



Literature Review

From: Transgender Legal Defense & Education Fund

Re: Medical necessity of mastectomy and male chest reconstruction to treat gender dysphoria in people under 18

Date: June 17, 2020

Cited articles available upon request.

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I. Chest reassignment surgery is medically appropriate for and consistent with the symptoms and proper diagnosis of the patient’s disease, gender dysphoria.

Gender dysphoria characterized by a marked and persistent incongruence between an individual’s experienced sex and their assigned sex. In gender dysphoria, the person’s experienced sex and external sex characteristics do not match, resulting in marked distress, which is often heightened at onset of puberty with the associated development of secondary sex characteristics.¹

Chest reassignment surgery (“surgery”)—a double mastectomy and male chest reconstruction—is a procedure that changes female secondary sex characteristics into male ones for the purpose of treating gender

¹ Andreas Kyriakou et al., *Current Approach to the Clinical Care of Adolescents With Gender Dysphoria*, 91 ACTA BIOMEDICA: ATENEI PARMENSIS 165-175 (2020).

dysphoria.² Male and female chests are anatomically distinct.³ Accordingly, gender dysphoria in trans males and non-binary people who were assigned female at birth results in “significant discomfort with the presence of breasts (chest dysphoria).”⁴

Changing physical sex characteristics from one sex to another is a standard treatment for gender dysphoria. The goal is to ameliorate the discrepancy between an individual’s internal sense of sex and their assigned sex.⁵ According to the World Professional Association for Transgender Health (WPATH), the recognized effective treatment of gender dysphoria is a triadic approach of providing mental health treatment, hormone therapy, and surgeries.⁶ The WPATH *Standards of Care* recognize that for those who do not experience relief due to other measures, “surgery is essential and medically necessary to alleviate their gender dysphoria . . .

² Giulia Lo Russo et al., *Masculine Chest-Wall Contouring in FtM Transgender: A Personal Approach*, 41 AESTHETIC PLASTIC SURGERY 369, 369 (2017) (“The first and arguably the most important step in sexual reassignment surgery in female-to-male (FtM) transsexuals is the creation of an aesthetically pleasing male chest. Breasts are a stigma of feminine identity, and their presence poses social and psychological problems for transmen.”); Rachel Bluebond-Langer et al., *Top Surgery in Transgender Men: How Far Can you push the Envelope?*, AM. SOCIETY OF PLASTIC SURGEONS 873e, 878e (2017) (“[T]he goals of surgery are more akin to those of gynecomastia surgery: to flatten the chest and to reduce and shape the nipple to mimic the male phenotype”); Patricia Cregten-Escobar et al., *Subcutaneous Mastectomy in Female-to-Male Transsexuals: A Retrospective Cohort-Analysis of 202 Patients*, 9 J. OF SEXUAL MEDICINE 3148, 3149 (2012) (“The principal aim in mastectomy for female-to-male transsexuals is to masculinize the chest by removing the female contour. This is an important procedure in the female-to-male transition, because it helps the patient to obtain a more male-like physique and therefore improves their psychosocial state of mind.”).

³ Karel E.Y. Claes et al., *Chest Surgery for Transgender and Gender Nonconforming Individuals*, 45 CLINICS IN PLASTIC SURGERY 369-380, 372 (2018).

⁴ See generally Johanna Olson-Kennedy et al., *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults*, 172 JAMA PEDIATRICS 431-436 (2018).

⁵ See Shane Morrison, Stelios Wilson & Scott Mosser, *Breast and Body Contouring for Transgender and Gender Nonconforming Individuals*; 45 CLINICS IN PLASTIC SURGERY 333, 338 (2018).

⁶ See American Medical Association (AMA) House of Delegates’ Resolution 122, *Removing Financial Barriers to Care for Transgender Patients* at 1, ¶¶ 24-26 (April 18, 2008) (“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 gender dysphoria.”).

relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence.”⁷

The value of this treatment protocol is reflected in the fact that all major insurance companies cover surgery, hormones, and puberty-delaying treatments for the purpose of changing (or preventing the change of) sex characteristics to treat gender dysphoria.⁸

A. Peer-reviewed literature demonstrates that chest surgery is an effective treatment for gender dysphoria.

Peer-reviewed literature shows chest reassignment surgery to be highly effective in treating gender dysphoria. This surgery decreases body dissatisfaction and experienced dysphoria in social interactions.⁹ It also allows people to be recognized as male by others and facilitates living in accordance with a male or non-binary social role.¹⁰ In a 2017 study, the satisfaction rate for trans men receiving mastectomies was 94%.¹¹ Additionally, the results showed that “satisfied respondents reported a relatively positive QoL [quality of life]. This confirm[ed] that medical transition al-

⁷ WPATH, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7th Ed.), at 54-55, [https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20\(2\)\(1\).pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf).

⁸ TLDEF, *Health Insurance Medical Policies*, <https://transhealthproject.org/resources/health-insurance-medical-policies> (providing links to 150+ insurance company clinical guidelines on gender reassignment surgery and related treatments); Jaime Stevens et al. *Insurance Coverage of Puberty Blocker Therapies for Transgender Youth*, 136 *PEDIATRICS* 1029-31 (2015) (noting shift toward coverage of GnRH agonists).

⁹ Tim C. van de Grift et al., *Body Image of Transmen: Multidimensional Measurement and the Effects of Mastectomy*, 13 *J. OF SEXUAL MEDICINE* 1778, 1785 (2016).

¹⁰ See Claes, *supra* note 3, at 372.

¹¹ Tim C. van de Grift et al., *Surgical Satisfaction, Quality of Life and Their Association after Gender Affirming Surgery*, *J. OF SEX & MARITAL THERAPY* 1, 4 (2017).

leviates feelings of gender dysphoria and improves life satisfaction to normative levels.”¹² A 2018 study also found improved quality of life, reduced gender dysphoria, and no regret aside from a few aesthetic concerns.¹³

The prevailing opinion among transgender specialists both nationally and globally is that mastectomies are safe and effective for treating gender dysphoria, which is why it is recognized as medically necessary for adults under virtually all insurance company medical policies on gender dysphoria treatments.¹⁴ Insurance companies universally recognize that chest surgery is medically appropriate to treat gender dysphoria in people over 18 and would cover the procedure once the patient turns 18.

¹² *Id.* at 16. See also Christina Richards & J. Barrett, *The case for bilateral mastectomy and male chest contouring for the female-to-male transsexual*, 95 ANNALS OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND 93 (2013) (literature review recognizing an improvement in quality of life following surgery); Lisa Nelson et al., *Transgender Patient Satisfaction Following Reduction Mammoplasty*, 62 J. OF PLASTIC, RECONSTRUCTIVE & AESTHETIC SURGERY 331, 334 (2009) (reporting “high patient satisfaction and a clear positive impact on the lives of these patients”); Ashli A. Owen-Smith, *Association Between Gender Confirmation Treatments and Perceived Gender Congruence, Body Image Satisfaction, and Mental Health in a Cohort of Transgender Individuals*, 15 J. OF SEXUAL MED. 591 (2018) (showing that chest surgery reduces depression and anxiety and improved body satisfaction).

¹³ Grace Poudrier et al., *Assessing Quality of Life and Patient-Reported Satisfaction with Masculinizing Top Surgery: A Mixed-Methods Descriptive Survey Study*, 143 PLASTIC AND RECONST. SURG. 272 (2018); Justine Defreyne et al., *Healthcare Costs and Quality of Life Outcomes Following Gender Affirming Surgery in Trans Men: A Review*, 17 EXPERT REV. OF PHARMACOECONOMICS & OUTCOMES RESEARCH 543-556 (2017) (noting decreased regret rates over time and in recent studies, “regret rates have decreased to virtually zero”).

