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AB 5193 CON

Testimony of
Quinnipiac University School of Law Legal Clinic

On Behalf of

Northeast Medical Student Queer Alliance
Quinnipiac University School of Law OutLaws
UConn Schools of Medicine and Dental Medicine Reach Out
UConn School of Law Lambda Law Society
Yale School of Medicine OutPatient
Yale Law School OutLaws

In Opposition to House Bill 5193

Real Estate and Insurance Committee
February 24, 2015

Good afternoon distinguished committee members. My name is Ali Toumekian, and I am a resident of Hamden and a second-year law student at the Quinnipiac University School of Law. The testimony that I will offer today in opposition to House Bill 5193 is truly a joint effort, because I am here today on behalf of LGBT organizations at law schools and medical schools throughout Connecticut and the northeast: Northeast Medical Student Queer Alliance, Quinnipiac University School of Law OutLaws, UConn Schools of Medicine and Dental Medicine Reach Out, UConn School of Law Lambda Law Society, Yale School of Medicine OutPatient, and Yale Law School OutLaws.

As discussed below, Gender Dysphoria (GD) is a serious medical condition that can be ameliorated through medically necessary treatments such as Gender Reassignment Surgery (GRS). By permitting insurers to refuse coverage for GRS, H.B. 5193 is inconsistent with Connecticut's mental health parity laws, which mandate insurance coverage for the medically necessary treatment of mental health conditions. H.B. 5193 is also inconsistent with Connecticut's antidiscrimination laws, which prohibit discrimination based on "gender identity or expression." Furthermore, by permitting insurers to deprive transgender individuals—and *only* transgender individuals—of access to coverage for medically necessary treatment, H.B. 5193 may well violate equal protection principles under the federal and state constitutions. This is especially true given that the cost of covering GRS is de minimus. Lastly, H.B. 5193 violates public policy by putting transgender lives at risk and sending a strong symbolic message that transgender lives are not worth protecting.

For all of these reasons, we oppose H.B. 5193.

I. GENDER DYSPHORIA IS A SERIOUS MEDICAL CONDITON THAT CAN BE AMELIORATED THROUGH MEDICAL TREATMENT.

Gender Dysphoria (GD) is a serious medical condition. If left untreated, it can result in clinically significant psychological distress, debilitating depression and—for some people

without access to appropriate medical care and treatment, including GRS—suicidality and death.¹

To understand the GD diagnosis and its medically necessary treatment, it is first helpful to understand the meaning of “transgender.” A transgender person is someone whose gender identity—that is, an individual’s internal sense of being male or female—does not align with his or her assigned sex at birth.² Usually, people born with the physical characteristics of males psychologically identify as men, and those with the physical characteristics of females psychologically identify as women. However, for a transgender person, this is not true; the person’s body and the person’s gender identity do not match.³ A growing body of medical research suggests that this incongruence is caused by “genetics and/or in utero exposure to the ‘wrong’ hormones during the development of the brain, such that the anatomic physical body and the brain develop in different gender paths.”⁴

For many transgender people, this incongruence between gender identity and assigned sex does not interfere with their lives; they are completely comfortable living just the way they are.⁵ For some transgender people, however, the incongruence results in gender dysphoria—i.e., a feeling of stress and discomfort with one’s assigned sex.⁶ Such gender dysphoria, if clinically significant and persistent, is a serious medical condition that can be ameliorated through medical treatment.⁷

A. GD is widely recognized by the medical community as a serious medical condition that can be ameliorated through medical treatment.

The concept of gender dysphoria as a serious medical condition first emerged in the 1950’s.⁸ At that time, Dr. Harry Benjamin, a New York endocrinologist, began treating people

¹ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 454-55 (5th ed. 2013) [hereinafter “DSM-5”]; *id.* at 451 (“[M]any are distressed *if* the desired physical interventions by means of hormone and/or surgery are not available.”).

² *See, e.g.*, DSM-5, *supra* note 1, at 451; U.S. OFFICE OF PERSONNEL MANAGEMENT, GUIDANCE REGARDING THE EMPLOYMENT OF TRANSGENDER INDIVIDUALS IN THE FEDERAL WORKPLACE [hereinafter OPM GUIDANCE], <http://www.opm.gov/policy-data-oversight/diversity-and-inclusion/reference-materials/gender-identity-guidance/>.

