

**STATE OF CONNECTICUT  
COMMISSION ON HUMAN RIGHTS & OPPORTUNITIES**

**Declaratory Ruling on  
October 31, 2019 Petition  
Regarding Health Insurers'  
Categorization of Certain Gender  
Confirming Surgeries as Cosmetic**

**BRIEF OF AMICUS CURIAE CONNECTICUT TRANSADVOCACY COALITION**

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On October 31, 2019, Tanya A. Hughes, Executive Director of the Connecticut Commission on Human Rights and Opportunities (CHRO) filed a Petition for a Declaratory Ruling Regarding Health Insurers' Categorization of Certain Gender Confirming Surgeries as Cosmetic (the Petition). By a majority vote of its members present and voting, CHRO agreed on November 13, 2019 to issue a declaratory ruling on the Petition within 180 days. By letter dated January 9, 2020, CHRO granted the application of the Connecticut TransAdvocacy Coalition to file an *amicus* brief in this matter.

## **I. INTRODUCTION**

As it is for all people, access to health care is vitally important – even life-saving – for transgender and gender non-conforming individuals. Having robust health insurance is the single most important element of meaningful access to care. Health insurance plans typically provide a wide array of coverage for all different kinds of care – preventive, routine, emergency, inpatient, chronic and mental health, among many others. The core element common across all these categories is coverage for care when it is medically necessary to the individual enrollee's mental and physical health. So fundamental is this principle that Connecticut law requires all group health plans in the state to include a broad definition of medical necessity.<sup>1</sup> Connecticut further recognizes the importance of access to care for all its residents by requiring coverage

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<sup>1</sup> See Conn. Gen. Stat. § 38a–513c.

for all medically necessary treatment of gender dysphoria, a medical condition that some, though not all, transgender and gender non-conforming individuals experience in their lives.<sup>2</sup>

Yet some health insurance plans have singled out treatment of gender affirming care for differential treatment. As set forth in the Petition, several public employers and the insurers who work with them offer health insurance plans that disregard the medical necessity of ancillary procedures often performed in a course of gender affirming care. Question 1 of the Petition addresses circumstances where an insurance plan categorically excludes coverage in every instance where certain of these treatments are sought as part of gender affirming care, deeming the procedures “cosmetic” (Categorical Exclusion). Question 2 of the Petition is addressed to similar denials of care where the same procedures are generally approved outside of the context of gender affirming care (Comparative Treatment). Question 3 raises the issue of whether insurers responsible for such plans may also fall within the enforcement powers of the CHRO.

The experiences of the Connecticut TransAdvocacy Coalition reveal that the answers to each of these questions ought to fall resoundingly on the side of CHRO’s use of its enforcement authority to strike down Categorical Exclusion and Comparative

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<sup>2</sup> See Connecticut Ins. Comm., Bulletin IC-34: Gender Identity Nondiscrimination Requirements 1 (2013) (Bulletin IC-34); World Professional Association for Transgender Health, *The Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* 5 (2012) (WPATH Standards).

Treatment provisions. Such policies target individuals seeking medically necessary gender affirming care in a manner that flatly contradicts the standard of care. For this reason, the proponents of plans including these provisions have engaged in discriminatory practices under Connecticut law, subjecting their enrollees to less favorable treatment because of their gender identity. The stakes for accessing meaningful gender affirming care are high, the consequences of being turned away can be dire. It is in this atmosphere that the CHRO's mission to establish equal opportunity and justice for all persons within the state must be brought to bear. This mandate is especially paramount where discrimination can be traced to Connecticut's state and local governments and the insurance companies that sell their health care plans, vested as they are with the public trust and responsibility for representing the interest of all Connecticut citizens.

## **II. STATEMENT OF INTEREST OF AMICUS PARTY**

The Connecticut TransAdvocacy Coalition (CTAC) is a grassroots-oriented 501(c)(3) organization dedicated to making Connecticut a safe and tolerant place for transgender and gender non-conforming individuals.<sup>3</sup> We represent a coalition of individuals and organizations that are committed to effecting social change in

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<sup>3</sup> CONNECTICUT TRANSADVOCACY COALITION, <http://www.transadvocacy.org/> (last visited February 7, 2020).

Connecticut.<sup>4</sup> We have a long history of advocating with the State to protect the lives of transgender and gender non-conforming people, and have provided education, training, and testimony before many state agencies, commissions, and hearings in this regard.<sup>5</sup>

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<sup>4</sup> Declaration of Diana Lombardi (attached hereto as Appendix A) at ¶¶ 4-5 (Lombardi Decl.)

<sup>5</sup> See, e.g., *Hearing on HB 5505: An Act Concerning the Updating of State Forms and Applications to Include Nonbinary Gender Option, Before the Government Administration and Elections Committee*, 2019 Leg. (Conn. 2019) (written testimony of Diana Lombardi, Executive Director, Connecticut TransAdvocacy Coalition); *Hearing on SB 58: An Act Concerning Gay and Transgender Panic Defense, Before the Joint Committee on Judiciary*, 2019 Leg. (Conn. 2019) (written testimony of Diana Lombardi, Executive Director, Connecticut TransAdvocacy Coalition); Diana Lombardi, Executive Director, Connecticut TransAdvocacy Coalition, Presentation at Connecticut Coalition to End Homelessness: Safe Shelter and Fair Housing for Transgender Individuals (May 18, 2017), slides available at <http://cceh.org/wp-content/uploads/2017/05/Cultural-Competency-and-Equal-Access-Law.pdf>; *Hearing on HB 7006: An Act Concerning Birth Certificates, Before the Joint Committee on Health*, 2015 (statement by Diana Lombardi). CTAC also provided testimony each year that a house bill was introduced to prohibit discrimination on the basis of gender identity or expression. See, e.g., *Hearing on HB 6599: An Act Concerning Discrimination, Before the Judiciary Committee*, 2011 Leg. (Conn. 2011) (written testimony of Jerimarie Liesegang, Executive Director, Connecticut TransAdvocacy Coalition); *Hearing on HB 6452: An Act Concerning Discrimination, Before the Judiciary Committee*, 2009 Leg. (Conn. 2009) (written testimony of Jerimarie Liesegang, Executive Director, Connecticut TransAdvocacy Coalition); *Hearing on HB 5723: An Act Concerning Discrimination, Before the Judiciary Committee*, 2008 Leg. (Conn. 2008) (written testimony of Jerimarie Liesegang, Executive Director, Connecticut TransAdvocacy Coalition); *Hearing on HB 5597: An Act Concerning Discrimination, Before the Judiciary Committee*, 2006 Leg. (Conn. 2006) (written testimony of Jerimarie Liesegang, Executive Director, Connecticut TransAdvocacy Coalition).