¹⁴ TLDEF, *Health Insurance Medical Policies*, <https://transhealthproject.org/resources/health-insurance-medical-policies>.

A. Being under 18 does not negate the effectiveness of chest surgery in alleviating gender dysphoria.

Substantial evidence reveals that a person's gender identity is fully formed in youth¹⁵ and that is not possible to change gender identity.¹⁶ The American Academy of Pediatrics notes that gender identity is stable by age four.¹⁷ Nearly all transgender adults report first experiencing gender dysphoria by age 7.¹⁸ In one study of transgender youth, 8.3 years was the mean age they realized their gender differed from their assigned gender.¹⁹ Transgender children know and express their genders as clearly and consistently as cisgender children express their genders,²⁰ and transgender youth report body dissatisfaction with their genitals and chest.²¹

¹⁵ See, e.g., Sarah M. Burke et al., *Hypothalamic Response to the Chemo-Signal Androstadienone in Gender Dysphoric Children and Adolescents*, 5 FRONTIERS IN ENDOCRINOLOGY 1 (2014) (demonstrating that adolescents with gender dysphoria have sex-linked olfactory responses congruent with their affirmed sex rather than their sex assigned at birth indicating that their brain sex was formed during early brain development).

¹⁶ See generally Milton Diamond & H. Keith Sigmudson, *Sex Reassignment at Birth: Long-term Review and Clinical Implications*, 151 ARCH. PEDIATRIC MED. 298 (1997) (arguing that gender identity is formed at an early age and cannot be changed through therapy).

¹⁷ David A. Levine and the Committee on Adolescence, *Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth*, 132 PEDIATRICS e297, e299 (2013).

¹⁸ Michael Zaliznyak et al., *Age at First Experience of Gender Dysphoria Among Transgender Adults Seeking Gender-Affirming Surgery*, 3 JAMA NETWORK OPEN e201236.

¹⁹ Johanna Olson et al., *Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria*, 57 THE JOURNAL OF ADOLESCENT HEALTH : OFFICIAL PUBLICATION OF THE SOCIETY FOR ADOLESCENT MEDICINE 374, 378 (2015) (reporting an age range of 2-22).

²⁰ Kristina R. Olson et al., *Gender cognition in transgender children*, 26 PSYCHOLOGICAL SCIENCE, 467-474 (2015); Selin Gülgöz et al., *Similarity in Transgender and Cisgender Children's Gender Development*, 116 PROCEEDINGS OF THE NAT'L ACAD. OF SCIENCES 24480-24485 (2019) (finding that transgender children's gender development was not impacted by sex-assignment or sex-specific socialization and that their gender development paralleled cisgender children's gender development).

²¹ Anisha Gohil et al., *Baseline Body Satisfaction in Gender-Diverse Youth*, 4 J. ENDOCRINE SOC. SUN-079 (May 8, 2020).

While the exact biological root causes of gender dysphoria have not been identified, magnetic resonance imaging studies have shown that the brains of transgender children, adolescents and adults match the patterns associated with their affirmed sex rather than sex assigned at birth, even before any hormonal treatment.²² The regions affected play a role in body perception and self-awareness.²³ Separately, family and twin studies indicate a strong genetic component.²⁴ This biological origin is reflected in the new ICD-11; the “gender incongruence” diagnosis has been moved from a mental health diagnosis to a physical one.²⁵

The widespread endorsement of and insurance coverage GnRH analog treatment at the start of puberty²⁶ is based on this stability of gender identity. There is no medical basis to believe that the patients’ need for surgery will abate or that their gender identity will change to female. Furthermore, the acceptance for initiating cross-sex hormone therapy by age 16 is based on the fact that most individuals of that age have sufficient mental capacity to give informed consent.²⁷

²² Elyse Pine-Twaddle, *Medical Management Updates for Gender Minority Youth and Difficult Cases*, 29 *ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS* 97, 98 (2018) (compiling the literature).

²³ *Id.*

²⁴ *Id.*

²⁵ World Health Organization, *ICD-11: Classifying disease to map the way we live and die* (2018), <https://www.who.int/news-room/spotlight/international-classification-of-diseases> (“Gender incongruence, meanwhile, has also been moved out of mental disorders in the ICD, into sexual health conditions. The rationale being that while evidence is now clear that it is not a mental disorder, and indeed classifying it in this can cause enormous stigma for people who are transgender, there remain significant health care needs that can best be met if the condition is coded under the ICD.”).

²⁶ TLDEF, *Health Insurance Medical Policies - Youth Services*, <https://transhealthproject.org/resources/health-insurance-medical-policies/view/youth-services>; Anthem, *Gonadotropin Releasing Hormone Analogs for the Treatment of Non-Oncologic Indications*, ING-CC-0061 (Sept. 23, 2019), https://www11.anthem.com/provider/noapplication/f0/s0/t0/pw_g350526.pdf.

²⁷ Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 *J. CLINICAL ENDOCRINOLOGY & METABOLISM* 1, 3, 15, 17 (2017).

B. There is no medical basis to delay until age 18.

Insurance companies bear the burden of demonstrating why the legal age of majority is an appropriate medical criterion for this treatment. There is no medically relevant event that occurs when a person turns 18, and the legal age of majority is not a relevant criterion for any medical treatments where the patient and the parents have provided informed consent.

The symptoms of gender dysphoria are consistent whether an individual is over 18 or under 18 and stem from the physical condition of having breasts. While interventions such as talk therapy, GnRH analogs, and hormones may be sufficient to relieve some symptoms of gender dysphoria, the only way to permanently treat dysphoria caused by having breasts is to remove the breasts. The fact that the minor is under 18 does not make the procedure any less effective or any less medically necessary in resolving those symptoms.²⁸

Surgeons are focusing more attention to gender reassignment surgeries in minors.²⁹ For the more complex surgery of vaginoplasty, over half of the surgeons practicing in this area have performed vaginoplasty on an individual under age 18.³⁰ Nearly all surgeons relied on the term “maturity” rather than chronological age to determine patients’ readiness for the procedure.³¹ Only one third of the surgeons thought that age 18 was an appropriate criterion.³² Concerning the less controversial chest surgery, one study simply noted that patients who were 16 or older could be considered for virilizing mammoplasty.³³ The authors of this study, Laura

²⁸ See generally Olson-Kennedy, *supra* note 4.

²⁹ Simona Giordano, César Palacios-González & John Harris, *Sex Change Surgery for Minors: Should Doctors Speak Out?*, in PIONEERING HEALTHCARE LAW: ESSAYS IN HONOUR OF MARGARET BRAZIER 181, 186 (Catherine Stanton ed., 2016); Christine Milrod, *Age Is Just a Number: WPATH-Affiliated Surgeons’ Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States*, 14 J. OF SEXUAL MEDICINE 624, 631-2 (2017).

³⁰ Milrod, *Age Is Just a Number*, *supra* note 29, at 626.

³¹ *Id.* at 631.

³² *Id.* at 630.

³³ Laura Edwards-Leeper & Norman P. Spack, *Psychological Evaluation and Medical Treatment of Transgender Youth in an Interdisciplinary “Gender Management Service” (GeMS) in a Major*

Edwards-Leeper, Ph.D., and Norman Spack, MD, are co-founders of the Gender Management Service of the Boston Children's Hospital. The clinic afforded them the experience of treating hundreds of dysphoric children and adolescents, and their expertise is acknowledged in the field.³⁴

As one researcher puts it, “transgender adults started as transgender children. This concept is finally starting to translate into an affirmative practice model across the domains of law, ethics, advocacy, and health care.”³⁵ At issue should be the provider's assessment of whether the individual has gender dysphoria, is ready for treatment, and can provide informed consent—not the patient's chronological age.³⁶

II. This surgery is provided in accordance with applicable medical and/or professional standards and is known to be effective, as proven by scientific evidence, in materially improving health outcomes.

