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ARTICLE

Mental Health Parity Arguments for Accessing Gender Affirmation Surgery

Craig Konnoth

School of Law, University of Virginia, Charlottesville, VA, USA
Email: craig.konnoth@law.virginia.edu

Abstract

Many insurers exclude coverage for transgender individuals. Litigation challenging these exclusions has increased. Most of these cases successfully advance equality claims by arguing that trans exclusions discriminate based on sex. That is, procedures performed on patients for reasons unrelated to gender affirming care are being denied to transgender individuals. There are, however, limitations to this argument. First, some courts may construe care narrowly and hold that some procedures are unique to gender affirming care that have no analog in other contexts. Second, a court that is hostile to the sex discrimination argument might hold that the denial does not arise from sex discrimination, but rather, because of the kind of diagnosis at issue. Further, the sex discrimination argument might force transgender individuals into making claims based on a binarized gender identity which may not conform with their lived experience.

Claims based on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) can address these shortcomings. This Act prohibits insurers from discriminating against mental health diagnoses—for example, procedures that insurers cover because of medical or surgical diagnoses should also be covered if indicated for mental health diagnoses. Gender dysphoria is a recognized mental health diagnosis. Transgender individuals seeking gender affirming care arising from gender dysphoria can thus claim that exclusions of coverage violate the MHPAEA. Some transgender individuals might raise concerns that such an approach would lead to increased medicalization of trans identity. However, an MHPAEA claim would only appear in cases where a transgender individual is voluntarily submitting themselves to medical assistance in order to advance their own autonomy.

Keywords: gender affirmation surgery; mental healthy parity; insurance coverag; insurance denials; transgender health care

In the last several years, individuals have sought access to gender affirming surgery in increasing numbers.[1] Yet, insurance coverage has frequently not kept up, with numerous insurers continuing to deny coverage. Transgender individuals have identified insurance denials as the main problem they face in accessing appropriate healthcare.[2] While denials for care relating to gender affirmation are prohibited in 24 states and the District of Columbia,[3] denials are encouraged in the remaining states.[4]

[1] *Gender Confirmation Surgeries Rise 20% in First Ever Report*, Am. Soc. Of Plastic Surgeons (May 22, 2017), https://www.plasticsurgery.org/news/press-releases/gender-confirmation-surgeries-rise-20-percent-in-first-ever-report [https://perma.cc/K9GX-QH7L].

[2] Anna Kirkland et al., *Health insurance rights and access to health care for trans people: The social construction of medical necessity*, 55 Law & Soc. Rev. 539 (Dec. 6, 2021).

[3] *State Health Insurance Laws and Guidance*, TLDEF's Trans Health Project (2023), https://transhealthproject.org/resources/state-health-insurance-laws-and-guidance/views/explicit-guidance/ [https://perma.cc/39X6-XF76]; Kirkland, *supra* note 2.

[4] Christy Mallory & Will Tentindo, *Medicaid Coverage for Gender-Affirming Care*, UCLA School of L. Williams Inst. (Dec. 2022), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Medicaid-Gender-Care-Dec-2022.pdf.

Federal statutes preempt state protections, and existing legal strategies that rely on sex or disability discrimination claims have fallen short of offering full protections,[5,6] and indeed, may soon be undermined by the Supreme Court.[7]

To address these shortcomings, this Article offers a novel approach: using mental health parity claims to achieve coverage. Mental health parity refers to the goal of offering the same level of care for mental health diagnoses as is offered from diagnoses concerning physiological issues.[8] The underlying argument is simple: transgender individuals who seek gender affirmation usually do so as the result of a gender dysphoria diagnosis. The treatment offered for this diagnosis—whether psychological, chemical, or surgical—should be on par with the treatment offered for comparable physiological complaints.

Part I explains the problem. Transgender individuals are experiencing insurance denials for coverage of gender-affirming care and existing legal strategies are falling short. Part II lays out a new approach that relies on mental health parity claims. Mental health parity statutes at the federal level may provide a strong basis for advancing gender affirmation, and recent state-level administrative guidance as well as federal litigation appear to recognize this fact. Part III lays out limitations, mainly arising from fragmentation and procedural hurdles present in mental health parity laws.

I. Explaining the Problem

A. Defining the Term "Transgender"

Transgender advocate and law professor, Dean Spade, defines "[t]ransgender" as "a term that emerged in the 1990s to describe people who experience discrimination or bias because they identify or express gender differently than what is traditionally associated with the sex they were assigned at birth."[9] This phenomenon was understood as having a medical, and specifically psychiatric, etiology. Earlier editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), classified such non-alignment between assigned and experienced sex as a medical diagnosis: "[t]he essential feature" of a "gender identity disorder" was "an incongruence between assigned sex (i.e., the sex that is recorded on the birth certificate) and gender identity."[10]

Many transgender advocates registered concern. As one court put it, "the gender identity disorder diagnosis marked being transgender as a mental illness."[11] Further, all individuals might engage in a diversity of gender expression without identifying as transgender or experiencing it as pathological.[12] Addressing this concern, and after consultation with a range of transgender rights organizations, the fifth edition of the DSM replaced the term "'gender identity disorder' with 'gender dysphoria' … to avoid stigma."[13] At the same time, retaining the diagnosis allowed individuals who wanted medical care to access it, given that insurance companies bill using diagnostic codes.[14]

[5]Kirkland et al., *supra* note 2.

