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# Ensuring Benefits Parity and Gender Identity Nondiscrimination in Essential Health Benefits

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## Introduction

At the core of the Patient Protection and Affordable Care Act is the most comprehensive overhaul of the American health insurance system since the creation of Medicare and Medicaid more than 40 years ago. In particular, the health reform law enacts an important change to the private insurance industry: It creates the framework for a minimum set of essential benefits that many plans in every state will have to cover. As our nation begins a robust discussion of what constitutes appropriately comprehensive insurance coverage, nondiscrimination in plan design must rank alongside cost and quality as a fundamental consideration for regulators, policymakers, and insurance carriers themselves. These actors must define and address the impermissible discrimination against consumers purchasing insurance products based on the essential benefit standard during this crucial period before the essential benefits provision comes into force in 2014.[1] If they do not, it will seriously undermine the health reform law's goal of promoting equitable, comprehensive, and affordable coverage for all Americans.

This issue brief explores the problem of insurance discrimination from the perspective of one of the clearest and most widespread examples of arbitrary discrimination in plan design: coverage exclusions targeting transgender people for denial of benefits that are routinely covered for nontransgender people.

## Establishing the essential health benefit standard

A centerpiece of the Affordable Care Act is the concept of an essential health benefit standard designed to ensure that insurance plans offer a comprehensive package of covered benefits. As defined in Section 1302 of the law, the essential health benefit standard will apply to all nongrandfathered plans in the individual and small-group markets in every state and will apply equally to plans inside and outside the health insurance exchanges, which are state-based marketplaces where individuals and small businesses

will be able to shop for affordable coverage beginning in 2014. This standard will also apply to the basic health programs that states may establish under the Affordable Care Act and to Medicaid benchmark and benchmark-equivalent plans.[2]

At its core, the essential health benefit concept requires insurers to cover benefits across 10 categories of care.[3] The Affordable Care Act defines these categories as follows:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance-use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

The essential health benefit standard will take effect in 2014.[4] To determine which benefits must be covered in each of the 10 categories, the U.S. Department of Health and Human Services has proposed using a state-specific benchmark approach. In this approach, states will have the flexibility to select a benchmark plan that broadly reflects the scope of benefits covered by a "typical employer plan."[5] Plans subject to the essential health benefit standard must then make any adjustments necessary to ensure they are offering coverage that is "substantially equal" to the benefits offered by the state's benchmark plan.

Using guidance from the U.S. Department of Labor, the Department of Health and Human Services released a bulletin in December 2011 that identifies four kinds of plans intended to represent typical employer plans.[6] States may choose any of these plans as their benchmark:

- The largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market
- Any of the largest three state employee health benefit plans by enrollment
- Any of the largest three national Federal Employee Health Benefit Program plan options by enrollment
- The largest insured commercial non-Medicaid Health Maintenance Organization, or HMO, operating in the state

The Department of Health and Human Services set September 30, 2012 as the deadline for states to select their essential health benefit benchmarks.[7] The department's guidance indicates that any state that did not select a benchmark plan by that date will use the default benchmark, which is the largest plan by enrollment in the largest product in the state's small-group market.[8]

Research undertaken by the Center for American Progress shows that as of the September deadline, 24 states had selected benchmark plans. Importantly, these state-selected benchmark plans do not themselves comprise a state's essential health benefit standard: States must also supplement and modify their selected benchmarks according to federal requirements before they are considered final.[9] According to the Affordable Care Act, essential health benefits benchmarks:[10]

- Must cover services in all 10 categories
- Must balance coverage across all 10 categories
- Must account for varying health needs across diverse populations
- May not discriminate against individuals on the basis of age, disability, or expected length of life in benefit design, coverage decisions, reimbursement rates, or incentive programs

State essential health benefit benchmark plans must also comply with the Mental Health Parity and Addiction Equity Act of 2008 and other relevant federal and state nondiscrimination laws.[11]

## The problem of exclusions: Transgender Americans and the essential benefit standard

State essential health benefit benchmark plans, after supplementation and modification, will establish a baseline of coverage that will significantly affect access to care for diverse populations of consumers. It is thus vital that each state's essential health benefit benchmark comply with the nondiscrimination requirements of the Affordable Care Act and other relevant state and federal laws. These laws will be important to ensuring that plans subject to the essential health benefit standard do not arbitrarily discriminate on any protected basis, and that they appropriately provide consumers with parity in coverage for medically necessary services across the 10 categories of essential benefits.