³ DSM-5, *supra* note 1, at 452-53.

⁴ Christine Michelle Duffy, *The Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973*, in GENDER IDENTITY AND SEXUAL ORIENTATION DISCRIMINATION IN THE WORKPLACE: A PRACTICAL GUIDE at 16-77 (Christine Michelle Duffy ed. Bloomberg BNA 2014) (discussing recent medical studies); *see also* DSM-5, *supra* note 1, at 457 (discussing genetic and, possibly, hormonal contribution to GD); *id.* at 20 (defining “mental disorders” to include dysfunctions of “biological” and “developmental”—as well as “psychological”—processes underlying mental functioning).

⁵ *See* Duffy, *supra* note 4, at 16-10; *see also* DSM-5, *supra* note 1, at 453 (stating that, in addition to a marked incongruence between gender identity and assigned sex, individuals with gender dysphoria exhibit “distress about this incongruence”).

⁶ DSM-5, *supra* note 1, at 451 (“Gender dysphoria as a general descriptive term refers to an individual’s affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category.”).

⁷ *See id.*

⁸ *See* Jack Drescher et al., *Minding the body: Situating gender identity diagnoses in the ICD-11*, INTERNATIONAL REVIEW OF PSYCHIATRY, at 569 (Dec. 2012), available at <http://atme-ev.de/download/psychoszuICD11.pdf>; Dallas Denny, *Transgender Communities of the United States in the Late Twentieth Century*, in TRANSGENDER RIGHTS 175

struggling with gender identity issues by providing them with hormonal therapy and referrals for surgery.⁹ In 1966, in his influential treatise, “The Transsexual Phenomenon,” Dr. Benjamin defined “transsexualism” as a “syndrome” that results in one’s being “deeply unhappy as a member of the sex (or gender) to which he or she was assigned by the anatomical structure of the body, particularly the genitals.”¹⁰ In 1969, a medical protocol for gender reassignment was developed and, in the ensuing decade, over forty university-affiliated gender programs sprang up across the U.S., providing treatment, including GRS, to individuals with gender identity issues.¹¹

In 1980, the American Psychiatric Association introduced the GD diagnosis in the third edition of the DSM.¹² For over thirty-five years, the DSM has recognized GD as a serious health condition.¹³ According to the DSM-5, published in 2013, GD is characterized by: (1) a marked incongruence between one’s gender identity and one’s assigned sex, which is often accompanied by a strong desire to be rid of one’s primary and secondary sex characteristics and/or to acquire primary/secondary sex characteristics of the other gender; and (2) intense emotional pain and suffering resulting from this incongruence.¹⁴ Among adolescents and adults, GD often begins in early childhood, around the ages of 2-3 (“Early onset gender dysphoria”), but it may also occur around puberty or even later in life (“Late-onset gender dysphoria”).¹⁵ If left medically untreated, GD can result in debilitating depression, anxiety and, for some people, suicidality and death.¹⁶ In its recent adoption of a regulation allowing Medicaid coverage for GRS and related services and treatments, Connecticut’s Department of Social Services acknowledged the grave consequences of excluding insurance coverage for GD. “[W]ithout medically necessary treatment,” the Department stated, “individuals may experience clinical depression, loss of self-esteem, serious self-harm and suicide.”¹⁷

(2006). Although psychiatric and medical theorizing about gender dysphoria began in the Western world in the 19th century, and physicians in Europe began performing gender reassignment surgery as early as the 1920’s, gender dysphoria and gender reassignment surgery remained little known until 1952, when the U.S. media sensationally reported ex-G.I. George Jorgensen undergoing gender reassignment surgery in Denmark and returning to the U.S. as Christine Jorgensen. Drescher et al., *supra* note 8, at 569.

⁹ Denny, *supra* note 8, at 175.

¹⁰ HARRY BENJAMIN, M.D., THE TRANSSEXUAL PHENOMENON 11-12 (1966), available at <http://www.mut23.de/texte/Harry%20Benjamin%20-%20The%20Transsexual%20Phenomenon.pdf>.

¹¹ Denny, *supra* note 8, at 175-76.

¹² AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 261-66 (3rd ed.1980).