### III. BACKGROUND FACTS

Transgender and gender non-conforming people have historically faced discrimination across the country and within the state of Connecticut.<sup>6</sup> The discrimination remains ongoing, as the circumstances raised by the Petition demonstrate. Many transgender and gender non-conforming people are discriminated against because of their gender identity and/or expression in public accommodations, employment, education, housing, federal and state programs, and in health care coverage and settings.<sup>7</sup> While Connecticut has been a leader in protecting the

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<sup>6</sup> See Katelyn Burns, *It Sucks to Go to the Doctor If You're Trans*, Vox (June 21, 2019), <https://www.vox.com/first-person/2019/6/21/18692924/trump-transphobia-health-care-discrimination-protections>; Oliver Knight, *Catholic Bishops Stopped My Surgery Because I'm Transgender*, ACLU (March 21, 2019), <https://www.aclu.org/blog/lgbt-rights/transgender-rights/catholic-bishops-stopped-my-surgery-because-im-transgender>; *Faces of Breast Cancer: Jay Kallio*, N.Y. TIMES (2014), <https://www.nytimes.com/interactive/projects/well/breast-cancer-stories/stories/717>; Yusef Najafi, *A Life Remembered*, METRO WEEKLY (Dec. 20, 2006), <https://www.metroweekly.com/2006/12/a-life-remembered/> (“[Tyra] Hunter’s story gained national attention in 1995 when it was discovered that rescue workers had interrupted her medical treatment upon discovering she had male genitalia. Instead of providing treatment for Hunter’s severe injuries, rescue workers spent time making derogatory comments.”)

<sup>7</sup> See, e.g., Maya Moore, *Opponents Decry Rollback of Federal Health Care Protections for Transgender People*, THE CT MIRROR, Aug. 6, 2019 (“In Connecticut, one woman was denied health care when she went into the emergency room and they found out she was trans. They told her to go home and take two Aspirin. She later found out she had a broken hip and spine.”). See generally TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY 161, 174-210, 520 (Laura Erickson-Schroth ed., 2014); National Center for Transgender Equality, THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY (2016), <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>.

transgender and gender non-conforming communities, enforcement of these protections has been an ongoing challenge. For example, while insurance companies are prohibited from discriminating against members based on their gender identities, transgender and gender non-conforming people still face discriminatory policies that effectively block them from medically necessary care.<sup>8</sup>

Access to nondiscriminatory health care is particularly important for people who are transgender and gender non-conforming, as it can have positive health outcomes.<sup>9</sup>

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<sup>8</sup> Bulletin IC-34 at 1; Declaration of AJ Eckert, D.O. (attached hereto as Appendix B) at ¶¶ 2-4 (Eckert Decl.).

<sup>9</sup> Access to nondiscriminatory health care coverage can help transgender and gender non-conforming people improve linkage to preventive and primary care and general health outcomes. California's state economic impact analysis of its gender nondiscrimination insurance regulation concluded that antidiscrimination protections would have "a significant beneficial impact on health, welfare and safety[.]" State of California Department of Insurance, *Economic Impact Assessment, Gender Nondiscrimination in Health Insurance*, Reg-2011-00023 at 9 (Apr. 13, 2012) (describing the impact the proposed regulation would have on suicide reduction, mental health outcomes, substance use, and adherence to HIV care). Other studies have confirmed that access to gender affirming care reduces rates of suicidality, major depression, and anxiety in transgender patients. See M. Hassan Murad, et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 *CLINICAL ENDOCRINOLOGY* 214, 214 (2010); see also Tiffany Ainsworth & Jeffrey Spiegel, *Quality of Life of Individuals with and Without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 *QUALITY LIFE RES.* 1019, 1019 (2010). Additionally, access to appropriate care is associated with decreased substance use and improved HIV medication adherence among the transgender population. Jamil Rehman, et al., *The Reported Sex and Surgery Satisfaction of 28 Postoperative Male to-Female Transsexual Patients*, 28 *ARCHIVES SEXUAL BEHAV.* 71, 71 (1999); Jae Sevelius, Adam Carrico & Mallory Johnson, *Antiretroviral Therapy Adherence Among Transgender Women Living with HIV*, 21 *J. ASS'N NURSES AIDS CARE* 256, 256 (2010).

Barriers continue to exist when transgender and gender non-conforming people access gender affirming care.<sup>10</sup> Many health insurance plans include categorical exclusions of certain gender affirming services (Question 1) and/or consider these services cosmetic when used to treat gender dysphoria but medically necessary when used to treat other conditions (Question 2). These policies often target services that address secondary sex characteristics, or characteristics that typically arrive with puberty such as breasts or facial hair.<sup>11</sup> While hormone therapy and genital surgeries can be important parts of transitioning for some transgender and gender non-conforming people, for others, services that address secondary sex characteristics are more crucial to treatment and are medically necessary to address their gender dysphoria.<sup>12</sup> Without access to such services, transgender and gender non-conforming people can face continued trauma related to their gender dysphoria.<sup>13</sup> Transgender and gender non-conforming people in Connecticut work closely with licensed providers to develop individualized treatment

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<sup>10</sup> See, e.g., Lombardi Decl. at ¶¶ 14-15; Eckert Decl. at ¶¶ 9-17.

<sup>11</sup> TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY 98 (Laura Erickson-Schroth ed., 2014) (“The changes that happen due to hormones during puberty, such as increased body hair, changes in voice pitch, and breast development are typically called secondary sex characteristics. For many transgender people, puberty is a difficult time because secondary sex characteristics begin to make us look less and less like the gender with which we identify.”) (emphasis removed).

<sup>12</sup> See, e.g., Ryan Nicholas Gorton & Laura Erickson-Schroth, *Hormonal and Surgical Treatment Options for Transgender Men (Female-to-Male)*, 40 PSYCHIATRIC CLINICS OF NORTH AMERICA 79, 79 (2017) (“Mastectomy is the most common surgery for transgender men as it significantly diminishes gender dysphoria. . .”); WPATH Standards, 52, 54-55, 58 (2012).

<sup>13</sup> See *supra* n.12.

plans, yet insurance plans like those offered by governmental entities stymie this care with non-medically based policies and exclusions.<sup>14</sup>

The proper enforcement of antidiscrimination statutes among the state, its agencies, and municipalities is particularly important in Connecticut where these entities are some of the largest employers in the state.<sup>15</sup> Among employers who alone employ more than one thousand people are the City of Hartford Connecticut, Waterbury Board of Education, Hospital of Central CT-New Britain, UConn Health Center, UConn John Dempsey Hospital, Sgt. John L. Levitow Health Care Center (at the Connecticut Department of Veterans Affairs), the Connecticut Transportation Department, the Connecticut State Police, Connecticut Valley Hospital, Whiting Forensic Hospital, Southern Connecticut State University, Southbury Training School, Fairfield Public School District, and the Connecticut Environmental Protection Department.<sup>16</sup>

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<sup>14</sup> The barriers that transgender and gender non-conforming people in Connecticut face when using their health insurance extend beyond those listed in the notice of declaratory ruling, including non-medically based barriers to care and documentation requirements that far exceed those recommended by professional organizations such as the World Professional Association for Transgender Health. Eckert Decl. at ¶¶ 3, 9-17.

<sup>15</sup> Nearly 222,000 people in Connecticut work for state and local government employers. See CONNECTICUT DEPARTMENT OF LABOR, *State of Connecticut Employment*, LABOR MARKET INFORMATION, <https://www1.ctdol.state.ct.us/lmi/ces/nfstatcm.asp> (last updated Jan. 23, 2020).

<sup>16</sup> CONNECTICUT DEPARTMENT OF LABOR, *Search for Connecticut Employers*, LABOR MARKET INFORMATION, <http://www1.ctdol.state.ct.us/lmi/EmpSearch.asp> (last updated Oct. 7, 2019).