[6]That is, who underwrite the costs of employee medical care, though they might use another plan administrator. *See* Craig Konnoth, *Health Data Federalism*, 101 B.U. L. Rev. 2205 (Dec. 2021).

[7]*See* Petition for Writ of Certiorari, L.W., by and Through her Parents and Next Friends, Samantha Williams and Brian Williams, et. Al, Petitioners, v. Jonathan Skrmetti, et al., Respondents, No. 23-466 (Nov. 1, 2023), 2023 WL 7300257 [hereinafter "Williams Petition"].

[8]64 A.L.R. Fed. 3d Art. 1 (originally published in 2021).

[9]Dean Spade, *Documenting Gender*, 59 Hastings L.J. 731, 733 n. 2 (2008). *See also* E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. of Transgender Health S1 (Sept. 15, 2022).

[10]Am. Psych. Ass'n, Diagnostic & Statistical Manual 71 (3d ed., rev. 1987) (DSM-III-R).

[11]*Williams v. Kincaid,* 45 F.4th 759, 766–68 (4th Cir. 2022).

[12]*See* Coleman, *supra* note 9 ("gender diversity is common to all human beings and is not pathological.").

[13]*Gender Dysphoria*, Am. Psychiatric Ass'n (2013), https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Gender-Dysphoria.pdf.

[14]*Id.*

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B. Insurance Denials

Gender dysphoria, codified as diagnostic code section 302.85, "refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender," and offers some guidelines for assessing the extent of observed distress.[15] Not all transgender individuals experience gender dysphoria.[16] Of individuisabilials experiencing gender dysphoria, different courses of treatment are indicated. As the World Professional Association for Transgender Health explains, "[w]hat helps one person alleviate gender dysphoria might be very different from what helps another person."[17] The Guidelines, updated in 2022, offer various approaches to helping address gender dysphoria, including assisting individuals with gender expression, hormone therapy, surgery, and psychotherapy.[18]

Most of the legal challenges discussed below concern access to gender-affirming surgery. As courts recognize, "[o]f those individuals who seek treatment for [g]ender [d]ysphoria, only a subset requires surgical intervention."[19]

Transgender individuals have brought suits when insurance companies, medical providers, employers, or custodial institutions have refused access to gender affirming treatment. These prohibitions can take several forms.[20] In some cases, coverage is excluded for *all* services related to gender affirmation, including hormonal treatments and counseling services.[21] Next, coverage may be excluded for all services relating to gender affirmation *surgery*, including the counseling and hormonal treatment that accompanies it.[22] Next, while counseling and hormonal treatment might be covered, only the surgery may be excluded.[23]

Yet another: Numerous religious medical providers have forbidden employees from providing "[p]rocedures that induce sterility" unless "their direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available."[24]

C. Existing Strategies and their Limitations

In challenging refusals to cover gender-affirming care, advocates have advanced various arguments. The two most prominent lines of attack have been to challenge these refusals as sex discrimination and disability discrimination.[25] Both arguments have their strengths but raise concerns.

[15]Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 451 (5th ed. 2013).

[16]Kevin M. Barry et al., *A Bare Desire to Harm: Transgender People and the Equal Protection Clause*, 57 B.C. L. Rev. 507, 516 (2016) ("For many transgender people, the incongruence between gender identity and assigned sex does not interfere with their lives; they are completely comfortable living just the way they are."); DSM-5, *supra* note 14, at 451 ("[N]ot all individuals will experience distress as a result of such [gender] incongruence.").

[17]Spade, *supra* note 9, at 1171.

[18]*See* Coleman et al., *supra* note 9.

[19]Good v. Iowa Dep't of Hum. Servs., 924 N.W.2d 853, 857 (Iowa 2019).

[20]"In the most extreme example, an insurer denied a transsexual coverage for routine treatments: office visits, blood tests, physical exams, sinus medication, and two emergency visits, once for a cut on the hand and another for a deviated septum." *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 Colum. J. Gender & L. 88, 97 (2002). I have not identified similar restrictions more recently, but Hong herself obtained data through interviews.

[21]Lange v. Houston Cnty., Georgia, No. 5:19-CV-392 (MTT), 2022 WL 1812306, at *11 (M.D. Ga. June 2, 2022) (defendant claiming that all coverage relating to transition not covered).

[22]Boyden v. Conlin, 341 F. Supp. 3d 979, 988 (W.D. Wis. 2018); Kadel v. Folwell, No. 1:19CV272, 2022 WL 3226731, at *3 (M.D.N.C. Aug. 10, 2022).

[23]Fletcher v. Alaska, 443 F. Supp. 3d 1024, 1027 (D. Alaska 2020) ("AlaskaCare no longer excluded hormones, hormone therapy and counseling related to changing sex or sexual characteristics, but continued to exclude "[s]urgical procedures to alter the appearance or function of the body" and "[p]rosthetic devices.").