A. Medical opinions of professional societies hold mastectomy in transgender minors to be appropriate treatment.

The internationally recognized authorities on treatment in transgender patients and gender dysphoria are the World Professional Association for Transgender Health (WPATH) and The Endocrine Society.³⁷

Pediatric Center, 59 J. OF HOMOSEXUALITY 321, 329 (2010).

³⁴ *Id.* at 323-4. See also Laura Edwards-Leeper, Ph.D, Pacific University, <https://www.pacificu.edu/about-us/faculty/laura-edwards-leeper-phd> (last visited June 5, 2017).

³⁵ Johanna Olson-Kennedy, *Hot Topics and Fresh Paradigms in Gender, Diversity, and Care*, 29, ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS 85, 85 (2018).

³⁶ Olson-Kennedy, *supra* note 4, at 436.

³⁷ See Daniel E. Shumer, Natalie J. Nokoff & Norman P. Spack, *Advances in the Care of Transgender Children and Adolescents*, 63 ADVANCES IN PEDIATRICS 79, 83 (2016).

1. This surgery is in accordance with the WPATH Standards of Care, which explicitly endorse surgery for people under 18.

WPATH is recognized by the American Medical Association (“AMA”) and others as “the leading international, interdisciplinary professional organization devoted to the understanding and treatment of gender identity disorders.”³⁸ WPATH publishes the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*,³⁹ (“SOC”) which the AMA recognized as the “internationally accepted Standards of Care . . . recognized within the medical community to be the standard of care for treating people with” gender dysphoria.⁴⁰ WPATH released a statement on medically necessary therapy and treatment for trans people that specifically listed mastectomy and chest reconstruction as medically necessary surgeries.⁴¹

WPATH supports social transition for transgender youth, including puberty suppression, hormones, and surgeries where appropriate.⁴² The criteria for adults includes the age of majority to medical treatment, but

³⁸ American Medical Association (“AMA”) House of Delegates’ Resolution 122, Removing Financial Barriers to Care for Transgender Patients at 1, ¶¶ 15-17 (April 18, 2008); see also Madeline B. Deutsch & Jamie L. Feldman, *Updated Recommendations from the World Professional Association for Transgender Health Standards of Care*, 87 AM. FAM. PHYSICIAN 89 (2013) (WPATH “is an international multidisciplinary professional association that publishes recognized standards for the care of transgender and gender-variant persons.”).

³⁹ WPATH, STANDARDS OF CARE FOR THE HEALTH OF TRANSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE (7th ed.) (2011) [hereinafter WPATH STANDARDS OF CARE] https://amo_hub_content.s3.amazonaws.com/Association140/files/Standards%20of%20Care,%20V7%20Full%20Book.pdf.

⁴⁰ AMA House of Delegates’ Resolution 122, Removing Financial Barriers to Care for Transgender Patients at 1, ¶¶ 16-20 (April 18, 2008).

⁴¹ WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, POSITION STATEMENT ON MEDICAL NECESSITY OF TREATMENT, SEX REASSIGNMENT, AND INSURANCE COVERAGE IN THE U.S.A. (Dec. 21, 2016), https://s3.amazonaws.com/amo_hub_content/Association140/files/WPATH-Position-on-Medical-Necessity-12-21-2016.pdf.

⁴² WPATH STANDARDS OF CARE *supra* note 39 at 10-21.

“if younger, follow the SOC for children and adolescents.”⁴³ Specifically, WPATH lists no minimum age for chest surgery in adolescents and notes that “[c]hest surgery in FtM patients could be carried out earlier [than genital surgery at the age of majority], preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent’s specific clinical situation and goals for gender identity and expression.”⁴⁴

Not only do the SOC recommend treatment for minors on a case-by-case basis, but they identify the important role of chest surgery in the health of transgender minors. A year of hormone therapy is listed as preferred, but it is not a requirement. Under WPATH standards, it is not the patient’s chronological age that determines whether surgery is appropriate, but their individual circumstances.

The most recent WPATH statement on the matter its June 2018 list of services that, based on the SOC, it recommends should be covered by insurance plans.⁴⁵ The document lists prior approval requirements, including that informed consent has been provided, but it does not list any age requirements. Having a categorical prohibition on surgery until 18 thus contravenes the SOC.

2. Furthermore, there have been significant advances in the field since the Standards of Care were published eight years ago.

Clinical decisions made now must reflect current clinical practice and not be beholden to outdated standards. The most recent SOC were released in 2011, but the field of transgender youth care has exponentially grown over the past five years. The age of people seeking care has steadily

⁴³ *Id.* at 59.

⁴⁴ *Id.* at 21.

⁴⁵ WPATH, *Transgender Medical Benefits* (2018), https://www.wpath.org/media/cms/Documents/Public%20Policies/2018/6_June/Transgender%20Medical%20Benefits.pdf.

fallen.⁴⁶ Historically, few parents supported children and adolescents who expressed that they were a different sex, but that has rapidly changed with wider societal awareness of and acceptance of transgender people.⁴⁷ The increase in information available about gender dysphoria has led to a dramatic increase in recent years in the number of children and adolescents who, with parental support, are seeking treatment for their gender dysphoria.⁴⁸ Increased physician awareness due to the publication of clinical guidelines, such as the publication of the 2009 Endocrine Society guidelines⁴⁹ and the 2011 version of the SOC itself also likely contributed to the increase in referrals to gender clinics.⁵⁰ A final factor is the increased number of clinical care options, including youth-

⁴⁶ Christine Milrod, *How Young Is Too Young: Ethical Concerns in Genital Surgery of the Transgender MTF Adolescent*, 11 J. SEXUAL MED. 338 (2014).

⁴⁷ Britt Colebunders et al., *New Criteria for Sex Reassignment Surgery: WPATH Standards of Care, Version 7, Revisited*, 16 INT'L J. OF TRANSGENDERISM 222, 228 (2015); Marta R. Bizic et al., *Gender Dysphoria: Bioethical Aspects of Medical Treatment*, BIOMED RESEARCH INT'L, vol. 2018, Article ID 9652305, <https://doi.org/10.1155/2018/9652305> (“Presence of public figures who are openly transgender, their appearance in mainstream media, and political and social climate lead to more individuals coming out in the open as to their state.”).

⁴⁸ Melinda Chen et al., *Characteristics of Referrals for Gender Dysphoria Over a 13-Year Period*, 58 J. ADOLESC. HEALTH (2016) (74% of patients at the Pediatric Endocrinology, Riley Hospital for Children, Indiana University School of Medicine were referred during the last 3 years); Norman P. Spack, et al. *Children and Adolescents with Gender Identity Disorder Referred to a Pediatric Medical Center*, 129 PEDIATRICS 418, 4210 (2012) (reporting a fourfold increase following the 2007 establishment of the Gender Management Service clinic at Children’s Hospital Boston); Karine Khatchadourian et al., *Clinical management of youth with gender dysphoria in Vancouver*, 164 J. OF PEDIATRICS 906, 907 (2014) (reporting a dramatic increase in new patients at British Columbia Children’s Hospital in 2011); Madison Aitken et al., *Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria*, 12 J. SEX. MED. 756 (2015) (showing an increase in patients a Toronto clinic starting in 2004 and rising dramatically after 2010); Hayley Wood et al., *Patterns of Referral to a Gender Identity Service for Children and Adolescents (1976–2011): Age, Sex Ratio, and Sexual Orientation*, 39 J. SEX & MARITAL THERAPY 1-6 (2013) (showing a sharp increase in adolescent referrals to a Toronto clinic from 2008–2011); Ehrensaft, *supra* note 58, at 255.