Additionally, the state is home to over two hundred public school districts and nearly 52,000 certified educator full-time equivalents (FTEs).<sup>17</sup> State and local governments are also responsible for enrolling approximately 113,000 students within its 18 public colleges and universities each year, many of whom receive health insurance through their respective schools.<sup>18</sup>

Many transgender and gender non-conforming people find employers in the public sector to be more accepting than those in the private sector, and thus will migrate to this area of employment.<sup>19</sup> However, they still find it difficult to navigate past systemic barriers to care and discriminatory policies.<sup>20</sup> Transgender and gender non-conforming people in Connecticut rely on state agencies – especially the Commission on Human Rights and Opportunities – to hold employers and insurance companies responsible for complying with antidiscrimination statutes. The non-enforcement of such laws, particularly as applied to the State, municipalities, and the insurance companies licensed and contracted to sell these health care plans, would sanction a

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<sup>17</sup> CONNECTICUT DEPARTMENT OF EDUCATION, *Connecticut Education at a Glance*, EDsIGHT: INSIGHT INTO EDUCATION, <http://edsight.ct.gov/> (last accessed Feb. 7, 2020).

<sup>18</sup> See Office of Higher Education, State of Connecticut, 2018 CONNECTICUT HIGHER EDUCATION SYSTEM DATA AND TRENDS REPORT 10 (2018).

<sup>19</sup> Lombardi Decl. at ¶ 9.

<sup>20</sup> Lombardi Decl. at ¶¶ 10-15; Eckert Decl. at ¶¶ 9-17.

detrimental and illegal practice of discriminating against transgender and gender non-conforming people in Connecticut.

#### **IV. ARGUMENT**

##### **A. Each of the Types of Entities Presented in the Petition Are Subject to the Statutes Enforced By the CHRO**

The Commission has the duty to “[i]nvestigate and proceed in all cases of discriminatory practices as provided in [Chapter 814c].” Conn. Gen. Stat. § 46a–56(a)(3). Chapter 814c includes: § 46a–60, which regulates discriminatory employment practices; § 46a–71, which regulates discriminatory practices by state agencies; and § 46a–64, which regulates discriminatory public accommodations practices. The Commission’s duty also includes “monitor[ing] state contracts to determine whether they are in compliance” with antidiscrimination statutes. § 46a–46(a)(5). Viewing the questions presented by the Petition through the lens of the identity of the person or entity regulated yields affirmative answers in each case.

##### *1. The State of Connecticut, its agencies, and its municipalities are subject to the Commission’s jurisdiction for enforcement of antidiscrimination laws.*

State agencies and entities, as well as all municipalities, are regulated entities under the Connecticut Fair Employment Practices Act, codified at § 46a–60 (CFEPA). Under CFEPA, it is “discriminatory . . . [f]or an employer, by the employer or the employer’s agent, . . . to discriminate against [an employee] in compensation or in terms, conditions or privileges of employment because of the individual’s . . . gender identity.” Conn. Gen. Stat. § 46a–60(b). Chapter 814c of the Connecticut General Statutes, within which CFEPA is codified, defines “employer” to include “the state and all political subdivisions.” Conn. Gen. Stat. § 46a–51(10). This definition is interpreted

to be “inclusive” relative to federal law. *Wasik v. Stevens Lincoln-Mercury, Inc.*, 2000 WL 306048, at \*6 (D. Conn. 2000). Courts have observed that the state employment discrimination statutes extend liability to employers unless otherwise excepted by the statute’s plain text. *Miner v. Town of Cheshire*, 126 F. Supp. 2d 184, 203 (D. Conn. 2000). Connecticut and its municipalities are therefore subject to § 46a–60, bringing nearly 222,000 public employees within the umbrella of its protection.<sup>21</sup>

Connecticut’s state agencies are likewise subject to § 46a–71. The text of this statute – as is the case with CFEPA – does not exclude public entities from its scope. It requires that “[a]ll services of every state agency shall be performed without discrimination . . . based upon . . . gender identity.” Conn. Gen. Stat. § 46a–71(a) (emphasis added). Nor is it permissible for “any state agency [to] become a party to any agreement, arrangement or plan which has the effect of sanctioning discrimination.” Conn. Gen. Stat. § 46a–71(b). Indeed, the Connecticut Supreme Court has held that an “action pursuant to § 46a–99,” the statutory section providing for a cause of action arising from violations of § 46a–71, “is directed at discrimination by state agencies, such as the University of Connecticut.” *Gay & Lesbian Law Students Ass’n at Univ. of Connecticut Sch. of Law v. Bd. of Trustees, Univ. of Connecticut*, 673 A.2d 484, 493 (Conn. 1996). As with CFEPA, this brings many public employees within purview of the statute. Among its public institutions of higher education, the University of Connecticut

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<sup>21</sup> See CONNECTICUT DEPARTMENT OF LABOR, *State of Connecticut Employment, LABOR MARKET INFORMATION*, <https://www1.ctdol.state.ct.us/lmi/ces/nfstatcm.asp> (last updated Jan. 23, 2020).

has 32,257 students, the Connecticut State University system, 32,722 students, and the Connecticut Community College system, 47,909 students. See Office of Higher Education, State of Connecticut, 2018 Connecticut Higher Education System Data and Trends Report 10 (2018).<sup>22</sup>

2. *Third-party administrators to public employer plans are subject to the Commission's jurisdiction for enforcement of antidiscrimination laws.*

a. CFEPA

The Petition also presents a third question pertaining to “an insurer that sells health insurance plans. . .” to state or municipal employers. Depending on the circumstances present in the relationship between an insurer and a public employer, state antidiscrimination laws may apply.<sup>23</sup> Stated broadly, insurers that have responsibility for the content of health insurance plans that discriminate (especially in their role as third-party administrators who create plan content), or that aid or abet public employers in executing discrimination, may be subject to Connecticut antidiscrimination law.

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<sup>22</sup> Because the employer and state agency antidiscrimination statutes directly extend CHRO jurisdiction to the State of Connecticut, its agencies, and its political subdivisions, Conn. Gen. Stat. §§ 46a-60, 46a-71, it is unnecessary to address the question whether these entities are also subject to Conn. Gen. Stat. § 46a-64, which extends jurisdiction to public accommodations.

<sup>23</sup> Such plans are not subject to the Employee Retirement Income Security Act. 29 U.S.C. § 1003 (b)(1) (exempting government plans).

State law extends the Commission’s jurisdiction to any persons that “subject, or cause to be subjected, any other person to the deprivation of any rights,” § 46a–58(a).<sup>24</sup> Asked to interpret the scope of this statute, the Connecticut Supreme Court confirmed that “[t]he repeated use in § 46a–58(a) of the word ‘any’ — ‘any person,’ ‘any other person,’ and ‘any rights, privileges or immunities secured or protected by the Constitution or laws of this state or of the United States’ — indicates an intention to protect a broad and inclusive range of persons from broadly specified forms of discrimination by a broad and inclusive range of actors.” *Commission on Human Rights and Opportunities v. Board of Education of the Town of Cheshire et al.*, 270 Conn. 665, 707 (2005). Even where another administrative body can lay claim to a dispute, the Commission can exercise jurisdiction.<sup>25</sup> See *id.* at 708.

The state’s employment discrimination statute is no different. Those protections reach “any person, whether an employer or an employee or not, to aid, abet, incite, compel or coerce the doing of any act declared to be a discriminatory employment practice or to attempt to do so.” Conn. Gen. Stat. § 46a-60(b)(5). That Connecticut law provides a broader scope than federal law is instructive, *Wasik v. Stevens Lincoln-*

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<sup>24</sup> The Commission can also scrutinize plan administration under its duty to “monitor state contracts to determine whether they are in compliance” with antidiscrimination statutes. Conn. Gen. Stat. § 46a-56(a)(5).

