HEALTH PLAN COVERAGE FOR GENDER-AFFIRMING CARE: CONTINUED
SHORTCOMINGS AT THE FEDERAL LEVEL
AND A ROLE FOR PROGRESSIVE STATES

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INTRODUCTION

Gender-affirming healthcare, sometimes called transition-related care, encompasses a wide range of medical services that many transgender adults\(^1\) rely on to help them safely transition to living lives consistent with their gender identity.\(^2\) For the million or more transgender individuals in this country,\(^3\) needs differ; some transgender individuals, in consultation with their doctors, will end up needing more extensive treatments than other transgender people.\(^4\) But at least two things are common to all transgender people who find themselves in need of gender-affirming care: (1) the overwhelming consensus among doctors is that such care is often “medically necessary”—a term of art in the insurance industry—and yet (2) it has been, and continues to be, challenging in many instances for transgender people to convince their health plans to cover the cost of the care. Denials of coverage can have devastating consequences—not only undermining individuals’ mental health and leading to suicide in some cases, but also prompting some to seek hormonal therapies or even surgeries from illegal or untrained sources.\(^5\)

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\(^1\) Owing purely to a need to limit scope, this Article does not tackle the rich set of additional legal questions that are specific to minors’ access to gender-affirming care. The Article therefore assumes throughout that the transgender insureds being discussed have legal autonomy to make healthcare decisions and that the care they are seeking is legal to provide—which is not always the case where minors are involved. See generally Legislative Tracker: Youth Healthcare Bans, FREEDOM FOR ALL AMERICANS, https://freedomforallamericans.org/legislative-tracker/medical-care-bans/ [https://perma.cc/8TF6-Q8AA].


\(^3\) Id. (“[E]stimates have suggested that 0.3 percent of US adults, or close to 1 million people, identify as transgender.”).

\(^4\) Liza Khan, Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform, 11 YALE J. HEALTH POL’Y, L. & ETHICS 375, 380, 414 (2011) (“Given the diversity of the transgender population, it is not surprising that healthcare needs and desires vary dramatically among transgender individuals... Just because some transgender individuals do not need transitional procedures does not mean they are inappropriate for all transgender individuals. Patients with the same condition often have diverse medical needs, and interventions that are medically necessary for one patient may not be medically necessary for another.”).

\(^5\) Id. at 376 (“One study reports, for example, that forty-one percent of transgender individuals have attempted suicide at some point in their lives.”); see also Sarah E. Gage, The Transgender Eligibility Gap: How the ACA Fails to Cover Medically Necessary Treatment for Transgender Individuals and How HHS Can Fix It, 49 NEW ENG. L. REV. 499, 517 (2015); Brian C. Thoma et al., Suicidality Disparities Between Transgender and Cisgender Adolescents, 144 PEDIATRICS (2019); Marla E. Eisenberg et al., Risk and Protective Factors in the Lives of Transgender/Gender Non-Conforming Adolescents, 61 J. ADOLESCENT
Picture, for example, a transgender woman who has lived her life as a woman for years and undergone some surgical procedures to transition. She asks her doctor whether insurance will cover hair removal treatments and voice feminization therapy to address issues of deep concern to her. Her doctor says that, although the treatments would be medically indicated, insurance payments would depend on what her health plan covers. Could the health plan administrators deem the treatments “cosmetic” and thus not “medically necessary” and not covered? Would they do so? Who would be involved in that decision? If they deny it, what options would the woman have? How onerous would those options be, and how likely would they be to result in a reversal of the decision?

The answers to those questions and others are often nonexistent, confusing, or inconsistent. This story, while familiar to all who navigate the American healthcare system, is especially pronounced in the context of gender-affirming care. Whether and to what extent American health plans cover and are required to cover gender-affirming care remains largely up in the air. On the surface, yes, progress has been made. But like so much in America’s byzantine healthcare system, the devil is in the details, many of which lurk in obscurity and complexity. Direct discrimination against transgender people is nominally illegal in many states and now also, at least to some degree, at the federal level. Further, the federal Affordable Care Act (ACA) now ensures a certain degree of independent review of coverage claims that are denied. But beneath the surface, several factors persist in permitting unpredictable and unjust denials of coverage for gender-affirming care.

This Article will discuss those factors and how they fit into the federal system of healthcare regulation in the post-ACA, post-Bostock v. Clayton County world. Then, in light of congressional dysfunction and the current bent of the federal courts,6 this Article will look for solutions not from the federal government but instead from progressive states,7 exploring the crucial ways in which states are able to—and have already started to—expand upon federal protections and fill the gaps.

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7 Throughout this Article, the term “state” includes the District of Columbia.
I. DESPITE IMPROVEMENTS IN FEDERAL LAW, THE PERSISTENT PROBLEM OF HEALTH PLANS’ DENYING GENDER-AFFIRMING CARE TOO OFTEN

For transgender, nonbinary, and other gender-nonconforming individuals, medical interventions are often needed to bring certain physiological traits into harmony with the individuals’ gender identity. Such interventions could include hormone therapies, hysterectomies, chest reconstruction, vaginoplasty, hair removal, facial feminization, or a range of other treatments tailored to the individual.\(^8\) And because few have the financial resources to cover the costs of care out of pocket, transgender individuals rely on insurance coverage through health plans to make gender-affirming care accessible.

The American healthcare system has improved when it comes to providing insurance coverage for gender-affirming care, but only to a point. Compared to even just ten years ago, far fewer health plans contain explicitly transgender-specific exclusions that result in zero coverage for gender-affirming care.\(^9\) And recent developments have made it increasingly clear that federal law protects members of nearly all American health plans from discrimination on the basis of gender identity—at least on a superficial level.

The Supreme Court’s decision in *Bostock v. Clayton County* interpreted Title VII of the Civil Rights Act of 1964 to protect employees from discrimination on the basis of sexual orientation or gender identity.\(^10\) And, consistent with Equal Employment Opportunity Commission (EEOC) guidance,\(^11\) courts have applied Title VII’s protections to the health-benefits component of the employment relationship—that is, to prohibit employers from providing health benefits in a manner that discriminates on the basis of protected categories, including gender identity.\(^12\) In addition, many entities, even when not acting in their capacity as employers, are separately subject to the antidiscrimination provision of Section 1557 of the ACA: any entity that receives federal funds or lists plans on ACA exchanges, including state Medicaid programs.\(^13\)

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\(^13\) See generally Section 1557: Frequently Asked Questions, U.S. DEP’T HEALTH & HUMAN SERVS. (May 18, 2017), https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html [https://perma.cc/CJL8-XYBT] (“[B]oth Section 1557 and employment nondiscrimination laws may apply in some circumstances where health benefits are offered through an employee health plan. By contrast, some activities may be subject to
1557 prohibits discrimination “on the basis of sex,” incorporating a provision of Title IX that mirrors the language of Title VII.\textsuperscript{14} Thus, after Bostock, explicitly transgender-specific exclusions would appear to be unlawful in the vast majority of health plans.\textsuperscript{15}

Despite those advances, “transgender-related insurance denials are pervasive,” and transgender individuals continue to face barriers and legal ambiguity regarding health plan decisions.\textsuperscript{16} A recent study found that 25 percent of transgender individuals who sought coverage for hormone therapy were denied coverage, 55 percent of those seeking transition-related surgery were denied coverage, and 42 percent received only partial coverage of needed surgical care.\textsuperscript{17} And anecdotally, that situation can exist even in states, like Connecticut, that are often thought of as transgender-friendly. One major clinic in Connecticut that specializes in gender-affirming care reports that “denials are common”—on a “daily [basis] or at least several times weekly”—both for gender-affirming surgeries and for hormone therapies.\textsuperscript{18}

Why might denials still be so common? For one, many health plans have simply resisted change and are still explicitly excluding gender-affirming care from coverage. As recently as 2020, 9 percent of self-funded corporate health
plans still contained total exclusions of gender-affirming care.\textsuperscript{19} And in the public sector, many states deny gender-affirming care coverage to their employees\textsuperscript{20} or to enrollees in state Medicaid programs. Arizona, Georgia, Hawaii, Iowa, Minnesota, Missouri, Nebraska, Ohio, Tennessee, Texas, West Virginia, and Wyoming still explicitly exclude gender-affirming care from Medicaid coverage.\textsuperscript{21}

But what about Bostock? The practical effect of Bostock in the healthcare domain remains to be seen. As further explained below, the federal antidiscrimination mandate is still open to debate vis-à-vis gender-affirming care and, when it comes to on-the-ground enforcement, is no silver bullet. Many current health plans cover only a limited list of gender-affirming treatments (such as surgical changes to primary sex characteristics) while excluding other gender-affirming treatments (such as breast reduction, breast augmentation, facial feminization, voice surgery, and hair removal).\textsuperscript{22} It is far from certain that Bostock prohibits such treatment-specific exclusions. Further, in lieu of or in addition to explicitly excluding particular treatments, health plans often invoke exclusions of “medically unnecessary” care in denying coverage for gender-

\textsuperscript{19} Anna Kirkland et al., Transition Coverage and Clarity in Self-Insured Corporate Health Ins. Benefit Plans, 6 TRANSGENDER HEALTH 207, 214 (2020); see also Mot. to Dismiss at 2, Pritchard v. BCBS of Ill., No. 3:20-cv-06145-RJB (W.D. Wash. Feb. 25, 2021) (health plan arguing that federal law permits the categorical exclusion of gender-affirming care).


\textsuperscript{22} Elliana K. DeVore et al., Coverage for Gender-Affirming Voice Surgery and Therapy for Transgender Individuals, 131 LARYNGOSCOPE E896 (Aug. 10, 2020) (finding that only 2.7 percent of insurance policies fully cover gender-affirming voice treatments); Shekhar K. Gakdaree et al., National Variation of Ins. Coverage for Gender-Affirming Facial Feminization Surgery, 23 FACIAL PLASTIC SURGERY AESTHETIC MED. (July 6, 2021) (finding that facial feminization surgeries are often deemed cosmetic by insurance companies and that only 18 percent of policies cover them); Kirkland et al., supra note 19, at 211–12 (finding that many corporate health plans contain exclusions for specific treatments that are commonly part of gender transitioning).
affirming treatments.\textsuperscript{23} That is, health plans can \textit{purport} to include coverage for gender-affirming care but then, as applied to individual claimants, deny a large percentage of claims as being “medically unnecessary.” “Medically unnessa-


ty” treatments are those that health plans deem “cosmetic,” “experimental,” or otherwise inappropriate.\textsuperscript{24} In most health plans, “medical necessity” is defined vaguely—in substance, to require that the treatment “comport[] with the standards of good medical practice” and, tautologically, that the treatment be “appropriate for the level of care needed”\textsuperscript{25}—leaving plans wide discretion to invoke medical necessity requirements. And health plans have a long history of denying gender-affirming care on the grounds that it is “medically unneces-


sary.”\textsuperscript{26}

This Article therefore identifies the many ways in which existing federal law will, despite some seeming advances, likely fail to significantly decrease the number of denials for gender-affirming care. First, in several respects, post-


\textit{Bostock} federal antidiscrimination law is likely to receive a narrow application in the context of gender-affirming care and be subject to religious exemptions. Second, multiple factors, including both the usual financial incentives and some aspects specific to gender-affirming care, slant the use of “medical necessity” determinations towards denying coverage. Third, the sheer complexity of the claims review system makes it incredibly difficult to enforce the substantive standards, however fair they might seem on their face.

\textit{A. The Likely Narrow Application of Bostock’s Antidiscrimination Mandate}

Crucially, it remains to be seen how narrowly and formally the courts will apply \textit{Bostock}’s reasoning to healthcare and other contexts. Although explicitly transgender-specific exclusions would appear to be unlawful after \textit{Bos-


tock}, at least five important questions remain:

\begin{enumerate}
\item Are health plan exclusions of all or some forms of gender-affirming care necessarily a form of unlawful anti-trans discrimination, as far as federal law is concerned?
\item To what degree must a health plan treat gender-dysphoria-related medical necessity the same as other forms of medical necessity? For example, can a health plan impose onerous documentation requirements on a transgender claimant who seeks coverage for a treatment, such as a
\end{enumerate}

\textsuperscript{23} Kirkland et al., \textit{supra} note 19, at 209, 211 (finding that many corporate health plans contain broad exclusions for “cosmetic” or “experimental” care).


