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SYMPOSIUM: DISABILITY RIGHTS: PAST, PRESENT, AND FUTURE

CHALLENGING TRANSITION-RELATED CARE EXCLUSIONS THROUGH DISABILITY RIGHTS LAW

Kevin M. Barry*

INTRODUCTION

Despite the growing visibility and acceptance of transgender people, discrimination against them persists.\(^1\) Transgender people are routinely denied identity documents that accurately reflect their sex.\(^2\) They are excluded from service in the U.S. military and from the protections of state civil rights laws.\(^3\) They are fired from their jobs, evicted from their homes, turned away

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2 See, e.g., Movement Advancement Project, Identity Document Laws and Policies, http://www.lgbtmap.org/equality-maps/identity_document_laws/name_change (last visited Dec. 19, 2019) (discussing barriers to updating one’s name and gender on driver’s licenses, birth certificates, and other identity documents); see also 2015 Trans Survey, supra note 1, at 81-91 (discussing barriers to changing one’s name and identity on government-issued identity documents); Broadus & Minter, supra note 1, at 174-80 (same); see also Kevin M. Barry, Themed Issue: The Tenth Anniversary of the ADA Amendments Act—Challenging Inaccurate Sex Designations On Birth Certificates Through Disability Rights Law, 26 GEO. J. ON POVERTY L. & POL’Y 313, 315–16 (2019) (discussing “restrictive birth certificate laws that require people to undergo gender confirmation surgery . . . in order to change the sex designation on their birth certificates”).

3 See Jennifer L. Levi & Kevin M. Barry, Transgender Tropes & Constitutional Review, 37 YALE L. & POL’Y Rev. 589, 627 (discussing North Carolina’s passage of two successive laws that “prohibit[] municipalities from passing new or amended anti-discrimination ordinances to protect transgender people”) (internal quotation marks
from homeless shelters, denied custody of their children, harassed by law enforcement, and deprived of access to appropriate single-sex services in schools, prisons, and immigration detention centers—because they are transgender.4

Another area in which transgender people experience discrimination is healthcare—specifically, the denial of coverage for transition-related care such as hormone therapy and surgery.5 In a recent national survey of nearly 30,000 transgender people, 91% of respondents reported that they wanted transition-related medical care at some point in their lives, but only 65% of respondents reported actually receiving such care.6 One of the primary reasons those who desire transition-related care do not receive such care is the denial of insurance coverage.7 Many private insurance plans have archaic provisions that exclude transition-related care based on the discredited assumption that such care “is ‘cosmetic’ or ‘experimental.’”8 Indeed, more than half (55%) of respondents in the national survey who sought insurance coverage for transition-related surgery were denied, and one-quarter (25%) of those who sought coverage for hormones were denied.9

In addition to public education campaigns and legislative and administrative advocacy,10 the transgender community has relied on impact litigation to dismantle transition-related care exclusions. Advocates have successfully argued that such exclusions constitute sex discrimination under Title VII of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act (“ACA”), and the Equal Protection Clause of the Fourteenth Amendment of the United States Constitution.11 In several cases, advocates have pursued an additional legal theory:

omitted); id. at 640 (discussing U.S. Department of Defense’s enforcement of transgender military service ban beginning on Apr. 12, 2019).

4 See generally 2015 Trans Survey, supra note 1 (discussing various forms of discrimination that transgender people experience). Tragically, the mistreatment of transgender people extends beyond discrimination to physical violence, including disproportionately high rates of physical attacks, sexual assault, and intimate partner violence—especially among people of color and those working in the underground economy. Id. at 197, 209.

5 Id. at 95; see also id. at 232 (“When asked about what they believed the most important policy priorities were for transgender people, respondents [in the 2015 Trans Survey] most often identified addressing violence against transgender people (25%), health insurance coverage (15%), and racism (11%) as their top priorities.”) (emphasis added).

6 Id.

7 2015 Trans Survey, supra note 1, at 93 (discussing “barriers to accessing quality, affordable health care,” including a “lack of adequate insurance coverage”).

8 See Broadus & Minter, supra note 1, at 182.

9 2015 Trans Survey, supra note 1, at 95.

10 See infra notes 47-55 and accompanying text (discussing Human Rights Campaign’s Corporate Equality Index and state laws and policies that prohibit the exclusion of transition-related care in public and private health insurance).

11 Numerous courts have concluded that transition-related care exclusions constitute sex discrimination in violation of Title VII of the Civil Right Act of 1964, Section 1557 of the Affordable Care Act, and the Equal Protection Clause. See, e.g., Tovar v. Essentia Health, 857 F.3d 771, 775-76 (8th Cir. 2017) (assuming that third party administrator could be held liable for sex discrimination under Title VII for administering a self-funded plan that excluded transition-related care, but dismissing claim because the challenged discrimination was not based on the employee’s own protected characteristic, but rather the characteristic of her transgender son); Toomey v. State of Arizona, No. CV-19-00035, 2019 WL 7172144, at *5-6, *8-9 (D. Ariz. Dec. 23, 2019) (holding that plaintiff stated claim that transition-related care exclusion in state employee health plan violated Title VII and Equal Protection Clause); Tovar v. Essentia Health, 342 F. Supp. 3d 947, 954 (D. Minn. 2018) (holding that third party administrator
transition-related care exclusions constitute disability discrimination under the Americans with Disabilities Act of 1990 (“ADA”), its predecessor, Section 504 of the Rehabilitation Act (“Section 504”), and the ACA. Specifically, advocates argue, such exclusions discriminate based on gender dysphoria—the clinically significant distress experienced by transgender people who cannot live consistent with their gender identity.

Although underdeveloped in the legal literature, disability theory is an important tool for the advancement of transgender rights, particularly given the uncertain fate of sex discrimination protections for transgender people under a newly constituted Supreme Court and the success of transgender litigants in securing protection under disability rights laws.


AM. Psychiatr. Ass’n, Diagnostic and Statistical Manual of Mental Disorders 451–53 (5th ed. 2013) [hereinafter DSM-5] (“Gender dysphoria refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available.”).


See, e.g., Doe v. Massachusetts Dep’t of Corr., No. 17-12255, 2018 WL 2994403, at *8 (D. Mass. June 14, 2018) (holding that transgender inmate stated claim that department of corrections violated, inter alia, the ADA, Rehabilitation Act, and Equal Protection Clause by placing her “into a prison environment that is contrary to a critical aspect of [her] prescribed treatment (that [she] be allowed to live as . . . a woman”)); see also infra note 81 (collecting cases).
This Article considers the use of disability rights laws to challenge transition-related care exclusions. Part I provides context for this challenge by discussing transgender status, its relationship to the diagnosis of gender dysphoria, and the growing trend toward coverage for transition-related care in public and private health insurance. Building on the briefing in several district court cases, Part II analyzes why the refusal of employers and insurance companies to cover transition-related care violates disability rights laws. This Article concludes that there is no legitimate reason to deny insurance coverage for transition-related care. Such care is medically necessary and effective treatment for gender dysphoria, and its costs are “immaterial,” given the small fraction of people who utilize such care. The only conceivable purpose for denying coverage for transition-related care is its effect: to single out transgender people for inferior medical coverage, and to avoid paying for a stigmatized form of health care.

I. **Transgender Status, Gender Dysphoria, and Transition-Related Care**

A transgender person is someone whose assigned sex at birth, as determined by the appearance of one’s physical sex characteristics, does not match one’s gender identity, that is, the innate, internal sense of being male, female, or some category other than male or female (also referred to as “brain sex”). Typically, people born with the physical characteristics of males are psychologically male, and those with the physical characteristics of females are psychologically female. However, for a transgender person, body and brain do not match.

According to recent estimates, there are

17 See infra notes 24-57 and accompanying text.
19 See infra notes 58-228 and accompanying text.
20 See infra notes 229-37 and accompanying text.
21 See infra note 44 and accompanying text (discussing medical consensus that hormonal and surgical treatment to align physical sex characteristics with one’s gender identity is medically necessary and successful in alleviating gender dysphoria).
22 See infra notes 127-30 and accompanying text (citing Flack v. Wisconsin Department of Health Services, 395 F. Supp. 3d 1001, 1021-22 (W.D. Wis. 2019) and Boyden v. Conlin, 341 F. Supp. 3d 979, 1000-01 (W.D. Wis. 2018)).
23 See Lange Compl. ¶105, supra note 12.
24 2015 Trans Survey, supra note 1, at 40; see also U.S. EQUAL EMP’T OPPORTUNITY COMM’N, BATHROOM/FACILITY ACCESS AND TRANSGENDER EMPLOYEES, https://www.eeoc.gov/eeoc/publications/fs-bathroom-access-transgender.cfm (last visited Dec. 19, 2019) (“Transgender” refers to people whose gender identity and/or expression is different from the sex assigned to them at birth.”); DSM-5, supra note 13, at 451 (stating that gender identity “refers to an individual’s identification as male, female, or... some category other than male or female.”). In addition to transgender men and women, the transgender community includes “people who are non-binary, which is a term that is often used to describe people whose gender identity is not exclusively male or female, including those who identify as having no gender, a gender other than male or female, or more than one gender.” 2015 TRANS SURVEY, supra note 1, at 6-7.
25 DSM-5, supra note 13, at 452–53.
26 See, e.g., CHRISTINE MICHELLE DUFFY, GENDER IDENTITY AND SEXUAL ORIENTATION DISCRIMINATION IN THE WORKPLACE: A PRACTICAL GUIDE 16–77 (Christine Michelle Duffy ed., 2014) (discussing recent medical studies pointing to biological etiology for transgender identity); Randi Kaufman, INTRODUCTION TO TRANSGENDER IDENTITY AND HEALTH, FENWAV GUIDES TO LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH 331, 337–38 (Harvey J. Makadon et al., 2d. ed. 2008) (“The predominating biological theory suggests that a neurohormonal

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approximately 1.4 million transgender adults living in the United States—0.6 percent of the adult population.\textsuperscript{27}

For transgender individuals who cannot live consistent with their gender identity, the incongruence between assigned sex and gender identity may result in gender dysphoria, which is a feeling of stress and discomfort with one’s assigned sex.\textsuperscript{28} Gender dysphoria, if clinically significant and persistent, is a serious medical condition.\textsuperscript{29} According to the fifth edition of the American Psychiatric Association’s \textit{Diagnostic and Statistical Manual of Mental Disorders} (‘‘\textit{DSM-5}’’), gender dysphoria is characterized by: (1) a marked incongruence between one’s gender identity and one’s assigned sex, which is often accompanied by a strong desire to be rid of one’s primary and secondary sex characteristics and/or to acquire primary/secondary sex characteristics of the other gender; and (2) intense emotional pain and suffering resulting from this incongruence.\textsuperscript{30} If left medically untreated, gender dysphoria can result in debilitating depression, anxiety, suicidality, and death.\textsuperscript{31} In addition to the negative health conditions directly attributable to gender dysphoria, people with gender dysphoria are frequently subjected to


\textsuperscript{28} \textit{DSM-5}, supra note 13, at 451 (“Gender dysphoria as a general descriptive term refers to an individual’s affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category.”).

\textsuperscript{29} \textit{Id.} at 454; see also AMA Amic. Br., \textit{supra} note 27, at 8-9.

\textsuperscript{30} See \textit{DSM-5}, \textit{supra} note 13, at 452 (“The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.”). The World Health Organization’s International Classification of Diseases similarly recognizes the medical condition of “gender incongruence,” which is characterized “by a marked and persistent incongruence between an individual’s experienced gender and the assigned sex, which often leads to a desire to ‘transition’, in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual’s body align, as much as desired and to the extent possible, with the experienced gender.” HA60 \textit{Gender Incongruence of Adolescence or Adulthood}, ICD-11 FOR MORTALITY AND MORBIDITY STATISTICS (Apr. 2019), https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fjid.who.int%2ficon%2fentity%2fj0875286.

\textsuperscript{31} \textit{DSM-5}, \textit{supra} note 13, at 454–55.
discrimination in multiple areas of their lives (e.g., housing, employment, school, healthcare, and interactions with police and other government officials) that exacerbates these negative health outcomes.  

Gender dysphoria, like most medical conditions, can be ameliorated through medical treatment. The World Professional Association for Transgender Health (“WPATH”), an interdisciplinary professional and educational organization devoted to transgender health, has established internationally-accepted Standards of Care (“SOC”) for the treatment of people with gender dysphoria. Pursuant to the SOC, individuals with gender dysphoria undergo a medically necessary and supervised gender transition in order to live life consistent with their brain sex and alleviate the distress caused by gender dysphoria.

The transition process has three main components—social, pharmacological, and surgical. Social transition involves bringing a transgender person’s gender expression and social sex role into alignment with the person’s gender identity. The transition may include wearing clothes, using a different name and pronouns, and interacting with peers and one’s social environment in a manner that matches one’s gender identity. Pharmacological transition involves taking medications that change the body’s hormone balance to be consistent with one’s gender identity. For example, a transgender man would take medications that reduce estrogen and replace those hormones with testosterone, which will further masculinize their sex characteristics. Lastly, a transgender person may pursue surgical treatment to bring their

32 Id. at 458 (“Gender dysphoria . . . is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks, especially in individuals from resource-poor family backgrounds. In addition, these individuals’ access to health services and mental health services may be impeded by structural barriers, such as institutional discomfort or inexperience in working with this patient population.”); 2015 TRANS SURVEY, supra note 1, at 19 (“This report demonstrates that transgender people continue to face discrimination in numerous areas that significantly impact quality of life, financial stability, and emotional wellbeing, including employment, education, housing, and health care. Furthermore, many respondents experienced discrimination in multiple areas of their lives, the cumulative effect of which leads to severe economic and emotional hardship and can in turn have devastating effects on other outcome areas, such as health and safety.”).


34 The SOC were originally approved in 1979 and have undergone seven revisions through 2012. SOC, supra note 33, at 1. “Many of the major medical and mental health groups in the United States,” including the American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association, “expressly recognize the WPATH Standards of Care as representing the consensus of the medical and mental health community regarding the appropriate treatment for gender dysphoria.” AMA Amic. Br., supra note 27, at 10-11.

35 See SOC, supra note 33, at 9-10.

36 Id.

37 See id. at 9; see also AMA Amic. Br., supra note 27, at 11.

38 See Am. Psychol. Ass’n, Guidelines for Psychological Practice with Transgender and Gender Nonconforming People, 70 AM. PSYCHOLOGIST 832, 863 (2015).