⁴⁹ Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: Endocrine Society Clinical Practice Guideline*, 94 J. OF CLINICAL ENDOCRINOLOGY & METABOLISM 3132–3154 (2009).

⁵⁰ See Karine Khatchadourian et al. *Clinical management of youth with gender dysphoria in Vancouver*, 164 J. OF PEDIATRICS 906, 909 (2014).

specific clinics.⁵¹ Indeed, centers specializing in the care of transgender youth have experienced profound growth in the numbers of youth seeking care related to physical gender transition.⁵²

The SOC recognize that the field of gender care evolves rapidly.⁵³ Youth care has come very far since 2011. In 2011, researchers at the Amsterdam Gender Clinic noted an increase from 3% to 30% of youth who were socially transitioned at the time of entry into care.⁵⁴ When Version 7 of the SOC were released in 2011, the practice of suppressing puberty and induction of an exogenous puberty in adolescence was quite recent in the U.S. Indeed, “[b]efore 2006, medical intervention for transgender youth was almost non-existent in the United States.”⁵⁵

This increased time between the initiation of hormone therapy at younger ages and the delay of surgery “increases the gap between the two medical procedures and postpones the desired outcome of the transition.”⁵⁶ It is “only logical that if social transitioning and administration of hormones are being sought at younger ages, the request for surgical procedures among younger individuals will follow.”⁵⁷ Indeed, “the members of the working committee preparing the standards of care (SOC) could not have foreseen the explosion in gender care that was about to

⁵¹ Agnieszka Janicka, *Mental Health and Well-Being of Transgender Youth: Clinical Considerations*, 29 *ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS* 20 (2018).

⁵² Christine Milrod, *Age Is Just a Number: WPATH-Affiliated Surgeons’ Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States*, 14 *J. OF SEXUAL MEDICINE* 624, 626 (2017).

⁵³ *WPATH STANDARDS OF CARE* *supra* note 39, at 41 (“Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues.”).

⁵⁴ Thomas D. Steensma & Peggy T. Cohen-Kettenis, *Gender Transitioning before Puberty*, 40 *ARCH. SEX. BEHAV.* 649, 649 (2011).

⁵⁵ Johanna Olson-Kennedy, *Hot Topics and Fresh Paradigms in Gender, Diversity, and Care*, 29 *ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS* 85, 85 (2018).

⁵⁶ Bizic, *supra* note 47, at 3.

⁵⁷ Colebunders, *supra* note 47, at 229.

transpire.”⁵⁸ Today, however, “the concept of living full-time as an early teen in the affirmed gender is no longer considered rare or unusual.”⁵⁹

The SOC are undergoing changes in order to reflect the rapidly evolving field of transgender care, and a Revision Committee is reassessing the minimum age for genital surgery.⁶⁰ The new SOC will likely suggest an even greater need to help patients make decisions on a case-by-case basis, so that sweeping recommendations do not overlook the needs of each individual.⁶¹ Tellingly, the most recent document issued by WPATH is its June 2018 list of services—based on the SOC—that it recommends should be covered by insurance plans.⁶² The document lists prior approval requirements, including that informed consent has been provided, but it does not list any age requirements.

3. The Endocrine Society endorses surgical treatment prior to age 18.

The Endocrine Society—the world’s oldest, largest, and most active organization devoted to research on hormones and the clinical practice of endocrinology—has published clinical guidelines for treatment of gender dysphoric people, which provide detailed guidance for treatment consistent with the WPATH SOC.⁶³ Mastectomy is recognized as “the most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility.”⁶⁴ The Endocrine Society guidelines rec-

⁵⁸ Diane Ehrensaft et al., *Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens*, 19 INT’L J. OF TRANSGENDERISM 251 (2018).

⁵⁹ Milrod, *How Young Is Too Young*, *supra* note 46, at 340; Colebunders, *supra* note 47, at 222.

⁶⁰ Colebunders, *supra* note 47, at 231.

⁶¹ *Id.*

⁶² WPATH, *Transgender Medical Benefits* (2018), https://www.wpath.org/media/cms/Documents/Public%20Policies/2018/6_June/Transgender%20Medical%20Benefits.pdf.

⁶³ Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102(11) J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 26 (2017).

⁶⁴ *Id.* at 26.

ommend medical treatment for adolescents, including puberty suppression⁶⁵ followed by cross-sex hormones at age 16 or earlier.⁶⁶ A transgender male who was treated according to Endocrine Society standards would initiate puberty suppression prior to breast development at Tanner stage 2—perhaps as young as 8-12 years old—then start cross-sex hormones, and would never develop breasts.⁶⁷ What is relevant for treatment is physiological age and the persistence of gender dysphoria, not chronological age.

The Endocrine Society recognizes the need for some patients to undergo mastectomies before reaching the age of majority. They note: “Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual.”⁶⁸ They offer no specific age requirement: “We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement.”⁶⁹ Accordingly, having a categorical prohibition on surgery until 18 contravenes the Endocrine Society clinical guidelines.

4. The American College of Obstetricians and Gynecologists endorses surgical treatment prior to age 18.

Surgery under age 18 as per the Endocrine Society guidelines is similarly endorsed by The American College of Obstetricians and Gynecologists.⁷⁰

⁶⁵ *Id.* at 12 (“We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2).”).

⁶⁶ *Id.* at 15.

⁶⁷ *Id.* at 13 (“We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics.”).

⁶⁸ Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 1, 26 (2017).

⁶⁹ *Id.* at 26.

⁷⁰ The American College of Obstetricians and Gynecologists, *Care for transgender adolescents*.

5. The American Academy of Pediatrics recognizes a case-by-case approach to surgery for minors.

The American Academy of Pediatrics (AAP) is an organization of 67,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults.⁷¹

The AAP endorses both WPATH and Endocrine Society approaches noting that their standards “integrate the best available evidence with clinical experience from experts in the field of assisting transgender patients with transition.”⁷² They also endorse the guidelines published by Johanna Olson, MD, et al., based on their clinical experiences with a large number of transgender youth in Los Angeles.⁷³

The AAP has published its own policy statement, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse* endorsing medical treatment for transgender minors.⁷⁴ The policy statement, issued on October 4, 2018, is the most recent statement from a professional society on treatment for transgender youth. Accordingly, it reflects current best practices in this area more than earlier position statements.

Committee Opinion No 685, 129 OBSTET. GYNECOL. e11, e14 (2017).

⁷¹ American Academy of Pediatrics, *AAP Policy Statement Urges Support and Care of Transgender and Gender-Diverse Children and Adolescents* (Sept. 17, 2018), <https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Policy-Statement-Urges-Support-and-Care-of-Transgender-and-Gender-Diverse-Children-and-Adolescents.aspx>.

⁷² *Id.* at e308.

⁷³ Johanna Olson et al., *Management of the transgender adolescent*, 165 ARCH. PEDIATR. ADOLESC. MED. 171 (2011) (noting that mastectomies in people under 18 are becoming more common).

⁷⁴ Jason Rafferty, American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health, AAP Committee on Adolescence, and AAP Section on Lesbian, Gay, Bisexual, And Transgender Health and Wellness, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*. 142 PEDIATRICS, e20182162 (2018).