\textsuperscript{26} Khan, \textit{supra} note 24, at 411, 413 (“When insurance coverage turns on medical necessity, however, transgender individuals almost always lose . . . . [I]nsurers frequently deny coverage for transition-related care on the grounds that such care is not ‘medically necessary.’”)}
hysterectomy, that a cisgender claimant could have covered with much less documentation?

(3) Must a health plan cover a treatment (such as breast augmentation) that would be deemed cosmetic/unnecessary for most claimants if the claimant at issue is a transgender person for whom the treatment is medically indicated? In other words, must a health plan entertain the possibility that a treatment that is cosmetic or unnecessary in most contexts could be medically necessary when used to affirm gender?

(4) Can a health plan entertain such a possibility without engaging in impermissibly gender-conscious decision-making?

(5) Will purportedly religious entities be exempted from Bostock’s antidiscrimination mandate?

Conceivably, federal courts could answer those questions in multiple ways and still claim to be enforcing “neutrality” or “nondiscrimination” principles. But some answers would protect access to gender-affirming care, while others would restrict it. Bostock itself approached the applicability of Title VII to sexual orientation and gender identity at a very abstract, uncomplicated level. Although enough Justices agreed that “[a]n employer who fires an individual merely for being gay or transgender defies the law,”27 the Justices or the lower courts could respond differently to the five questions above. And with a solid conservative Supreme Court majority and large conservative contingents on lower federal courts, such formalist arguments may again prevail. In at least one early test of Bostock’s applicability to gender-affirming care in the District of Arizona, they already have.28

One can readily imagine health plans successfully arguing in federal court that refusal to cover a breast reduction for gender-affirming reasons, while at the same time covering a breast reduction for cisgender women on other grounds, is not discrimination, in that the transgender person and cisgender person are not similarly situated: the reasons they seek the treatment are meaningfully different, the argument would go, and therefore insurers can treat one as “medically necessary” and the other as “cosmetic” without discriminating on the basis of gender identity per se. Similar arguments stymied efforts in the 1970s to combat discrimination against pregnancy, until Congress finally intervened by passing the Pregnancy Discrimination Act.29

28 Hennessy-Waller v. Snyder, 539 F. Supp. 3d 1031, 1045 (D. Ariz. 2021) (“[A]lthough AHCCCS does not cover the surgery Plaintiffs seek for the purpose of treating gender dysphoria, Plaintiffs have not clearly shown AHCCCS denies coverage on the basis of sex and not on the basis of some other permissible rationale.”).
29 See Gen. Elec. Co. v. Gilbert, 429 U.S. 125, 136 (1976) (“But we have here no question of excluding a disease or disability comparable in all other respects to covered diseases or disabilities and yet confined to the members of one race or sex. Pregnancy is, of course, confined to women, but it is in other ways significantly different from the typical covered disease or disability. . . . We do not therefore infer that the exclusion of pregnancy disability benefits from petitioner’s plan is a simple pretext for discriminating against women.”); Geduldig v. Aiello, 417 U.S. 484, 496–97 n.20 (1974) (“Absent a showing that distinctions involving pregnancy are mere pretexts designed to effect an invidious discrimination against
Similarly, existing federal law could give health plans room to maintain much more onerous documentation requirements for transgender claimants than for cisgender claimants regarding the same treatments, thereby cutting off many people’s access to gender-affirming care. Take the example of hysterecomies. Many existing insurers generally require, among other things, multiple letters of referral from mental health professionals and a showing of “persistent, well-documented gender dysphoria” or something similar, and a year or more of closely monitored hormonal therapy in order to deem a gender-affirming hysterectomy medically necessary; so do state Medicaid programs. Insurers often expect such letters to be “extremely detailed,” addressing “invasive” topics such as how often a person uses makeup or wears wigs, or to come from doctors with certain specialties. Given the dearth of doctors who are willing and competent to provide transgender healthcare, especially in some regions of the country, those requirements can be virtually insurmountable for many.


32 Correspondence with Dr. A.J. Eckert, Anchor Health Initiative (Sept. 21, 2021) (on file with author); see also Notes from Interview with Layne Giankos, formerly of Anchor Health Initiative (Dec. 9, 2021) (on file with author).

Health plans can compound the scarcity problem by demanding that letter-writers have rare credentials or have been seeing the claimant as a patient for multiple years. Moreover, many health plans’ strict hormone-therapy prerequisites “deny[ ] the existence of trans people who do not want to/cannot take hormones.” Yet one would expect many health plans to argue, perhaps successfully, that there is no discrimination in how transgender claimants are treated because hysterectomy to treat gender dysphoria is very different from hysterectomy to treat, say, pelvic inflammatory disease, and thus that the health plan is entitled to create radically different documentation standards for establishing that each treatment is medically necessary.

As to the third question posed above, federal courts might well take the position that health plans are free to categorically label certain treatments as medically unnecessary across the board, without regard to the possibility that the treatments might be medically necessary for certain transgender individuals. Many existing insurers do precisely that, categorically deeming “cosmetic” or “medically unnecessary” a panoply of treatments such as facial bone modification, body contouring, hair removal, and voice therapy, with no allowance that such treatments might sometimes be medically indicated for transgender claimants. And federal courts might well accept health plans’ arguments that such categorical exclusions do not discriminate on the basis of gender identity per se, in that no person has coverage for those excluded treatments. Further, recalling the familiar anti-classification/anti-subordination divide in antidiscrimination law, it would not be surprising for federal courts to hold that health plans cannot make exceptions to provide usually cosmetic treatments to transgender individuals, as doing so would constitute a sort of “reverse discrimination” on the basis of gender identity.

34 Kirkland et al., supra note 25 (“Insurance companies also selectively reject letters if the therapist does not hold a PhD (so excluding MSW-degreed social workers), or the right kind of PhD . . . . Although the insurance policy indicated the required period was 6 months, people often waited 2 years in practice . . . .”); Notes from interview with Layne Gianakos, formerly of Anchor Health Initiative (Dec. 9, 2021) (on file with author).
35 Correspondence with Dr. A.J. Eckert of Anchor Health Initiative (Sept. 21, 2021) (on file with author).
36 See supra notes 22–23.
Outside the courts, transgender individuals cannot count on Congress or federal agencies to ensure that *Bostock*’s holding is carried through to decisions about healthcare coverage in a transgender-friendly way. Given that Congress cannot even manage to pass a basic LGBTQ antidiscrimination statute to merely reflect *Bostock*’s holding regarding per se discrimination, it is hard to imagine legislators agreeing to explicitly regulate decisions about what is “medically unnecessary.” Executive agencies are a better bet: in 2016, the Obama Administration attempted to promulgate a rule requiring plans to “apply the same neutral, nondiscriminatory criteria that it uses for other conditions when the coverage determination is related to gender transition.” But that rule was tied up in litigation and later rescinded by the Trump Administration, and the rescission is itself being challenged in court, leaving federal regulators at a loss to provide clear guidance. Even if the Biden Administration seeks to clear the confusion and enact new regulations similar to the 2016 rule, those regulations will again be subject to legal challenges and to rescission by subsequent administrations. And, more fundamentally, a regulation requiring “neutral” or “nondiscriminatory” application of medical necessity standards adds very little guidance; it is still subject to the same debates about what “neutrality” means.

In addition, for those enrolled in private health plans, a further barrier to using federal law to attain gender-affirming care is the threat of defenses under the Religious Freedom Restoration Act (RFRA). As has already been attempted in federal district court, health plans that have some linkage to a purportedly religious employer may argue that RFRA compels an exception to federal antidiscrimination law to permit the plan to deny cover to gender-affirming care on the basis of religious objections to gender transition. It remains to be seen

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38 Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31435 (May 18, 2016).


40 See Religious Sisters of Mercy v. Azar, F. Supp. 3d 1113, 1122 (D. N.D. 2021) (holding that the ACA’s prohibition on gender identity discrimination imposed substantial burden on religion under RFRA); Franciscan All., Inc. v. Burwell, 227 F. Supp. 3d 660, 690–91 (N.D. Tex. 2016) (same); Franciscan All., Inc. v. Becerra, 553 F. Supp. 3d 361 (N.D. Tex. 2021) (granting a permanent injunction); Mot. to Dismiss at 2, 12, 14, Pritchard v. BCBS of Ill.,
whether a large number of employers will claim such exemptions and, if so, whether they will face substantial pushback from employees and courts. But such religious freedom claims could easily become more common and more successful than one might expect, given that free exercise doctrine defines religion extremely broadly and, increasingly, defers to the assertions made by purportedly religious litigants, including for-profit business.\footnote{See Richard Luedeman, \textit{Voting as a Genuinely Religious Act in a World of Free Exercise Maximalism}, 55 U.C. DAVIS L. REV. ONLINE 1, 3–7 (2021).}

In one recent case, for example, a corporation named Braidwood Management, Inc., successfully sought a religious exemption from Title VII’s antidiscrimination mandate for the “health and wellness” centers that the corporation allegedly “operate[d] . . . as Christian businesses.”\footnote{Bear Creek Bible Church v. EEOC, No. 4:18-CV-00824, 2021 WL 5449038, at *3, *24 (N.D. Tex. Nov. 22, 2021).} Applying the Supreme Court’s holdings from \textit{Fulton v. City of Philadelphia}, a federal district court held that both the federal RFRA and the Free Exercise Clause required the EEOC to demonstrate not merely a compelling governmental interest in eradicating workplace discrimination, but rather a compelling governmental interest in denying Braidwood Management, specifically, an exception from Title VII’s requirements, and that the EEOC failed to meet that high burden.\footnote{\textit{Id.} at *23–26 (citing Fulton v. City of Philadelphia, 141 S. Ct. 1868, 1881 (2021)).}

\section*{B. The Likely Overuse of “Medical Necessity” Denials}

Even if a health plan were to cover “all medically necessary gender-affirming care” and not seek a religious exemption, the plan would retain a great deal of discretion to deem treatments medically unnecessary and thus deny coverage, as well as an incentive to contain costs by denying coverage whenever possible.\footnote{Amy B. Monahan & Daniel Schwarz, \textit{Rules of Medical Necessity}, IOWA L. REV. (forthcoming 2022) (“Although coverage mandates prevent insurers from categorically excluding mandated treatments or services, they do not necessarily prevent an insurer from adopting rules of medical necessity that limit the circumstances under which the mandated benefit will be provided.”).} As explained below, that combination of discretion and cost-containment incentive is a likely source of unwarranted denials coverage—as a general matter but also in particular with respect to gender-affirming care.

First, a disclaimer: Medical necessity is an immensely complex concept—made even more complicated by the enormous diversity of approaches that insurers take towards defining and applying the concept of medical necessity\footnote{See \textit{Id.}}—and this Article does not endeavor to address all its facets.\footnote{Nor does this Article mean to suggest that challenging questions about medical necessity and about what is “cosmetic” exist only in the world of transgender healthcare.} Rather, this Article...
asks readers to start from a few modest stipulations: first, bracketing genuine concerns about pathologizing or over-medicalizing gender identity, gender dysphoria is an insurable condition that often calls for certain medically necessary treatments tailored to individuals; second, some exclusion of “medically unnecessary” healthcare is essential to the financial viability of the health insurance industry, but the exact amount is open to reasonable debate and will inevitably vary somewhat from plan to plan; third, there will always be challenging gray areas in defining the concept of medical necessity, making it all the more important to design fair procedures for applying the definition to individual cases; and fourth, no set of rules or procedures will perfectly balance the competing interests inherent in the concept of medical necessity. Starting from those premises, this Article then argues that “medical necessity” provisions in modern health plans—both in how they are defined and in how they interact with the procedures and infrastructure of the American medical system—are, on average, currently tilted too far towards denying coverage for gender-affirming treatments that health plans ought to cover, by the plans’ own terms and by the terms of any reasonable vision of an equitable healthcare system.

The concept of “medical necessity” is not only a common basis for denying coverage for gender-affirming care; it is also central to modern healthcare insurance coverage of all types. Early private insurance policies routinely covered any healthcare ordered by a physician. In the 1960s, however, insurers began to suspect that physicians were ordering treatments that were excessive or unnecessary to achieve the desired therapeutic outcome. In the 1970s, insurers began adding to their policies a powerful tool to push back against physician orders: clauses limiting coverage to “medically necessary” treatments—usually without offering any meaningful definition of what that two-word term meant. Without repeating here the well-documented history of healthcare developments in the latter half of the 20th century, suffice it to say that medical necessity determinations have been a major focus of the tug-of-war between advocates of greater healthcare coverage on one side and, on the other side, the insurance industry and its sometimes understandable concerns about cost-containment.