39 SOC, supra note 33, at 9, 36-38.

40 Id. at 37.
physical sex characteristics into conformity with their gender identity.41 This may include surgery to increase breast size or create a more masculine chest contour, and surgeries performed on genitals or reproductive organs.42 The precise medical treatments required to alleviate a particular person’s gender dysphoria will vary based on individualized medical needs.43

A well-established medical consensus, supported by sixty years of clinical experience, finds that hormonal and surgical treatment to align physical sex characteristics with one’s gender identity is medically necessary and successful in alleviating gender dysphoria.44 According to the American Medical Association, health experts in gender dysphoria “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.”45 Courts have likewise recognized the necessity of transition-related care to assist individuals with gender dysphoria. All nine of the U.S. Courts of Appeals that have been presented with the question have either concluded or assumed without deciding that gender dysphoria poses a “serious medical need” for purposes of the Eighth Amendment, and no court of appeals has held otherwise.46

41 Id. at 10, 54-55, 57.
42 Id. at 57; see also Jules Chyten-Brennan, Surgical Transition, in TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY ch. 13 (Laura Erickson-Schroth ed., 2014).
43 SOC, supra note 33, at 5 (“Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person.”).
44 See, e.g., SOC, supra note 33, at 8 (“[H]ormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people.”); DSM-5, supra note 13, at 451 (“[M]any are distressed if the desired physical interventions by means of hormones and/or surgery are not available.”) (emphasis added); Am. Med. Ass’n, Removing Financial Barriers To Care For Transgender Patients 1 (2008), http://www.tgender.net/taw/ama_resolutions.pdf [perma.cc/H2FE-3PYT] (stating that 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 those diagnosed with gender dysphoria); accord Position Statements of the American Psychiatric Association: Access to Care for Transgender and Gender Variant Individuals, ASS’N OF LGBTQ PSYCHIATRISTS (2013), http://www.aglp.org/pages/LGBTPositionStatements.php [perma.cc/H7ZF-WCHP]; Transgender, Gender Identity, and Gender Expression Non-Discrimination, AM. PSYCHOLOGICAL ASS’N (2008), http://www.apa.org/about/policy/transgender.aspx; AMA Amic. Br., supra note 27, at 10 (“Medical experts agree that transition-related care is ‘reliable, safe, and effective.’”); WPATH, Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. (Dec. 2016), https://www.wpath.org/media/cms/Documents/Web%20Transfer/Policies/WPATH-Position-on-Medical-Necessity-12-21-2016.pdf (“[G]ender affirming/confirming treatments and surgical procedures, properly indicated and performed as provided by the Standards of Care, have proven to be beneficial and effective in the treatment of individuals with transsexualism or gender dysphoria.”); Decl. George Richard Brown, MD, DFAPA in Supp. of Opp’n to Defs.’ Mot. to Dismiss and Mot. to Dissolve the Prelim. Injunc., Doe v. Trump, at 4-5 ¶¶ 13-14 (May 11, 2018), https://www.glad.org/wp-content/uploads/2017/08/dvt-george-r-brown-declaration-5-11-18.pdf (“[T]he consensus of the mainstream medical community [is] that gender dysphoria is amenable to treatment through social and medical transition. The American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association all agree that medical treatment for gender dysphoria is medically necessary and effective. Sixty years of clinical experience and data have demonstrated the efficacy of treatment for the distress resulting from gender dysphoria . . . .”) (citations omitted); id. at 2 ¶ 8 (“[G]ender dysphoria . . . is curable through appropriate medical care that allows the individual to live consistently with their gender identity. . . .”).
46 See, e.g., O’Donnabhain v. C.I.R., 134 T.C. 34, 69 (2010) (holding that the costs of transition-related care are tax deductible, and stating that “[t]he evidence is clear that a substantial segment of the psychiatric profession has
Accordingly, transition-related care for gender dysphoria is widely covered under public and private health insurance plans. With respect to public insurance: in 2014, the U.S. Department of Health and Human Services eliminated its decades-old exclusion of transition-related care under Medicare and the overwhelming majority of Medicaid programs—forty-three states and the District of Columbia—have either removed or never adopted exclusions of transition-related care in their Medicaid programs. Additionally, the federal Office of Personnel Management (“OPM”) prohibits the exclusion of transition-related care in federal employee health plans and seventeen states and the District of Columbia provide for coverage for transition-related care in state employee health plans. As for private insurance, twenty states and the District of Columbia prohibit the exclusion of transition-related care in individual health insurance plans and employer-sponsored fully-insured health insurance plans. Nearly three-quarters (73%) of the 1,028 private-sector businesses surveyed in the Human Rights Campaign’s 2019 Corporate Equality Index—which includes nearly two-thirds of Fortune 500 businesses—have eliminated

been persuaded of the advisability and efficacy of hormone therapy and sex reassignment surgery as treatment for [gender dysphoria], as have many courts. . . . [Such procedures] are undertaken by [people with gender dysphoria] in an effort to alleviate the distress and suffering occasioned by [gender dysphoria], and . . . have positive results in this regard in the opinion of many in the psychiatric profession.”); see also id. (collecting cases); Transcend Legal Mem., supra note 14, at 4 & n.16 (June 24, 2019).

47 Globally, transition-related care has long been standard in national health plans, including in Argentina, Brazil, Canada, Cuba, Iran, and the following European countries: Austria, Belgium, the Czech Republic, Denmark, Finland, France, Germany, Hungary, Ireland, Italy, Latvia, the Netherlands, Poland, Portugal, Spain, Sweden, and the United Kingdom. Transcend Legal Mem., supra note 14, at 6-7. The Council of Europe has likewise passed a resolution calling on member states to “make gender reassignment procedures, such as hormone treatment, surgery and psychological support, accessible for transgender people, and ensure that they are reimbursed by public health insurance schemes.” Id.


49 Movement Advancement Project, FEHB Program Carrier Letter No. 2015-12, Covered Benefits for Gender Transition Services (June 23, 2015), https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015-2015-12.pdf (“[N]o carrier participating in the Federal Employees Health Benefits Program may have a general exclusion of services, drugs or supplies related to gender transition or ‘sex transformations.’”).


51 Movement Advancement Project, Healthcare Laws and Policies: Private Insurance, at http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies (last visited Dec. 19, 2019). Importantly, these state laws do not apply to employer sponsored self-insured plans. See The U.S. EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE, No. 915.002, at n.3 (June 8, 1993) [hereinafter 1993 EEOC Guidance], https://www.eeoc.gov/policy/docs/health.html (distinguishing employer-sponsored “insured” health insurance plans, which are “purchased from an insurance company or other organization, such as a health maintenance organization” and are “regulated by both [the Employee Retirement Income Security Act of 1974 (ERISA)] and state law,” from “self-insured” health plans, in which the employer directly assumes the liability of an insurer, and which are “typically subject to ERISA, but are not subject to state laws that regulate insurance”). ERISA “is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans.” See U.S. DEP’T OF LABOR, HEALTH PLANS & BENEFITS: ERISA, https://www.dol.gov/general/topic/health-plans/erisa (last visited Dec. 19, 2019).
all transition-related care exclusions from their employer-sponsored health insurance plans, finding the cost of such coverage “negligible.”

Insurance companies have overwhelmingly eliminated transition-related care exclusions from individual health insurance plans, and all major insurance companies administer employer-sponsored self-funded health insurance plans that will cover transition-related care.

Notwithstanding this trend toward coverage for transition-related care in public and private health insurance, significant gaps remain—particularly with respect to employer-sponsored self-funded health insurance. Despite widespread recognition of the medical necessity of transition-related care and the lack of a legitimate, nondiscriminatory basis for singling out such care for exclusion, insurance companies continue to offer—and employers continue to purchase—self-funded health insurance plans that exclude transition-related care. In response, transgender employees have successfully argued that these exclusions constitute discrimination based on gender dysphoria in violation of disability rights laws—a topic to which this Essay now turns.

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53 Human Rights Campaign, Corp. Equality Index 2019, at 14 (July 30, 2019) [hereinafter HRC CEI]; https://www.hrc.org/campaigns/corporate-equality-index; see also id. 5-6, 14, 24 (stating that 752 of 1029 responding businesses eliminated transition-related care exclusions from all health plans, as did at least 193 of 346 responding Fortune 500 companies). Colleges and universities have likewise removed transition-related care exclusions from student and staff health insurance plans. See Campus Pride, Trans Policy Clearinghouse: Colleges and Universities that Cover Transition-Related Medical Expenses under Student Health Insurance (2018), www.campuspride.org/tpc-student-health-insurance (“88 colleges and universities cover hormones and gender-affirming surgeries for students.”); Campus Pride, Cover Transition-Related Medical Expenses Under Employee Health Insurance, https://www.campuspride.org/tpc/employee-health/ (last visited Dec. 19, 2019) (“55 colleges and universities cover hormones and/or gender reassignment/confirmation surgeries for employees.”).


56 In a self-insured plan, “the employer directly assumes the liability of an insurer,” see 1993 EEOC Guidance, supra note 52, at n.3., and “usually contracts with a third-party administrator (‘TPA’), often an insurance company,” to manage the plan’s day-to-day operations. America’s Health Ins. Plans v. Hudgens, 915 F. Supp. 2d 1340, 1344 (N.D. Ga. 2012); see, e.g., Loren v. Blue Cross & Blue Shield of Mich., 505 F.3d 598, 602 (6th Cir. 2007) (“Insurance companies such as [Blue Cross & Blue Shield of Mich.] often act as third-party administrators to carry out the daily operations of employers’ self-funded plans, since insurance companies already have operations in place to process claims, collect employee premiums, and manage enrollment.”).

57 See Kylar W. Broadus & Shannon Price Minter, Legal Issues, in TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY 182 (2014) (“Many private insurance plans still have provisions that exclude treatments for gender transition. These exclusions are often based on the [outdated and inaccurate] classification of gender transition treatments as ‘cosmetic’ or ‘experimental.’”); see also 2015 TRANS SURVEY, supra note 1, at 95 (“More than half (55%) of respondents who sought transition-related surgery coverage were denied, and one-quarter (25%) of those who sought coverage for hormones were denied.”).
II. THE EXCLUSION OF TRANSITION-RELATED CARE VIOLATES DISABILITY RIGHTS LAWS

The ADA, Section 504 of the Rehabilitation Act, and Section 1557 of the ACA collectively prohibit employers and health insurers (including those acting as third party administrators) from excluding transition-related care from health insurance plans. Specifically, when an employer excludes transition-related care from its employer-sponsored health insurance plans, the employer violates Title I of the ADA, which prohibits disability discrimination in employment. If the employer receives federal funds, the employer also violates Section 504, which prohibits disability discrimination by any entity receiving federal financial assistance. When a health insurer offers or administers a discriminatory health insurance plan, it violates Titles I and III of the ADA, the latter of which prohibits disability discrimination in public accommodations, as well as Section 1557 of the ACA, which prohibits federally-funded health programs from discriminating based on, inter alia, disability.

Generally speaking, in order to prevail under these disability anti-discrimination statutes, a person must establish that: (A) one is protected by the statute, i.e., one is a qualified individual with a disability; (B) one was subjected to discrimination by reason of one’s disability; and (C) the statute applies to the defendant, i.e., the defendant is a covered entity. This Part discusses each requirement in turn.

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58 See supra note 56 (discussing health insurers’ role in administering employer-sponsored self-funded health insurance).
60 42 U.S.C. § 12112 (2018) (prohibiting employment discrimination). If the public employer is a “State or local government” or any “other instrumentality of a State or States or local government,” 42 U.S.C. § 12131(1)(A)-(B) (2018), Title II may also apply. Compare, e.g., Bledsoe v. Palm Beach County Soil and Water Conservation Dist., 133 F.3d 816, 822 (11th Cir. 1998) (“Title II of the ADA encompasses public employment discrimination.”), with Taylor v. City of Shreveport, 798 F.3d 276, 282 (5th Cir. 2015) (applying Title I to public employers but declining to apply Title II); see also 28 C.F.R. § 35.108 (2019) (DOJ ADA Title II regulation regarding employment discrimination). Additionally, if a public employer receives federal funds, Section 504 of the Rehabilitation Act would apply. See infra notes 147-51 (discussing Section 504).
A. A Person with Gender Dysphoria Who is Denied Transition-Related Care is a Qualified Individual with a Disability

In order to claim the protection of Title I of the ADA, one must be a “qualified individual” with a “disability.” Generally, the question of whether a person is a “qualified individual” is not at issue in the context of transition-related care exclusions because there is no dispute that the individual “can perform the essential functions of the employment position that such individual holds.” In short, with respect to the exclusion of coverage for transition-related care, the issue is whether the denial of the benefit is discriminatory, not whether the plaintiff is eligible to receive the benefit.

For nearly two decades, proving “disability” under the ADA was extraordinarily difficult as a result of several Supreme Court decisions that “narrowed the broad scope of protection intended to be afforded by the ADA, thus eliminating protection for many individuals whom Congress intended to protect.” This is no longer the case. As amended by the ADA Amendments Act of 2008 (“ADAAA”), the ADA’s definition of disability is to be “construed in favor of broad coverage.” Specifically, the three-prong definition protects any person: (1) with a physical or mental impairment that substantially limits—or that would, when considered in its active state and without regard to treatment, substantially limit—a major life activity or bodily function; (2) who has a “record of”—that is, a history of—“such an impairment”; or (3) who is “regarded as having such an impairment,” which is defined to mean being subjected to discrimination based on a real or perceived physical or mental impairment—regardless of whether it substantially limits a major life activity. Section 504 and, by extension, Section 1557, explicitly incorporate the ADA’s definition of disability, as amended.

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64 42 U.S.C. § 12112(a) (2018); accord 29 U.S.C. § 794(a) (2018). Title III of the ADA does not require that an individual with a disability be “qualified” to receive the goods and services of a place of public accommodation. 42 U.S.C. § 12182(a) (2018).
67 42 U.S.C. § 12102(4)(A) (2018); see also 29 C.F.R. § 1630.1(c)(4) (2019) (“[T]he definition of ‘disability’ in this part shall be construed broadly in favor of expansive coverage to the maximum extent permitted by the terms of the ADA.”); 28 C.F.R. § 36.101(b) (2019) (same); ADAAA, supra note 66, at § 2(b)(1), (5) (“reinstating a broad scope of protection to be available under the ADA” and stating that “the question of whether an individual’s impairment is a disability under the ADA should not demand extensive analysis”).
69 The definition of disability under the ADA and Section 504 of the Rehabilitation Act is identical and, therefore, the expanded definition of “disability” under the ADAAA applies with equal force to both statutes. Compare 42 U.S.C. § 12102 (2018) (defining “disability”), with 29 U.S.C. § 705(9)(B), (20)(B) (2012) (cross-referencing ADA definition of “disability”); see also ADAAA, supra note 66, at § 7 (codified at 29 U.S.C. § 705 (2018)) (conforming Section 504 of Rehabilitation Act’s definition of “disability” to definition of disability “in section 3 of the Americans with Disabilities Act of 1990”). Because Section 1557 incorporates Section 504’s anti-discrimination mandate, see 4 U.S.C. § 18116 (2018), the expanded definition of disability under the ADAAA applies with equal force to Section 1557.
Gender dysphoria easily meets this definition of “disability” under the ADA. Gender dysphoria is a “physical . . . impairment” because it derives from an atypical interaction of sex hormones and the developing brain, which results in a person being born with circulating hormones inconsistent with the person’s brain sex. Gender dysphoria is also a “mental impairment” because, according to the DSM-5, gender dysphoria refers to clinically significant distress with one’s assigned sex.

A person who has gender dysphoria satisfies the first prong of the definition of disability: when considered in its active state and absent medical treatment, gender dysphoria would substantially limit major life activities like caring for oneself, interacting with others, eating, sleeping, concentrating, and communicating. Gender dysphoria would also limit major bodily functions, such as neurological and brain functions. Indeed, when left untreated, gender dysphoria can result in depression, anxiety, suicidality, and death. Furthermore, even with medical treatment such as hormones and surgery, gender dysphoria substantially limits major life activities such as reproduction.

Similarly, under the second prong of the definition of disability, a person who has been diagnosed with gender dysphoria has a “record of” a substantially limiting impairment and is therefore protected by the ADA, even if they have successfully treated the condition. Lastly, and critically, a person who is refused transition-related care has been subjected to discrimination based on gender dysphoria and is therefore protected under the broad “regarded as” prong of the definition of disability.