¹³ The international medical community similarly recognizes GD as a serious medical condition. The International Classification of Diseases (ICD), published by the World Health Organization pursuant to a consensus of 194 member states, has classified GD as a mental health condition since 1975. See Drescher, *supra* note 8, at 570.

¹⁴ See DSM-5, *supra* note 1, at 452 (“The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.”); *id.* at 453 (stating that, in addition to marked incongruence, “[t]here must also be evidence of distress about this incongruence”).

¹⁵ DSM-5, *supra* note 1, at 455-56.

¹⁶ *Id.* at 454-55.

¹⁷ STATE OF CONNECTICUT, DEPARTMENT OF SOCIAL SERVICES, NOTICE OF DECISION TO TAKE ACTION ON PROPOSED REGULATION (2014), http://www.sots.ct.gov/sots/lib/sots/regulations/notices_of_intent/nod_2014_1204_01.pdf.

Fortunately, like many other medical conditions, GD can be ameliorated through medical treatment.¹⁸ There is no single course of medical treatment that is appropriate for every person with GD. Instead, the World Professional Association For Transgender Health, Inc. (“WPATH”) (formerly known as “The Harry Benjamin International Gender Dysphoria Association, Inc.”), has established internationally accepted Standards of Care (“SOC”) for the treatment of people with GD.¹⁹ The SOC were originally approved in 1979 and have undergone seven revisions through 2012. As part of the SOC, many transgender individuals with GD undergo a medically-recommended and supervised gender transition in order to live life consistent with their gender identity.²⁰

The current SOC recommend an individualized approach to gender transition, consisting of a medically-appropriate combination of hormone therapy, “living part time or full time in another gender role, consistent with one’s gender identity,” gender reassignment surgery (“GRS”), and/or psychotherapy.²¹ Living consistent with one’s desired gender role consists of “present[ing] consistently, on a day-to-day basis and across all settings of life, in [one’s] desired gender role,” which is “based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.”²² To complete their medical transition, some transgender individuals may only need to live part time or full time in their desired gender role without undergoing hormone therapy or surgery.²³ Others may decide with their health care provider that it is medically necessary for them to undergo hormone therapy and/or gender reassignment surgery as well.²⁴ The correct course of treatment for any given individual—in order for the patient to achieve genuine and lasting comfort with his or her sex—can only be determined by the treating physician and the patient.²⁵

The American Medical Association (AMA), the American Psychiatric Association, and the American Psychological Association, among others, have each acknowledged the necessity of medical interventions to assist transgender individuals. According to the AMA,

¹⁸ See WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, STANDARDS OF CARE 5 (7th ed., 2012) [hereinafter “SOC”], available at http://admin.associationonline.com/uploaded_files/140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf (“Gender dysphoria can in large part be alleviated through treatment.”); see also DSM-5, *supra* note 1, at 451 (stating that “many [individuals] are distressed if the desired physical interventions by means of hormone and/or surgery are not available”) (emphasis added).

¹⁹ See SOC, *supra* note 18, at 1.

²⁰ See *id.* at 9-10; see also OPM GUIDANCE, *supra* note 1 (discussing gender transition).

²¹ SOC, *supra* note 18, at 9.

²² *Id.* at 60-61.

²³ *Id.* at 8 (“[W]hile many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither.”); see also DSM-5, *supra* note 1, at 454 (discussing those who resolve incongruence between gender identity and assigned sex “without seeking medical treatment to alter body characteristics”) (emphasis added).

²⁴ SOC, *supra* note 18, at 10; see also DSM-5, *supra* note 1, at 453 (recognizing “cross-sex medical procedure[s] or treatment regimen[s]—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender . . .”).

²⁵ SOC, *supra* note 18, at 5 (“Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person.”).