[24]Hammons v. Univ. of Maryland Med. Sys. Corp., 551 F. Supp. 3d 567, 573 (D. Md. 2021), reconsideration denied, No. CV DKC 20-2088, 2021 WL 4951921 (D. Md. Oct. 25, 2021).

[25]I do not consider arguments that might be specific to a certain kind of coverage. For example, some challenges have proceeded under Medicaid medical necessity standards, Smith v. Rasmussen, under deliberate indifference standards in prison contexts, Hicklin v. Precynthe, No. 4:16-CV-01357-NCC, 2018 WL 806764, at *10 (E.D. Mo. Feb. 9, 2018), and under ERISA. Baker v. Aetna Life Ins. Co., 228 F. Supp. 3d 764, 769 (N.D. Tex. 2017). I also do not consider other less prominent lines of

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A primary argument is that refusals to provide coverage for transgender individuals counts as a form of sex discrimination. The sex discrimination argument proceeds on several fronts under the Equal Protection Clause of the Constitution, employment discrimination statutes, and health discrimination statutes as I detail elsewhere.[26] Relying on *Bostock v. Clayton County*, in which the U.S. Supreme Court held that Title VII's prohibition on sex discrimination prohibits discrimination against transgender individuals,[27] courts have held that a refusal to cover gender affirming treatment constitutes sex discrimination.[28] Yet, a non-trivial number of courts have held that the sex discrimination argument fails—and the Supreme Court may soon side with those courts.[29]

Another somewhat more controversial[30] strategy, which I describe in detail elsewhere,[31] is to argue that non-coverage constitutes disability discrimination. The most important of these laws, the Americans with Disabilities Act (ADA), prohibits discrimination against individuals with an actual or perceived disability, that is, a "a physical or mental impairment that substantially limits one or more major life activities of such individual."[32] While the ADA and its associated statutes exclude "transvestism, transsexualism, …[and] gender identity disorders not resulting from physical impairments,"[33] some courts—most prominently the Fourth Circuit Court of Appeals—have held that the ADA exclusion did not apply in cases involving gender *dysphoria*, which is not expressly listed in the ADA's exemption.[34] However, other courts, including the Sixth Circuit Court of Appeals most recently, have suggested that the ADA's exemption will continue to apply to gender dysphoria.[35]

II. The Mental Health Parity Approach

Mental health parity refers to the equalizing of coverage between mental health and substance use conditions as well as physical or surgical conditions. Given the limitations of the earlier arguments, some have suggested that mental health parity is a useful strategy to advance for transgender individuals.[36] This Part offers a background to parity legislation, discusses how transgender litigants can file claims, and strategic considerations and limitations.

argument. *See, e.g.,* OutFront Minnesota v. Piper, No. 62-CV-15-7501, 2016 WL 11898980 (Minn.Dist.Ct. Nov. 14, 2016) (right of control and autonomy).

[26]*See* Boyden v. Conlin, 341 F. Supp. 3d 979, 982 (W.D. Wis. 2018); Flack v. Wis. Dep't of Health Servs., 328 F.Supp.3d 931 (W.D. Wis. 2018); Hammons v. Univ. of Md. Med. Sys. Corp., 551 F. Supp. 3d 567, 590 (D. Md. 2021); Fain v. Crouch, 618 F. Supp. 3d 313, 320 (S.D.W. Va. 2022).

[27]Fain v. Crouch, 618 F. Supp. 3d 313, 335 (S.D.W. Va. 2022). "The West Virginia Medicaid Program exclusion denying coverage for the surgical care for gender dysphoria invidiously discriminates on the basis of sex and transgender status. Such exclusion violates the Equal Protection clause of the Fourteenth Amendment, the Affordable Care Act, and the Medicaid Act. Defendants are enjoined from enforcing or applying the exclusion."

[28]Kadel v. Folwell, No. 1:19CV272, 2022 WL 3226731, at *19 (M.D.N.C. Aug. 10, 2022) is the only case I have seen that lays out the distinctions clearly.

[29]As this article goes to press, the Supreme Court has a pending cert petition seeking reversal of the Sixth Circuit's holding in L.W., et al., and United States of America v. Skrmetti, et al., No. 23-5600 (6th Cir. June 30, 2023) rejecting the sex discrimination argument. *See* Williams Petition, *supra* note 7.

[30]Franklin H. Romeo, *Note, Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law*, 36 Colum. Hum. Rts. L. Rev. 713, 731 (2005).

[31]*Id.*

[32]42 U.S.C. § 12102(1)(A).

[33]*Id.* at § 12211(b); 29 U.S.C. § 701 et seq.

[34]Williams v. Kincaid, 45 F.4th 759, 779–80 (4th Cir. 2022), cert. denied, 143 S. Ct. 2414 (2023).

[35]*Sixth Circuit Allows Tennessee's Ban on Care for Transgender Youth to Take Effect*, ACLU (July 8, 2023), https://www.aclu.org/press-releases/sixth-circuit-allows-tennessees-ban-on-care-for-transgender-youth-to-take-effect [https://perma.cc/L82T-RLGU].