One might argue that a person with gender dysphoria is categorically prohibited from claiming the protection of the ADA because the ADA explicitly excludes from the definition of disability “gender identity disorders not resulting from physical impairments” (and “transsexualism,” which has always been understood to be interchangeable with gender identity

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71 See infra notes 89, 95-99 and accompanying text (discussing physical etiology of gender dysphoria).
72 DSM-5, supra note 13, at 451-53.
73 42 U.S.C. § 12102(1), (2)(a), (4) (2018); see 29 C.F.R. § 1630.2(i), (j) (2019).
75 DSM-5, supra note 13, at 455-56.
76 See SOC, supra note 33, at 36-38 (discussing cessation of menses in people taking masculinizing hormones and decreased sperm production in people taking feminizing hormones); 29 C.F.R. § 1630.2(j)(4)(ii) (2019) (“[T]he non-ameliorative effects of mitigating measures, such as negative side effects of medication or burdens associated with following a particular treatment regimen, may be considered when determining whether an individual’s impairment substantially limits a major life activity.”) (emphasis added).
78 Id. § 12102(3)(A) (“An individual meets the requirement of “being regarded as having such an impairment” if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.”); see 29 C.F.R. § 1630.2(l) (2019).
disorder). As at least two major employers have conceded, as four federal district courts have held, and as the U.S. Department of Justice has concluded under two successive administrations—in three separate cases in Pennsylvania, New Jersey, and Connecticut—gender dysphoria is not excluded under the ADA. There are numerous reasons for this conclusion.

1. Gender Dysphoria is a New and Distinct Diagnosis

Gender dysphoria is not excluded under the plain language of the ADA because, as the District of Massachusetts recently observed in Doe v. Massachusetts Department of Correction, gender dysphoria “is not merely another term for ‘gender identity disorder,’” but is rather a new and distinct diagnosis with different diagnostic criteria. In 2013, the DSM-5 replaced the diagnosis of “gender identity disorders” with gender dysphoria. This replacement was more than semantic; the change reflects a substantive difference between the medical conditions themselves. Unlike the outdated diagnosis of gender identity disorder, the hallmark or presenting feature of gender dysphoria is not a person’s gender identity. Rather, it is the clinically significant distress, termed dysphoria, that some people experience as a result of the mismatch between their gender identity and their assigned sex. Reflecting this distinction, the diagnostic

79 42 U.S.C. § 12111(b)(1) (2018); see Duffy, supra note 26, at 16–48 (“It was not uncommon at the time [the ADA was being debated] for people to use the terms ‘transsexualism’ and ‘GID’ interchangeably.”); see also id. at 16–98 to 16–103 (explaining that, beginning in 1980, successive versions of the DSM referred to transsexualism as a subtype of gender identity disorder applicable to adults and adolescents, until 1994, when transsexualism was removed from the DSM). Because the now obsolete diagnosis of transsexualism merely referred to gender identity disorder in adolescents and adults, the ADA’s exclusion of transsexualism does not apply to gender dysphoria for the very same reasons that the ADA’s exclusion of gender identity disorders does not apply to gender dysphoria. See infra notes 83–108 and accompanying text (discussing ADA’s coverage of gender dysphoria).


81 See Iglesias v. True, 2019 WL 3340652, at *4 (S.D. Ill. 2019) (concluding, on preliminary review pursuant to 28 U.S.C. § 1915A, that “the Court cannot categorically say that gender dysphoria falls within the [Rehabilitation Act’s] exclusionary language and will err on the side of caution to allow Plaintiff’s claim to proceed.”); Edmo v. Idaho Dep’t of Corr., No. 1:17-cv-00151-BLV, 2018 WL 2745898, at *8 (D. Idaho June 7, 2018) (“[T]he issue of whether Edmo’s diagnosis falls under a specific exclusion of the ADA presents a genuine dispute of material fact in this case. Therefore, Edmo’s ADA claim will not be dismissed.”); Doe v. Massachusetts Dep’t of Corr., No. 17-12255, 2018 WL 2994403, at *7 (D. Mass. June 14, 2018) (denying defendant’s motion to dismiss based on “a dispute of fact as to whether Doe’s [gender dysphoria] falls outside the ADA’s exclusion of gender identity-based disorders as they were understood by Congress twenty-eight years ago.”); Blatt v. Cabela’s Retail, Inc., No. 5:14-cv-04822, 2017 WL 2178123, at *2 (E.D. Pa. May 18, 2017) (holding that gender dysphoria “is not excluded by § 12211 of the ADA, and Cabela’s motion to dismiss Blatt’s ADA claims on this basis is denied”).


84 See DSM-5, supra note 13, at 451-53.

85 See Am. Psychiatric Ass’n, Gender Dysphoria 2 (2013), https://www.psychiatry.org/ File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf (stating that gender identity disorder connoted “that the patient is ‘disordered’”).

86 See DSM-5, supra note 13, at 451 (“The current term is more descriptive than the previous DSM-IV term gender identity disorder and focuses on dysphoria as the clinical problem, not identity per se.”); compare id. at 814
criteria for gender dysphoria in the DSM-5 are different than those for gender identity disorder. Indeed, there are people with gender dysphoria—namely, those who have “undergone at least one medical procedure or treatment to support the new gender assignment”—that would not meet the criteria for gender identity disorder. Furthermore, unlike the DSM’s treatment of gender identity disorders, the DSM-5 includes a new section entitled “Genetics and Physiology,” which discusses the possible genetic and physiological underpinnings of gender dysphoria.

2. The ADA Excludes Transgender Identity, Not Medical Conditions Associated with Transgender People

Alternatively, gender dysphoria is not excluded under the ADA because it is not a “gender identity disorder” as that term was understood by Congress approximately thirty years ago. As the U.S. District Court for the Eastern District of Pennsylvania held in Blatt v. Cabela’s Retail, Inc., “gender identity disorder” in the ADA refers simply to transgender identity, i.e., “the condition of identifying with a different gender”—not to medical conditions like gender dysphoria that transgender people may have. Like being gay, lesbian, or bisexual, the court reasoned, being transgender is, by itself, not a medical condition and therefore is excluded under the ADA. Gender dysphoria, by contrast, is a medical condition, and therefore is not excluded under the ADA.

(Stating that DSM-5 “emphasiz[es] the phenomenon of ‘gender incongruence’ rather than cross-gender identification per se, as was the case in DSM-IV gender identity disorder”), with AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 532-38 (4th ed. 1994) (characterizing “gender identity disorder” as involving a “strong and persistent cross-gender identification” and a “persistent discomfort” with one’s sex or “sense of inappropriateness” in the gender role of that sex) (emphasis added).

See Doe v. Massachusetts Dep’t of Corr., No. 17-12255, 2018 WL 2994403, at *7 (D. Mass. June 14, 2018) (“In contrast to DSM-IV, which had defined ‘gender identity disorder’ as characterized by a ‘strong and persistent cross gender-identification’ and a ‘persistent discomfort’ with one’s sex or ‘sense of inappropriateness’ in a given gender role, the diagnosis of GD in DSM-V requires attendant disabling physical symptoms, in addition to manifestations of clinically significant emotional distress.”); see also id. (expressing agreement with plaintiff’s argument that “the decision to treat ‘Gender Dysphoria’ in DSM-V as a freestanding diagnosis is more than a semantic refinement. Rather, it reflects an evolving re-evaluation by the medical community of transgender issues and the recognition that GD involves far more than a person’s gender identification.”).

See, e.g., DSM-5, supra note 13, at 815 (adding a “posttransition specifier to identify individuals who have undergone at least one medical procedure or treatment to support the new gender assignment (e.g., cross-sex hormone treatment). Although the concept of posttransition is modeled on the concept of full or partial remission, the term remission has implications in terms of symptom reduction that do not apply directly to gender dysphoria.”).

See DSM-5, supra note 13, at 457; see also infra notes 95-99 and accompanying text (discussing physical etiology of gender dysphoria).


Blatt v. Cabela’s Retail, Inc., No. 5:14-cv-04822, 2017 WL 2178123, at *2 (E.D. Pa. May 18, 2017); id. at *3 (“exclud[ing] certain sexual identities from the ADA’s definition of disability”—not the medical conditions “that persons of those identities might have”) (emphasis added).

See id. at *3 n.3 (likening “gender identity disorder” to “homosexual[ity] or bisexual[ity],” none of which are medical conditions covered by the ADA); see also Kevin Barry & Jennifer Levi, Blatt v. Cabela’s Retail, Inc. and a New Path for Transgender Rights, 127 YALE L.J. FORUM 373, 385 (2017) (discussing Blatt’s holding).

See supra notes 70-72 and accompanying text (discussing reasons why gender dysphoria is a physical impairment and/or mental impairment under the ADA).

Blatt, 2017 WL 2178123, at *2 (concluding that “a condition like Blatt’s gender dysphoria goes beyond merely identifying with a different gender and is characterized by clinically significant stress and other
Gender Dysphoria Falls within the ADA’s Safe Harbor

Even allowing, arguendo, that gender dysphoria is somehow a “gender identity disorder” within the meaning of the ADA, it is not excluded because it falls within the ADA’s safe harbor for gender identity disorders that “result[] from [a] physical impairment[].” The burgeoning medical research underlying gender dysphoria points to a physical etiology—namely, an atypical interaction of sex hormones with the developing brain that results in a person being born with circulating hormones inconsistent with the person’s brain sex. This atypical interaction of sex hormones with the developing brain is a “physiological . . . condition . . . affecting one or more body systems,” including “neurological . . . [and] endocrine” systems. As the U.S. Department of Justice opined in Blatt v. Cabela’s Retail, Inc., and reaffirmed in two subsequent cases, “current research increasingly indicates that gender dysphoria has physiological or biological roots” and, therefore, the ADA’s exclusion of gender identity disorders not resulting from physical impairments “should be construed narrowly such that gender dysphoria falls outside its scope.” In rejecting the argument that gender dysphoria is excluded under the ADA, the District Court of Massachusetts similarly observed that “[w]hile medical research in this area remains in its initial phases,” recent studies suggest that gender dysphoria diagnoses may “have a physical etiology, namely hormonal and genetic drivers contributing to the in-utero development of dysphoria.”

impairments”). But see Parker v. Strawser Constr., Inc., 307 F. Supp. 3d 744, 754-755 (S.D. Ohio 2018) (erroneously equating gender dysphoria with “gender identity disorders,” and ignoring Blatt’s conclusion that gender dysphoria refers to a medical condition that is not excluded from the ADA, whereas “gender identity disorders”—as used in the ADA—refer to transgender identity, which is excluded from the ADA).

52 U.S.C. § 12211(b)(1) (2018); see Doe v. Massachusetts Dep’t of Corr., No. 17-12255, 2018 WL 2994403, at *6 (D. Mass. June 14, 2018) (“Doe has raised a dispute of fact that her GD may result from physical causes.”). Notably, in Parker v. Strawser Constr., Inc., in which the court erroneously concluded that gender dysphoria was not protected by the ADA, the plaintiff failed to allege that gender dysphoria results from a physical impairment. 307 F. Supp. 3d at 755 (“It was . . . Parker’s obligation to allege in her Amended Complaint that her gender dysphoria is caused by a physical impairment. Having failed to do so, her disability claims under the ADA and [state law] are foreclosed.”).

55 See, e.g., Mass. Dep’t of Corr., 2018 WL 2994403, at *6 (noting “recent studies demonstrating that GD diagnoses have a physical etiology, namely hormonal and genetic drivers contributing to the in-utero development of dysphoria”); DSM-5, supra note 13, at 457 (discussing genetic and hormonal contributions to gender dysphoria); Duffy, supra note 26, at 16-72 to 16-74 & n.282 (citing numerous medical studies that “point in the direction of hormonal and genetic causes for the in utero development of gender dysphoria”); DOJ Blatt Stat. of Int., supra note 26, at 5 (“While no clear scientific consensus appears to exist regarding the specific origins of gender dysphoria (i.e., whether it can be traced to neurological, genetic, or hormonal sources), the current research increasingly indicates that gender dysphoria has physiological or biological roots.”).


59 See Mass. Dep’t of Corr., 2018 WL 2994403, at *7 (“[T]he continuing re-evaluation of GD underway in the relevant sectors of the medical community is sufficient, for present purposes, to raise a dispute of fact as to whether Doe’s GD falls outside the ADA’s exclusion of gender identity-based disorders as they were understood by Congress twenty-eight years ago.”); see also Duffy, supra note 26, at 16-52, 16-76 (noting similarities between gender dysphoria and physical conditions with complex etiologies not fully understood by the medical community that are nevertheless protected by the ADA, including polycystic ovary syndrome, cerebral palsy, strabismus,
4. The Exclusion of Gender Dysphoria Would Contradict the ADA’s Remedial Purpose, as Clarified by the ADAAA and its Implementing Regulations

According to the U.S. Department of Justice, “the remedial nature of the ADA and the relevant statutory and regulatory provisions directing that the terms ‘disability’ and ‘physical impairment’ be read broadly” strongly support the inclusion of gender dysphoria. Indeed, a contrary interpretation would contradict the primary purpose of the ADAAA, which is to clarify that “[t]he primary object of attention in cases brought under the ADA should be whether covered entities have complied with their obligations and whether discrimination has occurred, not whether the individual meets the definition of disability.” Under the ADA, as amended, “[T]he question of whether an individual’s impairment is a disability under the ADA should not demand extensive analysis.”

5. The ADA’s Exclusion of Gender Dysphoria Would Violate Equal Protection

Lastly, interpreting the ADA to discriminate facially against people with gender dysphoria would give rise to “a serious doubt of constitutionality” under the Equal Protection Clause and must therefore be avoided under the well-settled doctrine of constitutional avoidance. Specifically, by excluding a medical condition that is closely associated with transgender people (indeed, only transgender people have gender dysphoria), the exclusion would constitute a

dyslexia, microvascular angina, stuttering, and Tourette syndrome—the latter two of which were once believed to be purely mental conditions).

100 DOJ Blatt Stat. of Int., supra note 26, at 5; compare Tcherepnin v. Knight, 389 U.S. 332, 336 (1967) (discussing “familiar canon of statutory construction that remedial legislation should be construed broadly to effectuate its purposes”), City of Edmonds v. Oxford House, Inc., 514 U.S. 725, 731 (1995) (“[A]n exception to ‘a general statement of policy’ is sensibly read ‘narrowly in order to preserve the primary operation of the [policy].’”) (quoting Commissioner v. Clark, 489 U.S. 726, 739 (1989)), Disabled in Action of Pennsylvania v. Se. Pennsylvania Transp. Authority, 539 F.3d 199, 208 (3d Cir. 2008) (“The ADA is a remedial statute, designed to eliminate discrimination against the disabled in all facets of society, and as such, it must be broadly construed to effectuate its purposes.”) (internal quotations and citation omitted), Hason v. Medical Bd. of California, 279 F.3d 1167, 1172 (9th Cir. 2002) (“Courts must construe the language of the ADA broadly in order to effectively implement the ADA’s fundamental purpose of ‘provid[ing] a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.’”), and Richards v. Gov’t of Virgin Islands, 579 F.2d 830, 833 (3d Cir. 1978) (“Remedial legislation is traditionally construed broadly, with exceptions construed narrowly.”), with supra note 67 and accompanying text (discussing statutory and regulatory provisions directing that ADA’s definition of disability be construed broadly).

101 29 C.F.R. § 1630.1(c)(4) (2019); 28 C.F.R. § 36.101(b) (2019); accord ADAAA, supra note 66, at § 2(b)(5).

102 ADAAA, supra note 66, at § 2(b)(5); see also 42 U.S.C. § 12102(4)(B) (2018) (“The term ‘substantially limits’ shall be interpreted consistently with the findings and purposes of the ADA Amendments Act of 2008.”).

103 U.S. Const. amend. XIV; Doe v. Mass. Dep’t of Corr., No. 17-12255-RGS, 2018 WL 2994403, at *5–6 (D. Mass. June 14, 2018) (“[A] court has a duty where ‘a serious doubt of constitutionality is raised’ with respect to a statutory provision to ‘first ascertain whether a construction of the statute is fairly possible by which [a constitutional] question may be avoided.’”) (citing Crowell v. Benson, 285 U.S. 22, 62 (1932)); see also United States v. Dwinells, 508 F.3d 63. 70 (1st Cir. 2007) (“[A]s between two plausible constructions of a statute, an inquiring court should avoid a constitutionally suspect one in favor of a constitutionally uncontroversial alternative.”).