<sup>25</sup> Per Conn. Gen. Stat. § 38a-720m, the Insurance Commissioner may prosecute a third-party administrator for violating “any lawful rule or order of the commissioner or any provision of the insurance laws of this state.” Among these insurance laws is § 38a-488, which prohibits discrimination “in any of the terms or conditions of such policy.”

*Mercury, Inc.*, No. CIV. 3:98-CV-1083 (DJS), 2000 WL 306048, at \*6 (D. Conn. March 20, 2000), as even federal courts have held third-party administrators liable under federal discrimination provisions targeting employers. See, e.g., *Brown v. Bank of America*, N.A., 5 F.Supp.3d 121, 130-35 (D. Me. 2014) (holding that plan administrator Aetna can be considered an employer under Title I of the ADA where it acted as an agent of Bank of America); *Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n of New England, Inc.*, 37 F.3d 12, 17–21 (1st Cir. 1994) (holding that plan administrators could be liable under Title I and Title III of ADA); *Iwata v. Intel Corp.*, 349 F. Supp. 2d 135, 158 (D. Mass. 2004) (permitting federal and state employment discrimination claims to proceed against a third-party administrator); *Petty v. El Dorado Eng'g, Inc.*, No. CIV. A. 94-3203, 1996 WL 191749, at \*3 (E.D. La. Apr. 19, 1996) (holding that plaintiff stated claim that third-party administrator discriminated against employee in violation of Title I of the ADA); *E.E.O.C. v. Benicorp Ins. Co.*, No. IP 00–014–MISC, 2000 WL 724004, at \*2-\*4 (S.D. Ind. May 17, 2000) (rejecting argument that third party-administrator of health plan that excluded cochlear implant surgery was not an “employer” under Title I of the ADA); *Grossman v. Suffolk Cty. District Atty's Office*, 777 F. Supp. 1101, 1104-1105 (E.D.N.Y. 1991).

Underlying these decisions are the practicalities of the health insurance business; even if third-party administrators do not bear *actuarial* risk, they can play a *significant* role in discriminatory benefit administration, benefit plan design, and plan interpretation. Thus, in *Spirit v. Teachers Ins. & Annuity Ass'n*, the Second Circuit held that the principal employer's delegation of benefit processing does not insulate its agent plan administrator from liability under Title VII of the Civil Rights Act. See 691 F.2d

1054, 1063 (2d Cir. 1982), *vacated and remanded on other grounds*, 463 U.S. 1223 (1983).

Likewise, federal regulations promulgated under the Affordable Care Act's antidiscrimination provision recognize plan administrator liability. In 2016, the Department of Health and Human Services confirmed that it would therefore follow a "case-by-case inquiry" that rests on "principles developed in longstanding civil rights case law, such as the degree of common ownership and control between the [third-party administrator and institution receiving federal assistance]." 81 Fed. Reg. 31433. Following these regulations, the Eighth Circuit recently held that a third-party administrator was an appropriate defendant under a federal discrimination claim because the discriminatory plan terms could have originated with the administrator. *Tovar v. Essentia Health*, 857 F.3d 771, 778-79 (8th Cir. 2017).

Indeed, TPAs are not helpless bystanders to the discriminatory conduct of self-insured employers. Plan administrators recommend to their principals the "best courses of action to ensure compliance and efficiency." Jay W. Kempton, *How Third-Party Administrators Can Save Millions*, 20 J. AM. PHYSICIANS & SURGEONS 60, 60 (2015). And because public employer contracts are coveted in the plan administrator industry, these groups vigorously "appeal to employers and help them reduce costs and improve care." Bob Herman, *Self-Service Insurance: Insurers Forced to Compete Harder for Self-Insured Customers*, MODERN HEALTHCARE (Jan. 3, 2015) (reporting Aetna's \$1.5 billion contract with the Teacher Retirement System of Texas). In short, plan administrators have both the expertise and the incentive to work closely with public employers to

develop benefit schemes. Like the federal government, the Commission should exercise its jurisdiction to determine when that advice moves over the line from shrewd to discriminatory.

Fact finding will likely be necessary to determine the exact contours of responsibility. The University of Connecticut student health plan, for example, contains categorical exclusions for “cosmetic procedures related to gender reassignment” and is administered by the Wellfleet Group.<sup>26</sup> But parsing the precise role of Wellfleet from its publicly available materials can be challenging. To be sure, the same exclusion is incorporated in several other Wellfleet-administered student health insurance plans.<sup>27</sup>

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<sup>26</sup> See *Benefits at a Glance*, University of Connecticut 9 (May 14, 2019), <https://shs.uconn.edu/wp-content/uploads/sites/344/2019/05/2019-20-UCONN-UG-1920-BGlance-5.20.19-MJB.pdf>. The same is true of the State of Connecticut’s plans, which also contain categorical exclusions, and which are administered by Anthem Blue Cross and Blue Shield (Anthem BCBS) and UnitedHealthcare/Oxford. State of Connecticut, Medical Benefit Plan: Plan Document 1 (Jan. 1, 2019). Likewise, the City of Waterbury’s Fire Department has a plan administered by Vimly Benefit Solutions. City of Waterbury, Waterbury Fire Department 2019 Retiree Enrollment Form 1 (2019).

<sup>27</sup> See, e.g., CONNECTICUT COLLEGE 2019–2020 STUDENT HEALTH PLAN 3 (2019), <https://www.gallagherstudent.com/brochures/11123.pdf> (excluding “Cosmetic procedures related to Gender Reassignment” at item 38); WESLEYAN UNIVERSITY 2019–2020 STUDENT HEALTH INSURANCE PLAN 18 (2019), <https://www.wesleyan.edu/healthservices/insurance/insbrochure1920.pdf> (excluding “cosmetic procedures related to gender reassignment” at item 38); CARLETON COLLEGE 2019–2020 STUDENT HEALTH INSURANCE PLAN 8 (2019), [https://apps.carleton.edu/campus/business/assets/2019\\_2020\\_Benefits\\_at\\_a\\_Glance.pdf](https://apps.carleton.edu/campus/business/assets/2019_2020_Benefits_at_a_Glance.pdf) (excluding “cosmetic procedures related to gender reassignment” at item 35); RHODE ISLAND COLLEGE STUDENT HEALTH INSURANCE PLAN 2019–2020 at 7 (2019). [https://www.universityhealthplans.com/pdf/RIC\\_BenefitsSummary-1920.pdf](https://www.universityhealthplans.com/pdf/RIC_BenefitsSummary-1920.pdf) (excluding

And the plan administrator’s own promotional materials suggest that it provides both plan administration and benefit design services.<sup>28</sup>

b. Connecticut Public Accommodations Law

Insurers who administer public insurance plans are also subject to CHRO jurisdiction under § 46a-64, the antidiscrimination provision governing public accommodations. The question whether an entity is “cover[ed] under this statute depends, in each case, upon the extent to which a particular establishment has maintained a private relationship with its own constituency or a general relationship with the public at large.” *Corcoran v. German Soc. Soc’y Frohsinn, Inc.*, 99 Conn. App. 839, 844–45 (2007) (citing *Quinnipiac Council, Boy Scouts of Am., Inc. v. Comm’n on Human Rights & Opportunities*, 204 Conn. 287, 300 (1987)). In assessing the jurisdictional scope of § 46a-64, the Connecticut Supreme Court has deemed important “the unconditional language of the statute, the history of its steadily expanded coverage, and the compelling interest in eliminating discriminatory public accommodation practices.” *Quinnipiac Council*, 204 Conn. at 297. Because they offer services to the general public, plan administrators are public accommodations. That they both sell plans and offer the

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“cosmetic procedures related to gender reassignment” at item 36); LEHIGH UNIVERSITY STUDENT HEALTH INSURANCE PLAN 2019–2020 at 8 (2019), <https://www.universityhealthplans.com/pdf/Lehigh-Benefits-at-a-Glance-1920.pdf?20191121> (excluding “cosmetic procedures related to gender reassignment” at item 39).