To be sure, health plans might sometimes have legitimate reasons to deem a particular gender-affirming treatment “unnecessary” as applied to a specific

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49 Id. at 1645.
50 Id. at 1647.
51 See, e.g., Anna Kirkland et al., Health insurance rights and access to health care for trans people: The social construction of medical necessity, 55 LAW & SOC’y REV. 539, 543 (2021) (“‘Medical necessity,’ . . . and the overarching exclusion language in most policies . . . serve as key gatekeeping provisions between people and insurance companies . . . .”).
insured. And health plans are entitled, of course, to define medical necessity differently from how an individual treating physician would. But, when held up in contrast to the overwhelming medical consensus among both researchers and professional organizations that a wide range of gender-affirming treatments are often medically necessary, the high rate of health plan denials for

52 See, e.g., Rachel C. Kurzweil, “Justice Is What Love Looks Like in Public”: How the Affordable Care Act Falls Short on Transgender Health Care Access, 21 WASH. & LEE J. CIVIL RTS. & SOC. JUST. 199, 201 (2014) (“An overwhelming majority of medical authority recognizes transition-related care as an effective and medically necessary treatment for gender dysphoria.”); Daphna Strousma, The State of Transgender Health Care: Policy, Law, and Medical Frameworks, 104 AM. J. PUB. HEALTH e31, e33 (2014) (“Gender-confirming surgery has been shown to be beneficial in alleviating gender dysphoria (the distress associated with the difference between an individual’s expressed or experienced gender and socially assigned gender).”); Ashli A. Owen-Smith et al., Association between gender confirmation treatments and perceived gender congruence, body image satisfaction, and mental health in a cohort of transgender individuals, 15 J. SEX. MED. 591 (2018) (finding that “depression, and especially anxiety, were lower among individuals who received a more extensive [gender confirmation treatments] compared to those who received less treatment or no treatment at all.”); Abby Walch et al., Proper Care of Transgender and Gender Diverse Persons in the Setting of Proposed Discrimination: A Policy Perspective, 106 J. CLINICAL ENDOCRINOLOGY & METABOLISM 305, 307 (2021) (“[G]ender-affirming care is known to significantly improve mental health outcomes.”); Jack L. Turban et al., Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults, 17 PLOS ONE 1, 11 (2022) (finding that access to gender-affirming hormones was associated with “lower odds of past-year suicidal ideation [and] past-month severe psychological distress . . . .”); Rosalia Costa et al., Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria, 12 J. SEX. MED. 2206, 2212 (2015) (finding that puberty-suppressing drugs led to significantly better psychosocial functioning among adolescents with gender dysphoria); Annelou L.C. de Vries et al., Puberty Suppression in Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study, 8 J. SEX. MED. 2276 (2010) (similar findings to Costa et al.).

gender-affirming care\textsuperscript{54} suggest a system that is currently tilted too far towards denials.

Further, the design of the current system is highly conducive to excessive denials of coverage. Notably, federal law does not define “medically necessary” or require health plans to use particular criteria to apply those labels to treatments.\textsuperscript{55} State Medicaid programs use a variety of definitions of medical necessity,\textsuperscript{56} as do private health plans.\textsuperscript{57} Judicial constructions of medical necessity are both limited in number and bound up in the particular language of each plan.\textsuperscript{58} Even the Obama Administration, in requiring plans to apply their criteria for medical necessity “neutrally,” expressly declined to set standards for or “second-guess” medical necessity determinations beyond the low bar of requiring them to be “evidence-based.”\textsuperscript{59} In addition, those definitions themselves “explain very little about what happens when trans people and their professional allies have to argue for coverage”\textsuperscript{60}—much depends on how the definitions are applied in practice.

Thus, health plans are largely left to make their own decisions about how to interpret these exclusions in their policies, often disagreeing with the judg-

\textsuperscript{54} See supra notes 16–21 and accompanying text.

\textsuperscript{55} See Daniel Skinner, Defining Medical Necessity under the Patient Protection and Affordable Care Act, 73 PUB. ADMIN. REV. S49, S50–S51 (2013) (“The specific language of ‘medical necessity’ or ‘medically necessary’ appears at only three points in the ACA (§§ 2707, 520K, 9007), each of which does little more than evoke an unsettled, seemingly open-ended term. . . . [T]he ACA ensures that plans cover a wide range of benefits, . . . [but] neither the ACA nor the HHS engages the question of medical necessity with the same vigor or precision.”).


\textsuperscript{57} See Linda A. Bergthold, Medical Necessity: Do We Need It?, 14 HEALTH AFFAIRS 180, 182–83 (1995).

\textsuperscript{58} See Kathryn J. Kennedy, Coverage in Transition: Considerations When Expanding Employer-Provided Health Coverage to LGBTI Employees and Beneficiaries, 24 CARDOZO J. EQUAL RTS. & SOC. JUST. 1, 45 (2017) (“[T]here are not many cases that delineate the line between what is medically necessary versus what is cosmetic . . . .”); Amy B. Monahan & Daniel Schwarz, Rules of Medical Necessity, 107 IOWA L. REV. 423, 478 (2022) (“The very fact that caselaw is largely silent on how to interpret coverage mandates containing undefined medical necessity qualifiers suggests that insurers have a tremendous amount of leeway in implementing these mandates.”).

\textsuperscript{59} Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31375, 31436–37 (May 18, 2016) (“OCR will not second-guess a covered entity’s neutral nondiscriminatory application of evidence-based criteria used to make medical necessity or coverage determinations. Therefore, we refrain from adding any regulatory text that establishes or limits the criteria that covered entities may utilize when determining whether a health service is medically necessary or otherwise meets applicable coverage requirements.”).

\textsuperscript{60} Anna Kirkland et al., Health insurance rights and access to health care for trans people: The social construction of medical necessity, 55 LAW & SOC’Y REV. 539, 547 (2021).
ment of transgender patients’ physicians.\textsuperscript{61} Moreover, plans are not required to provide claimants with decisional precedents or to adhere to those precedents.\textsuperscript{52} With no uniformity in definition or application, very little—other than plans’ own voluntary efforts to achieve consistency—prevents “medical necessity” determinations from becoming one-off decisions that are wildly inconsistent across plans and even among participants in a single plan.

While a vague standard like “medical necessity” might be benign or even beneficial in the context of some treatments, decisions about the “necessity” of gender-affirming care invite misconceptions, inconsistency, and prejudice if not guided by uniform standards.\textsuperscript{63} Several distinctive features of gender-affirming care are likely causes of resistance by health plans. First, many health plan officials might be most familiar with a conception of medical necessity based solely on the diagnosis or the body parts involved, whereas gender-affirming care is necessarily tailored to individual needs; certain treatments may be necessary for one transgender person but not for another.\textsuperscript{64} Second, health plan officials

\textsuperscript{61} Liza Khan, Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform, 11 YALE J. HEALTH POL’Y, L. & ETHICS 375, 399–401, 415 (2011) (“The medical-necessity requirement is at once the broadest and least defined exclusion clause in most insurance plans. . . . Despite widespread endorsement of transition-related interventions in the medical community, insurers as well as courts remain skeptical of their medical necessity. . . . Insurers and courts typically defer to the physician’s judgment . . . When insurers review claims for gender-confirming care, however, they are often less willing to accept a physician’s conclusions about medical necessity.”).

\textsuperscript{62} Katherine T. Vukadin, Unfinished Business: The Affordable Care Act and the Problem of Delayed and Denied ERISA Healthcare Claims, 47 J. MARSHALL L. REV. 887, 916 (2014) (“[P]lan participants do not have access to past decisions in order to assert them as precedent. During the public comment period on the new rules, some urged that information on IRO decisions should be released but these arguments were not successful. External review decisions, then, are non-public and are not subject to the courts’ standard of stare decisis.”); Roy F. Harmon, An Assessment of New Appeals and External Review Processes - ERISA Claimants Get “Some Kind of A Hearing”, 56 S.D. L. REV. 408, 444 (2011) (“Unlike the judicial branch, proceedings before the plan administrator or external review organizations are case-specific with no requirement of even the form of adherence to any rule of consistency approaching stare decisis. In fact, the decisional model will likely result in different outcomes on very similar facts given the requirement of random assignment of claims to different external review organizations.”).

\textsuperscript{63} Daniel Skinner, Defining Medical Necessity under the Patient Protection and Affordable Care Act, 73 PUB. ADMIN. REV. S49, S53 (2013) (noting the problem of “physicians who are empowered to make medical necessity determinations but are LGBT insensitive, regardless of whether such insensitivity is the result of discrimination or poor training”).

\textsuperscript{64} Rachel C. Kurzweil, “Justice Is What Love Looks Like in Public”: How the Affordable Care Act Falls Short on Transgender Health Care Access, 21 WASH. & LEE J. CIVIL RTS. & SOC. JUST. 199, 262 (2014) (“[A] strict definition of medical necessity does not comport with how modern medicine treats medical conditions—patients with the same condition often have diverse medical needs and treatments that are necessary interventions for one patient may not be necessary for another.”); Khan, supra note 61, at 380, 414 (“Just because some transgender individuals do not need transitional procedures does not mean they are inappropriate for all transgender individuals. Patients with the same condition often have diverse medical needs, and interventions that are medically necessary for one patient may not be medically necessary for another.”); Samuel Rosh, Beyond Categorical Exclusions: Access to
might struggle to understand that, while gender transition often has “certain cosmetic features” and can involve stereotypically cosmetic procedures like rhinoplasty, the underlying basis for those treatments is very different from a mere desire to improve one’s appearance.  

Third, health plan officials might lean towards a myopic “life-or-death” standard of “necessity” when evaluating gender-affirming care—a standard rarely applied to, for example, treating chronic conditions like Lyme disease sequelae—because of unfamiliarity with or lack of concern for the enormous social and psychological consequences of being unable to transition.  

And fourth, the false perception that gender dysphoria is “just a phase” or merely “confusion” on the insured’s part can lead health plans to impose a higher standard of informed consent—for example, by requiring extensive documentation to support a request for sex hormones in the gender-affirming context but not in the analogous context of birth control.  

In addition, case-by-case application of a poorly defined standard can create opportunities for transphobia, whether conscious or subconscious, to influence medical necessity determinations by making it difficult to scrutinize any individual decision with reference to objective criteria. Absent a shocking admission buried in internal documents or the like, it is likely that in the great majority of cases health plans could claim plausibly that a good faith, nondiscriminatory decision was made. And absent a clear-cut pattern of disparate impact, even systemic discrimination could be difficult to prove. What is more, a disparate impact theory will become impossible to pursue if other courts follow


See Alex Dubov & Lianna Fraenkel, Facial Feminization Surgery: The Ethics of Gatekeeping in Transgender Health, 18 AM. J. BIOETHICS 3, 6 (2018) (“This distinction between ‘medical necessity’ for [gender reassignment surgery] coverage and ‘cosmetic’ when it comes to [facial feminization surgery] coverage based on specific body parts is in direct opposition to the scientific community’s understanding of gender identity.”); Khan, supra note 61, at 397 (“[I]nterventions that are regarded as cosmetic in certain contexts should not necessarily be considered cosmetic in all contexts. Transgender patients do not pursue treatments that alter their physical features to simply improve their looks, but rather to cure or mitigate the distress and maladaptation caused by [gender identity disorder].” (quotation marks omitted)); Kirkland et al., supra note 60, at 548–49.

See Khan, supra note 61, at 399 n.123, 413–15.