104 See DSM-5, supra note 13, at 451 (“Transgender refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their [assigned] gender. . . . Gender dysphoria refers to the
transgender classification that fails heightened scrutiny because it is not narrowly tailored or substantially related to the achievement of a compelling or important governmental interest.\textsuperscript{105} If heightened scrutiny does not apply, the ADA exclusion fails even the most minimal level of scrutiny because it is rooted in moral animus against transgender people,\textsuperscript{106} and such “a bare


Under the second theory, courts have held that heightened scrutiny is warranted because discrimination based on gender identity is a form of sex discrimination—either because it reflects sex stereotypes, or because the root of the discrimination is based on a person’s change of sex or assigned sex at birth. See, e.g., Whitaker, 858 F.3d at 1051 (applying “heightened review” because school district’s bathroom policy, which required transgender students to use the bathroom consistent the sex listed on their birth certificates, was “inherently based upon a sex-classification”); Glenn v. Brumby, 663 F.3d 1312, 1316, 1319 (11th Cir. 2011) (affirming trial court’s grant of summary judgment in favor of transgender employee because “discriminating against someone on the basis of his or her gender non-conformity constitutes sex-based discrimination under the Equal Protection Clause” and is therefore “subject to heightened scrutiny”); Smith v. City of Salem, 378 F.3d 566, 577 (6th Cir. 2004) (holding that transgender employee’s “claims of gender discrimination . . . easily constitute a claim of sex discrimination grounded in the Equal Protection Clause”); Doe v. Mass. Dep’t of Corr., 2018 WL 2994403, at *9 (holding that housing transgender inmates in facilities that correspond to their birth sex was discrimination “based on sex and is therefore subject to heightened judicial scrutiny above the normal ‘rational basis’ test”); Stockman v. Trump, 331 F. Supp. 3d 990, 1002 (2018) (applying “intermediate scrutiny”); Trump, 275 F. Supp. 3d at 209-210 (applying “intermediate level of scrutiny” because transgender discrimination is “a form of discrimination on the basis of gender, which is itself subject to intermediate scrutiny”); Norsworthy v. Beard, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015) (“[D]iscrimination against transgender individuals is a form of gender-based discrimination subject to intermediate scrutiny.”).

\textsuperscript{106} The ADA’s legislative history reveals that the ADA’s exclusion of “gender identity disorders” was based on the morose opprobrium of two senior senators, conveyed in the eleventh hour of a marathon day-long floor debate, who erroneously believed that gender identity disorders were “sexual behavior disorders” undeserving of legal protection. See, e.g., 135 CONG. REC. S10753, available at 1989 WL 183115 (daily ed. Sept. 7, 1989) (“I could not imagine the [ADA] sponsors would want to provide a protected legal status to somebody who has such [mental] disorders, particularly those [that] might have a moral content.”) (statement of Sen. Armstrong); id. at S10768, available at 1989 WL 183216 (“If this were a bill involving people in a wheelchair or those who have been injured in the war, that is one thing. But how in the world did you get to the place that you did not even [extend] transvestites? What I get out of all of this is here comes the U.S. Government telling the employer that he cannot set up any moral standards for his business . . . . [H]e cannot say, look I feel very strongly about people who engage in
with disabilities continually encounter various forms of discrimination, including discrimination based on their disability. For example, Radaszewski ex rel. Radaszewski v. Maram, 383 F.3d 599, 607 (7th Cir. 2004) (“In view of the similarities between the Rehabilitation Act and Transsexualism”) (supplemental statement of Sen. Armstrong); see also Pl.’s Mem. Law in Opp’n, Blatt v. Cabela’s Retail, Inc., No. 5:14-CV-04822, 2015 WL 1360179 (E.D. Pa. Jan. 20, 2015) (“[T]o argue that moral animus was not the primary motivation for excluding the subset of mental impairments that these Senators viewed as morally problematic runs contrary to the words explicitly spoken on the Senate Floor on September 7, 1989.”); Kevin M. Barry et al., A Bare Desire to Harm: Transgender People and the Equal Protection Clause, 57 B.C. L. REV. 507, 574 (2016) (“Senators Armstrong, Helms, and Rudman repeatedly invoked immorality as the justification for the transgender exclusions, deeming the ADA’s coverage of ‘sexually deviant behavior.’”); accord Duffy, supra note 26, at 16-38 to 16-39 (compiling ADA’s legislative history); Ruth Colker, Homophobia, AIDS Hysteria, and the Americans with Disabilities Act, 8 J. GENDER RACE & JUST. 33, 36-38, 42-44, 50 (2004) (same).

105 Romer v. Evans, 517 U.S. 620, 634-35 (1996) (emphasis in original) (quoting U.S. Dep’t of Agriculture v. Moreno, 413 U.S. 528, 534 (1973); see also City of Cleburne, Tex. v. Cleburne Living Center, 473 U.S. 432, 446 (1985) (“The State may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational.”).

106 See Doe v. Mass. Dep’t of Corr., No. 17-12255, 2018 WL 2994403, at *7 (D. Mass. June 14, 2018) (citing, inter alia, United States v. Carolene Prods. Co., 304 U.S. 144, 152 n.4 (1938)); see also id. at *8 (“It is virtually impossible to square the exclusion of otherwise bona fide disabilities [like gender dysphoria] with the remedial purpose of the ADA, which is to redress discrimination against individuals with disabilities based on antiquated or prejudicial conceptions of how they came to their station in life.”).

107 Fulton v. Goord, 591 F.3d 37, 43 (2d Cir. 2009); see, e.g., Nunes v. Mass. Dep’t of Corr., 766 F.3d 136, 144-45 (1st Cir. 2014) (“[W]e need make no distinction between the [ADA and Section 504] for purposes of our analysis in this case. . . . A plaintiff can press several different types of claims of disability discrimination. First, a plaintiff can assert disparate treatment on account of disability, i.e., that the disability actually motivated the defendant’s challenged adverse conduct. . . . Alternatively, in an appropriate case a plaintiff can claim that a government policy, though neutral on its face, fall[s] more harshly on one group than another and cannot be justified by business necessity. Finally, a plaintiff can pursue a third path, claiming that a public entity has refused to affirmatively accommodate his or her disability where such accommodation was needed to provide meaningful access to a public service.”) (citations omitted); Allmond v. Akal Sec., Inc., 558 F.3d 1312, 1316 n.3 (11th Cir. 2009) (stating that the Rehabilitation Act and the ADA are governed by “the same standards” and therefore may be used “interchangeably”); Radaszewski ex rel. Radaszewski v. Maram, 383 F.3d 599, 607 (7th Cir. 2004) (“In view of the similarities between the relevant provisions of the ADA and the Rehabilitation Act and their implementing regulations, courts construe and apply them in a consistent manner.”); Henriott D. v. Bloomberg, 331 F.3d 261, 274-76 (3d Cir. 2003) (discussing three theories of discrimination available under ADA and Section 504); Mass. Dep’t of Corr., 2018 WL 2994403, at *8 (“Because Doe has adequately stated a claim under the ADA, it follows that her Rehabilitation Act claim is equally viable.”); see also 42 U.S.C. § 12101(5) (2018) (finding that “individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the purpose of the ADA, which is to redress discrimination against individuals with disabilities based on antiquated or prejudicial conceptions of how they came to their station in life.”).
care constitutes discrimination based on gender dysphoria in violation of the ADA (Titles I and III), Section 504, and Section 1557 under each of these three theories.

1. Title 1 of the ADA

Title I of the ADA prohibits covered entities from discriminating on the basis of disability in regard to, among other things, “employee compensation . . . and other terms, conditions, and privileges of employment.” Such discrimination includes intentional discrimination, such as: “limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee”; and participating in a contractual relationship with another entity—such as “an organization providing fringe benefits to an employee”—that “has the effect of” discriminating against an applicant or employee.

Health insurance plans that exclude transition-related care intentionally discriminate based on gender dysphoria in two ways. First, broadly speaking, these plans purposefully deny coverage for medically necessary treatment of gender dysphoria (e.g., hormone therapy and surgery) while covering medically necessary treatment of other disabilities. For example, an insurance policy that denies people with gender dysphoria insurance coverage for hormone therapy and surgery, while covering the cost of medically necessary drugs and surgery for people with heart disease, discriminates based on gender dysphoria. Those with gender dysphoria and those with heart disease both have disabilities in need of medically necessary treatment, but insurance covers the medically necessary treatment of heart disease only—not gender dysphoria.

Discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities); ADAAA, supra note 66, at § 2(a)(2) (finding that “people with physical or mental disabilities are frequently precluded from [fully participating in all aspects of society] . . . because of prejudice, antiquated attitudes, or the failure to remove societal and institutional barriers”.

Because Section 1557 explicitly references Section 504’s anti-discrimination mandate, it necessarily incorporates the three theories of discrimination available under the ADA and Section 504. See infra notes 152-54 (discussing Section 1557’s incorporation of Section 504’s antidiscrimination mandate and enforcement mechanisms).

110 42 U.S.C. § 12112(a) (2018); 29 C.F.R. § 1630.4 (2019) (prohibiting discrimination “in regard to . . . [f]ringe benefits available by virtue of employment, whether or not administered by the covered entity”).

111 42 U.S.C. § 12112(b)(1)-(2) (2018); see also 29 C.F.R. pt. 1630, app. (2019) (“Disparate treatment means, with respect to title I of the ADA, that an individual was treated differently on the basis of his or her disability.”). The ADA’s prohibition of intentional discrimination also includes associational discrimination, that is, “excluding or otherwise denying equal jobs or benefits to a qualified individual because of the known disability of an individual with whom the qualified individual is known to have a relationship or association.” 42 U.S.C. § 12111(b)(4) (2018); accord 29 C.F.R. § 1630.8 (2019).

112 A plaintiff may demonstrate disparate treatment under the ADA through direct or circumstantial evidence, the latter of which courts analyze under the burden-shifting framework of McDonnell Douglas Corp. v. Green, 411 U.S. 792 (1973). See, e.g., Grant v. Hosp. Auth. of Miller Cnty., No. 1:15-CV-201-LJA, 2017 WL 3527703, at *4 (M.D. Ga. Aug. 16, 2017) (“Where . . . a plaintiff presents no direct evidence of discrimination, she may present circumstantial evidence of discrimination . . . .”). The deliberate exclusion of medically necessary treatments for gender dysphoria constitutes direct evidence of disparate treatment or, alternatively, circumstantial evidence of disparate treatment that is without a legitimate, non-discriminatory basis.

Second, and more specifically, these exclusions purposefully deny coverage for certain medically necessary procedures used to treat gender dysphoria (e.g., hormone therapy and surgeries such as mastectomy, hysterectomy, phalloplasty, and vaginoplasty) while covering the same procedures when they are used to treat other disabilities. For example, an insurance policy that denies people with gender dysphoria coverage for hormone therapy and mastectomies, while covering the cost of hormone therapy and mastectomies for people with cancer, discriminates based on gender dysphoria. Those with gender dysphoria and those with cancer both have disabilities in need of the very same medically necessary procedures, but insurance covers these procedures for cancer only—not gender dysphoria.

Longstanding EEOC interpretive guidance is clear on this point:

[A]n employer or other covered entity cannot deny an individual with a disability who is qualified equal access to insurance or subject an individual with a disability who is qualified to different terms or conditions of insurance based on disability alone, if the disability does not pose increased risks. Although “it would be permissible for an employer to offer an insurance policy that limits coverage for certain procedures or treatments” to all employees, an employer’s limitation of coverage for certain employees with disabilities violates Title I. For example, according to the EEOC, “it would not be permissible to limit or deny [a] hemophiliac employee”—and no others—coverage for “procedures . . . such as heart surgery or the setting of a broken leg.” This is precisely what transition-related care exclusions do: they limit coverage for certain procedures for people with gender dysphoria, while covering the same procedures for those with other medical conditions.

Title I of the ADA also prohibits covered entities from engaging in conduct that, while not intentionally discriminatory, has a disparate impact on people with disabilities. Such discrimination includes the use of “standards, criteria, or methods of administration . . . that have the effect of discrimination on the basis of disability.” Insurance policies that exclude transition-related care have the effect of discriminating against people with gender dysphoria

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114 See id.
116 Id.; see also id. (“[A]n employer that reduces the number of paid sick leave days that it will provide to all employees, or reduces the amount of medical insurance coverage that it will provide to all employees, is not in violation of this part, even if the benefits reduction has an impact on employees with disabilities in need of greater sick leave and medical coverage.”) (emphasis added).
117 Id.
118 See 42 U.S.C. § 12112(b)(3), (6) (2018); see also 29 C.F.R. pt. 1630, app. (2019) (“Disparate impact means, with respect to title I of the ADA and this part, that uniformly applied criteria have an adverse impact on an individual with a disability or a disproportionately negative impact on a class of individuals with disabilities.”). Unlike Title VII, a plaintiff may demonstrate disparate treatment under the ADA “by demonstrating an adverse impact on himself rather than on an entire group.” Gonzales v. City of New Braunfels, Tex., 176 F.3d 834, 839 n.26 (5th Cir. 1999).
because such people receive lesser benefits than their co-workers for no reason other than disability.  

Lastly, and critically, Title I of the ADA prohibits a covered entity from failing to “mak[e] reasonable accommodations to the known physical or mental limitations” of a person with a disability, unless the covered entity “can demonstrate that the accommodation would impose an undue hardship” on the covered entity’s business. Showing undue hardship is an affirmative defense. An accommodation imposes an “undue hardship” when it “require[es] significant difficulty or expense,” as determined by reference to, *inter alia*, “the nature and cost of the accommodation needed” and “the overall financial resources of the covered entity.” To facilitate the provision of reasonable accommodations in the workplace, Title I’s implementing regulations require an employer to engage in an “interactive process” with the employee to “identify the precise limitations resulting from the disability and potential reasonable accommodations that could overcome those limitations.”

A covered entity’s refusal to offer insurance policies that cover transition-related care constitutes a failure to make reasonable accommodations. Specifically, the request to remove an exclusion for transition-related care is reasonable because it seeks a benefit that all other employees enjoy: coverage for medically necessary care. Furthermore, accommodation imposes little or no cost on the employer—especially larger employers. This point is worth emphasizing. Because transgender people comprise a small percentage of the U.S. population (0.6%), and because not all transgender people undergo all available treatments, multiple studies show that the cost of covering transition-related care is inconsequential or cost-neutral. Some studies...
suggest that coverage for transition-related care reduces costs, given the substantial costs that may result from untreated gender dysphoria, including costs arising from the “development of depression, anxiety, and substance abuse,” and suicide attempts.\textsuperscript{120} If the cost of healthcare were of genuine concern, it is difficult to see why an employer would not target for exclusion the treatment of far more prevalent and expensive medical conditions, such as cancer. In addition, the overwhelming number of private businesses (752) that report removing transition-related care exclusions from their health insurance plans, together with the twenty states and the District of Columbia that prohibit transition-related care exclusions under state insurance law, substantially undermines the claim that coverage of transition-related care is not financially viable.\textsuperscript{130}

Numerous cases support the conclusion that transition-related care exclusions constitute discrimination based on disability under Title I.\textsuperscript{131}


\footnotesize{DSM-5, supra note 13, at 454-55; see also Cal. Dep’t of Ins., \textit{supra} note 128, at 9 (“The evidence suggests that there may be potential cost savings resulting from the adoption of the proposed regulation [that prohibits the denial of coverage for transition-related care] 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 . . . .”).

\footnotesize{See \textit{supra} notes 52-53 and accompanying text (discussing coverage for transition-related care in private sector and under state law).