<sup>28</sup> See *About Us*, Wellfleet Student (2019), <https://wellfleetstudent.com/about/>.

service of administering plans for *any* entity—self-insured universities, businesses, and government employers, to name a few—demonstrates that plan administrators are “determined to eschew selectivity.” *Id.* at 299.

That plan administrators so offer services to the general marketplace is also sufficient for federal courts that have considered whether they are public accommodations. See *Carparts*, 37 F.3d at 19-21 (holding that administrators of an employer-sponsored health plan could be liable as public accommodations under Title III of ADA); *Pallozzi v. Allstate Life Ins. Co.*, 198 F.3d 28, 31–33 (2d Cir. 1999) (holding that Title III of the ADA applies to insurers as public accommodations and regulates insurance underwriting practices); *Fletcher v. Tufts Univ.*, 367 F. Supp. 2d 99, 115 (D. Mass. 2005) (permitting claim that administrator of employer-sponsored health plan violated Title III of ADA by providing inferior benefits to people with mental health conditions); *Boots v Nw. Mut. Life. Ins. Co.*, 77 F. Supp. 2d 211, 214-16 (D.N.H. 1999) (same). And although “federal law defines the beginning and not the end of [Connecticut courts’] approach to the subject,” state public accommodations law has been recognized as *broader* than its federal counterpart. *Corcoran*, 99 Conn. App. at 843–44. CHRO should rule that insurers responsible for discriminatory plan content employed by public entities, or those who aid or abet discrimination, are subject to § 46a-64.

B. Both Categorical Exclusion and Comparative Treatment Provisions in Health Insurance Plans Violate the Statutes Enforced by the CHRO

As set forth in the Petition, Connecticut health insurance plans have a statutory obligation to cover medically necessary treatments related to gender dysphoria.<sup>29</sup> Nevertheless, the question remains whether entities subject to CHRO jurisdiction may exclude coverage for certain ancillary procedures, sought as part of a course of treatment for gender dysphoria, yet labeled as “cosmetic,” and thus deemed not medically necessary.<sup>30</sup> Petition at 2-3. Drawing on a host of Connecticut health insurance policies, the Petition notes that such exclusions commonly arise from those seeking facial bone reconstruction, voice modification surgery and therapy, and rhinoplasty in a course of gender affirming care. *Id.* at 3.

The exclusions at the heart of the Petition are characterized in two ways. Question 1 of the Petition addresses circumstances where an insurance plan includes a categorical exclusion denying care in every instance where a certain treatment is sought as part of gender affirming care. Question 2 of the Petition posits the legal question somewhat differently, raising the issue in a comparative light. Requests for these same types of medical treatment in the context of gender affirming care may be routinely

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<sup>29</sup> Bulletin IC-34 at 1, *citing* Conn. Gen. Stat. §§ 38-488a & 38-514, Public Act 11-55, and Conn. Gen. Stat. § 38(a)-816(6).

<sup>30</sup> As referenced above, the answer to CHRO’s inquiry is properly aided by reference to federal jurisprudence. *Levy*, 236 Conn. at 103 (“Although this case is based solely on Connecticut law, we review federal precedent concerning employment discrimination for guidance in enforcing our own antidiscrimination statutes.”)

denied where the same such treatment is approved outside that context. For example, an insurance plan may deny rhinoplasty where it is sought in the course of gender affirming care, but approve that same procedure where it is sought to correct difficulty in breathing. Or, an insurance plan may consider rhinoplasty cosmetic in the course of addressing gender dysphoria, but consider it medically necessary when addressing other conditions. These two sets of circumstances form the basis for Questions 1 (Categorical Exclusion) and 2 (Comparative Treatment), respectively, of the Petition. In either scenario, the Petition requests a ruling whether such denials of care – veiled as they are in the language of not being medically necessary – can constitute illegal discrimination under the statutes enforced by the CHRO.<sup>31</sup> The CHRO’s Declaratory Ruling should answer in the affirmative.

1. *The Challenged Policies Constitute Discriminatory Practices Whether Framed under a Disparate Treatment or a Disparate Impact Theory*

CFEPA provides that “[i]t shall be a discriminatory practice in violation of this section . . . 1) [f]or an employer, . . . or the employer’s agent to discriminate against [an] individual . . . in terms, conditions or privileges of employment because of the

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<sup>31</sup> Question 3 of the Petition is addressed to the identity of the entity responsible for the coverage decision. This question is addressed in the preceding section above. As per that section, the CHRO should rule that any entity responsible for the alleged discriminatory practice at issue should come within the Commission’s jurisdiction.

individual's . . . gender identity or expression . . ."<sup>32</sup> Conn. Gen. Stat. § 46a-60(b).<sup>33</sup> Connecticut courts recognize at least two distinct theories of discrimination under § 46a-60(b) – disparate treatment and disparate or adverse impact.<sup>34</sup> *Levy v. Comm'n on Human Rights & Opportunities*, 236 Conn. 96, 104 (1996). “A disparate treatment claim involves differential treatment of similarly situated persons or groups [], whereas a disparate impact claim focuses on whether facially-neutral policies or practices have a disparate effect on a particular group.” *Blanc v. City of Stamford*, No. 3:05-CV-01354, 2008 WL 2996373, at \*2 n.2 (D. Conn. July 31, 2008) (internal citations omitted). See also *Levy*, 236 Conn. at 104 (“[D]isparate treatment” simply refers to those cases where certain individuals are treated differently than others”); *Miko v. Comm'n on Human Rights & Opportunities*, 220 Conn. 192, 202 n.8 (1991) (“[t]he disparate impact theory applies to patterns and practices [that] are facially neutral but discriminatory as applied,

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<sup>32</sup> Section 46a-60 likewise forbids discrimination against an individual because of, *inter alia*, the individual's sex and "present or past history of mental disability, intellectual disability, learning disability, physical disability." Conn. Gen. Stat. § 46a-60(b)(1). The arguments advanced here related to gender identity or expression apply with equal force to allegations of discrimination on these other protected characteristics.

<sup>33</sup> Also at issue in the Petition is Conn. Gen. Stat. § 46a-71, which forbids discriminatory acts by agencies of the State of Connecticut. Section 46a-71 is interpreted in a manner similar to other federal and state antidiscrimination law. See *Cameron v. Alander*, 39 Conn. App. 216, 222 (1995). The analysis described herein applies in equal measure to the CHRO's enforcement of § 46a-71.

<sup>34</sup> Connecticut courts also recognize that employers can violate § 46a-60(b) by failing to make a reasonable accommodation. *Curry v. Allan S. Goodman, Inc.*, 286 Conn. 390, 415 (2008). Although that theory may be implicated by the Petition, these Amicus Parties will not address this theory.

and does not require evidence of subjective intent to discriminate.”) Each of these alternative theories invoke their own method of proof and burden shifting framework.<sup>35,36</sup>

The insurance policies identified by the Petition – whether it be a Categorical Exclusion (Question 1) or Comparative Treatment (Question 2) provision – could be subject to challenge under either a disparate treatment or disparate impact theory.