Arbitrary discrimination is unfortunately a frequent practice in America's health insurance industry.[12] While it is true that discrimination is a fundamental premise of for-profit insurance, federal and state insurance law and regulation has consistently sought

to distinguish between discrimination in the form of rationally segmenting risk and pricing insurance products accordingly, and discrimination in the form of arbitrarily excluding services for particular conditions or groups of individuals. Too often, benefit exclusions and other coverage limitations have no sound medical or actuarial basis and serve only to arbitrarily discriminate against specific groups of consumers.

An example of such arbitrary discrimination by the health insurance industry is the proliferation of transgender-specific exclusions. A transgender person is someone whose internal sense of gender—also known as gender identity—is different from the gender typically associated with the sex on his or her original birth certificate. For example, a person who was assigned female at birth but who lives and identifies as male is a transgender man.

The medical diagnosis that correlates with a transgender identity is gender identity disorder, or GID. The American Medical Association and the World Health Organization both recognize gender identity disorder as a serious medical condition,[13] and it is included in the Diagnostic and Statistical Manual of Mental Disorders, or DSM, maintained by the American Psychiatric Association.[14] The current version of the manual describes gender identity disorder as a severe and persistent discomfort with one's assigned sex and with one's primary and secondary sex characteristics, which causes intense psychological pain and suffering.[15] 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."[16]

The American Medical Association, the American Psychological Association, the American Academy of Family Physicians, the Endocrine Society, the American College of Obstetricians and Gynecologists, and the World Professional Association for Transgender Health have all publicly stated that medically necessary treatments for transgender people may include mental health services, hormone therapy, and surgeries involving the primary and/or secondary sex characteristics.[17] The goal of these treatments is to bring the patient's physical body into alignment with their gender identity in order to alleviate the clinically significant psychological distress that is the hallmark of gender identity disorder.

The medical treatments that may be medically necessary for transgender individuals in gender transition are the same services needed by nontransgender people for a variety of conditions. The hormone therapy used in transition, for example, is provided to patients with endocrine disorders and to women with menopausal symptoms.[18] Surgeries and reconstructive procedures needed by many transgender people—such as breast removal or augmentation, hysterectomy, oophorectomy, orchiectomy, salpingectomy, phalloplasty, and vaginoplasty—are commonly used for treating injuries and intersex conditions, or for cancer treatment or prevention.[19]

To stay healthy throughout their lives, transgender people also need preventive care to keep from becoming ill, including services that are traditionally considered to be gender specific such as Pap smears, prostate exams, and mammograms. Transgender patients may need a mix of such screenings. Medically necessary preventive screenings for a transgender woman, for example, may include both a mammogram and a prostate exam.

Many health insurance plans, however, specifically target the transgender population for categorical denial of a wide range of services. In some instances these exclusions apply only to surgical treatments related to transition while permitting coverage for other benefits such as mental health services and hormone therapy. But most coverage exclusions are sweeping—excluding, for example, coverage of any "services, drugs, or supplies related to sex transformation,"[20] "all services related to sexual reassignment,"[21] or "any treatment, drug, service or supply related to changing sex or sexual characteristics."[22]

Further, insurance carriers routinely invoke these exclusions to deny coverage for any services provided to transgender individuals, including preventive screenings, setting broken bones, and hospitalization for pneumonia. A transgender woman in New Jersey, for example, 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." After a two-year appeals process and intervention from the Transgender Legal Defense and Education Fund, the carrier reversed its position and agreed that the exclusion had unfairly prevented her from receiving medically necessary care.[23]

Unfortunately, as Table 1 shows, at least 15 of the 24 states that have publicly reported their submitted benchmark selections have selected plans that contain transgender-specific exclusions. Nine states have not provided sufficient plan documentation to offer insight into the full scope of their plans' exclusions, but a review of the potential benchmarks in numerous states indicates that the likelihood is very high that these selected benchmarks will also include transgender-specific exclusions.