[36]Marie Casciari, *Recent Trends in Transgender Healthcare Law,* Debofsky (June 24, 2020), https://www.debofsky.com/articles/recent-trends-in-transgender-healthcare-law/ [https://perma.cc/GA6U-U8VJ].

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A. Background to Mental Health Parity

Efforts at achieving mental health parity at the federal level date back to the Kennedy Administration, when President Kennedy sought mental health parity for federal employees.[37] At the state level, the first such laws were passed in the 1970s.[38] Mental health parity legislation finally passed Congress in 1996 with the enactment of the Mental Health Parity Act (MHPA). Under the MHPA, group health plans were required to equalize annual and lifetime limits for mental health benefits and surgical and medical benefits.[39] The statute contained exceptions, including allowing disparate copays and coinsurance rates and exemptions for employers who showed that their premiums had increased more than one percent. In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA), which extended protections to substance use disorders, and prohibited differences in both treatment options and certain kinds of cost-sharing.[40] These laws apply to nearly all plans except Medicare and Medicaid, though the federal government has issued rules to create parity for Medicaid.[41] Finally, all 50 states have some kind of mental health parity law, though the laws have significant differences.[42]

Federal agencies have issued numerous regulations pursuant to these laws.[43] Most relevant are the implementing regulations for the 2008 Act that were passed in 2013. The MHPAEA separates benefits into various classifications such as in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency care, and prescription drugs.[44] The regulations, in turn, separate treatment limitations into two categories: numeric limitations, referred to as quantitative treatment limitations (QTL), and non-quantitative treatment limitations (NQTL), which "otherwise limit the scope or duration of benefits or treatment."[45] These include prior authorization requirements and fail first requirements, among others.[46]

Courts have taken different approaches to parity challenges, but in most circumstances a plaintiff must: "(1) identify a specific treatment limitation on mental health benefits, (2) identify medical/surgical care covered by the plan that is analogous to the mental health/substance abuse care for which the plaintiffs seek benefits, and (3) plausibly allege a disparity between the treatment limitation on mental health/substance abuse benefits as compared to the limitations that defendants would apply to the covered medical/surgical analog."[47]

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[37]Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 Milbank Q. 404, 408 (Sept. 2010).

[38]Caroline V. Lawrence & Blake N. Shultz, *Divide and Conquer? Lessons on Cooperative Federalism from a Decade of Mental Health Parity Enforcement*, 130 Yale L. J. 1952 (June 2021).

[39]Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (1996) ("annual or lifetime dollar limits on mental health benefits [can] be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan").

[40]*The Mental Health Parity and Addiction Equity Act (MHPAEA),* Ctrs. For Medicare & Medicaid Servs. (2023), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet [https://perma.cc/SP55-TZPY].

[41]Kaye Pestain, *Mental Health Parity at a Crossroads*, KFF (Aug. 18, 2022), https://www.kff.org/private-insurance/issue-brief/mental-health-parity-at-a-crossroads/ [https://perma.cc/GP6F-JLST]; Kelsey N. Berry et al., *Litigation Provides Clues to Ongoing Challenges in Implementing Insurance Parity*, 42 J. Health Politics, Pol'y & L. 1065, 1098 (2017).

[42]*See* Aviv Shamash, *A Piecemeal, Step-by-Step Approach Toward Mental Health Parity*, 7 J. Health & Biomedical L. 273, 287-92; Douglas et al, Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report (2018).

[43]For a helpful overview, see Substance Abuse and Mental Health Services Administration, The Essential Aspects Of Parity: A Training Tool For Policymakers (2021).

[44]*The Mental Health Parity and Addiction Equity Act (MHPAEA),* Ctrs. For Medicare & Medicaid Servs. (2023), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet [https://perma.cc/84VE-VGMA]; Ryan Kingshill, *Finding Parity Through Preclusion: Novel Mental Health Parity Solutions at the State Level*, 125 Dick. L. Rev. 555, 562–63 (2021).

[45]78 Fed. Reg. 68240.

[46]*Id.*

[47]Heather E. v. California Physicians' Servs., No. 2:19-CV-415, 2020 WL 4365500, at *3 (D. Utah July 30, 2020) (quoting Nancy S. v. Anthem Blue Cross & Blue Shield, No. 2:19-cv-231, 2020 WL 2736023, at *3 (D. Utah May 26, 2020)). New York

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A key hurdle that plaintiffs face in this context—possibly, the most difficult one—is identifying appropriate comparators, especially when it comes to non-quantitative challenges. The regulation permits the insurer to use "processes, strategies, evidentiary standards, or other factors" to determine "nonquantitative treatment limitation[s] to mental health … benefits" *if* they are "comparable to, and … applied no more stringently than" those involving medical/surgical benefits.[48] This means that as long as a plan sets a general standard for medical/surgical claims—"clinically appropriate standards of care," or "medical necessity"—it avoids "disparate treatment" and satisfies the MHPAEA as long as it applies the same standard to both mental and medical conditions.[49] That is true "even if the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition."[50] But it is hard to compare physical and mental ailments when assessing whether medical necessity claims are equally rigorous.