An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID Health experts in GID, including WPATH, have rejected the myth that such treatments are “cosmetic” or “experimental” and have recognized that these treatments can provide safe and effective treatment for a serious health condition. . . . Physicians treating persons with GID must be able to provide the correct treatment necessary for a patient in order to achieve genuine and lasting comfort with his or her gender, based on the person’s individual needs and medical history. . . . Delaying treatment for GID can cause and/or aggravate additional serious and expensive health problems, such as stress-related physical illnesses, depression, and substance abuse problems, which further endanger patients’ health and strain the health care system.²⁶

Given the demonstrated safety, effectiveness, and medical necessity of GRS and related treatments, the AMA:

- “opposes limitations placed on patient care by third-party payers when such care is based upon sound scientific evidence and sound medical opinion”;
- “support[s] public and private health insurance coverage for treatment of gender identity disorder”; and
- “oppose[s] categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician.”²⁷

The American Psychiatric Association (APA) has similarly concluded that “appropriately evaluated transgender and gender variant individuals can benefit greatly from medical and surgical gender transition treatments,” and that “[I]ack of access to care adversely impacts the mental health of transgender and gender variant people.”²⁸ The APA therefore “supports both public and private health insurance coverage for gender transition” and “[o]pposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician.”²⁹ The American Psychological Association likewise “recognizes the efficacy, benefit and medical necessity of gender transition treatments for appropriately evaluated

²⁶ AMERICAN MEDICAL ASSOCIATION, REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS 1 (2008) [hereinafter AMA STATEMENT], available at http://www.tgender.net/taw/ama_resolutions.pdf; accord. AMERICAN PSYCHIATRIC ASSOCIATION, POSITION STATEMENT ON ACCESS TO CARE FOR TRANSGENDER AND GENDER VARIANT INDIVIDUALS (2013) [hereinafter APA STATEMENT], available at <http://www.aglp.org/pages/LGBTPositionStatements.php>; AMERICAN PSYCHOLOGICAL ASSOCIATION, TRANSGENDER, GENDER IDENTITY, & GENDER EXPRESSION NON-DISCRIMINATION (2008) [hereinafter AM. PSYCH. ASSOC. STATEMENT], available at <http://www.apa.org/about/policy/transgender.aspx>; see also LAMBDA LEGAL, PROFESSIONAL ORGANIZATION STATEMENTS SUPPORTING TRANSGENDER PEOPLE IN HEALTH CARE (2012), http://www.lambdalegal.org/sites/default/files/publications/downloads/fs_professional-org-statements-supporting-trans-health_1.pdf.

²⁷ AMA STATEMENT, *supra* note 26.

²⁸ APA STATEMENT, *supra* note 26.

²⁹ *Id.*

individuals and calls upon public and private insurers to cover these medically necessary treatments.”³⁰

B. Gender Dysphoria is widely recognized by courts as a serious medical condition that can be ameliorated through medical treatment.

Federal courts have consistently recognized GD as a serious medical condition that can be ameliorated through medical treatment. For example, in the prisoner context, all seven of the U.S. Courts of Appeals that have been presented with the question have found that GD poses a “serious medical need” for purposes of the Eighth Amendment.³¹ Many federal courts have ruled likewise in the context of civil commitment.³² In 2010, the United States Tax Court held that GD “is a serious, psychologically debilitating condition” within the meaning of the Tax Code and that the costs of gender reassignment surgery are deductible—a decision in which the IRS subsequently acquiesced.³³ And on May 30, 2014, the U.S. Department of Health and Human Services Departmental Appeals Board likewise acknowledged that “GD is a serious medical condition” and invalidated its 1989 determination denying Medicare coverage of all gender reassignment surgery.³⁴ Many state courts and agencies have similarly held that GD is a serious medical condition under state disability antidiscrimination laws.³⁵

II. H.B. 5193 IS INCONSISTENT WITH CONNECTICUT STATUTES AND MAY VIOLATE FEDERAL AND STATE EQUAL PROTECTION PRINCIPLES.

By permitting insurers to refuse coverage for GRS, H.B. 5193 is inconsistent with multiple Connecticut statutes that protect people with GD. Moreover, by singling out transgender people for disparate treatment, H.B. 5193 may violate equal protection principles under both the federal and state constitutions.

A. H.B. 5193 is inconsistent with Connecticut’s individual and group mental health parity statutes.

Connecticut’s mental health parity statutes require that individual and group health insurance policies “provide benefits for the diagnosis and treatment of mental or nervous conditions . . . as defined in the most recent edition of the American Psychiatric Association’s

³⁰ AM. PSYCH. ASSOC. STATEMENT, *supra* note 26.