The statement notes that surgeries to treat gender dysphoria, including even surgery on genitals or reproductive organs, are performed on adolescents on a case-by-case basis. The AAP speaks to the lack of clarity in existing protocols noting: “Eligibility criteria for gender-affirmative surgical interventions among adolescents are not clearly defined between established protocols and practice. When applicable, eligibility is usually determined on a case-by-case basis with the adolescent and the family along with input from medical, mental health, and surgical providers.”⁷⁵ The AAP continues: “Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults, they are occasionally pursued during adolescence on a case-by-case basis, considering the necessity and benefit to the adolescent’s overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family.”⁷⁶

Finally, specifically as to insurance coverage for surgery, the AAP recommends “that insurance plans offer coverage for health care that is specific to the needs of youth who identify as [transgender and gender diverse], including coverage for medical, psychological, and, when indicated, surgical gender-affirming interventions.”⁷⁷

6. The UCSF Center of Excellence for Transgender Health endorses surgical treatment prior to age 18.

The *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* published by the Center of Excellence for Transgender Health at the University of California San Francisco⁷⁸ specifically note that any insurance policy requirement that the patient be 18

⁷⁵ *Id.* at 6.

⁷⁶ *Id.* at 7.

⁷⁷ *Id.* at 10.

⁷⁸ Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California San Francisco, GUIDELINES FOR THE PRIMARY AND GENDER-AFFIRMING CARE OF TRANSGENDER AND GENDER NONBINARY PEOPLE, (Madeline B. Deutsch, ed., 2nd ed. 2016),

is an “arbitrary barrier[] to surgery” and recommend that providers appeal denials to ensure that their minor patients can undergo chest surgery.⁷⁹ The *Guidelines* note that “care for transgender youth is a young and rapidly evolving field. In the absence of solid evidence, providers must often rely on the expert opinions of innovators and thought leaders in the field; many of these expert opinions are expressed in this youth guideline. The four primary authors for this youth protocol represent many years of expertise in clinical care and research, in both academic and community practice settings, and within the disciplines of adolescent medicine, pediatric endocrinology, family medicine, and advanced practice nursing.”⁸⁰

B. Peer-reviewed medical literature and clinical practitioners hold mastectomy in transgender minors to be clinically appropriate.

Peer-reviewed studies establish that this surgery is medically necessary regardless of chronological age. The Center for Transyouth Health and Development at Children’s Hospital Los Angeles is the largest trans youth clinic in the country, which currently serves over 900 gender non-conforming and transgender youth and young adults. Researchers there found that of minors who have undergone chest surgery, 93% reported being satisfied with the surgery “all of the time.”⁸¹ And trans males who had *not* undergone surgery—as compared to those who had undergone surgery—had significant effects of chest dysphoria in the areas of emotional well-being, physical well-being, recreational, occupational, social and life relationships.⁸² In the final results of the study, 100% of postsur-

<http://transhealth.ucsf.edu/trans?page=guidelines-home>.

⁷⁹ Johanna Olson-Kennedy, MD, Stephen M. Rosenthal, MD, Jennifer Hastings, MD and Linda Wesp, MSN, NP-C, *Health considerations for gender non-conforming children and transgender adolescents* in GUIDELINES FOR THE PRIMARY AND GENDER-AFFIRMING CARE OF TRANSGENDER AND GENDER NONBINARY PEOPLE, (Madeline B. Deutsch, ed., 2nd ed. 2016), <http://www.transhealth.ucsf.edu/trans?page=guidelines-youth>.

⁸⁰ *Id.*

⁸¹ Johanna Olson-Kennedy & Jonathon Warus, *The Impact of Male Chest Reconstruction on Chest Dysphoria in Transmasculine Adolescents and Young Men; A Preliminary Study*, 60 J. OF ADOLESCENT HEALTH S88 (2017).

⁸² *Id.*

gical participants affirmed the statement, “It was a good decision to undergo chest reconstruction” and 67 out of 68 participants reported no regret.⁸³ There is no evidence of statistically significant regret or adverse outcomes in minors who undergo this procedure.⁸⁴

Similarly, a retrospective observational study of youth seen at the Rady Children’s Hospital San Diego found that of fourteen subjects who had undergone chest surgery, the age ranged from 13.4 – 19.7 years.⁸⁵ Only seven subjects had been taking testosterone for one year or longer prior to surgery and the youngest patient was only on gonadotropin-releasing hormone agonist.⁸⁶ Readiness for surgery was not dependent on being on testosterone for a specific amount of time, but “rather on the patient’s maturity and strong desire for having the surgery.”⁸⁷ All subjects reported a high personal satisfaction with the surgical outcome, with the average score being 4.9 out of 5.⁸⁸ Subjects experienced improvements in depression and anxiety, and none reported regret.⁸⁹

Similarly, researchers from the Children’s Hospital of Pittsburgh of UPMC reported on 25 patients who underwent bilateral mastectomy over a 17-month period.⁹⁰ Six patients were under 18 years. All patients expressed satisfaction at postoperative visits.

A recent Adolescent Medicine: State of the Art Review (AM:STARS) on LGBTQ Youth: Enhancing Care for Gender and Sexual Minorities indicates

⁸³ Olson-Kennedy, *supra* note 4, at 434 (“Only 1 participant (who was older than 18 years at the time of surgery) reported experiencing regret ‘sometimes.’”)

⁸⁴ Olson-Kennedy, *supra* note 4, at 435.

⁸⁵ Maja Marinkovic and Ron S. Newfield, *Chest reconstructive surgeries in transmasculine youth: Experience from one pediatric center*, 18 INT’L J OF TRANSGENDERISM 376, 376 (2017).

⁸⁶ *Id.* at 378.

⁸⁷ *Id.* at 381.

⁸⁸ *Id.* at 379.

⁸⁹ *Id.* at 379.

⁹⁰ Jessica A. Lee et al., *Gender-affirming chest surgery in transgender adolescents and young adults: technical and ethical considerations*, The American Association of Plastic Surgeons 97th Annual Meeting (2018), <http://meeting.aaps1921.org/abstracts/2018/P11.cgi>.

that surgery—is appropriate for people under 18 and that individual readiness, maturity, and timing should be considered instead of simply chronological age.⁹¹ The preface indicates that the volume “provides new information and resources and promotes best practices.”⁹²

In the Netherlands, surgery has been performed on people under 18 for over 20 years. A 1997 follow-up study found that in a group of adolescents who began hormones at 16 and had surgery at 17, gender dysphoria resolved to the point where subjects did not differ in their scores from non-transgender control group.⁹³ No subjects reported regret.⁹⁴ The vast majority (90%) were satisfied or moderately satisfied with the surgery, and disappointment about the visibility of the scars—something that will not change with delaying the surgery—was the main reason for not being satisfied with the surgery.⁹⁵ As a result of these positive outcomes, the Dutch protocol was subsequently updated to include puberty suppression treatment at 12, which can result in the disappearance of any existing breast tissue.⁹⁶

Similarly, in 2014, the British Columbia Children’s Hospital Transgender Program reported patients as young as 14.9 years old undergoing chest surgery, and researchers noted that some patients treated

⁹¹ Ellie Zara Ley, Toby R. Meltzer, and Linda L. Takata, *Surgical Options in Transgender Youth*, 29 *ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS* 111, 112-113 (2018).

⁹² Michelle Forcier et al., *Preface LGBTQ Youth: Enhancing Care for Gender and Sexual Minorities*, 29 *ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS* xi (2018).

⁹³ Peggy T. Cohen-Kettenis & Stephanie H.M. van Goozen, *Sex reassignment of adolescent transsexuals: a follow-up study*, 36 *J. OF THE AM. ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY* 263, 267 (1997). *See also* Yolanda L.S. Smith, Leo Cohen & Peggy T. Cohen-Kettenis, *Postoperative psychological functioning of adolescent transsexuals: a Rorschach study*, 31 *ARCHIVES OF SEXUAL BEHAVIOR* 255–261 (2002) (following the same population and finding “stability in psychological functioning over time and that there were some areas in which improvement was evident.”).

⁹⁴ *Id.* at 267.