**TABLE 1**

| State | Benchmark-selection status | Exclusion language |
|---|---|---|
| Alabama | No selection | |
| Alaska | No selection | |
| Arkansas | Arkansas Blue Cross Blue Shield Health Advantage POS | No current evidence of coverage publicly available |
| Arizona | United Healthcare EPO | No current evidence of coverage publicly available |
| California | Kaiser Small Group HMO | "Transgender surgery" |
| Colorado | Kaiser Ded/CO HMO 1200D | "All services related to sexual reassignment" |
| Connecticut | ConnectiCare HMO | No current evidence of coverage publicly available |
| District of Columbia | BlueShield CareFirst BluePreferred | "Any treatment or procedure designed to alter an individual's physical characteristics to those of the opposite sex" |
| Delaware | BlueCross BlueShield small-group EPO | No current evidence of coverage publicly available |

| State | Benchmark-selection status | Exclusion language |
|---|---|---|
| Florida | No selection | |
| Georgia | No selection | |
| Idaho | No selection | |
| Hawaii | HMSA Preferred Provider Plan 2010 | "Services or supplies related to sexual transformation regardless of cause. This includes, but is not limited to, sexual transformation surgery." |
| Iowa | No selection | |
| Illinois | BlueCross BlueShield of Illinois BlueAdvantage small-group plan | No current evidence of coverage publicly available |
| Indiana | No selection | |
| Kansas | BlueCross BlueShield of Kansas Comprehensive Plan | "Services for gender reassignment or sex transformation" |
| Kentucky | Anthem PPO | "Services and supplies related to sex transformation and/or the reversal thereof…" |
| Louisiana | No selection | |
| Massachusetts | BlueCross BlueShield of Massachusetts HMO Blue | No current evidence of coverage publicly available |
| Maryland | State Employee Plan | "Any procedure or treatment designed to alter an individual's physical characteristics to those of the opposite sex" |
| Maine | No selection | |
| Michigan | Priority Health HMO | "Any procedure or treatment, including hormone therapy, designed to change your physical characteristics from your biologically determined sex to those of the opposite sex. This exclusion applies despite any diagnosis of gender role or psychosexual orientation problems." |
| Minnesota | No selection | |
| Mississippi | Network Blue | "Treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies regardless of Medical Necessity." |
| Missouri | No selection | |
| Montana | No selection | |
| Nebraska | High deductible health savings option | No current evidence of coverage publicly available |
| Nevada | No selection | |
| New Hampshire | Matthew Thorton Blue plan | No current evidence of coverage publicly available |
| New Jersey | No selection | |
| New Mexico | Lovelace Classic small-group PPO | "Services and procedures for sexual transformation" |
| New York | Oxford EPO | "Sex change procedures" |
| North Carolina | No selection | |
| North Dakota | No selection | |
| Ohio | No selection | |
| Oklahoma | No selection | |
| Oregon | PacificSource Preferred CoDeduct small-group plan | "Sex transformations," which prohibits coverage for "procedures includ[ing], but not limited to," surgical treatments that may be related to gender transition and "complications resulting from gender reassignment procedures." |
| Pennsylvania | No selection | |
| Rhode Island | United Health Choice Plus | "Sex transformation operations" |
| South Carolina | No selection | |
| Tennessee | No selection | |

| State | Benchmark-selection status | Exclusion language |
|---|---|---|
| Texas | No selection | |
| Utah | Utah Basic Plus State Employee Plan | "Gender reassignment surgery" and "All services related to gender dysphoria or gender identity disorder" |
| Vermont | BlueCross BlueShield Vermont | "Treatment leading to, or in connection with, transsexual surgery" |
| Virginia | No selection | |
| Washington | Regence Innova small group | "Treatment, surgery, and counseling services for sexual reassignment" |
| West Virginia | No selection | |
| Wisconsin | No selection | |
| Wyoming | No selection | |

The essential benefits concept established by the Affordable Care Act is intended to ensure that a comprehensive range of essential services is available to those who need them. By any standard, this range includes many services that may be medically necessary for transgender people at various points in their lives such as mental health services, prescription drugs, preventive services, and ambulatory and hospital care. The arbitrary singling-out of the transgender population for categorical denials of coverage through transgender-specific exclusions runs contrary to the fundamental principle of the essential benefits concept.

Moreover, these exclusions also run afoul of federal nondiscrimination law. To promote equitable access to comprehensive, affordable coverage, the Affordable Care Act and federal regulations have established nondiscrimination protections that apply to the essential health benefit standard design and the activities of qualified health plans. Qualified health plans as defined by the Affordable Care Act are those certified as meeting the federal and state standards, including the essential health benefit standard, required for entry to the health insurance exchange marketplace.[24] The Affordable Care Act and federal regulations implementing the exchanges include relevant protections on the basis of sex, gender identity, and disability, as we discuss below.