³¹ *See, e.g., O’Donnabhain v. C.I.R.*, 134 T.C. 34, 62 (2010) (citing cases); *see also Wolfe v. Horn*, 130 F. Supp. 2d 648, 652-53 (E.D. Pa. 2001) (holding that fact question precluded summary judgment as to whether defendants “were deliberately indifferent to treating Wolfe’s gender identity disorder,” and acknowledging that courts “have consistently considered transsexualism a ‘serious medical need’ for purposes of the Eighth Amendment.”).

³² *See, e.g., Battista v. Clarke*, 645 F.3d 449, 455 (1st Cir. 2011).

³³ *O’Donnabhain*, 134 T.C. at 61, *acquiesced in by* IRS Announcement Relating to *O’Donnabhain*, 2011-47 I.R.B. 789 (IRS ACQ 2011).

³⁴ U.S. Dep’t of Health & Human Servs. Dept’l App. Bd., NCD 140.3, DAB No. 2576, 2014 WL 2558402, at *1, *7-8 (H.H.S. May 30, 2014).

³⁵ *See, e.g., Duffy*, *supra* note 4, at 16-111 to -120 (discussing cases holding the GD is disability under state disability antidiscrimination laws); Br. of Amicus Curiae Pennsylvania Human Relations Commission, *Stacy v. LSI Corp.*, No. 5:10-CV-04693-ER, 2011 WL 10773442 (E.D. Pa. Jan. 3, 2011) (arguing that GD is medical impairment entitled to same protection as other impairments under Pennsylvania disability antidiscrimination law).

‘Diagnostic and Statistical Manual of Mental Disorders.’³⁶ Under these statutes, health insurers are required to pay “covered expenses”—such as “basic hospital expense coverage,” “basic medical-surgical expense coverage,” and “major medical expense coverage”³⁷—for treatment “deemed necessary under generally accepted medical standards.”³⁸

Since 1980, the DSM has listed GD as a mental health condition.³⁹ GD is therefore a “mental or nervous condition” under Connecticut law. As such, health insurers are required to pay covered expenses for medically necessary treatment of GD. For the reasons discussed in Section I, GRS is indisputably “medically necessary” treatment. By permitting insurers to refuse to pay covered expenses for GRS, H.B. 5193 is inconsistent with Connecticut’s mental health parity statutes.

B. H.B. 5193 is inconsistent with Connecticut’s antidiscrimination statutes.

On July 1, 2011, in recognition of the pervasive discrimination experienced by transgender people, Governor Malloy signed into law Public Act 11-55, “An Act Concerning Discrimination,” which adds “gender identity or expression” to Connecticut’s anti-discrimination laws.⁴⁰ These antidiscrimination laws provide a clear and comprehensive mandate for the elimination of discrimination based on gender identity or expression, including discrimination by health insurers.⁴¹ Among other things, these laws prohibit “any person” from “subject[ing] or caus[ing] to be subjected any other person to the deprivation of any rights, privileges or immunities, secured or protected by the Constitution or laws of this state . . . on account of . . . gender identity or expression.”⁴² As Connecticut’s Insurance Department recently stated,

the legislative intent to prohibit discriminatory practices based on gender identity and expression . . . extend[s] to health insurance practices. Accordingly, medically necessary services related to gender dysphoria should *not* be handled differently

³⁶ CONN. GEN. STAT. ANN. § 38a-488a (“Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, ‘mental or nervous conditions’ means mental disorders, as defined in the most recent edition of the American Psychiatric Association’s ‘Diagnostic and Statistical Manual of Mental Disorders.’”); *see also* CONN. GEN. STAT. ANN. § 38a-514 (mandating coverage of “mental or nervous conditions” for “each group health insurance policy”).

³⁷ CONN. GEN. STAT. ANN. § 38a-469.

³⁸ *Id.* §§ 38a-488a(e), 38a-514(e).

³⁹ In 1980, the American Psychiatric Association introduced the GID diagnosis in the third edition of the DSM. In 2013, “Gender Identity Disorder” was removed from the DSM and “Gender Dysphoria” was added.

⁴⁰ An Act Concerning Discrimination, Public Act No. 11-55, 2011 Conn. Acts (Reg. Sess.), *available at* <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00055-R00HB-06599-PA.htm>.

⁴¹ *See* STATE OF CONNECTICUT INSURANCE DEPARTMENT, BULLETIN IC-34, GENDER IDENTITY NONDISCRIMINATION REQUIREMENTS (Dec. 19, 2013) [hereinafter BULLETIN IC-34], http://www.ct.gov/cid/lib/cid/Bulletin_IC-37_Gender_Identity_Nondiscrimination_Requirements.pdf.