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<sup>35</sup> Where the challenged entity provides a legitimate reason to justify its policy, disparate treatment analysis is based on the method described in *Texas Dept. of Community Affairs v. Burdine*, 450 U.S. 248, 252–56 (1981) and *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 802 (1973). See *Martinez v. Premier Maint., Inc.*, 185 Conn. App. 425, 427 (2018). “Under the pretext/*McDonnell Douglas-Burdine* analysis, ‘the employee must first make a prima facie case of discrimination.’” *Id.*, 185 Conn. App. at 439 (internal citations omitted). “In order for the employee to first make a prima facie case of discrimination, the plaintiff must show: (1) the plaintiff is a member of a protected class; (2) the plaintiff was qualified for the [benefit]; (3) the plaintiff suffered an adverse employment action; and (4) the adverse employment action occurred under circumstances that give rise to an inference of discrimination” *Id.* “The employer may then rebut the prima facie case by stating a legitimate, nondiscriminatory justification for the employment decision in question.” *Id.* Where that burden is met, “[t]he employee then must demonstrate that the reason proffered by the employer is merely a pretext and that the decision actually was motivated by illegal discriminatory bias.” *Id.* (citations omitted; internal quotation marks omitted.)

<sup>36</sup> To make out a prima facie case of discrimination under a disparate impact theory, the proponent must identify a facially neutral policy that predictably or actually has a deleterious effect on a group sharing a protected characteristic. *C.H.R.O. v. Ackley*, No. CV-99550633, 2001 WL 951374, at \*3 (Conn. Super. Ct. July 20, 2001). In rebuttal, the challenged entity must identify a legitimate governmental or business interest “sufficiently compelling to justify the challenged practice.” *Id.*, 2001 WL 951374 at \*4 (citations omitted). The proponent may still prevail if it can “establish the availability of an alternative policy or practice that would also satisfy the asserted business necessity, but would do so without producing the disparate effect.” *Mosby v. Bd. of Educ. of the City of Norwalk*, No. 3:15-CV-01876 (JAM), 2017 WL 4368610, at \*6 (D. Conn. Sept. 30, 2017), *aff’d sub nom. Mosby v. Bd. of Educ. City of Norwalk*, 754 F. App’x 34 (2d Cir. 2018).

c. Question 1 – Categorical Exclusion

The Categorical Exclusion identified in Question 1 violates Connecticut antidiscrimination law under either a disparate treatment or a disparate impact theory. By imposing a one-size-fits-all categorical conclusion to the question of medical necessity only in connection with a group of procedures *when they are sought in the course of gender affirming care*, the challenged policies constitute disparate treatment by addressing similarly situated transgender and cisgender individuals differently. As the Petition's footnotes demonstrate, *see, e.g.*, Petition at 3 n.15, there is an ample body of medical literature supporting the medical necessity of the subject ancillary procedures. The categorical nature of the challenged policies ignores the individualized medical necessity determinations that are at the heart of the standard of care. Petition at 2. To single out individuals seeking medically necessary gender affirming treatment for categorical exclusion in contradiction of the standard of care, when other diagnoses are properly reviewed on an individualized basis, is the type of differential policy that gives rise to a disparate treatment claim.

Viewed differently, a Categorical Exclusion also runs afoul of Connecticut antidiscrimination law based on a disparate impact theory. The Categorical Exclusion constitutes a facially neutral policy when framed as generally applicable criteria that exclude certain ancillary procedures as never medically necessary when sought in the course of gender affirming care. This policy, on its face, applies equally to all health plan enrollees, regardless of gender identity. Accepting that frame, it becomes clear that

application of the policy has an adverse impact on transgender individuals, who are the only people in need of gender affirming care.<sup>37</sup>

d. Question 2 – Comparative Treatment

The Comparative Treatment issue raised by Question 2 could give rise to a disparate treatment claim. Comparative Treatment policies treat transgender individuals and cisgender individuals – both with a medical need for a given procedure – differently. In the case of the transgender plan enrollee seeking medically necessary gender affirming care, rhinoplasty is always deemed to be cosmetic. In the case of a cisgender plan enrollee, rhinoplasty is typically approved where it is medically necessary, for example, to correct breathing difficulty. Both individuals are similarly situated with respect to having a legitimate medical need, yet a Comparative Treatment policy handles those needs quite differently.

Comparative Treatment policies also constitute a discriminatory practice if framed as a disparate impact claim. Viewed in this manner, the policy has a facially neutral policy of covering rhinoplasty generally, but deems the procedure to be cosmetic in the context of gender affirming care. Imagine a scenario in which chemotherapy

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<sup>37</sup> To deny the application of antidiscrimination law to Comparative Treatment policies strictly due to their equal application to both transgender and cisgender individuals would ignore the satire in one of the late Justice Robert Berdon's favorite quotations. "The law, in its majestic equality, forbids the rich as well as the poor to sleep under bridges, to beg in the streets, and to steal bread." *Doe v. Maher*, 40 Conn. Supp. 394, 445 n.54 (Super. Ct. 1986) (quoting poet Anatole France).

were to be covered by a health insurance plan generally to treat cancer, but deemed medically unnecessary in the context of breast cancer.<sup>38</sup> In such circumstances, there would be little trouble concluding that the plan had a disparate impact on women and was therefore subject to antidiscrimination law. The same principles are invoked by Question 2 here.

2. *Discrimination is Apparent when Focusing on the Issue of Causation*

Disparate treatment and disparate impact theories generally require significantly different methods of proof. In the context of the declaratory judgment here at issue and in the absence of individualized facts, however, both of these roads lead to a single destination. Distilling the burden shifting under each of these alternative theories, the CHRO is faced with a fundamental question relating to causation. Are the medical treatments at issue being categorically excluded from coverage “because of” the gender identity of the individual seeking care? On what basis are the categorical exclusions justified by their proponents? What legitimate nondiscriminatory reason might be put forward to explain the reason the categorical exclusion is being employed? Why are certain procedures being denied in the context of gender affirming care, even where

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<sup>38</sup> This hypothetical circumstance is drawn from Professor Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 83 (2005).

their medical necessity is elsewhere recognized? Regardless of what discrimination rubric is utilized, the underlying question of causation arises.

As recounted above, it constitutes a discriminatory practice when an employer or its agent “discriminate[s] against [an] individual . . . in terms, conditions or privileges of employment *because of* the individual’s . . . gender identity or expression . . .” Conn. Gen. Stat. § 46a-60(b) (emphasis added). The United States Supreme Court has held that “‘because of’ appears frequently in antidiscrimination laws” and generally requires “but-for causation.” *E.E.O.C. v. Abercrombie & Fitch Stores, Inc.*, 135 S. Ct. 2028, 2032 (2015).<sup>39</sup> Thus, in order for an individual seeking gender affirming care to make out a prima facie case of discrimination, they must show that their health insurance plan’s decision to exclude coverage without regard to their individual circumstances would not be applied but for their gender identity.<sup>40</sup> Thus, where Categorical Exclusions are applied to transgender individuals seeking care under the Plan, but cisgender

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<sup>39</sup> The “but for” method described here generally applies in the context of identifying or inferring discriminatory intent in the context of a disparate treatment case. Although a disparate impact theory calls for a different method of analysis, *supra* notes 35-36, the same dispute over the nature of the challenged policy’s justification will arise.