## Nondiscrimination on the basis of sex and gender identity: Section 1557 of the Affordable Care Act and federal regulations regarding certification standards for qualified health plans

Section 1557 of the Affordable Care Act prohibits discrimination in any health program receiving federal funds or by any entity established under Title I of the health reform law.[25] This provision references the protections of several federal civil rights laws, including Title IX of the Education Amendments of 1972, through which Section 1557 incorporates nondiscrimination protections on the basis of sex.[26] Recent interpretations by federal courts and executive agencies indicate that such sex-based protections cover transgender people through an interpretation of the term "sex" that includes

gender identity and nonconformity with sex stereotypes.[27] In particular, the U.S. Equal Employment Opportunity Commission recently issued a formal ruling that gender identity discrimination is per se sex discrimination,[28] and the Office for Civil Rights at the Department of Health and Human Services has explicitly stated that the sex-based nondiscrimination protections of Section 1557 extend to claims of discrimination based on gender identity.[29]

Additionally, the Department of Health and Human Services issued regulations in March 2012 that prohibit discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation, or gender identity in all exchange activities,[30] as well as the activities of qualified health plan issuers with regard to their qualified health plans.[31] The cumulative effect of Section 1557 and these regulations is that qualified health plan issuers—whose qualified health plans and any other plans they offer in the individual and small-group markets must cover the full range of essential benefits—may not offer qualified health plans that discriminate on the basis of gender identity. This means that they cannot deny transgender consumers coverage for services that are covered for nontransgender consumers. As the American Medical Association recognizes, "the denial of … otherwise covered benefits for patients suffering from GID represents discrimination based solely on a patient's gender identity."[32]

### Nondiscrimination on the basis of disability: Section 1302 of the Affordable Care Act

Section 1302 of the Affordable Care Act prohibits essential health benefit package designs that discriminate against individuals on the basis of factors such as disability.[33] Though the statute directs this requirement at the secretary of Health and Human Services, any scope and duration limits included in state-selected essential health benefit benchmarks will be subject to review by the Department of Health and Human Services, which effectively extends this requirement to the states.[34]

Full compliance with federal nondiscrimination law thus requires appropriate restrictions on benefit exclusions and other limitations in state essential health benefit benchmarks. In particular, the goal of avoiding disability-based discrimination in essential health benefit design necessitates the review of exclusions in state-selected benchmarks to ensure that any coverage exclusions incorporated into final essential benefit standards do not arbitrarily discriminate against individuals with particular conditions.

Medicaid regulations similarly prohibit the arbitrary denial of benefits coverage based on diagnosis, type of illness, or condition.[35] The regulation is based on the view that "when a state singles out a particular medical condition ... it is ... wholly inconsistent with [the Medicaid statute's] objective of providing medical assistance to eligible individuals in need of medical assistance."[36] This standard, which has formed part of the bedrock of the Medicaid program for more than three decades, also reflects the coverage goals of the

Affordable Care Act and should provide guidance in establishing a limitation on condition-based exclusions in plans based on the essential health benefit standard.

Similar to other arbitrary exclusions that discriminate on the basis of medical condition without a sound medical or actuarial basis,[37] transgender exclusions represent exactly the kind of invidious barriers to coverage and care that the Affordable Care Act was designed to eliminate. The 2011 Institute of Medicine report on the essential benefits clarifies that Congress intended "to ensure that insurers do not make arbitrary and discriminatory decisions based on certain characteristics of people rather than assessing the individuality of each case when making medical necessity decisions and applying clinical policies."[38] State essential benefit standards must thus provide coverage for essential benefits without discrimination on the basis of disability, gender identity, or other protected classes. They must also ensure that all individuals have full access to the services that are part of the essential benefits, regardless of the diagnosis or condition for which the individual's health care provider has deemed these services medically necessary.