⁴² CONN. GEN. STAT. ANN. § 46a-58; *see also id.* § 46a-64 (prohibiting discrimination based on “gender identity or expression” in “public accommodations”); *cf. Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28, 33 (2d Cir. 1999) (holding that “public accommodations” under ADA encompassed more than actual physical structures and included insurance underwriting); *id.* at 32-33 (“We believe an entity covered by Title III [of ADA] is not only obligated by the statute to provide disabled persons with physical access, but is also prohibited from refusing to sell them its merchandise by reason of discrimination against their disability.”).

from medically necessary services for other medical and behavioral health conditions. . . . [L]icensed entities are prohibited from using an exclusion based solely on gender identity or expression, *including an exclusion for gender reassignment and related services*, or otherwise discriminating against insured individuals with gender dysphoria.⁴³

By permitting insurers to refuse coverage for GRS, H.B. 5193 treats medically necessary services for GD differently from medically necessary services for other medical and behavioral health conditions. This is discrimination based on “gender identity or expression” and is therefore inconsistent with Connecticut’s antidiscrimination laws.⁴⁴

C. H.B. 5193 may violate equal protection principles under the federal and state constitutions.

The concept of equal protection under the Fourteenth Amendment and Article 1, § 20 of the Connecticut Constitution prohibits treating similarly situated people differently. H.B. 5193 may offend equal protection principles because it singles out a discrete group—transgender individuals—for disparate treatment by permitting insurers to deprive them, and *only* them, of access to coverage for medically necessary treatment. If a court were to apply heightened scrutiny, as some courts have done when analyzing statutes that impact transgender people,⁴⁵ H.B. 5193 would almost certainly fail because it is not narrowly tailored to serve a compelling or substantially related to an important government interest.

If, on the other hand, a court were to apply the more deferential “rational basis” standard of review, H.B. 5193 may still fail because it represents “a bare . . . desire to harm a politically unpopular group.”⁴⁶ This is especially true given the de minimus costs at stake. Simply put, the number of people who undergo GRS is small, and the costs of such coverage are miniscule. A 2013 survey of 34 companies, conducted by the Williams Institute, confirmed the negligible impact that GRS coverage has on employers’ bottom line. According to the survey, “[e]mployers report very low costs, if any, from adding transition-related coverage to their health benefits plans or from actual utilization of the benefit after it has been added—with many

⁴³ BULLETIN IC-34 (emphasis added).

⁴⁴ See GLMA: Health Professionals Advancing LGBT Equality, *Letter of Testimony in Opposition to HB 5193*, at 3 (Feb. 23, 2015) (“Many medical and surgical services provided to transgender individuals are no different than those provided to the general population. Hormone therapy, Pap smears, prostate exams, mammograms, laboratory tests and surgical treatment, such as chest reconstruction, hysterectomy, orchiectomy and vaginoplasty are already provided to treat a variety of medical conditions. Parity in access to these medically necessary treatments and services for transgender individuals experiencing gender dysphoria is a matter of basic fairness.”).

⁴⁵ See, e.g., *Glenn v. Brumby*, 663 F.3d 1312, 1320 (11th Cir. 2011) (“[G]overnmental acts based upon gender stereotypes . . . must be subjected to heightened scrutiny because they embody ‘the very stereotype the law condemns.’”); *Norsworthy v. Beard*, No. 14-CV-00695-JST, 2014 WL 6842935, at *10 (N.D. Cal. Nov. 18, 2014) (“The Ninth’s Circuit’s conclusion that heightened scrutiny should be applied to Equal Protection claims involving discrimination based on sexual orientation applies with at least equal force to discrimination against transgender people, whose identity is equally immutable and irrelevant to their ability to contribute to society, and who have experienced even greater levels of societal discrimination and marginalization.”) (citations omitted).