Quantitative challenges are also hard. The second relevant doctrinal consideration is the nature of challenges. Courts separate challenges into facial challenges and as-applied challenges. Facial challenges occur when the disparate treatment of mental health disorders is apparent on the face of the policy. As-applied challenges involve situations where the policy is not unequal on its face but a review of claims shows that mental health claims treated or reimbursed inequitably.[51] The difficulty here is collecting information—especially quantitative information—regarding insurers' practices. This "often require access to internal carrier information such as relative reimbursement rates."[52] Thus, consumers rarely raise quantitative challenges.[53]

B. Transgender Litigation for Mental Health Parity

In some ways, the arguments for individuals seeking treatment for gender dysphoria under the parity laws appears straightforward. Take *Duncan v. Jack Henry & Associates, Inc*, which appears to be the only case in which such a claim is advanced.[54] There, the plaintiff who sought facial feminization surgery advanced both an as-applied claim and a facial claim.

To support her as-applied claim, the plaintiff alleged that the insurer's policy "'deems all facial surgeries prescribed to treat gender dysphoria as 'cosmetic' and never medically necessary,' whereas the 'medical policies applicable to facial surgeries for medical or physical reasons contain no such restriction.'" With respect to the facial challenge, "the Plan's definition of 'Cosmetic Treatment' applies to 'medical or surgical procedures that are primarily used to improve, alter, or enhance appearance," including for 'psychological or emotional reasons,' *except* "when a physical impairment exists and the surgery restores or improves function.'"[55] Apart from the cosmetic treatment clause, the court also considered plan provisions concerning reconstructive surgery. "[R]econstructive surgery is not considered cosmetic treatment (and thus is not excluded) simply because the physical appearance may change or improve 'when a physical

district courts add an extra requirement, that the "the mental-health treatment limitation is in the same classification as the medical treatment to which it is being compared." But that appears implicit in the comparison. Julie L. v. Excellus Health Plan, Inc., 447 F. Supp. 3d 38, 54 (W.D.N.Y. 2020); Bushell v. UnitedHealth Grp. Inc., No. 17-CV-2021 (JPO), 2018 WL 1578167, at *5 (S.D.N.Y. Mar. 27, 2018).

[48]29 C.F.R. § 2590.712(c)(4)(i).

[49]John R. v. United Behavioral Health, 2019 WL 6255085 (D. Utah 2019) ("insurer applied the medical-necessity requirement to determine coverage, whether it be for mental health and addiction treatment or treatment of disorders arising in the medical/surgical context.").

[50]Michael P. v. Aetna Life Insurance Company, 2017 WL 4011153 (D. Utah 2017). *See* C.M. v. Fletcher Allen Health Care, Inc., 2013 WL 4453754 (D. Vt. 2013).

[51]K.H.B. by and through Kristopher D.B. v. UnitedHealthcare Insurance Company, 2019 WL 4736801 (D. Utah 2019).

[52]Lawrence & Schultz, *supra* note 38, at 2226.

[53]*Id.* This is ironic as regulators find it harder to assess nonquantitative limitations in the abstract. *See* JoAnn Volk et al., *A Review of State Efforts to Enforce Mental Health Parity: Lessons for Policymakers and Regulators*, Georgetown Univ. Health Pol'y Inst. Ctr. on Health Insurance Reforms 3 (2022).

[54]Duncan v. Jack Henry & Assocs., Inc., 617 F. Supp. 3d 1011, 1057 (W.D. Mo. 2022).

[55]*Id.* at 1022.

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impairment exists and the surgery restores or improves function.'"[56] Each of these allegations supported a mental health parity claim, in that the surgical procedures deemed non-cosmetic and covered for physical reasons were not covered when those procedures were sought for gender dysphoria, a psychiatric diagnosis.

Duncan is not alone. The Connecticut Department of Insurance similarly concluded nearly a decade ago, and with very little reasoning, that the state mental health parity law requires equal coverage for gender affirmation treatment.[57] New York followed suit, citing, inter alia, state and federal mental health parity laws to justify regulations prohibiting insurers from discriminating against care relating to a gender dysphoria diagnosis.[58] Under state law, "a policy's definition of 'mental, nervous or emotional disorders or ailments' [cannot be]… 'unreasonable.'"[59] The agency also cited federal health parity regulations that require parity for mental health conditions, and that define "mental health condition … consistent[ly] with generally recognized independent standards of current medical practice."[60] The agency noted that "[i]ssuers in New York should use the DSM as the recognized independent standard of current medical practice," which, of course, includes a gender dysphoria diagnosis.[61] Following the state's recent expansion of its mental health parity law, California's state agency specifies that insurers must follow the treatment standards of the World Professional Association for Transgender Health (WPATH), and individuals have filed complaints for equal care under the law.[62] The Massachusetts Department of Insurance also considered the parity argument as a viable one but decided not to advance it for other reasons described below.[63]