⁹⁵ *Id.*

⁹⁶ Henriette A Delemarre-van de Waal & Peggy T Cohen-Kettenis, *Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects*, 155 *EUROPEAN J. OF ENDOCRINOLOGY* S131, S132-33 (2006) (“In girls, the present breast tissue will become weak and may disappear completely.”)

early with GnRH analogs may not require surgery at all.⁹⁷ That is, indeed, part of the purpose of such treatments.⁹⁸

The Center for Gender Surgery at Boston Children’s Hospital chose to deviate from the SOC and set 15 as a minimum age for undergoing a chest reconstruction or breast augmentation.”⁹⁹

In this emerging field, “care is often based on expert opinion.”¹⁰⁰ Practicing clinicians and specialists agree on the necessity of chest surgery for transgender patients, including people under 18.¹⁰¹ A case-by-case approach is what is currently recommended when deciding to perform surgery on a patient who is under 18.¹⁰² Clinicians note that “[d]ecisions in such cases must necessarily be individualized.”¹⁰³ Nothing medically or psychologically relevant occurs when the minor turns 18 that would make this procedure more effective than it would have been the day before.

C. Other insurers and state Medicaid plans acknowledge this care to be medically necessary.

That a categorical ban on surgery for people under 18 is not in alignment with prevailing medical opinion is also reflected by the fact that other insurance companies recognize the medical necessity of mastectomy for

⁹⁷ Karine Khatchadourian, *Clinical Management of Youth with Gender Dysphoria in Vancouver*, 164 J. OF PEDIATRICS 906, 909-10 (2014).

⁹⁸ Stanley R. Vance Jr. et al., *Psychological and Medical Care of Gender Nonconforming Youth*, 134 PEDIATRICS 1184, 1188 (2014) (“[T]his treatment can halt progression of physical changes that are medically irreversible once fully developed (including ... breast development in affirmed males) which will require surgery and other more tedious procedures to reverse.”).

⁹⁹ Elizabeth R. Boskey et al., *Ethical Issues Considered When Establishing a Pediatrics Gender Surgery Center* 143 PEDIATRICS e20183053 (June 2019).

¹⁰⁰ Lee Ann E. Conard et al., *Caring for Transgender and Gender-Nonconforming Youth*, 6 CURRENT PEDIATRICS REPORTS, 139, 139 (2018).

¹⁰¹ See Olson-Kennedy, *supra* note 4 (finding “professional guidelines and clinical practice should consider patients for chest surgery based on individual need rather than chronological age.”).

¹⁰² Colebunders, *supra* note 47, at 229.

¹⁰³ Scott F. Leibowitz & John D. Lantos, *Affirming, Balanced, and Comprehensive Care for Transgender Teenagers*, 143 PEDIATRICS e20190995 (June 2019).

trans men under age 18.¹⁰⁴ Government health plans such as Medicaid will also cover surgery for minors.¹⁰⁵ In cases where insurers do deny this

¹⁰⁴ See, e.g., Aetna, *Gender Reassignment Surgery* (Apr. 24, 2020) (“For members below the age of majority (less than 18 years of age), completion of one year of testosterone treatment”); Amerigroup and Anthem, *Gender Reassignment Surgery* (May 21, 2020) (“A provider with experience treating adolescents with gender dysphoria may request further consideration of a bilateral mastectomy case in an individual under 18 years old when they meet all other bilateral mastectomy criteria above (including prior mental health evaluation) by contacting a Medical Director.”); Asuris, *Transgender Services* (Jan. 1, 2020) (surgical “age requirement will not be applied to mastectomy with documented provider determination of medical necessity of earlier intervention”); Blue Cross Blue Shield of Florida, *Gender Reassignment Surgery* (May 15, 2019) (listing no age requirement for surgery); BCBS of Illinois, Montana, New Mexico, Oklahoma and Texas, *Gender Assignment Surgery and Gender Reassignment Surgery with Related Services* (May 1, 2019) (“The following services may be considered medically necessary for the treatment of gender dysphoria for children and adolescents: ... Chest surgery for FtM individuals.”); BCBS of Kansas City, *Treatment of Gender Dysphoria* (Oct. 2019) (“For the purposes of this guideline, the age of majority is age 18. However, this refers to chronological age not biological age. Where approval or denial of benefits is based solely on the age of the individual a case-by-case medical director review is necessary.”); BCBS of Massachusetts, *Transgender Services* (Nov. 1, 2019) (“Members < 18 years of age will be considered on a case-by-case basis.”); BCBS Vermont, *Transgender Services* (Jul. 2019) (requiring one year of living in the desired gender role and one year of testosterone treatment and evidence of puberty completion); Boston Medical Center HealthNet Plan, *Gender Reassignment Surgery* (Aug. 1, 2020), (allowing Plan Medical Director review for individuals under 18); BridgeSpan Health, *Gender Affirming Interventions for Gender Dysphoria* (Jan. 1, 2020) (“age requirement will not be applied to mastectomy with documented provider determination of medical necessity of earlier intervention”); Capital BlueCross, *Gender Reassignment Surgery for Gender Dysphoria* (“Individual consideration may be given to individuals under 18 years old wishing to undergo female to male chest surgery (e.g., mastectomy) after one year of testosterone therapy and when all other criteria are met.”); Centene Corporation, *Gender-Affirming Procedures* (Oct. 2019) (“Exception: in adolescent female to male patients < 18 years, chest surgery may be considered after one year of testosterone treatment”); EmblemHealth, *Gender Reassignment Surgery Medical Guideline MG.MM.SU.281C* (May 10, 2019) (“Requests for gender reassignment surgery, services and procedures for members less than 18 will be reviewed on a case-by-case basis.”); Geisinger Health Plan, *Gender Dysphoria and Gender Confirmation Treatment* (Sept. 2019) (citing WPATH guidelines); Harvard Pilgrim Health Care, *Transgender Health Services* (Jan. 7, 2020). (“Consideration for breast and chest surgery (e.g. nipple areola reconstruction, mastectomy, breast augmentation) will be given to trans-adolescents under the age of 18 who meet all other policy criteria (e.g. hormone therapy).”); Health Net, *Gender Reassignment Surgery* (May 20, 2020) (“in adolescent female to male patients < 18 years, chest surgery may be considered after one year of testosterone treatment”); Healthy Blue (Louisiana Medicaid), *Gender Reassignment Surgery* (May 21, 2020) (“A provider with experience treating adolescents with gender dysphoria may request further consideration of a bilateral mastectomy case in an individual under 18 years old when they meet all other bilateral mastectomy criteria above (including prior mental health evaluation) by contacting a Medical Director.”); HMSA, *Gender Identity Services* MM.06.026 (Aug. 23, 2019) (covering for age 16 and older with case-by-case below 16); Horizon BCBSNJ, *Gender Reassignment Therapy* (May

service for individuals under 18, they are routinely overturned on appeal. Of the 26 denials for denials of mastectomy and male chest reconstruction for people under 18 reviewed under California's Independent Medical Review program, 96% have been overturned with only one being upheld because of a lack of any mental health provider records.¹⁰⁶

1, 2019) (allowing case-by-case exceptions to age 18 requirement according to WPATH guidelines); Kaiser Permanente Northwest Region, *Transgender Surgery* (Sept. 2019) (“For FtM members under the age of 18, chest surgery can be carried out on adolescents 16 years or older after ample time of living in the desired gender role and after one year of testosterone treatment.”); Regence BCBS, *Uniform Medical Plan: Transgender Services Clinical Criteria and Policy*, (Jan. 1, 2020) (“age requirement will not be applied to mastectomy with documented provider determination of medical necessity of earlier intervention.”); Tufts Health Plan, *Transgender Surgical Procedures* (Jan 1, 2020) (listing no age requirement); UnitedHealthcare West - California (“WPATH guidelines address age of majority in a given country. For the purposes of this guideline, the age of majority is age 18. However, this refers to chronological age, not biological age. Where approval or denial of benefits is based solely on the age of the individual a case-by-case medical director review is necessary.”); UPMC Medical Plan, *Gender Confirmation Surgery* (Oct. 2019) (“on a case by case basis, the minimum age of 18 years may be reconsidered for mastectomy surgeries if sufficient documentation is provided”). All policies available at <https://transhealthproject.org/resources/health-insurance-medical-policies/view/youth-services>.

