonconformity with gender stereotypes	29
B. Adopting Title VII jurisprudence, the Department of Education and several courts have interpreted Title IX to protect LGBT persons against discriminatory harassment	32
1. DOE has declared that harassment based on perceived Nonconformity with gender stereotypes, including same-sex attraction and sexual activity, and transgender identity, violates Title IX	32
2. Courts have similarly recognized a cause of action under Title IX for harassment based on sex, including gender stereotype nonconformity	33
II. Recent Title VII case law has construed discrimination "because of sex" to encompass employment discrimination against LGBT persons	34
A. Recent cases recognize that discrimination based on an individual's attraction to the same sex is sex discrimination based on the individual's failure to conform to heterosexual gender norms	34

B.	Discrimination based on same-sex attraction and sexual activity also constitutes discrimination “because of sex,” <i>per se</i> , because the discrimination occurs simply because of the victim’s sex	36
C.	Title VII also prohibits discrimination based on the sex of the person(s) with whom the victim has a relationship	38
D.	Titles VII and Title IX also prohibit discrimination on the basis of gender identity and expression	40
1.	Transgender discrimination is impermissible discrimination based on gender nonconformity	40
2.	Transgender discrimination is also sex discrimination <i>per se</i>	41
III.	Conclusion: Regulations implementing Section 1557 of the ACA should bar discrimination based on same-sex attraction and sexual activity, and gender identity and expression	43
	Question 6	45
	Question 7	49
	Conclusion	52

Appendix – Whitman-Walker Health’s Language Access Policy

Language Access Plan

Memorandum to Staff on Implementation

Procedures for Assessing Language Skills of Staff and Volunteers

PowerPoint Presentation for Staff Training