\footnotesize{See, e.g., Carparts Distribution Ctr., Inc. v. Automotive Wholesaler’s Ass’n of New England, Inc., 37 F.3d 12, 14-15, 18 (1st Cir. 1994) (holding that caps on AIDS-related care in employer-provided health plan could constitute discrimination under Title I of ADA); see also Henderson v. Bodine Aluminum, Inc., 70 F.3d 958, 960 (8th Cir. 1995) (“[I]f the evidence shows that a given treatment is non-experimental—that is, if it is widespread, safe, and a significant improvement on traditional therapies—and the plan provides the treatment for other conditions directly comparable to the one at issue, the denial of that treatment arguably violates the ADA.”); Brown v. Bank of Am., N.A., 5 F. Supp. 3d 121, 136-37 (D. Me. 2014) (holding that plaintiff alleged facts sufficient to show that an employee benefits administrator discriminated against employee in violation of Title I of the ADA by denying leave of absence and failing to accommodate plaintiff); Fletcher v. Tufts Univ., 367 F. Supp. 2d 99, 104, 114 (D. Mass. 2005) (holding that plaintiff stated claim that employer violated Title I of the ADA by adopting and maintaining a health plan that provided inferior benefits to people with mental health conditions); Iwata v. Intel}
Some covered entities offer transition-related care in only one insurance plan but not in others. This is not a “reasonable” accommodation for two reasons. First, the provision of only one transition-inclusive plan effectively relegates people with gender dysphoria to that single plan. This deprives these employees of an opportunity that all other employees enjoy, namely, the ability to choose a plan. Second, by effectively mandating the insurance plan that people with gender dysphoria must use, the network of providers they must see, and the premiums they must pay, the provision of a single transition-inclusive plan stigmatizes people with gender dysphoria, branding them as financial liabilities undeserving of equal benefits.

2. Title III of the ADA

Title III of the ADA prohibits any person who operates a place of public accommodation from discriminating on the basis of disability in regard to, among other things, “the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations” provided by the public accommodation. Like Title I, Title III prohibits intentional discrimination, such as—“directly or through contractual, licensing, or other arrangements”—(i) denying an individual the opportunity “to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity” on the basis of disability, (ii) affording an individual the opportunity “to participate in or benefit from a good, service, facility, privilege, advantage, or accommodation that is not equal to that afforded to other individuals,” or

Musgrove Compl. ¶¶ 57, 60, supra note 12 (alleging that, of the four health plans offered by the University of Georgia to its employees, only one plan—which was over twice as expensive as the other three and had a far more limited selection of surgeons—covered treatments for gender dysphoria).


Musgrove Compl. ¶ 59, supra note 12 (“Contracting with one third-party HMO that does not discriminate in its plan while the Board persists in excluding medically necessary care does not address the inequity in plan choices, plan coverage, or the stigma caused by having exclusions at all. The simple existence of ‘sex change’ exclusions—which lack a legitimate, nondiscriminatory basis—devalues the medical needs of [the plaintiff] and all employees with gender dysphoria . . . .”)

(iii) providing an individual “with a good, service, facility, privilege, advantage, or accommodation that is different or separate from that provided to other individuals.”

A transition-related care exclusion intentionally discriminates by denying people with gender dysphoria the “full and equal enjoyment” of health care benefits. Specifically, by purposefully refusing to cover medically necessary procedures used to treat gender dysphoria (e.g., hormone therapy and surgery) while covering the same medically necessary procedures when they are used to treat other disabilities, the exclusion provides people with gender dysphoria with a service that is “different or separate from that provided to other individuals,” and plainly unequal.

Title III also prohibits conduct that has a disparate impact on people with disabilities. This includes (i) “directly or through contractual, licensing, or other arrangements, utiliz[ing] standards or criteria or methods of administration . . . that have the effect of discriminating on the basis of disability”; or (ii) imposing “eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any goods, services, facilities, privileges, advantages, or accommodations, unless such criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered.” The exclusion of transition-related care has a disparate impact: its effect is to discriminate on the basis of disability by utilizing “methods of administration” to provide lesser benefits to people with gender dysphoria. It also “screen[s] out” people with gender dysphoria by rendering them alone ineligible for coverage for medically necessary treatments.

Additionally, Title III requires making “reasonable modifications in policies, practices, or procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to individuals with disabilities, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations.” The exclusion of transition-related care constitutes a failure to make “reasonable modifications in policies, practices, or procedures” necessary to afford equal benefits to people with gender dysphoria.

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136 Id. § 12182(b)(1)(A). Title III’s prohibition on intentional discrimination also includes associational discrimination. See id. § 12182(b)(1)(E) (prohibiting a covered entity from “exclud[ing] or otherwise deny[ing] equal goods, services, facilities, privileges, advantages, accommodations, or other opportunities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association”).
138 See id. at § 12182(b)(1)(iii).
139 Id. § 12182(b)(1)(D), (b)(2)(A)(i); see also 28 C.F.R. pt. 36, app. C (2019) (stating that Title III “incorporate[s] a disparate impact standard to ensure the effectiveness of the legislative mandate to end discrimination. This standard is consistent with the interpretation of section 504 by the U.S. Supreme Court in Alexander v. Choate, 469 U.S. 287 (1985).”).
140 Id. § 12182(b)(1)(D).
141 Id. § 12182(b)(2)(A)(i).
142 Id. § 12182(b)(2)(A)(ii).
alter the nature” of the services provided by insurers. The cost of including transition-related care is negligible or even non-existent, as demonstrated by numerous studies, the nearly 800 private businesses that reported covering such care in 2019, and the twenty-one jurisdictions that prohibit transition-related care exclusions under state insurance law.

Numerous cases support the conclusion that transition-related care exclusions constitute discrimination based on disability under Title III.

3. Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act (“Section 504”) prohibits recipients of federal financial assistance from “exclud[ing]” or “deny[ing] . . . benefits” to a person, or otherwise “subject[ing]” a person to discrimination, based on disability. As the Supreme Court and numerous lower

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144 See Johnson v. Gambrinus Co./Spoetzl Brewery, 116 F.3d 1052, 1059 (5th Cir. 1997) (“While Title I provides an undue hardship defense and Title III provides a fundamental alteration defense, fundamental alteration is merely a particular type of undue hardship.”); see also 29 C.F.R. pt. 1630, app. (2019) (“‘Undue hardship’ refers to any accommodation that would be unduly costly, extensive, substantial, or disruptive, or that would fundamentally alter the nature or operation of the business.”)

145 See supra notes 127-30 and accompanying text (discussing inconsequential costs of covering transition-related care).

146 See, e.g., Carparts Distribution Ctr., Inc. v. Auto. Wholesaler’s Ass’n of New England, Inc., 37 F.3d 12, 19-21 (1st Cir. 1994) (reversing district court’s dismissal of action and holding that entities that administered employer-sponsored health insurance plan could be liable under Title III of ADA for imposing caps on AIDS-related care); Fletcher v. Tufts Univ., 367 F. Supp. 2d 99, 115 (D. Mass. 2005) (holding that plaintiff stated claim that third party administrator violated Title III of the ADA by providing inferior benefits to people with mental health conditions); Boots v. Nw. Mut. Life. Ins. Co., 77 F. Supp. 2d 211, 214-16 (D.N.H. 1999) (same); Attar v. UNUM Life Ins. Co. of America, No. CA 3-96-CV-367-R, 1998 WL 574885, at *3 (N.D. Tex. Aug. 31, 1998) (denying summary judgment to third party administrator and holding that “24-month limitation on [coverage for] mental disabilities strikes the Court as a rather overt ‘limit’ on the ‘extent’ of ‘coverage’ under the benefit plan” and “would thus be subject to an ADA [Title III] claim, unless of course it could be justified by actuarial principles or actual or reasonably anticipated experience”); Lewis v. Aetna Life Ins. Co., 982 F. Supp. 1158, 1165 (E.D. Va. 1997) (Title III applicable to third party administrator’s provision of inferior benefits to people with mental health conditions); see also Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 31 (2d Cir. 1999) (vacating district court’s motion to dismiss and holding that plaintiff stated claim that insurer violated Title III of ADA by refusing to offer life insurance policy to people with mental health conditions); accord Reid v. BCBSM, Inc., 984 F. Supp. 2d 949, 955, 957 (D. Minn. 2013) (Title III applicable to health insurer’s exclusion of behavioral therapy treatment for people with Autism Spectrum Disorder); Wai v. Allstate, 75 F. Supp. 2d 1, 8 (D.D.C. 1999) (Title III of ADA applicable to insurer’s provision of landlords’ insurance at less favorable rates and terms to landlords who rent to tenants with disabilities); Winslow v. IDS Life Ins. Co., 29 F. Supp. 2d 557, 562-63 (D. Minn. 1998) (Title III of ADA applicable to insurer’s provision of inferior benefits to people with mental health conditions); Dunlap v. Association of Bay Area Governments, 996 F. Supp. 962, 966 (N.D. Cal. 1998) (Title III of ADA applicable to insurer’s denial of coverage for, inter alia, recommended surgical procedure); Cloutier v. Prudential Ins. Co. of America, 964 F. Supp. 299, 307 (N.D. Cal. 1997) (Title III applicable to insurer’s denial of life insurance to plaintiff based on partner’s HIV-status); Kotev v. First Colony Life Ins. Co., 927 F. Supp. 1316, 1320-23 (C.D. Cal. 1996) (same); Doukas v. Metropolitan Life Ins. Co., 950 F. Supp. 422, 425 (D.N.H. 1996) (Title III applicable to insurer’s denial of mortgage disability insurance to person with mental health condition); Baker v. Hartford Life Ins. Co., No. 94 C 4416, 1995 WL 573430, at *3 (N.D. Ill. Sept. 28, 1995) (Title III applicable to insurer’s denial of health insurance to person with history of seizure disorder); infra note 171 (collecting cases applying Title III of ADA to insurers and third party administrators).

courts have held, Section 504, like the ADA, prohibits intentional discrimination, disparate impact, and the failure to make reasonable accommodations. 148 Section 504’s implementing regulations, upon which the ADA is based, 149 confirm as much. 150 Accordingly, transition-related care exclusions violate Section 504 for the same reasons that they violate the ADA. 151

4. Section 1557 of the ACA

Section 1557 of the ACA prohibits a health program or activity from discriminating “on the ground prohibited under . . . Section 504 of the Rehabilitation Act of 1973,” that is, based on disability. 152 Because Section 1557 explicitly incorporates Section 504’s anti-discrimination mandate and enforcement mechanisms, the requirements for showing discrimination under

148 See, e.g., Alexander v. Choate, 469 U.S. 287, 299, 301 (1985) (“assum[ing] without deciding that § 504 reaches at least some conduct that has an unjustifiable disparate impact upon the handicapped,” and stating that “to assure meaningful access, reasonable accommodations in the grantee’s program or benefit may have to be made [under Section 504]”); supra note 109 (collecting lower court cases applying identical antidiscrimination analysis under ADA and Section 504); see also 42 U.S.C. § 12201(a) (2018) (prohibiting courts from construing ADA “to apply a lesser standard than the standards applied under [Section 504] . . . of the Rehabilitation Act of 1973 (29 U.S.C. 790 et seq.) or the regulations issued by Federal agencies pursuant to such title”).

149 See Chai R. Feldblum, Definition of Disability Under Federal Anti-Discrimination Law: What Happened? Why? And What Can We Do About It?, 21 BERKELEY J. EMP. & LAB. L. 91, 127 (stating that the ADA “hewed . . . closely . . . to the language and structure of the Section 504 regulations[,] . . . diverg[ing] from those regulations in only a few, select circumstances”).

150 See, e.g., Alexander, 469 U.S. 287, 301 n.21 (citing DHHS regulations for proposition that “[t]he regulations implementing § 504 are consistent with the view that reasonable adjustments in the nature of the benefit offered must at times be made to assure meaningful access.”); 45 C.F.R. § 84.4(b)(1) (2019) (prohibiting disparate treatment on the basis of disability, including, “directly or through contractual, licensing, or other arrangements”: (i) “[d]eny[ing] a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service”; (ii) “[a]fford[ing] a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others”; (iii) “[p]rovid[ing] a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to others”; (iv) “[p]rovid[ing] different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others”; or (v) “[o]therwise limit[ing] a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving an aid, benefit, or service); id. § 84.4(b)(4) (prohibiting disparate impact on the basis of disability, including “directly or through contractual or other arrangements, utiliz[ing] criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, [or] (ii) that have the purpose or effect of defeating or substantially impairing the objectives of the recipient’s program or activity with respect to handicapped persons”); see also id. § 84.52(4) (prohibiting “[p]rovid[ing] benefits or services in a manner that limits or has the effect of limiting the participation of qualified handicapped persons”) (emphasis added); 28 C.F.R. § 42.503(b)(1), (3) (2019) (prohibiting disparate treatment and disparate impact based on disability); id. § 42.511(a) (prohibiting the failure to make “reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate, based on the individual assessment of the applicant or employee, that the accommodation would impose an undue hardship on the operation of its program or activity”).

151 See supra notes 110-46 and accompanying text (discussing reasons why transition-related care exclusions violate ADA).

Section 1557 are the same as those under Section 504. Accordingly, transition-related care exclusions violate Section 1557 for the same reasons that they violate Section 504.

C. Employers and Health Insurers are Covered Entities

The ADA, Section 504, and Section 1557 apply to employers and health insurers. Because each of these laws defines covered entities differently, this subpart discusses each law separately.

1. Title I of the ADA

Under Title I of the ADA, a “covered entity” refers to an entity “engaged in an industry affecting commerce” that “has 15 or more employees,” and “any agent” of the employer. So long as an employer is engaged in commerce and has the requisite number of employees, the employer is a covered entity for purposes of Title I.

The question of whether a health insurer that administers an employer-sponsored health insurance plan is an agent of the employer, and thus a “covered entity” within the meaning of Title I of the ADA, is more nuanced. According to the EEOC’s nearly twenty-year-old guidance, the answer is clearly yes: “[A]n insurance company that provides discriminatory benefits to the employees of [a separate entity] may be liable under the [equal employment opportunity] statutes as the [employer]’s agent.” The plain language of the ADA strongly supports this interpretation. The ADA explicitly defines discrimination to include “participating in a contractual or other arrangement or relationship that has the effect of subjecting a covered entity’s qualified applicant or employee with a disability to the discrimination prohibited by this subchapter (such relationship includes a relationship with . . . an organization providing fringe benefits to an employee of the covered entity . . . ).” In a separate section of the ADA, entitled “Miscellaneous Provisions,” under the heading, “Insurance,” the ADA expressly states that Title I (and Title III) of the ADA does not prohibit an insurer or plan administrator “from underwriting risks, classifying risks, or

153 Compare 29 U.S.C. § 794(a) (2018) (“No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . .”), with 42 U.S.C. § 18116 (2018) (“[A]n individual shall not, on the ground prohibited under . . . [section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794], 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 . . . . The enforcement mechanisms provided for and available under . . . section [504] . . . shall apply for purposes of violations of this subsection.”); cf. Radaszewski ex rel. Radaszewski v. Maram, 383 F.3d 599, 607 (7th Cir. 2004) (“In view of the similarities between the relevant provisions of the ADA and the Rehabilitation Act and their implementing regulations, courts construe and apply them in a consistent manner.”).

154 See supra notes 147-51 and accompanying text (discussing reasons why transition-related care exclusions violate Section 504 of Rehabilitation Act).