Notes from Dec. 9, 2021 Interview with Layne Gianakos, formerly of Anchor Health Initiative (on file with the author). Debunking the “just a phase” misconception, see generally Selin Gulgoz et al., Similarity in transgender and cisgender children’s gender development, 116 PNAS 24480 (2019) (finding that transgender children as strongly identify with their gender as their cisgender peers do); Michael Zaliznyak et al., Age at First Experience of Gender Dysphoria Among Transgender Adults Seeking Gender-Affirming Surgery, 3 JAMA NETWORK OPEN (2020) (finding that most transgender patients seeking gender-affirming surgery reported experiencing gender dysphoria by age seven); Sara Danker et al., A Survey Study of Surgeons’ Experience with Regret and/or Reversal of Gender-Confirmation Surgeries, 6 PLASTIC & RECONSTRUCTIVE SURGERY – GLOB. OPEN 189 (2018) (finding that regret after gender-affirming surgery is exceedingly rare).
the Sixth Circuit in concluding that Section 1557 of the ACA does not permit disparate impact theories. 68

Perhaps most importantly, existing law appears to do little to counteract the inherent anti-coverage bias built into a system in which the party making the medical necessity determination is also the party providing the costly coverage (or, in some cases, is closely tied to the party providing coverage). This problem exists in varying degrees for all healthcare claims, and gender-affirming care—which is thought (sometimes inaccurately) 69 to be costly and is therefore likely to trigger a cost-containment mentality—is no exception.

Before the ACA imposed requirements for external review, the risk of anti-coverage bias was quite visible in the virtually unfettered discretion that health plans had to make medical necessity determinations. Except for a court’s deferential review under Section 502(a) of the Employee Retirement Income Security Act (ERISA), 70 federal law did not guarantee any independent review of plans’ coverage denials. As critics pointed out, the supposed rationale for courts’ deference was dubious: analogizing health plans to trust administrators, who are often given discretion to administer a trust’s assets, ignored the conflicts of interest for health plans that would not exist for a proper trust administrator. 71 Further, health plans had little incentive not to deny claims; even if they improperly denied a claim that should have been granted, the only legal consequence (if a claimant ever actually challenged the denial) was that the plan would ultimately have to pay the claim that it was always legally obligated to pay. 72 Plans had, at most, a modest countervailing incentive to maintain a reputation for fairness among plan enrollees; and even for plans that hired third parties to administer claims decision, the third parties themselves had an incentive to contain costs and thereby make it easier to “retain[] the account and get[] others.” 73 To the extent that plans involved internal physicians in making coverage decisions, those physicians also had financial and career incentives to deny claims— incentives that were stronger than, or at least different in kind,

69 Khan, supra note 61, at 401–02 (“The experience of insurers who have covered transition-related care suggests, however, that the expense of providing transitional treatments is lower than insurers might imagine.”).
70 See infra Part I.C.
73 See Langbein, supra note 71.
from the incentives that treating physicians have to advocate in favor of coverage for their patients.\textsuperscript{74}

Despite those conflicts of interest, the rule was and continues to be that health plans’ coverage decisions receive deference under an “abuse of discretion” standard when reviewed in court if the health plan documents contain a “discretionary clause” (discussed more infra Part I.C) that grants discretion to adjudicators—a clause that plans have every incentive to include and no reason not to.\textsuperscript{75} Even proof of an actual financial conflict of interest does not subject a plan’s decision to de novo review; it is merely a factor the court can consider when judging whether discretion was abused.\textsuperscript{76} As regulators in multiple states have noted, discretionary clauses not only insulate claims denials from review, thereby depriving claimants of a meaningful judicial forum. They also distort \textit{ex ante} incentives for health plan adjudicators to deny debatable or borderline claims, secure in the knowledge that the claimant will see little hope in seeking judicial review and, in the unlikely event that the claimant does sue, the decision will not be reversed.\textsuperscript{77}

The ACA’s effort to insulate internal reviewers and its requirement of external review by “independent review organizations” (IROs)—more on them \textit{infra} Part I.C—was helpful but likely has not eliminated the problem. The ACA’s ban on internal personnel decisions “based upon the likelihood that [internal claims adjudicators] will support the denial of benefits”\textsuperscript{78} has thus far not been judicially enforced, and it is difficult to imagine that any but the most careless of health plans would be caught with clear-cut evidence of such personnel decisions. What matters is whether the claims adjudicators perceive that their future at the organization is in some way contingent on their claims’ decision history; it is unlikely that the ACA has eradicated that (often reasonable) perception.

As for the ACA’s requirement of “de novo” external review by IROs, it is difficult to assess whether IRO review yields significantly different results from


\textsuperscript{77} See, e.g., \textit{Memorandum 2004-13H}, HAW. DEP’T INS. (Dec. 8, 2004) (“Discretionary authority clauses in health plans sanction, and may even encourage, a breach of fiduciary duty. If HMSA is allowed discretionary authority to interpret the Plan as it wishes, HMSA’s manifest interest in maximizing its income and increasing its reserves conflicts with the interests of its members in obtaining coverage for medical care.”); \textit{Advisory Opinion 2010-01}, KY. DEP’T INS. (Mar. 9, 2010) (“It appears that in the marketplace, these clauses are still used to deny benefits to participants that would otherwise be guaranteed under the terms of the contract.”).

\textsuperscript{78} 45 C.F.R. § 147.136(b)(2)(ii)(D).
internal review. First, a much smaller subset of claims—only those that have already failed at internal review and, in some states, only those denied for certain reasons—ever reach IROs, making it misleading to compare reversal rates for claims in the external review pool to those in the internal review pool.\textsuperscript{79} Second, some health plans retain IROs to conduct the internal appeal process as well,\textsuperscript{80} creating the possibility that “internal” reversal rates reflect in part the influence of IROs. Third, IROs operate largely in darkness,\textsuperscript{81} and although some states collect data on IRO reversal rates, many variables create noise. On average, although roughly 40 percent of both internal and external appeals result in reversal, rates differ among insurers and from state to state: some insurers internally reverse denials in as little as 15 percent of cases, and some states have had external reversal rates as low as 23 percent.\textsuperscript{82} Moreover, reversal rates differ depending on the type of treatment requested and the reason for the denial.\textsuperscript{83} Denials of surgery are more likely to be upheld, and medical necessity denials, while of great significance in the context of gender-affirming care, constitute only a small fraction of the denials that are reported in national statistics.\textsuperscript{84}

One can say, however, that IRO reversal rates are not radically different from internal reversal rates, and that IROs’ incentives do not differ substantially from those of internal reviewers. To be sure, IROs’ separate legal status and accreditation requirements always provide some degree of insulation from health plans. In that respect, all external review offers some improvement over internal review. But at bottom, IROs are businesses and, if retained by health professional associations, may use their market power to withhold information,\textsuperscript{85} and they are under no obligation to disclose their decision-making process or the factors that contribute to the denial of claims. They are also not subject to the same regulatory oversight as internal review programs,\textsuperscript{86} and they may not be required to provide any information about the reasons for their decisions.\textsuperscript{87}


\textsuperscript{83} U. S. GOV’T ACCOUNTABILITY OFF., supra note 82.

\textsuperscript{84} Pollitz & McDermott, supra note 82 (reporting that approximately 1 percent of denials in 2019 were based on medical necessity); U. S. GOV’T ACCOUNTABILITY OFF., supra note 82 (reporting in 2011 that 8 percent of denials were based on medical necessity).
plans (or by the health plans’ third-party administrators), might reasonably expect that generous granting of claims will result in a loss of contracts.\textsuperscript{85} Indeed, part of IROs’ pitch is that they can save health plans money.\textsuperscript{86}

And then there is judicial review. Again, it is impossible to draw quantitative conclusions, as only a very small and selective sample of claims appeals ever reach the courts. Qualitatively, however, it appears that courts are both independent enough to act as a check on health plans’ anti-coverage bias and, conversely, unlikely to act as that check. Courts of course lack the conflicts of interest that health plans and IROs have, but at the same time are directed by ERISA to defer to health plans’ decisions. At least prior to the ACA’s nationwide requirement of IRO appeals, courts seemed fairly likely to view many forms of gender-affirming care as potentially “medically necessary”\textsuperscript{87} but also likely to defer in any particular instance to a health plan’s judgment regarding medical necessity.\textsuperscript{88}

In that setting, external review has a possible side effect on judicial review (though its existence is difficult to prove or disprove): namely, when claims have gone through external review, courts might tend to be even more deferential than they would be to a purely internal review, on the theory that the decision is more insulated from the plans’ conflict of interest.\textsuperscript{89} If that tendency exists, then the ACA in effect has swapped out truly independent and somewhat deferential review by a court for, instead, somewhat conflicted and nominally de novo review by an IRO followed by even more deferential (and further delayed) review by an independent court.

\section{The Inaccessibility and Underutilization of Review}

Finally, even if a health plan were in theory held to a desirable set of standards for covering gender-affirming care, the actual enforceability of those standards would likely falter in light of the byzantine procedures required to enforce them. Again, transgender people are as subject to that risk as any


\textsuperscript{86} See, e.g., \textit{Frequently Asked Questions}, supra note 80 (“Recent research has shown that for every dollar spent on an IRO, a healthcare plan can save up to $15.”); \textit{IROs Help Cut Health Payers’ Costs and Improve Image}, \textit{HEALTHCARE FINANCE} (Feb. 26, 2009), https://www.healthcarefinancenews.com/press-release/iro help-cut-health-payers-costs-and-improve-image [https://perma.cc/KB7G-5V8C].


\textsuperscript{88} See, e.g., Mario v. P & C Food Markets, Inc., 313 F.3d 758, 765 (2d Cir. 2002) (upholding, and subjecting to little scrutiny, a plan administrator’s determination that gender-affirming procedures were not medically necessary).

claimant in the American healthcare system is, if not more so, given the many forms of social disadvantage that transgender people face. First, this section describes the existing system for enforcing rights under a health plan. It then discusses why that system is flawed.

1. The Current System

What happens when an individual enrolled in a federally regulated health plan seeks to enforce their rights under federal antidiscrimination law by claiming that the plan should cover the cost of gender-affirming treatments? Procedures for making such claims could fill a treatise and vary greatly from health plan to health plan. Some apply to “internal” appeals, while others to “external” appeals; some apply to “self-insured” private plans, while others apply to “fully insured” private plans or to Medicaid plans; and among “fully insured” private plans, some plans called “managed care” plans (such as HMOs) are regulated differently from traditional “indemnity” plans. But in short, the process is convoluted and begins—and often ends—in the hands of the health plan’s own internal decision-makers.

It is impossible to paint in broad strokes when describing the complex patchwork of rights that individuals have in the American healthcare system. Rights differ greatly from one health plan to the next. Indeed, even the terms “health plan” and “health insurance” risk conflating disparate things. In the broadest sense, a “health plan” is any set of policies under which an entity pays for a person’s healthcare: that includes government insurance like state-run Medicaid programs, so-called “group plans” sponsored by a person’s employer, and insurance policies sold directly to individuals (sometimes called “non-group plans”). In a narrower sense applicable to employers, however, a “plan” is a quasi-independent entity set up by an employer to provide benefits to its employees. It is distinct from a health insurance company, but it might rely on insurance policies issued by an insurance company to underwrite costs, administer benefits, or both. If an insurance company underwrites a plan’s costs, it is deemed a “fully insured” group health plan subject to state insurance regulation. But if the insurance company does not underwrite costs, the plan is “self-insured” (a.k.a. “self-funded”) and subject only to the federal ERISA, which preempts all state laws in the field.