⁴⁶ *United States v. Windsor*, 133 S. Ct. 2675, 2693 (2013).

employers reporting no costs at all.”⁴⁷ Significantly, the survey demonstrated that “[f]ew people will utilize transition-related health care benefits when they are provided. . . . While utilization rates depend on the size of the employer, estimates based on the best data gathered in the survey result in annual utilization rates of approximately:

- 1 out of 10,000 employees for employers with 1,000 to 10,000 employees, and
- 1 out of 20,000 employees for employers with 10,000 to 50,000 employees.”⁴⁸

In 2001, the City of San Francisco became the first U.S. municipality to remove transgender access exclusions in its employee health plans. Due to fears of increased costs, especially given San Francisco’s disproportionately large transgender population, the city added a \$1.70 monthly subscriber charge, and imposed a one year enrollment requirement and a \$50,000 surgical cap. Because those fears never materialized and actual costs were minimal, the city dropped those measures and now treats GD-related medical treatment the same as “other medical procedures such as gall bladder removal or heart surgery.”⁴⁹

III. H.B. 5193 VIOLATES PUBLIC POLICY BECAUSE IT DEVALUES TRANSGENDER LIVES.

As the District of Columbia Court of Appeals recently observed, “the hostility and discrimination that transgender individuals face in our society today is well-documented.”⁵⁰ Transgender people face severe and pervasive discrimination in nearly every aspect of their lives, including employment, housing, education, public accommodations, and access to government services.⁵¹ Indeed, our society has so devalued transgender lives that many transgender individuals contemplate taking their own.⁵² Connecticut law should be part of the solution to this discrimination, not part of the problem.

H.B. 5193 violates public policy because it devalues transgender lives in two significant ways. First, by permitting insurers to refuse coverage for GRS, H.B. 5193 puts transgender lives at risk. As the American Psychiatric Association has stated, and as the Connecticut Department of Insurance has acknowledged, GD, if left untreated, can result in debilitating depression, anxiety and even suicidality and death.⁵³ For some people, access to GRS is therefore literally a matter of life and death.

⁴⁷ JODY L. HERMAN, PH.D., THE WILLIAMS INSTITUTE, COSTS AND BENEFITS OF PROVIDING TRANSITION-RELATED HEALTH CARE COVERAGE IN EMPLOYEE HEALTH BENEFITS PLANS, FINDINGS FROM A SURVEY OF EMPLOYERS 1 (September 2013).

⁴⁸ *Id.*

⁴⁹ HUMAN RIGHTS COMMISSION, CITY AND COUNTY OF SAN FRANCISCO, SAN FRANCISCO CITY AND COUNTY TRANSGENDER HEALTH BENEFIT, <http://www.tgender.net/taw/SanFranciscoTGBenefitUpdateMar3106.pdf>.

⁵⁰ *Brocksmith*, 99 A.3d at 698.

⁵¹ *See, e.g.*, JAIME M. GRANT ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY, NAT’L CTR. FOR TRANSGENDER EQUALITY AND NAT’L GAY AND LESBIAN TASKFORCE 2-8 (2011), *available at* http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf, *cited in Brocksmith v. United States*, 99 A.3d 690, 698 n.8 (D.C. 2014).

⁵² *See id.* at 82.

⁵³ *See DSM-5, supra* note 1, at 454-55.

Second, H.B. 5193 sends a strong symbolic message: transgender lives are not worth protecting. As Dr. Stanton C. Honig, a urologist at the Yale School of Medicine, stated in his letter to this Committee, GRS “is a life-changing, life-saving medical intervention.”⁵⁴ And studies show that the costs of covering GRS are de minimus. Surely, these de minimus costs are a small price to pay to guarantee life-changing, life-saving medical treatment for some of Connecticut’s most vulnerable citizens.

IV. CONCLUSION

In conclusion, Connecticut law should not permit insurers to refuse to cover GRS. The people of Connecticut, especially its most vulnerable, deserve better.

Thank you very much for your time and for the opportunity to present this testimony.

On Behalf of:

Northeast Medical Student Queer Alliance
Quinnipiac University School of Law OutLaws
UConn Schools of Medicine and Dental Medicine Reach Out
UConn School of Law Lambda Law Society
Yale School of Medicine OutPatient
Yale Law School OutLaws

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Jenna Lorusso, Law Student
Jenny Flynn, Law Student
Kevin Barry, Supervising Attorney

⁵⁴ Letter from Stanton C. Honig, M.D. to CT Insurance & Real Estate Committee in Opposition to H.B. No. 5193 (Feb. 22, 2015).