157 42 U.S.C. § 12112(b)(2) (2018); see also E.E.O.C. v. Benicorp Ins. Co., No. IP 00-014-MISC, 2000 WL 724004, at *2 (S.D. Ind. May 17, 2000) (rejecting argument “that an administrator of a health plan is not an ‘employer’ under Title I of the ADA” based, in part, on ADA’s prohibition on discriminatory contractual arrangements with organizations providing fringe benefits).
administering such risks that are based on or not inconsistent with State law.” This same section further states that an insurer or plan administrator is not prohibited “from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan” so long as the challenged disability-based distinction is not used “as a subterfuge to evade the purposes” of Titles I (and Title III) of the ADA. Logically, the converse is also true: The ADA does prohibit an insurer or plan administrator from “underwriting risks, classifying risks, or administering such risks” that are inconsistent with State law, and from using a disability-based distinction as a subterfuge to evade the ADA’s requirements. To the extent that there is ambiguity regarding Title’s I application to health insurers who administer employer-sponsored health insurance plans, Skidmore deference should apply to the EEOC’s interpretive guidance. This guidance has remained consistent for nearly two decades and reflects the “informed judgment” and “body of experience” of the agency charged with enforcing Title I of the ADA.

At least two circuit courts and numerous district courts throughout the Nation have concluded that a third party administrator can be held liable under Title I of the ADA for “act[ing] on behalf of the [principal] entity in the matter of providing and administering employee health benefits.”

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158 42 U.S.C. § 12201(c) (2018); see also 1993 EEOC Guidance, supra note 52, at ¶ III(A) (“[S]ection 501(c) permits employers, insurers, and plan administrators to establish and/or observe the terms of an insured health insurance plan that is ‘bona fide,’ based on ‘underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law,’ and that is not being used as a ‘subterfuge’ to evade the purposes of the ADA. Section 501(c) likewise permits employers, insurers, and plan administrators to establish and/or observe the terms of a ‘bona fide self-insured health insurance plan that is not used as a ‘subterfuge’.”).

159 42 U.S.C. § 12201(c).

160 See id.; see also Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 32 (2d Cir. 1999) (“The exemption for insurance underwriters whose practices are ‘not inconsistent with State law’ strongly implies that the Act is intended to reach insurance underwriting practices that are inconsistent with State law. If the ADA were not intended to reach insurance underwriting under any circumstances, there would be no need for a safe harbor provision exempting underwriting practices that are consistent with state law.”); Mason Tenders Dist. Council Welfare Fund v. Donaghey, No. 93 Civ. 1154, 1993 WL 596313, at *3 (S.D.N.Y. Nov. 19, 1993) (stating that ADA’s inclusion of subterfuge provision indicated congressional intent to apply Title I of the ADA to administrators of pension plans); 29 C.F.R. pt. 1630, app. (2019) (“The safe harbor [42 U.S.C. 12201(c)] permits insurers and employers (as sponsors of health or other insurance benefits) to treat individuals differently based on disability, but only where justified according to accepted principles of risk classification (some of which became unlawful subsequent to passage of the ADA.”) (emphasis added).


162 Carparts Distribution Ctr., Inc. v. Auto. Wholesaler’s Ass’n of New England, Inc., 37 F.3d 12, 17 (1st Cir. 1994); see, e.g., Henderson v. Bodine Aluminum, Inc., 70 F.3d 958, 960-61 (8th Cir. 1995) (holding that plaintiff was likely to succeed on merits of claim that employer-sponsored health plan and insurance providers discriminated based on disability in violation of ADA by covering high dose chemotherapy for certain cancers while denying it for breast cancer); Brown v. Bank of Am., N.A., 5 F. Supp. 3d 121, 137 (D. Me. 2014) (holding that plaintiff alleged facts sufficient to show that third party administrator was an agent of the employer under Title I of the ADA); Benicorp Ins. Co., 2000 WL 724004, at *2 (rejecting argument “that an administrator of a health plan is not an ‘employer’ under Title I of the ADA” based, in part, on ADA’s prohibition on participating in a contractual arrangement with an organization providing fringe benefits to an employee of the covered entity); Boots v. Nw. Mut. Life Ins. Co., 77 F. Supp. 2d 211, 214 (D.N.H. 1999) (denying motion to dismiss and holding that employee
Numerous circuit and district courts have likewise held that third party administrators can be held liable for discriminatory health plans pursuant to Title VII of the Civil Rights Act of 1964 and the ADEA, both of which share Title I of the ADA’s definition of “employer.” Importantly, many courts have concluded that the determination of who is an “employer” under Title I “will rarely be resolved on a motion to dismiss [because] . . . this assessment is highly fact-bound. Where a complaint alleges that a defendant is an employer or agent under the ADA, the allegation alone is typically sufficient to withstand dismissal.”

See, e.g., Spirt v. Teachers Ins. & Annuity Ass’n, 691 F.2d 1054, 1063 (2d Cir. 1982) (holding that third party insurance company that provided retirement benefits to employees of other employers was an “employer” under Title VII), vacated and remanded sub nom. Long Island Univ. v. Spirt, 463 U.S. 1223 (1983), reinstated on remand, 735 F.2d 23 (2d Cir. 1984), cert. denied, 469 U.S. 881 (1984); Boyden v. Conlin, 341 F. Supp. 3d 979, 998 (W.D. Wis. 2018) (denying summary judgment to state insurance board and holding that the board, which excluded transition-related treatment from state employee health insurance plans, was an agent of plaintiffs’ state employers under Title VII); Jansson v. Stamford Health, Inc., No. 3:16-cv-260, 2017 WL 1289824, at *19 (D. Conn. Apr. 5, 2017) (“[I]f delegated a core employer duty, the third party can incur liability under Title VII.”); Nealey v. Univ. Health Servs., Inc., 114 F. Supp. 2d 1358, 1368–70 & n.11 (S.D. Ga. 2000) (denying summary judgment to management company that provided administrative and management services to employer and holding that management company was employer’s agent under Title VII); Grossman v. Suffolk Cty. Dist. Attorney’s Office, 777 F. Supp. 1101, 1104–05 (E.D.N.Y. 1991) (holding that employee benefits administrator was “employer” under ADEA); Graf v. K-Mart Corp., No. 88-1254, 1989 WL 407247, at *4 (W.D. Pa. Aug. 28, 1989) (denying summary judgment to employee benefits administrator and holding that administrator was agent “with respect to [employer’s] provision of employee benefits under Title VII”).

“If a defendant contends that it is neither the employer nor agent, the wiser course is for the parties to engage in discovery, isolate undisputed and disputed facts, and present the issue as a matter of law based on a fully developed factual record.”; see, e.g., Oliver, 2016 WL 5419459, at *4 (quoting Brown); Burgie v. Euro Brokers, Inc., 482 F. Supp. 2d 302, 308 n.11 (E.D.N.Y. 2007) (“[C]ourts have frequently found that the question of whether or not someone is an ‘employer’ is a question of fact better determined on summary judgement than on a motion to dismiss.”); Hollander v. Paul Revere Life Ins. Co., No. 96 Civ. 4911, 1997 WL 811531, at *1 (S.D.N.Y. Apr. 21, 1997) (stating that “it is unclear at this point whether defendant is ‘so intertwined’ with plaintiff’s employer . . . that it should be deemed an ‘employer’ or ‘covered entity’”).
One might argue that Congress included the “agent” language to ensure respondeat superior liability of the principal for the acts of its agents. Even if true, it does not mean that the agent is not also liable. Stated another way, an agent’s actions may bind the principal, but the principal does not automatically assume all of the agent’s legal liability; the agent can be held liable for the same actions.165 This is particularly true where the agent being sued is not an individual employee who could be held personally liable: “[W]here the agent being sued is itself a company who obtains employer status pursuant to a contractual agreement with the plaintiff’s common law employer, policy considerations counsel that it ought to be individually liable for its violations of Title VII.”166 As the Seventh Circuit has stated, agents are liable under Title I of the ADA if they “otherwise meet the statutory definition of [an] ‘employer,’” namely, if they “ha[ve] the requisite number of employees and [are] engaged in an industry affecting commerce.”167

2. Title III of the ADA

Under Title III of the ADA, a “public accommodation” is a private entity whose operations affect commerce and fall within one of twelve broad types of businesses.168 These businesses range from “place[s] of lodging” (e.g., hotels), to “place[s] of recreation” (e.g., amusement parks), to “service establish[ment][s],” the latter of which explicitly include “insurance offices.”169 The Department of Justice has long interpreted this language to prohibit an insurer from “discriminat[ing] on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer,”170 as have numerous lower courts, including the First, Second, and Seventh Circuits.171 This broad interpretation of public accommodation is

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165 See, e.g., Schur v. L.A. Weight Loss Ctrs., Inc., 577 F.3d 752, 765 (7th Cir. 2009) (“[A]n agent can be individually liable even where his employer is also vicariously liable.”).


167 DeVito v. Chicago Park Dist., 83 F.3d 878, 882 (7th Cir. 1996); see also E.E.O.C. v. Benicorp Ins. Co., No. IP 00-014-MISC, 2000 WL 724004, at *3, 4 (S.D. Ind. May 17, 2000) (stating that “an individual or entity that . . . otherwise meet[s] the statutory definition of employer”—including “an administrator of a health plan”—“can be held liable under the ADA”).


169 Id.; see Levorsen v. Octapharma Plasma, Inc., 828 F.3d 1227, 1231 (10th Cir. 2016) (“[W]e conclude that a service establishment is a place of business or a public or private institution that, by its conduct or performance, assists or benefits someone or something or provides useful labor without producing a tangible good for a customer or client.”).

170 U.S. DEP’T OF JUSTICE, ADA Title III Technical Assistance Manual, Covering Public Accommodations and Commercial Facilities III-3.11000, https://www.ada.gov/taman3.html; see, e.g., 28 C.F.R. Pt. 36, app. C (1991) (explicitly rejecting the argument that Title III “does not apply to insurance underwriting practices or the terms of insurance contracts,” and relying upon “[l]anguage in the committee reports indicat[ing] that Congress intended to reach insurance practices by prohibiting differential treatment of individuals with disabilities in insurance offered by public accommodations unless the differences are justified”); see id. (“A few commenters representing the insurance industry conceded that underwriting practices in life and health insurance are clearly covered.”).

171 See, e.g., Carparts Dist. Ctr., Inc. v. Auto. Wholesaler’s Ass’n of New England, Inc., 37 F.3d 12, 19-21 (1st Cir. 1994) (reversing district court’s dismissal of action and holding that entities that administered employer-sponsored health insurance plan could be liable under Title III of ADA); see also Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 31 (2d Cir. 1999) (holding that Title III of the ADA regulates underwriting practices); accord Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 559 (7th Cir. 1999) (same); Fletcher v. Tufts Univ., 367 F. Supp. 2d 99, 115 (D. Mass. 2005) (holding that employee stated claim that third party administrator of employer-sponsored health plan violated Title III of ADA by providing inferior benefits to people with mental
consistent with the ADA’s “Insurance” provision, which, as discussed above, explicitly contemplates Title III’s (and Title I’s) application to an “insurer” that underwrites, classifies, or administers risks inconsistent with state law, and to insurers and third party administrators that use disability-based distinctions as a subterfuge to evade the ADA’s requirements.\footnote{42 U.S.C. § 12201(c) (2018).} It is also consistent with the Supreme Court’s interpretation of the term “public accommodation,” which, the Court stated in \textit{PGA Tour, Inc. v. Martin}, “should be construed liberally to afford people with disabilities equal access to the wide variety of establishments available to the nondisabled.”\footnote{PGA Tour, Inc. v. Martin, 532 U.S. 661, 676–77 (2001) (citing ADA’s legislative history).} This interpretation is likewise consistent with the ADA’s broad remedial purpose, which is to “invoke the sweep of Congressional authority in . . . order to address the major areas of discrimination faced day-to-day by people with disabilities,”\footnote{42 U.S. C. § 12101(b) (2018).} and with the ADA’s legislative history, which indicates Congress’s intent that “[t]he term ‘public accommodation’ . . . [be] defined very broadly” to “include much of the private sector.”\footnote{S. Rep. No. 116, 101st Cong., 1st Sess. at 87 (1989) (views of Sen. Hatch), available at https://static1.squarespace.com/static/57ebdf73e4fcb538c12657ba/t/5c9d15d1104c7bc3e7d6ff819/1553798725460/Senate+Report+101-116.pdf (stating that “public accommodation” under Title III of the ADA “includes not only businesses covered by Title II of the 1964 Civil Rights Act,” . . . [but also] retail stores, service establishments, and other elements of the private sector”); see also PGA Tour, Inc., 532 U.S. at 675 (“Congress enacted the ADA in 1990 to remedy widespread discrimination against disabled individuals. . . . After thoroughly investigating the problem [of discrimination against people with disabilities], Congress concluded that there was a compelling need for a clear and comprehensive national mandate to eliminate discrimination against disabled individuals, and to integrate them into the economic and social mainstream of American life. . . . In the ADA, Congress provided that broad mandate.”) (internal quotation marks omitted); Levorsen v. Octapharma Plasma, Inc., 828 F.3d at 1227, 1232 (10th Cir. 2016) (liberally construing the term “service establishment”); Carparts Distribution Ctr., Inc., 37 F.3d at 19 (same); 28 C.F.R. pt. 36, app. C (2019) (stating that ADA’s “representative examples of facilities within each [of the twelve categories] are not [exhaustive]”).} Indeed, Title III’s broad coverage was part of a “fragile compromise” struck by the bill’s chief sponsors in the Senate, who agreed to limit Title III’s remedies to injunctive relief “in exchange for an expansive list of commercial entities covered by the statute”—a list that includes insurers.\footnote{See Ruth Colker, \textit{ADA Title III: A Fragile Compromise}, 21 BERKELEY J. EMP. & LAB. L. 377, 385 (2000) (citing legislative history).}

There are three primary arguments against Title III’s application to transition-related care exclusions, all of which fail under scrutiny.

(a) “Physical Access Only”

One might first argue that because Title III refers to “places of public accommodation,” and more specifically, to “insurance office[s],” it is limited to physical access to the facilities of insurance providers and therefore does not apply to discriminatory health insurance plans.\footnote{42 U.S.C. § 12181(7)(F) (2018) (emphasis added).} Three circuits—the Third, Sixth, and Ninth—have taken this position.\footnote{See, e.g., Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1114 (9th Cir. 2000) (requiring “some connection between the good or service complained of and an actual physical place”); accord Ford v.}
cases represent a circuit split on the issue; they are directly at odds with the First, Second, and Seventh Circuits, which have concluded that Title III “was meant to guarantee . . . more than mere physical access” and thus extends to discrimination in insurance underwriting.\(^{179}\) As the First Circuit has stated, it “would be irrational to conclude that persons who enter an office to purchase services are protected by the ADA, but persons who purchase the same services over the telephone or by mail are not.”\(^{180}\) Indeed, “[i]t is even more difficult to believe that Congress intended this result to apply to the insurance industry, whose goods and services (insurance policies) are routinely purchased by customers who never set foot in an insurance office.”\(^{181}\)

Interpreting Title III to apply to insurance companies is also consistent with the ADA’s text, which contains no requirement “that a good or service offered by a place of public accommodation be purchased on the physical premises of that office in order for the protections of Title III to apply.”\(^{182}\) Additionally, this interpretation finds support in the ADA’s legislative history and the Department of Justice’s (DOJ’s) interpretive guidance, both of which expressly contemplate the ADA’s application to the terms of insurance policies.\(^{183}\)

**(b) “Access, Not Content”**

One might further argue that, even if Title III applies to health insurance plans, Title III requires only *access* to such plans (i.e., provision of the same services to everyone)—it does not regulate their content (i.e., provision of different services to people with disabilities).\(^{184}\) This is the position advanced by the Seventh Circuit in *Doe v. Mutual of Omaha*, which held that Title III did not apply to a health insurance policy that placed a $25,000 cap on lifetime benefits related to AIDS while providing a $1 million cap on lifetime benefits for other conditions.\(^{185}\) Importantly, two other circuits—the First and Second—have refused to adopt this argument, and for good reason.\(^{186}\)

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\(^{179}\) Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 32 (2d Cir. 1999); accord Doe v. Mutual of Omaha, 179 F.3d 557, 559 (7th Cir. 1999); Carparts Distribution Ctr., Inc. v. Auto. Wholesaler’s Ass’n of New England, Inc., 37 F.3d 12, 20 (1st Cir. 1994).