Indeed, in some ways the argument may seem more straightforward in the case of gender dysphoria. Recall that one difficulty plaintiffs face is showing that the mental health treatment they seek has an appropriate analogue to treatment for a physical condition. But in the context of gender dysphoria, the treatment being sought is often the same, as seen in the *Duncan* case. And while as-applied challenges can be difficult, a recent survey of case law suggests that courts are increasingly permitting discovery in parity litigation.[64]

Nonetheless, the ease of comparison might itself prove the problem. The MHPAEA requires equity in "mental health or substance use disorder benefits" and "medical and surgical benefits."[65] Surely, gender affirmation surgery falls—by virtue of its name—into a "surgical benefit []" category. One might argue that when gender affirmation surgery is denied, it is because it is not a mental health benefit, but rather a surgical benefit that the Act does not protect.

Both as a textual and functional matter, that understanding cannot stand. First, as a textual matter, while the Act does not define a "surgical benefit," it *does* define "mental health benefits." That term refers to "benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law."

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[56] *Id.*

[57] State of Conn. Insurance Dept., BULLETIN IC-34 (Reissued) (Nov. 2, 2011).

[58] *See Insurance Circular Letter No. 7*, N.Y. Dept. of Fin. Servs. (Dec. 11, 2014), https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2014_07 [https://perma.cc/PX7Q-AYKL].

[59] *Id.*

[60] *Id.* Note that the statute has been replaced with clearer parity requiring language: "Coverage under this paragraph shall not apply financial requirements or treatment limitations to mental health benefits that are more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy," and incorporated the DSM standard. N.Y. Ins. Law § 3221(l)(5)(C), § 3221(l)(5)(E)(iv) (McKinney).

[61] *Id.* Note that at the time, the diagnosis was for gender identity disorder. *See id.*

[62] *See* Insurance Commissioner Ricardo Lara, *Enactment of Senate Bill 855—Submission of Health insurance Policies for Compliance Review*, insurance.ca.gov (Dec. 10, 2020), https://www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/Notice-to-Health-Insurers-re-Requirements-of-Senate-Bill-855.pdf [https://perma.cc/86RL-6GMP]; Tiffany Stecker, *California Plans Deny Mental Health Claims Despite New Law (1),* Bloomberg (Dec. 21, 2022), https://news.bloomberglaw.com/health-law-and-business/california-plans-deny-mental-health-claims-despite-new-law [https://perma.cc/FJ3F-DFM3].

[63] Robert A. Whitney, *Transitioning to a New View: Coming to See Health Insurance Coverage For Gender Dysphoria in a New Light*, Conn. Insurance L. J. 20. (2019).

[64] *Key Parity Litigation Trends*, ParityTrack, https://www.paritytrack.org/key-parity-litigation-trends/ [https://perma.cc/C6U2-7CAX].

[65] H.R. 6983—110th Congress (2007-2008).

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The distinction here lies between "benefits" and "conditions." In the healthcare context, there are (inter alia) two important different categories of codes. First, there are diagnoses codes. "Diagnoses codes are set out in the International Classification of Diseases (ICD-10) system issued by the World Health Organization. Every professional that bills insurance uses these diagnoses codes as a condition of getting reimbursed."[66] On the other hand, there are "Current Procedural Terminology (CPT) codes [which] offer doctors and health care professionals a uniform language for coding medical services and procedures to streamline reporting, increase accuracy and efficiency."[67]

Under the definition that the Act provides, "[m]ental health benefits" are not defined by the services provided, such as counseling or therapy, but rather by the *condition* that gives rise the service.[68] To determine if a benefit is a mental health benefit, one looks not to the procedure code, but rather the diagnosis code. Thus, a mental health condition might require a surgical benefit—which would count as a mental health benefit—just as a physical condition might require a mental health benefit such as counseling. For instance, in *Bushell v. UnitedHealth Group*, a plaintiff sought nutritional counseling for a mental health condition.[69] The plaintiff noted that nutritional counseling was offered for diabetic patients because of their physical condition. In other words, a mental health benefit offered for a medical condition still counted as a medical, not a mental health, benefit.

Next, as a functional matter, most of the benefits sought are often similar, if not identical, between the mental health and medical/surgical contexts. Indeed, plaintiffs must prove similarity between the benefits to make their case. For example, the focus may be on financial remuneration for a service—a financial benefit—rather than whether a surgery is actually available. The benefit at issue is not actual surgery, but rather whether payment will be provided for the surgery. Or, the comparison is between the availability of nursing facilities after a surgery and the availability of residential programs for mental health counseling—and reimbursement of both.[70] The benefit, in other words, is often not surgical but ancillary to various conditions that often require comparable treatment. As *Bushell* suggests, the same treatment—mental or surgical—might be required for mental health or physical conditions. The distinction lies in the condition, not the procedure.

C. Limitations and Considerations

Three key limitations are worthy of consideration. First, a lack of surveillance; second, a lack of uniform definitions; and third, a lack of enforcement authority.[71] This Section addresses each concern in turn.

[66]Craig Konnoth, *Medicalizing Minorities* [working draft] 2023.