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94 Id.
In sum, the sorting of “health plans” into categories—Medicaid, self-insured group plan, fully-insured group plan, and individual insurance—is both confusing and highly consequential in terms of the rules that govern benefits, including gender-affirming care. Below, I summarize (a) the federal procedures for reviewing claims in self-insured plans, and (b) the joint federal-state procedures for reviewing claims in Medicaid plans and fully insured plans.

a. Federal Appeal Procedures—the Only Procedures Required of Self-Insured Plans

For self-insured private plans, federal law alone provides procedures. Federal law requires all private health plans, both self-insured and fully insured, to establish “reasonable claims procedures” and “full and fair review” of decisions—terms of art that receive a complex definition under the ACA and ERISA.95

First come initial decisions by plans as to whether a medical claim is covered, for which federal law sets minimum standards. Plans must provide claimants with notices regarding the claims process,96 make a decision within 180 days (with some exceptions),97 and provide a written explanation if a claim is denied.98 Crucially, neither at this initial phase nor at any subsequent phase is the health plan required to defer or give special weight to the judgment of the claimant’s treating physicians as to whether the treatment sought is medically necessary.99

Then come internal appeals within the plan itself if the claim is denied. For individual plans, only a single level of internal appeal is permitted; group plans may provide one or two levels.100 Initial appeals are decided by “fiduciaries” designated by the plan. The fiduciary may be “neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual,” and must not “afford deference to the initial ad-

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95 45 C.F.R. § 147.136(b)(2)(i)(C) (ACA regulations); 29 C.F.R. § 2560.503-1(b) (ERISA regulations). The ACA regulations articulate these requirements both as to group health plans themselves and as to “issuers,” i.e., insurance companies that offer health coverage to health plans or to individuals. See 45 C.F.R. § 147.136(b)(2). Depending on how a group health plan is structured, either the plan itself or an outside insurance company could potentially handle claims. For simplicity, and because these regulations are the exclusive procedures required of the self-insured group health plans to which ERISA preemption applies, I will refer to these regulations as applying to “health plans.” For fully insured plans, in contrast, these regulations do not provide the exclusive set of procedures; state rules apply as well.
96 29 C.F.R. § 2560.503-1(c)(1).
97 29 C.F.R. § 2560.503-1(f); 45 C.F.R. § 147.136(b)(2)(ii)(B).
98 29 C.F.R. § 2560.503-1(g); 45 C.F.R. § 147.136(b)(2)(ii)(C),(E).
100 29 C.F.R. § 2560.503-1(c)(2); 45 C.F.R. § 147.136(b)(3)(ii)(G). Arbitration can be used as a form of internal review, as long as it does not preclude the claimant from seeking further review. 29 C.F.R. § 2560.503-1(c)(4)(i).
verse benefit determination.”  The fiduciary must “consult with a health care professional who has appropriate training and experience in the field of medicine involved” and who, like the fiduciary, is “neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.” And plans must not make decisions “regarding hiring, compensation, termination, promotion” of claims adjudicators “based upon the likelihood that [they] will support the denial of benefits.” Claimants receive at least 180 days to file an internal appeal and are entitled to free access to records relevant to the claim. Plans must render a decision within 120 days, with some exceptions, and if the plan denies the claim, it must provide reasons and notify the claimant of the available external appeal. Unless the plan makes a material error in its internal appeal procedures, the claimant must exhaust internal appeals before seeking outside review.

If the appeal is denied internally, an external administrative appeal decided by independent review organizations (IROs)—private companies under contract with the plan or the plan’s administrator—follows. For self-insured plans to which ERISA preemption applies, limited federal regulations set the procedural floor for external appeals; self-insured plans may go further, or may opt to follow state-created procedures, but are not required to. The federal floor requires that claimants receive at least four months to file an external appeal. But the plan itself conducts a “preliminary review” in which the appeal may be rejected if, among other reasons, the claimant has not provided “all the information and forms required to process an external review,” at which point the claimant might have as little as 48 hours to cure the deficiency. If not rejected, the appeal is sent to an IRO at no cost to the claimant. Plans must have contracts with at least three IROs and assign claims to them via “unbiased methods” (but not necessarily at random) and must “ensure that the IRO process is not biased.” Although few concrete details accompany the requirement to be unbiased, it is at least prohibited for IROs to “be eligible for any fi-

102 Id. § 2560.503-1(b)(3)(iii),(v).
103 45 C.F.R. § 147.136(b)(2)(ii)(D).
105 Id. § 2560.503-1(i),(j).
106 Id. § 2560.503-1(j) (deeming internal appeals to be exhausted if the plan did not follow proper procedures); 45 C.F.R. § 147.136(b)(2)(ii)(F) (exempting from the preceding rule a plan’s “de minimis” and “good faith” failure to follow proper procedures).
108 45 C.F.R. § 147.136(c)(1)(ii).
109 Id. § 147.136(d)(2)(i).
110 Id. § 147.136(d)(2)(ii).
111 Id. § 147.136(d)(2)(ii)(A)(4).
112 Id. § 147.136(d)(2)(iii)(A)(1),(2).
nancial incentives based on the likelihood that the IRO will support the denial of benefits.” ¹¹³ IROs “review the claim de novo” and consider documents provided by the claimant and the insurer, as well as the claimant’s medical records, the “attending health care professional’s recommendation,” “the terms of the claimant’s plan or coverage,” “appropriate practice guidelines . . . developed by the Federal government, national or professional medical societies, boards, and associations,” and the opinion of the IRO’s own internal clinicians, if any, who reviewed the claim.¹¹⁴ IROs must decide appeals within 45 days, with reasons given if the claim is denied.¹¹⁵

If they manage to exhaust both internal and external administrative appeals,¹¹⁶ claimants can attempt a lawsuit under Section 502(a) of ERISA, alleging that the health plan violated the terms of the plan documents.¹¹⁷ Although not truly appeals in the traditional sense, Section 502(a) suits are usually subject to a highly deferential “abuse of discretion” standard that is typical of appellate review.¹¹⁸ As a result, courts will usually not overturn a private claims adjudicator’s decision unless it constituted an “abuse of discretion.”

b. Appeals for Medicaid Plans or Fully Insured Private Plans—Setting a Federal Floor with Room for State Regulation

For Medicaid plans and fully insured private plans, federal law again sets procedural requirements, but unlike with self-insured plans, states may require fully insured plans to meet higher standards.¹¹⁹

For internal appeals, the federal minimum procedures are the same for fully insured plans as for self-insured plans: that is, fully insured plans must all follow the same federal procedures as self-insured plans, plus whatever additional procedures are required in a particular plan’s state. But for external appeals, the federal floor is achieved differently, albeit with a functionally similar effect: fully insured plans need only to follow state procedures, as long as those procedures accord with certain minimum requirements set by the National Association of Insurance Commissioners (NAIC); if a state does not meet NAIC requirements, then fully insured plans must follow federal procedures.¹²⁰

The NAIC requirements for states’ external review processes are similar to, but not identical to, the requirements of federal external review that apply to

¹¹³ *Id.* § 147.136(d)(2)(iii)(A)(3).
¹¹⁴ *Id.* § 147.136(d)(2)(ii)(B)(5).
¹¹⁶ *But see* Hoover v. Harvard Pilgrim Healthcare, Inc., No. 15-CV-367-JL, 2016 WL 2636226, at *3 (D.N.H. May 9, 2016) (collecting cases and holding that, unless the health plan documents explicitly require exhaustion of external appeals, then only exhaustion of internal appeals is a prerequisite to filing suit in court).
¹¹⁸ *See supra* notes 75–76 and accompanying text.
¹¹⁹ 45 C.F.R. § 147.136(c)(1)(i).
¹²⁰ *Id.* § 147.136(c)(1).
self-insured plans. The federal floor requires plans to provide claimants with notice of external review procedures.\textsuperscript{121} The claimant must have at least four months to file the external appeal, and the IRO must decide the appeal within 45 days, with some exceptions.\textsuperscript{122} Plans must, at no cost to the claimant, send appeals to a rotating list of accredited IROs that are not “owned or controlled” by the insurer and do not otherwise have a “material professional, familial, or financial conflict of interest.”\textsuperscript{123} Importantly, the state itself maintains the rotating list IROs and assigns them randomly.\textsuperscript{124}

In addition, as to fully insured plans, states may prohibit the use of the common “discretion” clauses that could otherwise limit court review of claims adjudication to an abuse of discretion standard.\textsuperscript{125}

Much like for fully insured plans, federal Medicaid regulations set a procedural floor for handling coverage claims by Medicaid enrollees, and states have the option to provide further protections. States must provide Medicaid enrollees with fair notice of an adverse benefits determination and inform them of procedures for appealing the determination.\textsuperscript{126} Every state Medicaid program must have a system for handling appeals of claims denials.\textsuperscript{127} Claimants are entitled to appeal a decision within “a reasonable time, not to exceed 90 days.”\textsuperscript{128} Minimum due process requirements apply, including the reasonable opportunity to review and present evidence prior to the hearing and the right to appeal to someone not “directly involved in the initial determination.”\textsuperscript{129} Hearing officers must render decisions within 90 days, with exceptions, and must explain their reasons for denying claim and the claimant’s right to seek further review.\textsuperscript{130} The appeal system can take the form of either a single hearing before one or more hearing officers who make a final decision on behalf of the state Medicaid agency, or the form of an initial appeal to a local hearing officer with a second appeal to the state Medicaid agency’s final decision-makers.\textsuperscript{131} If the latter system applies and the local hearing officer denies the claim, the agency must inform the claimant of the right to a second appeal.\textsuperscript{132} If a second appeal is taken, the local hearing officer cannot be involved in the decision, and the

\begin{footnotes}
\footnote{121}{Id. § 147.136(c)(2)(ii),(xiv).}
\footnote{122}{Id. § 147.136(c)(2)(vi),(xii),(xiii).}
\footnote{123}{Id. § 147.136(c)(2)(iv),(vii),(viii),(ix).}
\footnote{124}{Id. § 147.136(c)(2)(vii),(viii); see Unif. Health Carrier External Rev. Model Act § 12 (NAT’L ASS’N INS. CARRIERS 2010).}
\footnote{125}{Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355, 386 (2002).}
\footnote{126}{42 C.F.R. §§ 431.206, 431.210.}
\footnote{127}{24 U.S.C. § 1396a(a)(3).}
\footnote{128}{42 C.F.R. § 431.221(d).}
\footnote{129}{Id. §§ 431.205, 431.240, 431.242.}
\footnote{130}{Id. §§ 431.244, 431.245.}
\footnote{131}{Id. § 431.205.}
\footnote{132}{Id. § 431.232.}
\end{footnotes}
“substantial evidence” standard of review applies unless the claimant expressly requests a de novo hearing.\textsuperscript{133}

After exhausting administrative appeals, claimants’ access to judicial review of Medicaid decisions is determined by state law, absent a showing that a state’s appeal system deprives them of due process.\textsuperscript{134}

2. **Flaws in the Current System**

The first flaw with the current system of enforcing health plan right is, of course, its sheer complexity, which the ACA has only made worse.\textsuperscript{135} Operating at a great informational disadvantage relative to the repeat players who review their claims, claimants must first make sense of the elaborate claims procedures that are specific to their plan.\textsuperscript{136} Denial letters can be “pages and pages long,” and insurers require exact adherence to appeal procedures.\textsuperscript{137} Federal law permits plans to using varying terminology and deadlines (within minimum parameters), and a claimant’s misinterpretation of the terminology or deadlines can foreclose external IRO appeals and any later judicial review due to the claimant’s “failure to exhaust” the plan’s review procedures. One study found that, among external appeals that were summarily rejected, 19% were rejected because the claimant had failed to exhaust internal appeals.\textsuperscript{138} And it is unclear whether this internal-before-external appeal structure actually incentivizes accurate, good faith decisions by health plans at the internal stage, given that

\textsuperscript{133} Id. § 431.233.


\textsuperscript{135} Katherine T. Vukadin, *Hope or Hype? Why the Affordable Care Act’s New External Review Rules for Denied ERISA Healthcare Claims Need More Reform*, 60 Buff. L. Rev. 1201, 1204–05 (2012) (“[F]or most plan participants, the new external review rules simply add to plan participants’ paperwork and procedural burden. The problem is not that there are too few levels of review, but instead, that too many claimants drop out of the appeal process, never questioning their denied claims at all.”).


\textsuperscript{137} Sep. 21, 2021 Correspondence with Dr. A.J. Eckert of Anchor Health Initiative (on file with the author).

health plans face no penalty for internally denying a claim that is later granted during external review.\textsuperscript{139}

Further, pursuing an appeal forces claimants to invest significant time, energy, and resources. Supportive providers are sometimes able to help in limited ways, but most are not; moreover, the claimants themselves must usually be persistently involved in the process to have any success.\textsuperscript{140} Often, the only way forward is for providers to “creatively” code the treatments when submitting or resubmitting the claim, a step that many providers cannot or will not take.\textsuperscript{141} The process can take months or even years to pursue to completion, as each of the multiple steps (initial claims processing, first internal appeal, second internal appeal, external appeal, court review) can take weeks or months to complete. Simply getting through the (usually two-level) internal appeal process “requires focus and determination.”\textsuperscript{142} As each successive appeal becomes more and more independent (in theory), it also becomes more and more onerous to reach. For many potential claimants, they have neither that much free time to invest in the process nor that much time to wait to receive healthcare.\textsuperscript{143} In addition, assembling the medical support and documentation necessary to appeal successfully can be a barrier for many.\textsuperscript{144} And while the ACA requires plans to cover the direct costs of appeals, claimants bear indirect costs—

\textsuperscript{139} See Mass. Mut. Life Ins. Co. v. Russel, 437 U.S. 134, 148 (1985) (holding that ERISA claimants cannot recover extra-contractual damages caused by improper processing of their benefit claims); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 57 (1984) (holding that ERISA’s “savings clause” did not permit common law claims arising out of allegedly improper processing of a benefits claim); Vukadin, supra note 72, at 1205 (“[T]here is no direct, negative, and substantial consequence of payers’ incorrect denial of legitimate healthcare claims.”).