¹⁰⁵ *E.g.*, Washington Apple Health—Gender dysphoria treatment program, WAC 182-531-1675 (covering GnRH analogs and allowing for surgery under age 18 for those eligible under Early and Periodic Screening, Diagnosis, and Treatment medical necessity criteria) <http://app.leg.wa.gov/wac/default.aspx?cite=182-531-1675>; Oregon Health Authority, *Prioritized List of Health Services*, Guideline Note 127 (Oct. 1, 2017), <http://www.oregon.gov/oha/HPA/CSI-HERC/PrioritizedList/10-1-2017%20Prioritized%20List%20of%20Health%20Services.pdf> (covering GnRH analogs and listing no age requirement for surgery); Oregon Health Authority, *Prioritized List: Guideline for Gender Dysphoria Frequently Asked Questions* (Oct. 2015), <http://www.oregon.gov/OHA/HPA/CSI-HERC/FactSheets/Gender-dysphoria.pdf> (noting that the age of medical consent in Oregon is 15); N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l)(3)(ii) (“[P]ayment for gender reassignment surgery, services, and procedures for patients under eighteen years of age may be made in specific cases if medical necessity is demonstrated and prior approval is received.”).

¹⁰⁶ California Department of Managed Care, Independent Medical Review Search, <https://wpso.dmhc.ca.gov/imr/default.aspx> (9 cases in 2017, 5 in 2018, 6 in 2019, and 2 in 2020); California Department of Insurance, Interactive Independent Medical Review Statistics, <https://interactive.web.insurance.ca.gov/IMR/faces/search> (overturning 3 out of 4).

III. Mastectomy is the most clinically appropriate level of service considering the potential benefits and harms to the patient; the condition would be adversely affected if the services were not provided.

A. Delaying care risks immediate, more severe mental health consequences.

Delaying care increases the risk of anxiety, depressive episodes and suicidal ideation. There is a direct correlation in more severe co-morbid symptoms following a denial of insurance coverage in transgender youth.¹⁰⁷ Delayed eligibility for medical interventions is associated with increased psychiatric comorbidity in transgender adolescents.¹⁰⁸ Transgender youth are already demonstrated to be at disproportionate risk for depression, suicidal ideation and life-threatening behaviors attributable to their transgender status.¹⁰⁹ Like its adult counterpart, untreated gender dysphoria in adolescents is strongly correlated with negative health outcomes such as depression and anxiety.¹¹⁰ Transgender

¹⁰⁷ Leena Nahata et al., *Mental Health Concerns and Insurance Denials Among Transgender Adolescents*, 4 LGBT HEALTH 188, 191-2 (2017).

¹⁰⁸ Annelou L.C. de Vries et al., *Psychiatric comorbidity in gender dysphoric adolescents*, 52 J. CHILD PSYCHOLOGY AND PSYCHIATRY 1195, 1201 (2011).

¹⁰⁹ Arnold H. Grossman & Anthony R. D'Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37 SUICIDE AND LIFE-THREATENING BEHAVIOR 527, 535 (2007); Sari L. Reisner et al., *Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health Center: A Matched Retrospective Cohort Study*, 56 J. OF ADOLESCENT HEALTH 274 (2015); Olson et al., *supra* note 19, at 379 (finding depression rates at 20% vs. 6.7% of the general population of youth aged 12-17 years, suicidal thoughts three times higher, and suicide attempts four times higher).

¹¹⁰ See, e.g., Veronica M. Figueredo & Alejandro Diaz, *SUN-062 Psychiatric Co-Morbidities, Sexual Orientation, and Impact of Therapeutic Interventions in a Gender Non-Conforming Pediatric Practice*, 4 J. ENDOCRINE SOCIETY, SUN-062 (2020) (finding a high prevalence of psychiatric co-morbidities, suicidal ideation, and self-injuring behavior in transgender youth that was significantly worse among affirmed males, but dysphoria improved after beginning hormonal treatment); Tracy A. Becerra-Culqui, et al., *Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers*, 141 PEDIATRICS e20173845, 7-8 (2018); Annelous L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-up Study*, 8 J. SEXUAL MEDICINE 2276, 2276 (2011) (finding that behavioral and emotional problems and depressive symptoms decreased, while general functioning improved significantly during hormone suppression treatment).

youth have higher rates of anxiety, depression, substance abuse, and suicide than their cisgender (non-transgender) peers.¹¹¹ “Body image is critically important during adolescence and young adulthood,”¹¹² and delaying surgery only prolongs and worsens these problems.

B. Delaying surgery prolongs the negative physical effects caused by chest binding.

The practice of chest binding is a self-help measure undertaken by the majority of trans men to relieve gender dysphoria.¹¹³ In addition to the negative psychological harm of delaying the surgery, there are negative physical effects caused by binding, such as back pain and respiratory problems. “Binders often restrict normal physical activity and can cause respiratory dysfunction (difficulties breathing, shortness of breath),

The above referenced studies closely align with those conducted on adult populations. See, e.g., Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review of Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 *CLINICAL ENDOCRINOLOGY* 214 (2010) (noting marked improvement in levels of anxiety, depression, and other mental health measures after sex-affirming care including hormone therapy sex reassignment surgery); Jan Eldh Agnes Berg & Maria Gustafsson, *Long Term Follow Up After Sex Reassignment Surgery*, 31 *SCANDANAVIAN J. PLASTIC & RECON. SURGERY & HAND SURGERY* 39 (1997) (same); Zoran Rakic et al., *The Outcome of Sex Reassignment Surgery in Belgrade: 32 Patients of Both Sexes*, 25 *ARCHIVES SEXUAL BEHAVIOR* 515 (1996) (same); C. Mate-Kole et al., *A Controlled Study of Psychological and Social Change after Surgical Gender Reassignment in Selected Male Transsexuals*, 157 *BRITISH J. PSYCHIATRY* 261 (1990) (same); Bram Kuiper & Peggy Cohen-Kettenis, *Sex Reassignment Surgery: A Study of 141 Dutch Transsexuals*, 17 *ARCHIVES SEXUAL BEHAVIOR* 439 (1988) (same).

¹¹¹ Samantha J. Gridley et al., *Youth and Caregiver Perspectives on Barriers to Gender-Affirming Health Care for Transgender Youth*, 59 *J. OF ADOLESCENT HEALTH* 254, 255 (2016); Michelle M. Johns et al. *Transgender Identity and Experiences of Violence Victimization, Substance Use, Suicide Risk, and Sexual Risk Behaviors Among High School Students — 19 States and Large Urban School Districts, 2017*. 68 *MORBIDITY AND MORTALITY WEEKLY REPORT* 67, 70 (2019) (Youth Risk Behavior Survey of 131,901 students finding “transgender students are at disproportionately higher risk than are cisgender students for violence victimization, substance use, and suicide risk”).

¹¹² Jenifer K. McGuire, et al. *Body Image in Transgender Young People: Findings from a Qualitative, Community Based Study*, 18 *BODY IMAGE* 96, 97 (2016).