<sup>40</sup> “‘Gender identity or expression’ means a person’s gender-related identity, appearance or behavior, whether or not that gender-related identity, appearance or behavior is different from that traditionally associated with the person’s physiology or assigned sex at birth, which gender-related identity can be shown by providing evidence including, but not limited to, medical history, care or treatment of the gender-related identity, consistent and uniform assertion of the gender-related identity or any other evidence that the gender-related identity is sincerely held, part of a person’s core identity or not being asserted for an improper purpose.” Conn. Gen. Stat. Ann. § 46a-51(21).

individuals requesting the same procedures have their claims evaluated individually, a prima facie case of discrimination will lie. In the Anthem, Oxford and Regence plans identified in the Petition, this distinction is apparent on the face of the policy.<sup>41</sup>

Proponents of the challenged policies will object to the assertion that Categorical Exclusion and Comparative Treatment provisions constitute a discriminatory practice. This rebuttal will be characterized as a simple difference of opinion as to the medical necessity of the requested treatment. Stated differently, the employers and insurers responsible for the challenged policies will contend that a Categorical Exclusion or Comparative Treatment provision does not differentiate “because of” a member’s gender identity, so much as it distinguishes based on differing medical need. CHRO’s declaratory ruling should reject this position out of hand.

Categorical Exclusion and Comparative Treatment provisions are not based on legitimate differences in medical need. Connecticut insurance law defines what is “medically necessary” in a group health insurance plan with so broad a lens as to preclude as pretextual this position:

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<sup>41</sup> See Petition Ex. A at 3 (“The following procedures are considered cosmetic when used to improve the gender specific appearance of *an individual who has undergone or is planning to undergo sex reassignment surgery . . .*”) (emphasis added); Petition Ex. B at 2 (“Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary, *when performed as part of gender reassignment: . . .*”) (emphasis added); Petition Ex. C at 3 (“additional interventions are considered not medically necessary *for gender dysphoria*”) (emphasis added).

‘Medically necessary’ or ‘medical necessity’ means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Conn. Gen. Stat. Ann. § 38a-513c(a). The Petition contains ample evidence of literature establishing under § 38a-513c(a) the medical necessity of a host of ancillary treatments within the scope of the challenged Categorical Exclusion and Comparative Treatment provisions. Petition at 2-3 (citing, *inter alia*, the generally accepted standards of medical practice contained in the WPATH Standards)). See also Eckert Decl. at ¶ 3. This evidence is further bolstered by the overwhelming weight of authority across state and federal jurisprudence.<sup>42</sup>

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<sup>42</sup> See, e.g., *Good v. Iowa Dep't of Human Servs.*, 924 N.W.2d 853, 857 (Iowa 2019) (recounting the testimony of Dr. Randi Ettner, Ph.D., a specialist and international expert in the field of gender dysphoria, as discrediting the medical necessity assertions justifying a Categorical Exclusion as “not reasonably supported by scientific or clinical evidence, or standards of professional practice, and fail to take into account the robust body of research that surgery relieves or eliminates Gender Dysphoria.”); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 948-50 (W.D. Wis. 2018) (describing the testimony of expert witness Dr. Loren Schechter as addressing medical necessity on both sides of the Comparative Treatment divide before concluding that “Wisconsin Medicaid covers medically necessary treatment for other health conditions, yet the Challenged Exclusion expressly *singles out and bars* a medically necessary treatment solely for transgender people suffering from gender dysphoria.”) (emphasis in original);

Even further to the point, the standard of care for gender dysphoria has as a central tenet the individualized nature of the treatment. Eckert Decl. at ¶ 3. “What helps one person alleviate gender dysphoria might be very different from what helps another person.”<sup>43</sup> As discussed above, Categorical Exclusion provisions not only single out individuals seeking gender affirming care for the purposes of differential treatment, they also directly contradict the core methodology in the medical standard of care. CHRO should not abide insurance practices that transform critical decisions of health care access into bureaucratic shortcuts. Such policies are, at best, based on nothing more than a discriminatory misinterpretation of the standard of care or, at worst, the breed of stigma that was roundly rejected by the Connecticut Legislature in Public Act 11-55.

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*Cruz v. Zucker*, 195 F. Supp. 3d 554, 572 (S.D.N.Y. 2016), *on reconsideration*, 218 F. Supp. 3d 246 (S.D.N.Y. 2016) (citing a raft of evidence to establish “cosmetic procedures can be medically necessary for individuals with gender dysphoria” and striking down a Categorical Exclusion).

<sup>43</sup> WPATH Standards at 5. See *also* Petition at n. 6 and accompanying text.

## V. CONCLUSION

For all of the above reasons, CHRO should issue a declaratory ruling answering each of the three questions identified in the Petition in the affirmative.

Date: February 8, 2019

Respectfully submitted,

/s/ Kevin Costello

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*Attorneys for Amicus Party  
Connecticut TransAdvocacy Coalition*

CERTIFICATE OF SERVICE

Pursuant to the January 9, 2020 letter of the Connecticut Commission on Human Rights & Opportunities granting permission to file an amicus brief in its declaratory ruling proceedings with regard to the applicability of antidiscrimination statutes to certain insurance-related practices, I hereby certify that on February 8, 2020, I submitted the foregoing document to the following individual via electronic mail transmission.

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Human Rights Attorney  
Commission on Human Rights & Opportunities  
Legal Division  
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Dated: February 8, 2020

# Appendix A

**STATE OF CONNECTICUT  
COMMISSION ON HUMAN RIGHTS & OPPORTUNITIES**

**Declaratory ruling on  
October 31, 2019 Petition  
Regarding Health Insurers'  
Categorization of Certain Gender  
Confirming Surgeries as Cosmetic**

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**DECLARATION OF DIANA LOMBARDI, MSW**

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1. I am over the age of 18 and am otherwise competent to declare in this manner.
2. I currently serve on the Executive Director of the Connecticut TransAdvocacy Coalition (CTAC). CTAC is a coalition and grassroots oriented organization comprising of individuals and organizations dedicated to the advancement and attainment of full human rights for all trans and gender non-conforming people in every aspect of society and to oppose discriminatory acts wherever they exist.
3. The CTAC is a 501(c)(3) organization based in Hartford, Connecticut. CTAC is submitting an amicus brief to the Connecticut Commission on Human Rights and Opportunities in connection with its forthcoming Declaratory Judgment related to health insurance policy exclusions for certain ancillary services related to gender affirming care.

4. The mission of the Connecticut TransAdvocacy Coalition is to make Connecticut a safe and tolerant place for the transgender and gender non-conforming individual through education and social advocacy. We regularly conduct trainings and work with policy makers to make Connecticut a safer place for all.
5. The Connecticut TransAdvocacy Coalition organizes an annual conference called “Transgender Lives: The Intersection of Health and Law” in Farmington, Connecticut. The conference brings together service providers, medical and legal professions, transgender and gender non-conforming community, allies, and other interested parties to discuss health and legal issues facing the transgender and gender non-conforming communities in Connecticut.
6. I also regularly volunteer at the Hartford Gay & Lesbian Health Collective in Hartford, Connecticut. In this capacity, I answer their phone line and help callers find information about their health insurance coverage, get connected with lesbian, gay, bisexual, and transgender-friendly providers, or learn more about available health and social services.
7. Many transgender and gender non-conforming people find it difficult to get and keep employment. When transgender and gender non-conforming people gain enrollment in health insurance, it is especially important that their plan facilitates, rather than blocks, can access to the care they need.
8. Many have never advocated for themselves in the health care context before. An insurance denial often means that the individual is completely blocked from receiving care, because they do not know how to appeal those decisions.