\textsuperscript{140} E-mail correspondence from Dr. A.J. Eckert, Anchor Health Initiative, to author (Sept. 21, 2021) (on file with author) (“[I]f a patient is not good at advocating for themselves and not good at staying in touch with the rendering provider’s office, then an appeal is basically impossible.”); Interview with Layne Gianakos, formerly of Anchor Health Initiative (Dec. 9, 2021) (on file with the author) (observing that it is essential during an appeal to have a provider go to bat for you, but that few have the time or skillset to do so).

\textsuperscript{141} Anna Kirkland et al., Health Insurance Rights and Access to Health Care for Trans People: The Social Construction of Medical Necessity, 55 LAW & SOC’Y REV. 539, 554–55 (2021); Correspondence with Dr. A.J. Eckert, supra note 140; Interview with Layne Gianakos, supra note 140.

\textsuperscript{142} Vukadin, supra note 72, at 1231–32 (“Analysts suggest that even after persisting through two levels of review, plan participants become discouraged—participants do not want to expend more time, trouble, and money, only to be denied yet again.”).

\textsuperscript{143} Katherine T. Vukadin, Unfinished Business: The Affordable Care Act and the Problem of Delayed and Denied ERISA Healthcare Claims, 47 J. MARSHALL L. REV. 887, 907 (2014) (“Significantly, to take advantage of the full benefit of the new rules, a plan participant must have time and energy to resist the default stance of denial and initiate an appeal. Time and energy are of course resources in short supply for those suffering from illness.”).

including the cost of retaining the legal counsel that might well be necessary to navigate the process.

It is no surprise, then, that the elaborate claims process achieves “rationing by hassle”\(^\text{145}\) — “the vast majority of denied claims are not appealed, and only a miniscule percentage reach external review.”\(^\text{146}\) In 2019, only 0.16 percent of claims were appealed internally.\(^\text{147}\) And out of millions of claims in 2019, most insurers reported only a handful of external appeals to IROs.\(^\text{148}\) Given how rare external IRO appeals are, providers of gender-affirming care might have had no experience with their patients pursuing them.\(^\text{149}\)

Although appeal statistics specific to transgender claimants are not known, one would expect the picture to be even worse, given that appeals require time, resources, and the aid of provider advocates. Transgender people are far more likely than cisgender people to live in poverty and more likely to experience discrimination and discomfort in their interactions with medical professionals.\(^\text{150}\) Further, the lack of trusted, transgender-competent medical professionals make it especially challenging for transgender claimants to find a provider who will advocate aggressively for them, as is often necessary to prevail in an appeal.\(^\text{151}\) Transgender advocates in the greater New Haven region, for example, report that no comprehensive database of transgender-competent providers exists, that word of mouth is the only source, and that only one surgeon in the region is known to be qualified to perform the most complex forms of gender-

\(^\text{145}\) Elizabeth F. Emens, Admin., 103 GEO. L.J. 1409, 1451 (2015) ("[I]nsurance companies can save money if their claim procedures are so complicated, or their appeals processes so onerous, that claimants give up trying to get reimbursed.").

\(^\text{146}\) Vukadin, supra note 143, at 904 & n.87.

\(^\text{147}\) Pollitz & McDermott, supra note 82.

\(^\text{148}\) Id.

\(^\text{149}\) Correspondence with Dr. A.I. Eckert, supra note 140 ("We do not have experience with them. By the time you got to the IRO stage of an appeal, the patient has probably moved on!").


\(^\text{151}\) See supra notes 33, 150.
affirming surgeries.\textsuperscript{152} One Connecticut transgender health clinic reports that “very few [transgender] people who have been denied for medical procedures get them overturned.”\textsuperscript{153} In addition, many insurers further alienate and deter transgender claimants by routinely using dated, offensive terminology like “gender identity disorder,” having no means for individuals to identify as non-binary, or lacking basic literacy in modern understandings of gender—for example, by responding with befuddlement when a doctor orders a Pap smear for a patient with an “M” gender designation.\textsuperscript{154} Finally, as yet another obstacle, some transgender claimants feel that a drawn-out appeal is pointless to pursue because the lengthiness of the process itself might well deprive them of relief—either because they are in crisis or, in the case of younger claimants, because completing puberty during the pendency of the appeal will render certain treatments ineffective.\textsuperscript{155}

When paired with the high rates of coverage denials for gender-affirming care,\textsuperscript{156} the minimal utilization of appeal procedures shows that many transgender individuals’ rights under federal law are simply not being enforced.

II. THE ROLE FOR PROGRESSIVE STATES

Fortunately, for many transgender Americans, federal law is not the sole source of healthcare coverage protections. States that are progressive on transgender rights have several options for regulating health plans in ways that expand or facilitate access to gender-affirming care.

In some parts of the nation’s healthcare patchwork, federal law alone governs, while other parts are subject to both federal and state regulation. States generally cannot regulate Medicare or private Medicare Advantage plans,\textsuperscript{157} health plans for federal government employees,\textsuperscript{158} or private employer-sponsored health plans that are “self-insured.”\textsuperscript{159} But in many other parts of the system, states are free to regulate health plans. Jointly with federal law, state laws govern individual (“non-group”) plans, private employer-sponsored plans

\textsuperscript{152} Interview with Layne Gianakos, formerly of Anchor Health Initiative (Dec. 9, 2021) (notes on file with author); Interview with Kirill Staklo, founder of PeerPride (Dec. 9, 2021) (notes on file with author).
\textsuperscript{153} E-mail correspondence with Dr. A.J. Eckert, supra note 140.
\textsuperscript{154} Id.
\textsuperscript{155} Interview with Layne Gianakos, supra note 18; Interview with Kirill Staklo, supra note 152.
\textsuperscript{156} See supra notes 16–21 and accompanying text.
\textsuperscript{157} See 42 U.S.C. § 1395w-26(b)(3) (preempting state law with respect to Medicare Advantage plans).
that are “fully insured”—i.e. underwritten by an insurance company—
as well Medicaid plans and plans for state and municipal employees. Together, enrollees in those plans constitute an estimated 45 to 50 percent of the population. And even if all private group plans were to convert to self-insurance, around 39 percent of the population would still be within the reach of state regulation of health plans.

For the substantial proportion of the transgender population with health plans subject to state regulation, progressive state legislatures may face increasing pressure to bolster state-level protections (depending on where federal courts land on these issues in the next several years). Up to now, regulations have been the key arena for progress. In many states, stronger legislative protections for transgender healthcare have not been achievable—either because of general legislative gridlock or because of conservative majorities in one or both chambers—but that has not necessarily been the end of the road. In states with existing prohibitions on sex and/or gender identity discrimination, basic administrative law principles suggest that courts will be more likely to adopt a broad interpretation if regulators have already done so. Although not as potent as legislation, regulation is more achievable in many instances. State regulators typi-


161 See 29 U.S.C. § 1003(a) (limiting ERISA’s application to plans “established or maintained” by an “employer” or “employee organization”).

162 See id. § 1003(b) (“The provisions of this subchapter shall not apply to any employee benefit plan if . . . such plan is a governmental plan . . . “); 29 U.S.C. § 1002(32) (defining “governmental plan”); Gualandi v. Adams, 385 F.3d 236, 242 (2d Cir. 2004); Fromm v. Principal Health Care of Iowa, Inc., 244 F.3d 652, 654 (8th Cir. 2001); Hightower v. Texas Hosp. Ass’n, 65 F.3d 443, 447 (5th Cir. 1995).

163 See RYAN J. ROSCO, CONG. Rsch. Serv., IF10820, U.S. HEALTH CARE COVERAGE AND SPENDING (2021) (reporting that as of 2019, 13.1 percent of the population was enrolled in non-group plans, 19.8 percent were enrolled in Medicaid, and 55.4 percent were enrolled in group plans); Al Stewart, U.S. DEP’T LAB., REPORT TO CONGRESS: ANNUAL REPORT ON SELF-INSURED GROUP HEALTH PLANS 11 (2021), https://www.dol.gov/sites/dolgov/files/EBIA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2021.pdf [https://perma.cc/2UFH-J6H2] (reporting that among group plans in 2017-18, 19 percent were fully insured); Adam Grundy, Education, Hospitals, Police Protection are Largest Government Employment Categories, U.S. CENSUS BUREAU (Oct. 7, 2020), https://www.census.gov/library/stories/2020/10/2019 Annual-Survey-of-Public-Employment-And-Payroll-is-Out.html [https://perma.cc/6YVS-82J4] (reporting that as of March 2019, 19.7 million workers, or approximately 6 percent of the population, work for state and local governments). Depending on the percentage of state and local government plans that are fully insured, the total number could be as high as approximately 49.6 percent and as low as approximately 43.6 percent.


165 See supra note 163.
cally can act more nimbly than legislators and, in states with divided government or politically insulated bureaucracies, can act even if one or both legislative chambers are ideologically opposed.\(^\text{166}\)

Whether they are achieved through legislation or through regulation, many possible reforms remain. This Article identifies eight areas for state-level reform: (A) do the bare minimum of explicitly eliminating categorical exclusions for gender-affirming care; (B) define “discrimination” and “medically necessary” in a way that meaningfully prevents inequity; (C) avoid or limit expansive religious liberty laws that create huge loopholes in antidiscrimination law; (D) if the state has not done so already, implement NAIC-compliant external appeal procedures under which state agencies select and assign IROs; (E) require medical doctors, giving weight to treating physicians’ views, to make medical necessity determinations, at least (for the time being) with respect to commonly misunderstood treatments like gender-affirming care that, until recently, most plans categorically excluded; (F) expand access to telemedicine by relaxing interstate licensing requirements; (G) prohibit “discretionary clauses”; and (H) eliminate or limit requirements to exhaust internal appeals.

A. The Bare Minimum: Explicitly Eliminate Categorical Exclusions for Gender-Affirming Care

The lowest-hanging fruit for progressive states is simply to make explicit under state law what is still open to question under federal law: namely, make clear that categorical health plan exclusions for all or some forms of gender-affirming care are necessarily an unlawful form of anti-trans discrimination. That effort would include both directly modifying the state’s own Medicaid standards for coverage to include gender-affirming care and indirectly regulating private health plans’ coverage.

It may come as a surprise to some readers that many states’ laws—while setting all sorts of standards for what must be included in health insurance policies—either say nothing about gender-affirming care or, even worse in the context of twelve states’ Medicaid programs, still affirmatively exclude gender-affirming care.\(^\text{167}\) For the time being, those exclusions persist. But the exclusions’ legality is highly suspect, and litigation is causing some states, such as New York and Wisconsin, to abandon their exclusions.\(^\text{168}\) As recently as July 2021, for example, Alaska removed its Medicaid exclusion as part of a legal

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\(^{166}\) As of this writing, for example, in eight states—Pennsylvania, North Carolina, Kentucky, Wisconsin, Michigan, Minnesota, Kansas, and Louisiana—the Democratic Party holds the governorship but not the state legislature.

\(^{167}\) See supra note 21.

settlement. In addition to those three states, sixteen more states have chosen to bring gender-affirming care within Medicaid’s coverage.

Further, twenty-five states now ban gender identity discrimination in private plans, and every state has an agency with statutory authority to implement regulations ensuring its implementation.
ment such a ban.\textsuperscript{172} The best of the existing antidiscrimination provisions not only ban “discrimination” but also make clear that categorically deeming gender-affirming treatments to be “cosmetic” or “unnecessary” is a form of discrimination. Washington law, for example, prohibits insurers from “apply[ing] categorical cosmetic or blanket exclusions to gender affirming treatment” and lists specific gender-affirming treatments (such as facial feminization, hair removal, and breast implants) that, if “prescribed as medically necessary gender affirming treatment,” cannot be “exclude[d] as cosmetic.”\textsuperscript{173} In California, insurers must cover “services related to gender transition if coverage is available for those services under the policy when the services are not related to gender transition, including but not limited to hormone therapy, hysterectomy, mastectomy, and vocal training.”\textsuperscript{174} Illinois, New Mexico, and New York adopted


\textsuperscript{174} CAL. CODE REGS. tit. 10, § 2561.2(a)(4)(A).
similar language.\textsuperscript{175} And in Connecticut, the state’s civil rights enforcement agency, the Commission on Human Rights and Opportunities, achieved a similar outcome by issuing a declaratory ruling\textsuperscript{176} that interpreted existing antidiscrimination laws to prohibit the categorical labeling of gender-affirming treatments as “cosmetic.”\textsuperscript{177} The ruling requires any cosmetic exclusion to be based on an individualized determination of medical necessity.\textsuperscript{178}

Thus, explicitly eliminating exclusions for gender-affirming care is not only a straightforward, bare-minimum step; it is also quite achievable. As discussed below, however, few states have offered meaningful guidance on what “discrimination” or “medical necessity” looks like in the context of gender-affirming care or addressed the ways in which \textit{de facto} discrimination can occur via discretionary decision-making and onerous processes.