\(^{180}\) Carparts Distrib. Ctr., Inc., 37 F.3d at 19.


\(^{182}\) Lewis, 982 F. Supp. at 1164.

\(^{183}\) See supra note 170 and accompanying text (discussing DOJ guidance and ADA’s legislative history).

\(^{184}\) See Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 560 (7th Cir. 1999) (“The common sense of the statute is that the content of the goods or services offered by a place of public accommodation is not regulated. A camera store may not refuse to sell cameras to a disabled person, but it is not required to stock cameras specially designed for such persons.”).

\(^{185}\) Id. at 558, 563.

\(^{186}\) See Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 32-33 (2d Cir. 1999) (“[T]he statute was meant to guarantee [people with disabilities] more than mere physical access. . . . We therefore hold that Title III . . . unambiguously covers insurance underwriting in at least some circumstances . . . .”); Carparts Distribution Ctr., Inc. v. Automotive Wholesaler’s Ass’n of New England, Inc., 37 F.3d 12, 19-20 (1st Cir. 1994) (stating that public accommodations “are not limited to actual physical structures,” and that “there is nothing in th[e ADA’s legislative] history that explicitly precludes an extension of the statute to the substance of what is being offered”).
First, Doe’s purported distinction between access and content is illusory because it depends entirely on the level of generality at which one defines the service that is being offered.187 If one defines the service at the highest level of generality—for example, access to health insurance, full stop—an insurer will not be liable unless it outright refuses to insure a person with gender dysphoria. In short, any health insurance coverage, no matter how disparate its terms, will suffice for purposes of the ADA.188 This was the Seventh Circuit’s holding in Doe.189 When the service is defined at a slightly lower level of generality, however, transition-related care exclusions are discriminatory under the Seventh Circuit’s test because they deny access to a service that people without gender dysphoria receive—namely, health insurance coverage for medically necessary care. At a still lower level of generality, transition-related care exclusions are discriminatory because they deny access to health insurance coverage for specific medical procedures that people without gender dysphoria receive, such as hormone therapy and mastectomies.190

To illustrate the incoherence of the Seventh Circuit’s access/content distinction, consider the case of Bragdon v. Abbott, in which the Supreme Court held that the ADA covered a person with HIV.191 In that case, the patient’s dentist refused to fill her cavity in his office but agreed to perform the procedure in the hospital, provided that the patient paid for the additional hospital costs.192 If one defines the service offered at a high level of generality—access to dental services—there was no discrimination; the dentist agreed to fill the patient’s cavity, albeit at a higher cost than for those not living with AIDS.193 However, if one defines the service at a lower level of generality—access to dental services in a dentist’s office, at the same cost as for those

187 See Carparts Distribution Ctr., Inc. v. Auto. Wholesaler’s Ass’n of New England, Inc., 37 F.3d 12, 19 (1st Cir. 1994) (“[T]here may be areas in which a sharp distinction between [access and content] is illusory.”); see also Boots v. Nw. Mut. Life Ins. Co., 77 F. Supp. 2d 211, 215 (D.N.H. 1999) (“This distinction between access and content, however, is not always clear.”).
188 See Alexander v. Choate, 469 U.S. 287, 301 n.21 (1985) (“Antidiscrimination legislation can obviously be emptied of meaning if every discriminatory policy is ‘collapsed’ into one’s definition of what is the relevant benefit.”); see also Lewis v. Aetna Life Ins. Co., 982 F. Supp. 1158, 1168 (E.D. Va. 1997) (“[T]his Court finds that the distinction drawn by defendants [between denying coverage and providing lesser coverage] is illusory. Both a decision to deny coverage on the basis of mental disability and to provide inferior coverage for mental disabilities target the mentally disabled for inferior treatment. In both cases, an insurer has subjected the mentally disabled individual to treatment inferior to that accorded to others solely on the basis of that individual’s disability.”).
189 Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 559, 562 (7th Cir. 1999) (stating that if “Mutual of Omaha [were] to take the position that people with AIDS are so unhealthy that it won’t sell them health insurance,” this “would be a prima facie violation of section 302(a),” but concluding that Mutual of Omaha’s caps on AIDS-related care did not amount to a “refus[al] to sell insurance policies to such persons—it was happy to sell health insurance policies to the two plaintiffs”) (emphasis added).
190 See Carparts Distribution Ctr., Inc., 37 F.3d at 19-20 (holding that caps on AIDS-related care in employer-provided health plan could constitute discrimination under Title III of ADA); see, e.g., Boots v. Nw. Mut. Life Ins. Co., 77 F. Supp. 2d 211, 215-16 (D.N.H. 1999) (rejecting the Seventh Circuit’s access/content distinction and holding that plaintiff stated a claim against third party administrator for discriminating against people with mental health conditions in violation of Title III of the ADA); Doukas v. Metropolitan Life Ins. Co., 950 F. Supp. 422, 425-26 (D.N.H. 1996) (“This court agrees with plaintiff that under the plain language of Title III, the Act would extend to the substance or contents of an insurance policy where, as here, the plaintiff has been denied access to insurance because of his or her disability.”).
192 Id. at 629.
193 See id.
not living with AIDS—the dentist did discriminate. In granting summary judgment to the plaintiff, the district court in Bragdon adopted the latter view: by charging a higher price for dental services, the dentist discriminated against his patient based on her disability. Significantly, the defendant in Bragdon conceded as much, and neither the First Circuit nor the Supreme Court suggested otherwise.

Second, Doe’s access/content distinction ignores the plain language of the ADA, which broadly prohibits not only “outright intentional exclusion,” but also “exclusionary qualification standards and criteria” that have a disparate impact on people with disabilities, and the “failure to make modifications to existing . . . practices.” By prohibiting only the outright refusal to insure people with disabilities, the Seventh Circuit’s access/content distinction ignores the latter two theories of discrimination contained in the ADA. According to the Seventh Circuit, insurers have no obligation to alter insurance criteria that screen out people with disabilities or to modify insurance policies in modest ways, because doing so necessarily implicates the content of (not access to) insurance policies.

Third, Doe’s access/content distinction was premised on two assumptions that are no longer true given intervening changes to the law. The first assumption was that regulation of the “content” of insurance would lead to arbitrariness: “Diseases that happened to be classified as disabilities could not be capped, but equally or more serious diseases that are generally not disabling, such as heart disease, could be.” Even assuming this argument had merit when Doe was decided in 1999, this argument lacks all force in the wake of the ADA Amendments Act of 2008, which broadened the scope of the ADA’s definition of disability to cover medical conditions—such as heart disease—that are not literally disabling but that would be disabling when considered in their active state and absent medication or other treatment. Because the ADA, as amended, now applies to an extraordinarily broad range of medical conditions,

194 See id.
196 See Abbott, 912 F. Supp. at 584. The only issues before the Supreme Court and the First Circuit were whether the plaintiff had a disability and whether the defendant had an affirmative defense for discriminating. See Bragdon, 524 U.S. at 628; Abbott, 107 F.3d at 937-38.
197 42 U.S.C. § 12101(5); see also ADAAA, supra note 66, at § 2(a)(2) (“[I]n enacting the ADA, Congress recognized that . . . people with physical or mental disabilities are frequently precluded from [fully participating in all aspects of society] . . . because of prejudice, antiquated attitudes, or the failure to remove societal and institutional barriers.”); supra notes 135-45 and accompanying text (discussing three theories of discrimination under ADA).
198 See Mutual of Omaha, 179 F.3d at 560.
199 See supra notes 170-71 and accompanying text (discussing courts’ and agencies’ broad interpretation of public accommodations under Title III of the ADA).
200 Mutual of Omaha, 179 F.3d at 559.
201 42 U.S.C. § 12102(4)(D), (E)(i).
202 See id. (“The definition of disability in this chapter shall be construed in favor of broad coverage of individuals under this chapter, to the maximum extent permitted by the terms of this chapter.”); ADAAA, supra note 66, at § 2(b)(1) (“reinstating a broad scope of protection to be available under the ADA”).
is little concern that Title III’s application to the content of insurance would lead to the arbitrariness that the Seventh Circuit feared.

*Doe’s* second assumption was that regulation of the “content” of insurance would upend insurance practices because “most health-insurance policies contain caps,” and insurance companies have a “right . . . to exclude coverage for an applicant’s pre-existing medical conditions.”203 This assumption no longer holds true in the wake of the ACA, which largely eliminated pre-existing condition bans as well as annual- and lifetime-coverage caps.204

Furthermore, application of the access/content distinction to caps on AIDS-related care, as was the case in *Doe*, is distinguishable from its application to transition-related care exclusions.205 The former implicates *limitations* on coverage for certain medical treatments, whereas the latter involves the denial of coverage for certain medical treatments altogether, which is far more akin to a denial of access than a regulation of content.

(c) “No Application to Employer-Sponsored Insurance”

Lastly, one might argue that, even if Title III reaches the content of health insurance policies, it applies only to policies issued directly by insurers to individuals—not to employer-sponsored policies that individuals receive via employment. This argument flatly contradicts not only DOJ guidance, which draws no such distinction, but also the plain language of the ADA, which expressly prohibits public accommodations from discriminating on the basis of disability either “directly, or through contractual licensing, or other arrangements.”206 The Supreme Court underscored this point in *PGA Tour, Inc. v. Martin*, stating that Title III “prohibit[s] public accommodations from discriminating against a disabled ‘individual or class of individuals’ in

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203 Doe v. Mutual of Omaha Ins. Co., 179 F.3d 557, 559 (7th Cir. 1999).

204 See 42 U.S.C. § 300gg-3 (2018) (“Prohibition of preexisting condition exclusions or other discrimination based on health status”), 300gg-11 (“No lifetime or annual limits”); accord 45 C.F.R. §§ 147.108, 147.126 (2019). *Doe*’s access-content distinction was also premised on the McCarran-Ferguson Act, which forbids federal preemption of state laws that regulate the business of insurance unless the federal law “specifically relates to the business of insurance.” *Mutual of Omaha*, 179 F.3d at 563. McCarran-Ferguson is not applicable to the ADA’s prohibition of transition-related care exclusions for two reasons. First, as the Second Circuit has held, “the ADA does ‘specifically relate to the business of insurance,’ and therefore falls outside the scope of McCarran–Ferguson’s prohibition.” *Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28, 34 (2d Cir. 1999) (emphasis added); accord *Marques v. Harvard Pilgrim Healthcare of New England, Inc.*, 883 A.2d 742, 747 n.13 (R.I. 2005). Second, even if the ADA is within the scope of the McCarran-Ferguson Act, the Act forbids federal laws that regulate “the business of insurance,” not the business of self-funded plans administered by third party administrators, who are not involved in any underwriting or spreading of risk. See *Bernard B. v. Blue Cross and Blue Shield of Greater New York*, 528 F. Supp. 125, 131 (S.D.N.Y. 1981) (holding that McCarran-Ferguson Act did not forbid application of Rehabilitation Act to Blue Cross Blue Shield’s exclusion of coverage for hospital services for mental health conditions, and noting that agreements between Blue Cross and hospitals did not constitute “business of insurance” within McCarran-Ferguson because they “did not involve any underwriting or spreading of risk, but [we]re merely arrangements for the purchase of goods and services by Blue Cross”).

205 Cf. *Pallozzi*, 198 F.3d at 35 & n.5 (distinguishing insurer’s imposition of cap on benefits for treatment of AIDS in *Doe* from insurer’s refusal to offer life insurance policy to people with mental health conditions in *Pallozi*).

certain ways either directly or indirectly through contractual arrangements with other entities,” and that Title III’s prohibitions therefore “cannot be avoided by means of contract.”

Accordingly, the First Circuit and numerous lower courts have concluded that an insurer may not discriminate in the terms of insurance, regardless of whether the insurance “is sold directly to a disabled individual or made available to that individual indirectly via an employer pursuant to a contractual or other relationship.” Significantly, the one circuit to reach a contrary result—the Seventh Circuit—did not address the ADA’s text, the Supreme Court’s interpretation of that text in *PGA Tour, Inc.*, or any other legal authority.

3. **Section 504 of the Rehabilitation Act**

Section 504 applies to public and private entities that receive “[f]ederal financial assistance,” which includes funds, services, or “[a]ny other thing of value by way of grant, loan, contract, or cooperative agreement.” It is well-established that the term “federal financial assistance” must be liberally construed “in order to give effect to the broad legislative intent expressed in section 504.” As the Eleventh Circuit has stated, “Congress intentionally gave broad scope to the term ‘federal financial assistance,’” as demonstrated by “legislative history to the 1974 amendments, [which] is replete with notations indicating that Section 504 was intended to encompass programs receiving federal financial assistance of any kind.” Accordingly, Section 504 applies to private insurance companies—including those acting as third party administrators—that receive, *inter alia*: Medicare Part A funds and, as participants in the federal health insurance

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208 Lewis v. Aetna Life Ins. Co., 982 F. Supp. 1158, 1165 (E.D. Va. 1997); see, e.g., Carparts Distribution Ctr., Inc. v. Auto. Wholesaler’s Ass’n of New England, Inc., 37 F.3d 12, 19-20 (1st Cir. 1994) (holding that entities that administered employer-sponsored health insurance plan could be liable under Title III of ADA); see also supra notes 146, 171 and accompanying text (collecting cases applying Title III of ADA to third party administrators).

209 Morgan v. Joint Admin. Bd., Ret. Plan of the Pillsbury Co. and Am. Fed. of Grain Millers, 268 F.3d 456, 459 (7th Cir. 2001) (Posner, J.) (holding, without citation to any statutory, judicial, or administrative authority, that Title III did not apply to the administrator of an employee retirement plan because “[n]o one could walk in off the street and ask to become a plan participant. The plan was a private deal, not a public offering.”).


211 Arline v. School Bd. of Nassau Cty., 772 F.2d 759, 762 n.9 (11th Cir. 1985), aff’d, 480 U.S. 273 (1987); see, e.g., U.S. v. Baylor Univ. Med. Ctr., 736 F.2d 1039, 1047 (5th Cir. 1984) (interpreting Section 504 “as part of a broad government policy . . . to prevent discrimination in programs receiving federal assistance”); id. (discussing “Congress’ clear and consistent purpose to protect handicapped persons and members of minority groups from discrimination in programs receiving federal assistance”); Jones v. Metro. Atlanta Rapid Transit Auth., 681 F.2d 1376, 1380 (11th Cir. 1982) (“The Rehabilitation Act is remedial in nature. As a general matter, courts eschew narrow interpretations of remedial statutes. Instead, remedial statutes are normally accorded broad construction in order to effectuate their purpose.”); Dorer v. Quest Diagnostics Inc., 20 F. Supp. 2d 898, 900 (D. Md. 1998) (discussing “broad remedial thrust of the Rehabilitation Act”); see also Tcherepnin v. Knight, 389 U.S. 332, 336 (1967) (recognizing the “familiar canon of statutory construction that remedial legislation should be construed broadly to effectuate its purposes”).

212 *Arline*, 772 F.2d at 762 n.9, aff’d, 480 U.S. 273 (1987) (emphasis added).

213 See, e.g., Austin v. Blue Cross and Blue Shield of Ala., No. 4:09-1647-VEH, 2009 WL 1070738, at *1 (N.D. Ala. 2009) (permitting the plaintiff to amend complaint to include Rehabilitation Act claim against insurer based on insurer’s receipt of Medicare, Part A funds, and concluding that such a claim was not futile based on, *inter alia*, the Eleventh Circuit’s conclusion in *Arline*, 772 F.2d at 762 n.9 (11th Cir. 1985), aff’d, 480 U.S. 273 (1987),
marketplace under the ACA, direct payments from the federal government related to individual consumers who receive tax credits or cost-sharing reductions in order to help them purchase insurance.\(^{214}\)

4. **Section 1557 of the ACA**

Private insurance companies, including those acting as third party administrators, are explicitly covered by Section 1557 of the ACA, which applies to “any health program or activity, any part of which is receiving federal financial assistance, including credits, subsidies, or

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\(^{214}\) 42 U.S.C. § 18082(a)(3) (2018) (“[T]he Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit.”) (emphasis added).
contracts of insurance.”