[67]*CPT overview and code approval*, Am. Med. Ass'n (2023), https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval#:~:text=CPT%C2%AE%20code%3F-,What%20is%20a%20CPT%C2%AE%20code%3F,reporting%2C%20increase%20accuracy%20and%20efficiency [https://perma.cc/ZGC7-35TM].

[68]This reflects judicial commentary on the Act. "Essentially, [the Parity Act requires] ERISA plans [to] treat sicknesses of the mind in the same way that they would a broken *728 bone." New York State Psychiatric Ass'n, Inc. v. UnitedHealth Grp., 980 F. Supp.2d 527, 542 (S.D.N.Y. 2013). 'to end discrimination in the provision of insurance coverage for mental health and substance use disorders as compared to coverage for medical and surgical conditions in employer-sponsored group health plans.'" Candace B. v. Blue Cross, No. 2:19-cv-39, 2020 WL 1474919, at *4 (D. Utah Mar. 25, 2020) (quoting Am. Psychiatric Ass'n v. Anthem Health Plans, Inc., 821 F.3d 352, 356 (2d Cir. 2016)). Munnelly v. Fordham Univ. Fac., 316 F. Supp. 3d 714, 727–28 (S.D.N.Y. 2018).

[69]No. 17-CV-2021 (JPO), 2018 WL 1578167, at *5 (S.D.N.Y. Mar. 27, 2018).

[70]Alice F. v. Health Care Serv. Corp., 367 F. Supp. 3d 817, 831 (N.D. Ill. 2019) 29 C.F.R. § 2590.712(c)(2)(ii).

[71]A final consideration is that treating gender dysphoria as mental illness pathologizes and de-normalizes transgender individuals. As the former Deputy Commissioner and General Counsel for the Massachusetts Division of Insurance explains, in 2014, the Division declined to follow its Connecticut counterpart and rely on parity laws out of this concern. I would argue that any national level enforcement can rely on the process that the DSM committee took in resolving to treat gender dysphoria as mental illness, which involved taking into account the opinions of transgender rights advocates around the world. *See* Konnoth, Stan. L. Rev. And any individual plaintiff can make their own decisions. Robert A. Whitney, *Transitioning to a New View: Coming to See Health Insurance Coverage For Gender Dysphoria in a New Light*, Conn. Insurance L. J. 20. (2019).

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One key consideration is lack of surveillance, and relatedly, compliance. As observed by a 2022 report by the United States Department of Labor (DOL), none of the 30 plans and insurers evaluated could show that they were complying with key requirements of MHPAEA and sought more enforcement power.[72] State insurance departments are responsible for enforcing fully insured plans. They have used "form review" and "market conduct exams"—which have both fallen short, according to assessments—and consumer complaints have not been forthcoming as plaintiffs have been unaware.[73]

Yet, there is some hope for change. Educating a small and highly engaged impact litigation program can advance complaints (even in the absence of a cause of action to litigate claims not arising from the Employee Retirement Income Security Act of 1974 (ERISA), as described below), which will hopefully provide results. In August 2021, the DOL finally sought to enforce the parity law through litigation in *Walsh v. United Behavioral Health (UBH).*[74] Next, states have taken their own actions. A survey of state action since 2018 found that "[s]tates continue to address gaps in parity through legislation and through regulatory, enforcement, and compliance efforts" by demanding insurers "demonstrate compliance; … report on compliance;" expand coverage; and offer "greater transparency by insurance providers."

The second hurdle to the mental health parity approach is the lack of a federal definition of "mental illness," so states are left to their own devices. [75] Deciding which disorders to cover at parity depends on several influential factors, including "the ideologies of advocacy groups and parity opponents, cost, and political necessity. States rarely, if ever, considered disease prevalence, needs-based studies, and clinical judgment."[76]

In three states—Minnesota, Indiana, and New Mexico—the definition of mental illness was left up to individual health plans.[77] But in the remaining 34 states with mental health parity laws, states used three statutory terms to define the scope of coverage. First, 10 states used the term "broad-based mental illness," which "is the most comprehensive and generally covers all disorders in DSM-IV" (though some of these states exclude certain childhood diagnoses).[78] Next, 14 states required "serious mental illness," while six additional states "chart[ed] new territory" by using "biologically based mental illness," a term that has never been used in federal legislation and has no accepted clinical definition. This often means that a state articulates specific "covered and uncovered illnesses."[79]

That said, the states that use the broad-based definition include states that lack trans-protective legislation. For example, Alabama relies on an ICD definition; Georgia, Kentucky, and Arkansas rely on a combination of ICD and the DSM; and Tennessee and Utah rely on the DSM.

Finally, the statute might create a private right of action only for ERISA plans. As one court has explained, "there is no private right of action to enforce the MHPAEA itself. It does not contain an enforcement provision…. Instead, the MHPAEA is inserted into other laws, and those laws have enforcement provisions… Thus, a plaintiff who sues for violations of the MHPAEA must follow the procedures outlined in the larger law that she thinks has been violated."[80] While the ERISA statute offers

[72]Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental health and Substance Use Disorder Coverage, 2022 MHPAEA Report to Congress 19 (2022).