\textbf{B. Define Discrimination and Medically Necessity Under State Insurance Law in a Way That Meaningfully Prevents Inequity}

Merely banning the explicit exclusion of gender-affirming treatments is of little help if, in applying a general exclusion for “cosmetic” or “medically unnecessary,” health plans in effect deny a large percentage of claims for gender-affirming treatments. And merely requiring health plans to not “discriminate” or to provide “medically necessary” care to transgender people does not address the underlying problem of health plans’ discretion over how to define and adjudicate “discrimination” and “medical necessity.” Even in states that already expressly prohibit gender identity discrimination in healthcare, current statutory language might lead state courts down the same formalist path as federal courts interpreting federal law—that is, turning a blind eye to medical necessity standards that are formally nondiscriminatory but inequitable in application.\textsuperscript{179} States

\begin{itemize}
  \item \textsuperscript{175} ILL. ADMIN. CODE tit. 50, § 2603.35(4)(6); Bulletin 2018-013, N.M. OFF. SUPERINTENDENT INS. (Aug. 23, 2018), 2018 WL 6928553; N.Y. COMP. CODES R. & REGS. tit. 11, § 52.75(4)(4).
  \item \textsuperscript{176} The Commission has traditionally stated its positions not through rulemaking procedures but rather through adjudications, including advisory opinions.
  \item \textsuperscript{177} Declaratory Ruling on Petition Regarding Health Insurers’ Categorization of Certain Gender-Affirming Procedures as Cosmetic, CONN. COMM’N HUMAN RIGHTS & OPPORTUNITIES (Apr. 15, 2020), at 24–26.
  \item \textsuperscript{178} \textit{Id.} at 26. Interestingly, although the Commission is not usually an insurance regulator, it found statutory authority to regulate this particular aspect of health insurance as a “public accommodations”—a move that other states’ civil rights agencies could potentially make. \textit{Id.} at 32–39.
  \item \textsuperscript{179} See, for example, laws in California, Vermont, New Hampshire, and Maine that prohibit gender identity discrimination \textit{per se} but appear to stop short of, or even to bracket, the question of coverage for specific treatments. \textit{See} 2005 Cal. Legis. Serv. Ch. 421 (A.B. 1586) ("[T]he benefits or coverage of any contract shall not be subject to any limitations, exceptions, [or] exclusions . . . because of . . . sex . . . . This act is not intended to mandate that health care service plans or insurers must provide coverage for any particular benefit . . . . Rather, the purpose of this act is to prohibit plans and insurers from denying an individual a plan contract or policy, or coverage for a benefit included in the contract or policy,
\end{itemize}
could do several things to address this problem, moving towards defining discrimination and medical necessity in a way that meaningfully prevents inequity.

In an ideal world, states would do what some Hawaii legislators have attempted (but thus far failed) to do: explicitly declare that specific gender-affirming treatments should be covered and deemed non-cosmetic if the health plan covers the same services for purposes other than gender transition. Hawaii’s HB285, unlike to pass in its original form, would enact such a requirement and represents the leading edge of legislation in this area.\textsuperscript{180}

For now, at a minimum, states can take the modest step of explicitly requiring medical necessity standards to be applied evenhandedly—that is, not to be applied more strictly or scrutinizingly to gender-affirming treatment than to analogous treatments sought by cisgender individuals. At this point, no such requirement has been judicially interpreted, but it at least has the potential to pave the way for disparate impact theories under which transgender claimants could argue that a seemingly neutral standard is being applied inequitably. Hawaii law, for example, provides that “[t]he medical necessity of any [gender-affirming] treatment ... shall be defined in a manner that is consistent with other covered services.”\textsuperscript{181} Similarly, regulations in Oregon require that medical necessity determinations for particular treatments be consistent as between cisgender and transgender patients.\textsuperscript{182} And a 2020 Virginia law provides that for transgender patients, “[h]ealth carriers shall assess medical necessity according to nondiscriminatory criteria.”\textsuperscript{183}

Second, states can require that health plans base medical necessity determinations on—and justify their decisions with specific reference to—the internationally recognized standards promulgated by the World Professional Association for Transgender Health (WPATH), a nonprofit professional organization that has published suggested standards of care for transgender


\textsuperscript{181} \textit{Haw. Rev. Stat.} § 431:10A-118.3(G).


\textsuperscript{183} \textit{Va. Code} § 38.2-3449.1(G).
health since 1979. WPATH’s standards are partly an educational tool, to inform medical providers about the types of gender-affirming treatments, but also partly a source of criteria for when certain treatments are medically indicated—such as four criteria to meet before initiating hormone therapy. The WPATH standards are not without criticism but are widely accepted and closely watched. And although third-party standards like WPATH can still leave health plans with some discretion to permit cost-containment bias, they likely mitigate that bias. The WPATH standards would also create a uniform, transgender-sensitive definition of “medical necessity,” displacing the one-size-fits-all definitions that are ill-suited to the gender-affirming context. And they would thereby facilitate a uniform body of decisional law that does not depend on peculiarities of individual health plans.

Pennsylvania and the District of Columbia have adopted the WPATH standards for their Medicaid plans, and a few states have come close to doing so for private insurers. Hawaii legislators recently introduced, but have failed to pass, an explicit requirement for insurers to use WPATH standards. Regulations in Oregon and Minnesota do not mandate use of WPATH standards but require that medical necessity determinations for particular treatments “must be based on the most recent, published medical standards set forth by nationally recognized medical experts in the transgender health field.” Regulations in the District of Columbia are akin to Oregon’s and Minnesota’s but use “should” rather than “must.” And Delaware’s insurance department has stated that it

185 See, e.g., Becky McCall, WPATH Draft on Gender Dysphoria ‘Skewed and Misses Urgent Issues’, MEDSCAPE (Dec. 10, 2021), https://www.medscape.com/viewarticle/964604; Interview with Kirill Staklo, supra note 152 (criticizing the WPATH standards for imposing too many barriers to transgender youth who seek gender-affirming care, for being ill-suited to nonbinary identities, and for potentially exposing transgender people to violence by requiring them to live for long periods as their gender before receiving certain treatments).
188 Medical Assistance Bulletin 99-16-11, supra note 170; Non-Discrimination in the District’s State Medicaid Program Based on Gender Identity or Expression, supra note 170.
190 Bulletin DFR 2016-1, supra note 182; Administrative Bulletin 2015-5, supra note 171.
191 Bulletin 13-JB-01-30/15, supra note 171 ("In determining the medical necessity of services and benefits provided to such patients, insurance companies should refer to the recognized professional standard of medical care for transgender individuals requiring treatment for gender dysphoria . . . "). (emphasis added).
will treat as a violation of the state’s Unfair Trade Practices Act the failure to use “current medical standards established by nationally recognized transgender health medical experts” to determine medical necessity.\textsuperscript{193}

Third, states can prohibit health plans from imposing substantially more onerous procedural or documentation requirements for gender-affirming treatments than for equivalent treatments that are designed to address other medical needs. Again, states have made a small start in this area. At the micro level, for example, Colorado recently revised its Medicaid regulations to no longer require preapproval of hair removal procedures.\textsuperscript{194} At a much higher level of generality, a Maine statute prohibits health plans from “impos[ing] additional cost sharing or other limitations or restrictions on coverage for specific health services related to gender transition if such denial, limitation or restriction results in discrimination against a transgender individual.”\textsuperscript{195} Though it is unclear whether the language of provisions like Maine’s will significantly reform insurers’ procedural requirements for seeking coverage of gender-affirming care, it provides a starting point for potential litigation or a threat of it.

C. Avoid or Limit Expansive Religious Liberty Laws

Another means of protecting access to gender-affirming care is to avoid or limit the expansive religious liberty laws that threaten to leave enormous loopholes for purportedly religious justifications for discrimination. To be sure, current trends in Free Exercise Clause jurisprudence may ultimately erase the distinction between universal federal constitutional commands and state-by-state statutory commands, leaving states no choice but to grant religious exemptions broadly.\textsuperscript{196} But because the federal RFRA does not apply to state laws,\textsuperscript{197} states have some room—at least for now—to decide for themselves the extent to which they want purportedly religious insurers and employers to be able to claim religious exemption from healthcare regulations that require coverage of gender-affirming care.

Many states already have their own “mini-RFRA” statutes with provisions similar to the federal version,\textsuperscript{198} but state legislatures are free to repeal or amend them at any time. While wholesale repeal is likely not a politically pal-

\textsuperscript{193} Domestic/Foreign Insurers Bulletin No. 86, supra note 171.
\textsuperscript{194} MSB 18-10-23-A, Revision to the Medical Assistance Benefits Rule Concerning Transgender Services, Section 8.735, Co.O. MED. SERVS. Bd. (June 30, 2019), https://www.sos.state.co.us/CCR/Upload/AGORquest/AdoptedRules32019-00128.doc [https://perma.cc/P5HA-97UG].
\textsuperscript{195} ME. REV. STAT. tit. 24-A, § 4320-L.
\textsuperscript{197} See City of Boerne v. Flores, 521 U.S. 507 (1997).
atable step, the more progressive-leaning states that have RFRA—such as Connecticut, Illinois, and New Mexico—could make modest amendments to limit the statutes’ reach. For example, the amended RFRA statutes could explicitly exempt certain core antidiscrimination protections from the statutes’ reach. Or, going not quite so far, they could provide that the state has a compelling interest in eliminating healthcare discrimination, providing access to gender-affirming care, or the like. The devil would of course be in the details of the language, but the bottom line is that states with existing RFRA statutes have wide flexibility to amend them in a manner that retains the core RFRA framework while closing the door to wide-ranging healthcare discrimination claims by insurers and employers.

Progressive-leaning states that do not yet have RFRA—such as New York, Massachusetts, Vermont, New Hampshire, Maine, Minnesota, Colorado, California, Oregon, Washington, and Hawaii—have the easier option to simply continue to resist the periodic waves of RFRA enactment that have occurred over the past three decades.

D. Create External Appeal Procedures Under Which State Agencies Select and Assign IROs

As discussed in Part I, the ACA leaves states the option to enact external appeal procedures that, if compliant with NAIC minimum standards, become binding on health plans that are not subject to ERISA preemption. In states that go beyond the bare minimum federal procedures and enact their own procedures pursuant to the NAIC Model Act, IROs’ conflict of interest is mitigated by two things. First, under the NAIC Model Act, state government agencies select and assign IROs for external appeals.199 Second, the NAIC Model Act instructs IROs to consult clinical reviewers who are “expert[s] in the treatment of the covered person’s medical condition”—potentially minimizing the likelihood that IROs will favor minimally qualified reviewers who tend to reject claims.200 (Even still, though, the IRO is required only to “consider” the clinical reviewer’s opinion, and an IRO adjudicator with no specialized medical training can make the final call and can disagree with a reviewer’s opinion, except with respect to experimental treatments.)201

In contrast, if a state opts not to enact NAIC-compliant standards, health plans need only follow the federal minimum procedures, under which the health plans themselves select and maintain contracts with IROs.202 Thus, for states without NAIC-compliant external appeal procedures, the IROs remain

199 Supra note 124.
200 UNIF. HEALTH CARRIER EXTERNAL REV. MODEL ACT § 13(B)(1) (NAT’L ASS’N INS. CARRIERS 2010).
201 Id. § 8(D)(2); see also id. § 10(J)(2) (providing that an IRO “shall make” the decision recommended by a majority of clinical reviewers with respect to experimental treatments).
202 See 45 C.F.R. § 147.136(c)(1).
open to a substantial conflict of interest, in that they have an incentive to develop reputations for stingy granting of health claims.