9. Many transgender and gender non-conforming people expect employers in the public sector to be more accepting. These jobs are subject to antidiscrimination laws that require employers to not discriminate based on sex and gender identity. As public entities, these employers have a heightened obligation to be free from discrimination.
10. Despite being an area where transgender and gender non-conforming people find more acceptance, state and municipalities continue to offer employment benefits that discriminate based on gender identity and gender dysphoria.
11. In my experience, I have seen electrolysis denied for a transgender woman who requests the procedure as treatment for her gender dysphoria, even though that same procedure is covered for a cisgender woman who has hirsutism (excess coarse hair growth on areas such as the face or chest).
12. When I see transgender or gender non-conforming people in Connecticut get denied services that would be otherwise covered for a cisgender person, they are often discouraged from appealing these policies or further communicating with their insurer.
13. Many transgender and gender non-conforming people do not have resources to help them navigate the health care insurance system effectively. They rely heavily on what representatives of their health insurance plan tell them is or is not covered.
14. If the State or local government continues to approve and offer health care plans that have discriminatory policies, the health disparities and worsened health

outcomes experienced by transgender and gender non-conforming people will continue unabated.

15. Discriminatory health insurance plans contribute to a climate of fear that transgender and gender non-conforming people experience due to discrimination in their everyday lives. The added fear of not knowing when you may be responsible for a large medical bill or when a service may be covered will discourage people from seeking the health care they need.

I declare under penalty of perjury that the foregoing is true and correct.

DATED: February 8, 2020, in Berlin, Connecticut.

/s/ Diana Lombardi  
Diana Lombardi, MSW

# Appendix B

**STATE OF CONNECTICUT  
COMMISSION ON HUMAN RIGHTS & OPPORTUNITIES**

**Declaratory ruling on  
October 31, 2019 Petition  
Regarding Health Insurers'  
Categorization of Certain Gender  
Confirming Surgeries as Cosmetic**

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**DECLARATION OF AJ ECKERT, D.O.**

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1. I am a physician licensed to practice medicine in the State of Connecticut. I am board certified in family medicine by American Board of Osteopathic Family Physicians. I am an expert in the provision of gender affirming care, treating approximately 200-300 patients in my clinical practice.
2. I completed my Doctor of Osteopathic Medicine degree from Touro University College of Osteopathic Medicine (Vallejo, California) in 2011. Following the receipt of my medical degree, I completed my residency at Maine-Dartmouth Family Medicine Residency (Augusta, Maine).
3. I am a member of the World Professional Association for Transgender Health, Inc. (WPATH). WPATH is an internationally recognized professional organization dedicated to developing evidence-based care for transgender

health. WPATH regularly publishes Standards of Care and Guidelines which represent provider consensus around the interdisciplinary management of gender dysphoria. In my opinion, the WPATH Standards of Care and Guidelines represent the medical standard of care for the treatment of gender dysphoria.

4. I am the owner of The Gender and Life-Affirming Medicine Center (GLAM Center), located in Wethersfield, Connecticut. The GLAM Center serves the Lesbian, Gay, Bisexual, Transgender, and other Queer identities (LGBTQ+) community by offering affirming primary and preventive care services.
5. Many of my patients are taking gender-affirming hormones or are interested in some form of gender affirmation.
6. I currently serve on the board of the Connecticut TransAdvocacy Coalition, which is submitting an amicus brief to the Connecticut Commission on Human Rights and Opportunities in connection with its forthcoming Declaratory Judgment related to health insurance policy exclusions for certain ancillary services related to gender affirming care.

### **Barriers to Gender-Affirming Care**

7. Because gender dysphoria expresses itself differently in each of my patients, I conduct individualized assessments to determine what type of gender affirming care is medically necessary for each patient. This is a central tenet of WPATH's standards of care. See World Professional Association for Transgender Health, *The Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* 5, 8-9 (2012).

8. Medically necessary care for my patients can include, but is not limited to, hormone therapy, puberty blockers, facial feminization surgeries, hair removal, mastectomy, chest reconstruction, genital reconstruction, and voice therapy and/or surgery.
9. Generally, I have found insurance companies' public-facing language about the coverage of gender-affirming care to be ambiguous, even when a plan covers some therapy or services. I regularly tell my patients that accessing this type of care is complicated and often subject to denials and appeals. My patients often face an extra level of non-medically based gatekeeping that makes it more difficult for them to access the care they need.
10. For example, facial feminization surgeries are often an important, medically necessary element in the treatment of gender dysphoria. In certain cases, facial feminization surgery facilitates the "passing" of transgender women, alleviating some symptoms of gender dysphoria.
11. While some insurance companies categorically exclude facial feminization surgeries when used to treat gender dysphoria and/or label these procedures as cosmetic, generally accepted standards of medical practice recognize these surgeries as medically necessary for some individuals with gender dysphoria.
12. My patients frequently experience additional barriers to medically necessary gender affirming care in the form of insurance policies that are incongruent with the medical standards of care.

13. For example, I recently treated a patient who required speech therapy services as a part of a course of gender affirming care. In order to determine whether the health insurance plan would authorize coverage of speech therapy, my patient was required to answer a number of invasive and medically-unnecessary questions about their inability to pass as their desired gender, including listing circumstances within the past three months where they were unable to pass as their desired gender. These requirements are not medically indicated for speech therapy. See World Professional Association for Transgender Health, *The Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* 52-54 (2012). As far as I know, similar barriers are not erected for cisgender people seeking voice therapy.

14. Another patient that I have treated is a 60 year-old assigned male at birth, female patient who was required to produce an additional letter before insurance coverage for a vaginoplasty was authorized. The letter was requested by her insurer to address the impact of a traumatic brain injury she experienced over thirty years ago and confirm that the traumatic brain injury was not the cause of her gender dysphoria. I have never encountered a similar requirement for other surgeries or cisgender patients.

15. I also treated a 25 year-old assigned male at birth, female patient who needed to present an additional letter in order to obtain insurance coverage for medically necessary orchiectomy and total vaginoplasty. The letter was required by the insurer to confirm that medication she was taking to deal with chronic pain was

unrelated to the genital region. I have never encountered a similar requirement for other surgeries or cisgender patients.

16. I also treated a 28 year-old assigned male at birth patient whose course of gender affirming care required facial feminization surgery. This patient had multiple letters from various health care professionals substantiating that facial feminization surgery was medically necessary, not cosmetic, for their gender dysphoria. My patient's insurer denied the request on the grounds that the surgery was cosmetic. In the eyes of the insurer, the surgery would not improve my patient's health, even though it would change her appearance.

17. Some insurers require my patients to live outwardly for twelve months in a manner that is congruent with their gender identity before approving coverage for certain gender affirming services. This is an outdated, binary concept and has made many patients feel they must appear "trans enough" in order to get medication.

18. My patients face many socioeconomic disparities and are often unable to self-pay for these procedures when coverage of these medically necessary services is denied by their insurance companies. Patients who have been able to self-pay have never been reimbursed by their insurance companies.

19. My patients face pervasive stigma in their everyday lives. My transgender and genderqueer patients are often subject to strict gatekeeping and non-medically based requirements that prevent them from care that can directly improve their safety, health, and wellbeing.

I declare under penalty of perjury that the foregoing is true and correct.

DATED: February 7, 2020, in Wethersfield, Connecticut.

/s/ AJ Eckert

AJ Eckert, D.O.