## Implementing equity

Transgender-specific exclusions are incompatible with these nondiscrimination mandates and with health reform's broader goal of ensuring that all Americans have access to a comprehensive set of essential benefits. Moreover, removing these exclusions improves the health of transgender people, particularly with regard to improved outcomes for some of the most significant health problems facing the transgender population. These include reduced suicide risk, lower rates of substance abuse, improved mental health outcomes, and increased adherence to HIV treatment regimens.[39]

The experiences of both public and private programs demonstrate that offering coverage without these exclusions does not negatively impact the bottom line. When San Francisco became the first major U.S. city to eliminate transgender-specific insurance exclusions for its employees in 2001, the city responded to cost concerns by implementing a $1.70 premium surcharge for all employees. Actual costs were so much less than expected that the premium surcharge produced a multi-million dollar surplus over the following years. In 2006, the city eliminated the surcharge entirely and endorsed widely available coverage free of transgender-specific exclusions.[40] Since then, Portland, Oregon; Seattle; and Oregon's Multnomah County have eliminated transgender-specific exclusions from their employee coverage. And in November 2012, the San Francisco Health Commission voted to remove these exclusions from its Healthy San Francisco health access program, a public safety net program designed to make health services accessible and affordable for San Francisco's 73,000 uninsured residents.[41]

In spring 2012, the California Department of Insurance released an economic impact assessment comparing the costs and benefits of a California law prohibiting insurance

discrimination against transgender people.[42] The Department concluded that there was an "immaterial" impact on premium costs" and that "the benefits of eliminating discrimination far exceed the insignificant costs." The experience of private employers overwhelmingly concurs. Kaiser Permanente removed transgender-specific exclusions from its non-represented employee plans in November 2012 and anticipates no resulting change to the cost trends of its health plans, and the 2013 Corporate Equality Index reports that 25 percent of Fortune 500 companies offer coverage with no transgender-specific exclusions.[43]

Removing transgender-specific exclusions does not mandate coverage for procedures related to gender transition, nor does it create a new category of essential benefits in addition to those already required under the Affordable Care Act. It instead requires insurers to not arbitrarily discriminate in coverage determinations on the basis of factors such as gender identity or condition for which such benefit is sought. Removing these exclusions reflects the fact that fair and appropriate coverage determinations and essential benefit designs must necessarily arise from medically and actuarially sound principles rather than from discriminatory bias and scientifically outdated standards.

## Recommended steps

To fulfill the comprehensive coverage and equity aims of the Affordable Care Act, ensure compliance with federal and state nondiscrimination laws,[44] and provide all consumers with a minimum standard of comprehensive and affordable coverage, regulators in states selecting their own benchmarks should take the following steps:

- Apply and enforce federal and applicable state nondiscrimination protections with regard to any plan required to cover the essential benefits, including those in the individual and small-group markets outside the exchanges.
- Remove arbitrary condition-based exclusions that lack a sound clinical and actuarial basis—including exclusions targeting the transgender population—from the state's essential health benefit standard.
- Prohibit any such arbitrary condition-based coverage exclusions, including those that unfairly discriminate against transgender people, in all plans based on the essential health benefit standard.
- Ensure that the benefit designs in the state essential health benefit standard do not arbitrarily limit the benefits covered within a category of essential health benefits in a manner that discriminates on the basis of condition, including against transgender people.

Similarly, federal policymakers reviewing state essential health benefit benchmark selections and establishing policy for plans sold through federally facilitated exchanges must also play a role in ensuring nondiscrimination in these benefit standards. To ensure that the promises of health reform reach all Americans, including transgender Americans, the Department of Health and Human Services can take the following steps:

- As part of applying federal nondiscrimination protections on the basis of sex, gender identity, and disability to state-selected benchmark plans, federal policymakers can require states to remove arbitrary condition-based exclusions from their selected essential health benefit benchmark plans. This includes transgender-specific exclusions.

- They can ensure that the benefit designs in state essential health benefit standards do not arbitrarily limit the benefits covered within a category of essential health benefits in a manner that discriminates on the basis of a particular condition, including against transgender people.

- Federal officials can implement a certification standard prohibiting plans sold in federally facilitated exchanges from discriminating on the basis of race, color, national origin, disability, age, sex, sexual orientation, or gender identity.

- They can implement a certification standard prohibiting plans sold in federally facilitated exchanges from incorporating arbitrary condition-based exclusions, including transgender-specific exclusions.

## Conclusion

The essential health benefit standard established under the Affordable Care Act and defined by the individual states is key in achieving the law's goal of making affordable, comprehensive health care coverage available to all Americans. Unless parity and nondiscrimination are part of the foundation for these standards, however, many transgender people and other underserved Americans will continue to face arbitrary barriers to coverage for the care they need. Thorough review of state-selected benchmark plans and strong standards for essential health benefit-based plans are crucial first steps to ensuring that these health insurance reforms live up to their promise of increasing access to care that supports healthy communities.

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## Endnotes


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