Great progress has already been made on this front. At present, all but six states—Alabama, Florida, Georgia, Pennsylvania, Texas, and Wisconsin—have enacted NAIC-compliant external appeal procedures. That is, in most states, state agencies select IROs. But for the six holdout states, enacting NAIC-compliant procedures remains a straightforward way to reduce conflicts of interest in the adjudication of medical necessity, including for gender-affirming care.

E. Require Medical Doctors, Giving Weight to Treating Physicians’ Views, to Make Medical Necessity Determinations

States can dampen conflicts of interest by requiring that medical necessity determinations—in all or some circumstances—be made by medical doctors retained by health plans or IROs, with weight given to treating physicians’ views. Rather than merely “considering” the “opinion” of qualified medical reviewers, as the rules in many states currently provide, IROs would be required to adhere to decisions rendered by those reviewers. Admittedly, such a requirement would not eliminate conflicts. As discussed above, any person, including a doctor, working for a health plan or its agent will feel some pressure to provide results that please the health plan. Exactly how differently doctors approach claims adjudication in comparison to non-doctors is difficult, if not impossible, to quantify using public data. But because of their medical training, the ethics of the medical profession, and the economic security that many doctors have in comparison to other claims adjudicators, that pressure is very likely mitigated to some degree. Somewhat lower, too, is the likelihood that trained medical professionals will be influenced by common misconceptions about gender-affirming care.

Several states have already shown that a requirement of adjudication by medical professionals can be achieved. In Arizona, medical necessity determinations must be made by a “physician, provider or other health care professional.” Florida law provides that any medical necessity determination can be appealed to a “to [a] licensed physician” retained by the insurer. In the context of managed care entities such as HMOs, New Jersey requires that


205 See supra note 201.


207 FLA. STAT. ANN. § 627.6141 (1996); see also id. § 641.51 (same requirement for HMOs).
of claims based on medical necessity “shall be made by a physician.”\textsuperscript{208} And in Washington, “[o]nly clinical reviewers may determine whether a service . . . is medically necessary and appropriate.”\textsuperscript{209} Other states are more specific about decision-makers’ credentials. In Alaska, medical necessity denials “may only be made by a health care provider trained in that specialty or subspecialty and licensed to practice in this state after consultation with the covered-person’s health care provider.”\textsuperscript{210} California law provides that only “a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider” may “deny or modify requests for authorization of health care services for an insured for reasons of medical necessity.”\textsuperscript{211} And for California Medicaid plans, “[t]he determination of whether a service requested by a transgender beneficiary is medically necessary . . . must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the beneficiary’s primary care provider.”\textsuperscript{212}

Even in some of those states, there is room for improvement. Terms like “health care professional” and “health care provider” might be too broad and allow health plans to utilize adjudicators with very little medical training. Alaska’s requirement of “specialty or subspecialty” training is helpful, given that the details of transgender healthcare are unfamiliar to many medical professionals, but still potentially too vague, given that health plans might decide to define “specialty” at too high a level of generality and allow, for example, a surgeon with no background in transgender care to make medical necessity determinations as to transgender claimants.\textsuperscript{213} California’s statutory requirement of competence in the “specific clinical issues involved” is perhaps a slight further improvement, but the most helpful specificity comes from the transgender-specific guidelines that California sets out for Medicaid plans.

In light of the unusually high degree of controversy and misunderstanding that surrounds gender-affirming care, progressive states might find it advisable to customize the requirements for gender-affirming care, as California Medicaid rules do. Requirements tailored specifically to gender-affirming care would make sense, given that until quite recently most health plans categorically excluded gender-affirming care; it is therefore reasonable to place less trust in health plan adjudicators to make purely medically based decisions about gender-affirming care than about most care. One option would be for states to

\textsuperscript{211} Cal. Ins. Code § 10123.135.
\textsuperscript{212} All Plan Letter 16-013, supra note 170.
\textsuperscript{213} See Daniel Skinner, Defining Medical Necessity Under the Patient Protection and Affordable Care Act, 73 PUB. ADMIN. REV. S49 (2013) (“The creation of an LGBT-sensitive medical necessity standard should involve recruiting LGBT-sensitive—and possibly even LGBT-identifying—physicians.”); supra note 35 (sources describing the lack of expertise about gender-affirming care among most doctors).
require that medical necessity decisions be made by medical doctors only in the context of gender-affirming care and possibly other commonly misunderstood types of care. Or they might require a higher degree of specialization for doctors who make decisions about gender-affirming care: limiting it, for example, to those licensed in relevant specialties like endocrinology or even to those with sufficient practice experience providing gender-affirming care.

Another improvement would be to give greater weight to treating physicians’ decisions, rather than allowing health plans to simply ignore a treating physician’s view and replace it with the views of a physician employed by the health plan.\textsuperscript{214} States could stop far short of giving dispositive weight to a treating physician’s decision—an extreme rule that would bring back the cost-containment concerns of the 1960s.\textsuperscript{215} Instead, for example, states could create a burden-shifting presumption: if the claimant’s treating physician has deemed a treatment medically necessary, the claim is immediately subject to external review in which the health plan bears the burden of proving that the treating physician is objectively wrong. Arkansas has done something similar in its Medicaid program, creating a “presumption in favor of the medical judgment of the performing or prescribing physician in determining medical necessity of treatment.”\textsuperscript{216} Hawaii and Louisiana statutes prohibit HMOs from using review standards that “impinge upon the independent medical judgment of the treating health care provider,” an interesting albeit vague requirement that remains untested in courts.\textsuperscript{217} Curiously, a 2020 Virginia law contains an internal tension on this issue: it prohibits insurers from denying “medically necessary transition-related care,” defined as “any medical treatment prescribed by a licensed physician for treatment of gender dysphoria,” but then disclaims “restrict[ing] a health carrier from determining, whether a particular health care service is medically necessary.”\textsuperscript{218}

And, again, given the heightened considerations specific to gender-affirming care (and perhaps other forms of care), states could be selective in imposing such a treating-physician presumption only with respect to certain care. With the caveat again that the exact impact of such reforms has yet to be tested, some progress has already occurred at the state level. Colorado regulators have interpreted state law to require insurers to provide coverage to transgender people on equal terms as to “medically necessary services, as de-

\textsuperscript{215} See supra Part I.B.
\textsuperscript{216} Ark. Code Ann. § 20-77-1708.
\textsuperscript{218} VA. CODE ANN. § 38.2-3449.1.


F. Expand Access to Telemedicine by Relaxing Interstate Licensing Requirements

As the COVID-19 pandemic has underscored, the benefits of telemedicine are not unique to gender-affirming care. But they are especially important in the context of gender-affirming care, given the exceptional difficulty that many transgender people have in finding transgender-competent psychotherapists, primary care doctors, endocrinologists, and other specialists in their regions. Some services, such as surgeries, will of course always be beyond the reach of telemedicine. Even for surgical services, though, telemedicine can lay groundwork by providing people with the referrals, letters, and other documentation necessary to attain coverage for surgeries.

States have a crucial role to play here. One hopes that the federal government will continue its COVID-instigated relaxation of certain federal regulations, such as HIPAA’s strict privacy standards, that pose challenges for telemedicine. But states, with their power over licensing physicians and psychologists, can also act. In response to COVID-19, many states have temporarily relaxed their licensing requirements, thereby allowing out-of-state medical professionals to provide services to in-state patients. Extending some or all of those modifications to the post-COVID world would go a long way towards making gender-affirming healthcare more accessible. So, too, would universal participation in interstate compacts that streamline the process for physicians and psychologists to become licensed in new states. Many states al-

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220 The State of New Hampshire, Insurance Department, Gender Identity Discrimination Prohibited, BULLETIN NO. INS 20-033-AB, N.H. INS. DEp’T (June 8, 2020) (“Any offered services . . . must be provided to all individuals for whom a medical provider, in consultation with the individual patient, has determined that the services are medically necessary . . . .”), https://www.nh.gov/insurance/media/bulletins/2020/documents/ins-20-033-ab-gender-identity-discrimination-prohibited.pdf [https://perma.cc/7P5C-FJ9S].

221 See supra notes 33, 150–51 and accompanying text.


ready participate, but holdouts, including several socially progressive states like California, Connecticut, Delaware, Hawaii, Massachusetts, New York, Oregon, and Rhode Island, have left large holes in the map.\textsuperscript{224}

G. Prohibit Discretionary Clauses

States can prohibit so-called “discretionary clauses” in health plans that insulate adjudicators’ decisions from all but highly deferential judicial review under the “abuse of discretion” standard. As discussed above, such clauses distort health plan adjudicators’ incentives and create a bias toward denying claims that might well be meritorious. Although discretionary clauses will remain a feature of self-insured plans to which ERISA preemption applies, states are under no obligation to permit such clauses in fully insured plans that are subject to state insurance regulation.\textsuperscript{225}

Several states already ban discretionary clauses in some or all health insurance policies. Eight states—California, Colorado, Maine, Minnesota, Rhode Island, Utah, Vermont, and Wyoming—have done so by statute.\textsuperscript{226} Fourteen additional states—Arkansas, Hawaii, Idaho, Illinois, Indiana, Kentucky, Michigan, New Hampshire, New Jersey, New York, Oregon, South Dakota, Texas, and Washington—have done so through regulatory action.\textsuperscript{227} Although the progress is encouraging, a majority of states still permit discretionary clauses in fully insured health plans. And for the states that have enacted bans only through regulation, the bans can more easily be repealed as political winds change or lobbying efforts succeed. Any state that considers itself a supporter of transgender rights should consider enacting a statutory ban on discretionary clauses.


\textsuperscript{225} See Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) (finding that ERISA preemption did not apply to similar provision in fully insured plan); see also Standard Ins. Co. v. Morrison, 584 F.3d 837, 845 (9th Cir. 2009) (upholding state ban on discretionary clauses).


H. Eliminate or Limit Requirements to Exhaust Internal Appeals

A final step that progressive states could take to make healthcare claims more accessible to all people, including transgender individuals, is to eliminate or limit legal requirements to exhaust internal appeals before pursuing independent external review by an IRO. Although most states have not yet moved in this direction, there is good reason to do so.

The benefits of internal appeals are dubious—especially in the context of decisions as to transgender healthcare, about which one might be especially skeptical of health plan administrators’ objectivity. Because external IRO review is more independent than internal review, no less expert than internal review, and conducted on a purportedly de novo basis, what precisely does internal review add to the process, other than complexity, paperwork, and opportunities for claimants to lose steam before they reach independent review? The multiple layers of review—often two internal appeals, followed by the external IRO appeal—are especially redundant within the many health plans that hire the same IRO companies to conduct their “internal” reviews.\(^228\)

States can choose to scale back exhaustion requirements; federal law does not mandate them for plans that follow state appeal procedures. ACA regulations expressly contemplate scenarios in which the claimant need not exhaust the internal appeals process before pursuing an external appeal under state law, as do the NAIC standards.\(^229\) States have the option to, in effect, altogether eliminate mandatory internal appeals by eliminating the exhaustion requirement. Missouri has already done so for managed care health plans.\(^230\) Or states could instead pursue a middle course. States could, for example, deem internal appeals exhausted after a single level of internal appeal. And as with Part II.E’s proposal that review be must conducted by doctors, a reasonable basis exists for states to single out gender-affirming care and possibly other categories or care for expedited review by eliminating exhaustion requirements for only those categories.

**CONCLUSION**

Progressive states should take advantage of their prerogative to regulate large swaths of the healthcare market in ways that, in addition to improving all

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\(^{228}\) *See supra* note 80.

\(^{229}\) 45 C.F.R. § 147.136(c)(2)(iii) (2021) (“To the extent the State process requires exhaustion of an internal claims and appeals process. . .”); Unif. Health Carrier External Rev. Model Act § 7 (Nat’l Ass’n Ins. Carriers 2010) (“States that do not require exhaustion of the internal grievance process prior to filing a request for external review should not adopt this [exhaustion] section.”).

consumers’ experience, will have an especially important impact on the transgender community’s access to reliable, affordable gender-affirming care. The many options explored in this Article are only some of the possible improvements that state legislators and regulators might imagine. The day may come when Congress will revisit federal healthcare laws, and the federal judiciary will interpret them, in a manner that addresses the issues identified in this Article on a uniform national scale. Until then, responsibility rests with the states.