[73]JoAnn Volk et al., *A Review of State Efforts to Enforce Mental Health Parity: Lessons for Policymakers and Regulators*, Georgetown Univ. Health Pol'y Inst. Ctr. on Health Insurance Reforms 7 (2022).

[74]The case settled for 15 million. *United Healthcare agrees to pays $15.6M in mental health parity law* case [sic], Schwartz, Conroy & Hack, PC (2021), https://schlawpc.com/case-study/united-healthcare-agrees-to-pays-15-6m-in-mental-health-parity-law-case/ [https://perma.cc/9GYT-8GQM].

[75]Kingshill, *supra* note 44, at 569.

[76]Marcia C. Peck & Richard M. Scheffler, *An Analysis of the Definitions of Mental Illness Used in State Parity Laws*, 55 Psychiatric Servs. 1089 (Sept. 2022).

[77]*Id.* at 1090.

[78]*Id. at* 1091.

[79]Kingshill, *supra* note 44, at 569.

[80]Mills v. Bluecross Blueshield of Tennessee, Inc., No. 3:15-CV-552-PLR-HBG, 2017 WL 78488, at *6 (E.D. Tenn. Jan. 9, 2017).

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a springboard for plaintiffs' claims for plans that fall under it,[81] plans that do not fall under the statute do not always (and indeed, are unlikely to) offer a vehicle for plaintiff enforcement, absent state legislation to the contrary.[82]

That said, ERISA-regulated claims usually present regulatory voids where limits are helpful.[83] State trans equity standards do not apply to ERISA plans. Similarly, the Trump Administration's interpretation of Section 1557 of the Affordable Care Act—and some lower court opinions today—would interpret the sex and disability discrimination provisions to not apply to ERISA-regulated plans.[84] If ERISA plans end up lacking regulation, mental health parity laws present a useful backstop. As far as non-ERISA regulated plans are concerned, the federal government retains residual authority to ensure enforcement of parity regulations where states fail to do so.[85] If the federal administration makes it a priority to address trans parity, they can do so under mental health parity regulation based on consumer complaints.[86]

Litigation can also proceed under state laws in states that have good mental health parity regulation but lack trans-supportive regulation. For example, a prominent mental health parity group rates Alabama and Tennessee as having two of the top five parity laws in the nation.[87] These laws apply to non-ERISA regulated plans. Thus, ERISA presents a stopgap resource.

Conclusion

As gender-affirming care remains a hot button issue, mental health parity might offer a technical approach that escapes politicization—at least relative to sex- and disability-based arguments. It also offers an approach to support claims that proceed under ERISA plans and in states that may otherwise not offer protections to transgender individuals. At the same time, plaintiffs will face hurdles. Advocates should deploy mental health parity claims in conjunction with federal and state sex and disability discrimination laws to protect the interests of transgender clients seeking gender-affirming care.

Craig Konnoth is the Martha Lubin Karsh and Bruce A. Karsh Bicentennial Professor of Law at University of Virginia School of Law and serves as a Greenwall Foundation Faculty Scholar, John Casteen III Faculty Fellow, Affiliated Faculty, Center for Health Humanities and Ethics, University of Virginia. My thanks to Dr. Kellan Baker, Executive Director of the Whitman-Walker Institute, for helpful comments. Note that the article was written in February 2023, and numerous developments have occurred as it goes to press in the state of litigation pertaining to transgender care that cannot be incorporated into the commentary, unless otherwise noted, as it goes to press. The essential elements of the mental health parity argument remain the same, however.

[81] Am. Psychiatric Assoc. v. Anthem Health Plans, 50 F. Supp. 3d 157, 161 (D. Conn. 2014), aff'd sub nom. Am. Psychiatric Ass'n v. Anthem Health Plans, Inc., 821 F.3d 352 (2d Cir. 2016) (dictum); Mingus v. Blue Cross & Blue Shield of Kansas, Inc., No. 217CV02362JARKGS, 2017 WL 4882658, at *2 (D. Kan. Oct. 30, 2017) (dictum).

[82] Rea v. Blue Shield of California, 226 Cal. App. 4th 1209, 1219, 172 Cal. Rptr. 3d 823, 830 (2014), as modified on denial of reh'g (July 9, 2014).

[83] Craig Konnoth, *Privatization's Preemptive Effects*, 134 Harv. L. Rev. 1937, 1961 (2021).

[84] Baker v. Aetna Life Ins. Co. & L-3 Commc'ns Corp., No. 3:15-CV-3679-D, 2018 WL 572907, at *2 (N.D. Tex. Jan. 26, 2018); *see also* 84 F.R. 27846.

[85] Lawrence & Schultz, *supra* note 38, at 2226.; *see also* Executive Office Of The President Of The United States, The Mental Health & Substance Use Disorder Parity Task Force Final Report 14-15 (2016).

[86] Notably, one concern that commentators raise—that patients lack awareness and resources—likely presents less of an issue in the trans context, which involves a more cohesive community and litigation resources.

[87] Megan Douglas et al., *Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report* 10 (2018).

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