Section 1557’s specific reference to “credits” and “subsidies” makes clear that Section 1557’s anti-discrimination mandate applies to private insurance companies that receive federal tax credits and subsidies through their participation in the federal health insurance marketplace. Such an interpretation is also consistent with Section 1557’s remedial purpose, which is to “address[] the problem of those who cannot obtain insurance coverage because of pre-existing conditions or other health issues,” and with the failure of Congress to exclude private insurers explicitly from Section 1557. As the Eleventh Circuit has stated, a court “act[s] beyond [its] authority” when it reads into civil rights laws “limitations which Congress chose not to establish when it clearly could have done so.” Accordingly, the fact that an insurer acts as a

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215 42 U.S.C. § 18116(a) (2018); see also Rumble v. Fairview Health Servs., No. 14-CV-2037, 2015 WL 1197415, at *12 (D. Minn. Mar. 16, 2015) (“[A]s long as part of an organization or entity receives federal funding or subsidies of some sort, the entire organization is subject to the anti-discrimination requirements of Section 1557.”).

216 42 U.S.C. § 18082(a)(3) (2018) (discussing “advance payments of such credit or reductions to the issuers of the qualified health plans”); see also Griffin v. Gen. Elec. Co., No. 1:15–CV–4439, 2017 WL 3449607, at *5 (N.D. Ga. Jan. 6, 2017) (discussing Section 1557’s application “not only to public insurance such as Medicare and Medicaid, but also to the private insurance market and many employer-sponsored insurance plans”); Letter from 138 Members of the U.S. House of Representatives to The Honorable Mick Mulvaney, Director, Office of Management and Budget 1-2 (May 23, 2018), https://juliabrownley.house.gov/wp-content/uploads/2018/05/Letter_toOMB_05_23_18.pdf (stating that “[i]n drafting and enacting the Health Care Rights Law, members of the 111th Congress, including many of the signatories of this letter, clearly and unambiguously intended the Health Care Rights Law to prohibit sex discrimination in health care,” which encompasses the decision by “health care providers—including insurance companies, hospitals, and doctors—to deny people health care because of the provider’s personal beliefs”) (emphasis added); Valarie K. Blake, An Opening for Civil Rights in Health Insurance After the Affordable Care Act, 36 B.C. J.L. & SOC. JUST. 235, 238 n.21 (2016) (“The broadening of civil rights law into private [insurance] markets [under the ACA] is a direct effect of these entities receiving federal dollars.”); Sidney D. Watson, Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity, 55 HOW. L.J. 855, 873 (2012) (“Section 1557’s specificity that federal financial assistance includes ‘credits’ and ‘subsidies’ unequivocally establishes that Section 1557’s antidiscrimination mandate covers private insurance companies, physicians, and other providers who will be receiving new federal tax credits and subsidies authorized by the ACA.”) (emphasis added).


218 Cf. Arline, 772 F.2d at 762 & n.9 (11th Cir. 1985) (declining to interpret “federal financial assistance” under Section 504 to exclude impact aid absent a “specifically delineated exception to the statute”), aff’d, 480 U.S. 273 (1987).

219 Id. at 762; see also Andrus v. Glover Const. Co., 446 U.S. 608, 616–17 (1980) (“Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence to the contrary legislative intent.”). On May 24, 2019, the Office for Civil Rights of the Department of Health and Human Services issued a proposed rule that would repeal and replace portions of its 2016 regulations implementing Section 1557 of the Affordable Care Act. Katie Keith, HHS Proposes To Strip Gender Identity, Language Access Protections From ACA Anti-Discrimination Rule, HEALTH AFFAIRS BLOG (May 25, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190525.831858/full/. To the extent that the Department’s final regulations do not apply to private insurers that receive credits and subsidies through their participation in the federal health insurance marketplace, the regulations are undeserving of Chevron deference because they are at odds with the plain language of Section 1557 and congressional intent. See supra notes 215-220 and accompanying text; cf. Moore v. Sun Bank of North Fla., N.A., 923 F.2d 1423, 1431 (11th Cir. 1991) (declining to defer to Department of Health, Education, and Welfare’s restrictive interpretation of “federal financial assistance” under Section 504 because it was inconsistent with “the plain language of section 504, the failure of Congress to amend the Rehabilitation Act to exclude [the financial assistance at issue in the case], and the clearly expressed intent of
third party administrator of a discriminatory plan does not undermine coverage; as the District of Minnesota has stated, “[n]othing in Section 1557, explicitly or implicitly, suggests that [third party administrators] are exempt from the statute’s nondiscrimination requirements.”

D. The ADA’s “Safe Harbor” is Inapplicable

Unlike Section 504 and Section 1557, the ADA provides a “safe harbor” for certain disability-based health insurance plan distinctions. Generally speaking, § 12201(c) of the ADA permits employers and their agents (under Title I) and private insurers (under Title III) to discriminate on the basis of disability in the provision of health insurance so long as they can show that the health insurance plan is “bona fide” and the challenged disability-based distinction is not being used as a “subterfuge to evade the purposes of [the ADA].” A plan is “bona fide” if “it exists and pays benefits, and its terms have been accurately communicated to employees.” A plan’s disability-based distinction is not being used as a “subterfuge” if it is “justified by the risks or costs associated with the disability,” for example: if the treatment sought “does not provide any benefit (i.e., has no medical value)”; if the disability-based distinction “is attributable to the application of legitimate risk classification and underwriting procedures to the increased risks (and thus increased cost to the health insurance plan) of the disability, and not to the disability per se”; or if the desired coverage “would have been so expensive as to cause the health insurance plan to become financially insolvent” or resulted in “a drastic increase in premium payments (or in co-payments or deductibles), or a drastic alteration to the scope of coverage or level of benefits provided.” Whether a disability-based health

Congress in providing broad remedy for handicapped discrimination in programs receiving ‘Federal financial assistance’


221 42 U.S.C. § 12201(c) (2018); see also 29 C.F.R. § 1630.16(f) (2019) (applying safe harbor to entities covered under Title I of ADA); 28 C.F.R. § 36.212 (2019) (applying safe harbor to entities covered under Title III of ADA).

222 42 U.S.C. § 12201(c) (2018). If the health insurance plan is not an employer-sponsored self-funded plan, and is therefore “subject to State laws that regulate insurance,” there is an additional requirement: the plan must also be “based on or not inconsistent with State law.” 42 U.S.C § 12201(c)(1)-(2) (2018); see also 1993 EEOC Guidance, supra note 52, at § III(C)(1) (distinguishing between “insured plan[s]” and “self-insured plan[s]”).

223 1993 EEOC Guidance, supra note 52, at § III(C)(1).

224 Id. at § III(C)(2); see also U.S. DEP’T OF JUSTICE, ADA TITLE III TECHNICAL ASSISTANCE MANUAL III-3.11000 (“[A] public accommodation . . . may not refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience. The ADA, therefore, does not prohibit use of legitimate actuarial considerations to justify differential treatment of individuals with disabilities in insurance.”); Technical Assistance Letter from Bill Lan Lee, Acting Assistant Attorney General, U.S. Dep’t of Justice to the Hon. Joseph I. Lieberman, United States Senate (Nov. 16, 1999), https://www.justice.gov/crt/americans-disabilities-act-technical-assistance-letters-49 (“The ADA, therefore, does not prohibit the use of legitimate actuarial considerations to justify differential treatment of individuals with disabilities in insurance.”).

Agency interpretations of the ADA’s safe harbor provision are consistent with the ADA’s legislative history. See S. Rep. No. 101-116, at 85 (stating that a health insurance plan may not refuse or limit insurance based on a physical or mental impairment, “except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience”); H.R. Rep. No. 101-485, pt. 3, at 71 (1990)
insurance plan distinction falls within the ADA’s safe harbor “is determined on a case by case basis, considering the totality of the circumstances,” and the burden of proof is on the defendant.\(^{225}\)

In the context of transition-related care exclusions, employers and private insurers cannot meet their burden for two reasons. First, it is beyond cavil that transition-related care has medical value; for over a half-century, the medical community has recognized transition as a safe and effective means of treating gender dysphoria.\(^{226}\) Second, there simply is no actuarial basis for excluding transition-related care, particularly where the very treatments that health plans label as “transgender healthcare”—including hormone therapy, mastectomy, hysterectomy, phalloplasty, and vaginoplasty—are routinely covered when they are administered to non-transgender people.\(^{227}\) As numerous courts have held, a disability-based health insurance plan distinction does not fall within the ADA’s safe harbor absent proof of an actuarial basis.\(^{228}\)

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\(^{225}\) 1993 EEOC Guidance, supra note 52, at § III(C)(2); see, e.g., Zamora-Quezada v. HealthTexas Med. Grp. of San Antonio, 34 F. Supp. 2d 433, 442 (W.D. Tex. 1998) (rejecting “defendants’ affirmative defense argument they are insulated from liability and protected from further proceedings in this case by the safe harbor provision of the ADA”); see also 1993 EEOC Guidance, supra note 52, at § III(C) (“Requiring the respondent to bear th[e] burden of proving entitlement to the protection of [42 U.S.C. 12201(c)] is consistent with the well-established principle that the burden of proof should rest with the party who has the greatest access to the relevant facts. In the health insurance context, it is the respondent employer (and/or the employer’s insurer, if any) who has control of the risk assessment, actuarial, and/or claims data relied upon in adopting the challenged disability-based distinction. Charging party employees have no access to such data, and, generally speaking, have no information about the employer provided health insurance plan beyond that contained in the employer provided health insurance plan description.”).

\(^{226}\) See supra note 44 and accompanying text.

\(^{227}\) See supra notes 114, 128-30 and accompanying text.

\(^{228}\) See, e.g., Doukas v. Metropolitan Life Ins. Co., 950 F. Supp. 422, 432 (D.N.H. 1996) (denying summary judgment to insurer under Title III of the ADA because genuine issue of fact existed as to whether insurer’s denial of mortgage disability insurance to woman with bipolar disorder was based on sound actuarial principles); accord Carparts Distribution Ctr., Inc. v. Auto. Wholesaler’s Ass’n of New England, Inc., 987 F. Supp. 77, 83 (D.N.H. 1997) (denying summary judgment to defendant third party administrators under Titles I and III of the ADA because genuine issue of fact existed as to whether defendants’ caps on AIDS-related care was based upon “unlawful discriminatory animus and/or upon unreasonable speculation regarding the medical and fiscal threat posed by the Human Immunodeficiency Virus and AIDS”), on remand from, 37 F.3d 12 (1994); Cloutier v. Prudential Ins. Co. of America, 964 F. Supp. 299, 307 (N.D. Cal. 1997) (denying summary judgment to insurer under Title III of the ADA because genuine issue of fact existed as to whether insurer’s denial of life insurance to gay man whose partner had HIV was based on sound actuarial principles); id. (“It defies the spirit of the ADA for the Court to accept Prudential’s proffer of vague explanations of the risks of HIV infection where the business of insurance requires sound risk assessment practices. Because plaintiff has pointed to evidence revealing the possibility of discriminatory denial of an insurance policy, Prudential can only prevail on summary judgment by coming forward with actuarial or other data supporting its actions.”); Morgenthal ex rel. Morgenthal v. American Telephone & Telegraph Co., Inc., No. 97 Civ. 6443, 1999 WL 187055, at *3 (S.D.N.Y. Apr. 6, 1999) (“finding it premature, on a motion to dismiss, to determine whether defendant’s policy was exempted by the safe harbor provision”) (citing Hollander v. Paul Revere Life Ins. Co., No. 96 Civ. 4911, 1997 WL 811531, at *2 (S.D.N.Y. Apr. 21, 1997)); Baker v. Hartford Life Ins. Co., No. 94 C 4416, 1995 WL 573430, at *4 (N.D. Ill. Sept. 28, 1995) (denying motion to dismiss and stating that “[i]t is possible that the decision to deny plaintiff coverage was not based on considerations of underwriting or classifying risks, in which case plaintiff might be entitled to recover under the ADA. Also, even though an insurer may claim to be basing a denial of coverage on actuarial or classification of risk considerations, that claim is not conclusive as the
CONCLUSION

There is no legitimate reason to deny insurance coverage for transition-related care. The consensus of the mainstream medical community, backed by decades of clinical experience, is that transition-related care is a medically necessary and effective treatment for gender dysphoria. Furthermore, the cost of coverage for transition-related care, is, in the words of at least two federal district courts, “immaterial,” given the small fraction of people who utilize such care. Therefore, when insurers offer and employers adopt healthcare plans that exclude transition-related care, they necessarily do so out of indifference—or, worse, hostility—toward the health and safety of people with gender dysphoria. This Essay argues that such treatment constitutes disability discrimination.

Fortunately, transition-related care exclusions are in decline. When confronted with the injustice of targeting gender dysphoria treatments for exclusion from health plans, most private employers have voluntarily removed the exclusion. But the same is not true with respect to public employers. In 2018, for example, a transgender employee named Skyler Jay sued his employer, the University of Georgia, for excluding coverage for transition-related care in violation of, inter alia, Title VII, the ADA, and Section 504 of the Rehabilitation Act. The question of whether section 12201(c)(1) is being used as a subterfuge would remain.

See supra note 44 and accompanying text (discussing medical consensus that hormonal and surgical treatment to align physical sex characteristics with one’s gender identity is medically necessary and successful in alleviating gender dysphoria).

See supra notes 128-30 and accompanying text (citing Flack v. Wis. Dep’t of Health Servs., 395 F. Supp. 3d 1001, 1021-22 (W.D. Wis. 2019) and Boyden v. Conlin, 341 F. Supp. 3d 979, 1000-01 (W.D. Wis. 2018)).

See, e.g., TLDEF Files Federal Lawsuit Against Houston County, Georgia for Excluding Medically-Necessary Transgender Health Care in Employee Health Plan, TLDEF Press Release, http://www.transgenderlegal.org/headline_show.php?id=985 (“By denying coverage for [an employee’s transition-related care, the employer] . . . is showing complete disregard for her health and well being. . . . Rejecting an employee’s medical needs is negligent and reckless.”) (quoting Kayla Gore, Southern Regional Organizer for Transgender Law Center@SONG); see also Lange Compl. ¶105, supra note 12 (“[T]he only conceivable purpose of the [exclusion of transition-related care] is its effect: to single out transgender people undergoing a gender transition for inferior compensation as compared to their colleagues, and to unlawfully seek to avoid paying for a stigmatized form of health care”).

See supra notes 47-55 and accompanying text (discussing trend toward coverage for transition-related care in public and private health insurance).

TLDEF Press Release, supra note 231 (citing Senior Staff Attorney Noah Lewis).

See Musgrove Compl. ¶6, supra note 12.
following year, the University settled the lawsuit, agreeing to remove the exclusion and compensate Mr. Jay $100,000.\textsuperscript{235} And, in 2019, police Sargent Anna Lange sued her employer, Houston County, Georgia, for excluding transition-related care, alleging that such an exclusion constitutes both sex and disability discrimination under federal and state law.\textsuperscript{236} That case remains pending.

More lawsuits await and disability rights law will continue to play an important role. In the words of Mr. Jay, the practical effect of the exclusion of coverage for transition-related care is to deny “life-saving access to care” for people with gender dysphoria.\textsuperscript{237} Such a result is untenable, and it is precisely one that disability rights law should remedy.


\textsuperscript{236} See id.