¹¹³ Marinkovic, *supra* note 85, at 376.

reflux, dermatosis, and skin infections.”¹¹⁴ Studies on the health consequences of binding found that nearly every respondent experienced at least one negative health effect.¹¹⁵ The length of time one bound their chest was particularly connected to physical harms. “[D]uration (number of years spent binding regardless of frequency or intensity) was independently and positively associated with 13 health outcomes, particularly skin and soft tissue outcomes and musculoskeletal outcomes.”¹¹⁶ Binders restrict physical activity and result in transgender men exercising less than they would otherwise. Despite the pain, many trans males will continue binding to manage dysphoria¹¹⁷ even as binding becomes less effective over time. Binding can also cause transient elevation of prolactin which can cause galactorrhea, while high levels of prolactin are associated with prolactinomas.¹¹⁸ The need to bind would be alleviated permanently through mastectomy whereas delaying surgery will only prolong and worsen these physical consequences of binding.

C. Chest dysphoria worsens as length of hormone treatment continues.

Researchers note that requiring 12 months of hormone therapy prior to surgery may cause additional harm.¹¹⁹ Insurance coverage for testosterone therapy prior to age 18 but not surgery places transgender males in an untenable position. For transgender males who have started testos-

¹¹⁴ *Id.*

¹¹⁵ Sarah Peitzmeier et al., *Health Impact of Chest Binding Among Transgender Adults: A Community-Engaged, Cross-sectional Study*, 19 *CULTURE, HEALTH & SEXUALITY* 64, 70 (2016); Brooke A. Jarrett et al., *Chest Binding and Care Seeking Among Transmasculine Adults: A Cross-Sectional Study*, 3.1 *TRANSGENDER HEALTH* 170, 173 (2018).

¹¹⁶ *Id.* at 72.

¹¹⁷ *Id.* at 73.

¹¹⁸ Laura Bond Maycock and Holly Powell Kennedy, *Breast Care in the Transgender Individual*, 59 *J. OF MIDWIFERY & WOMEN’S HEALTH* 74, 78 (2014).

¹¹⁹ Olson-Kennedy, *supra* note 4, at 435.

terone therapy but not undergone chest surgery, chest dysphoria increases over time.¹²⁰ This reflects the fact that as testosterone masculinizes the rest of the body, there is greater disparity and distress caused by having a female chest.

Additionally, as the voice deepens and facial hair grows, the person is increasingly likely to be recognized by others as male. Having breasts increases the anxiety of being outed as transgender and also presents a significant safety concern. A person is no longer able to safely use female single-sex spaces such as bathrooms and locker rooms, but retaining breasts makes it difficult and unsafe to use male single-sex spaces or participate in male athletics.

D. Delaying care is not a clinically appropriate or neutral act and risks long-term negative outcomes.

Worse outcomes in adults are associated with late—rather than early—treatment. Although potential regret is a concern, “it is also considered important to avoid life-long suffering due to postponement of treatment.”¹²¹ Specifically, early treatment can prevent “delay or arrest in areas that are particularly important during adolescence (e.g. peer relationships, romantic involvements or academic achievement) which may, in itself, lead to additional, yet avoidable problems. Thus, early treatment may be particularly suitable to prevent unnecessary psychological and emotional problems.”¹²² Indeed, Dutch researchers note “the psychological functioning of adult transsexuals is worse than in adolescent transsexuals from the same clinic who had been treated in early adolescence. The poorer psychological functioning of adult transsexuals compared with adolescent transsexuals could partly result from the enduring distress the adults had experienced in their lives.”¹²³ In the context of pu-

¹²⁰ *Id.*

¹²¹ Yolanda L.S. Smith, Stephanie H.M. van Goozen SH & Peggy T. Cohen-Kettenis, *Adolescents with Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-Up Study*. 40 J. OF THE AM. ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, 472–481 (2001).

¹²² *Id.*

¹²³ Baudewijntje P C Kreukels & Peggy T. Cohen-Kettenis PT. *Puberty Suppression in Gender*

erty suppression, researchers note that “[n]onintervention is not a neutral option, but has a negative life-long impact on the quality of life of nontreated adolescents. Realizing the potential harmfulness of nonintervention, one may even wonder whether not treating may not only be doubtful on ethical grounds, but also have legal implications.”¹²⁴

The possible harms of the surgery are those associated with major surgeries in general. However, surgery would improve quality of life, end the need to bind, and treat one of the main causes of gender dysphoria in transgender males. As the benefits of the surgery outweigh the risks and the surgery itself is widely accepted as appropriate treatment for a patient with gender dysphoria, the procedure is medically necessary.

IV. The surgery is not experimental or investigative.

Mastectomy in patients under 18 years of age is neither experimental nor investigational. The procedure is not subject to clinical trial, IRB approval, or special consent on account of its experimental or investigational nature. There is no applicable research protocol indicating that the service is experimental or investigational. Prevailing opinion within the medical profession is settled among transgender specialists and surgeons performing this surgery. Transgender individuals with gender dysphoria experience “significant improvements” in quality of life after undergoing chest masculinization surgery.¹²⁵ This appeal includes published research reports, medical organization consensus statements, and clinical practitioner statements that support the medical necessity of this procedure in people under 18.

Identity Disorder: The Amsterdam Experience, 7 NAT. REV. ENDOCRINOL. 466-72 (2011).

¹²⁴ Luk Gijs & Anne Brewaeys, *Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges*, 18 ANNU REV SEX RES. 178, 214 (2007).

¹²⁵ See e.g., Cori A. Agarwal, Melody F. Scheefer, Lindsey N. Wright, Norelle K. Walzer, Andy Rivera, *Quality of Life Improvement After Chest Wall Masculinization in Female-to-Male Transgender Patients: A Prospective Study Using the BREAST-Q and Body Uneasiness Test*, 71 J. PLASTIC, RECONSTRUCTIVE & AESTHETIC SURGERY 651-657 (2018).

V. A categorical denial of treatment for gender dysphoria is unlawful discrimination.

A. Unlawful sex discrimination under § 1557

Given that surgery to treat gender dysphoria in a minor can be medically necessary in *at least some* cases, blanket denials for gender dysphoria surgeries in people under 18 is unlawful sex discrimination under Section 1557 of the Affordable Care Act (“§ 1557”).¹²⁶ An insurance company would not deny medically necessary treatment of mastectomy to a minor under any other circumstance. If the minor had breast cancer and needed a mastectomy, the insurance company would approve the procedure. Coverage for treatment is being denied because the purpose of the surgery is to change sex characteristics and because of animus toward transgender-related health care, which is a denial of benefits on the basis of sex.¹²⁷ Courts have and continue to find that § 1557 itself—independent of any regulation—protects transgender individuals from discrimination in health care in general,¹²⁸ and that transgender insurance denials in particular trigger sex discrimination protections under § 1557.¹²⁹

¹²⁶ See 42 U.S.C. § 18116 (2017); 45 C.F.R. § 92.207(b)(1) (2017) (prohibiting denial or limitation of a health-related insurance plan or policy on the basis of sex). Companies that sell plans on the Marketplace or otherwise receive federal funding are covered entities. 45 C.F.R. § 92.4 (2017).

¹²⁷ See *Bostock v. Clayton Cty., Georgia*, No. 17-1618, 2020 WL 3146686, at *11 (U.S. June 15, 2020) (holding under Title VII that “discrimination based on ... transgender status necessarily entails discrimination based on sex”).

¹²⁸ *Rumble v. Fairview Health Servs.*, No. 14-cv-2037, 2015 WL 1197415 at *2 (D. Minn. Mar. 16, 2015); *Prescott v. Rady Children’s Hospital-San Diego*, 265 F. Supp. 3d 1090, 1099 (S.D. Cal. Sept. 27, 2017) (“Because Title VII, and by extension Title IX, recognize that discrimination on the basis of transgender identity is discrimination on the basis of sex, the Court interprets the ACA to afford the same protections.”).

¹²⁹ *Kadel v. Folwell*, No. 1:19-cv-272-LCB-LPA, 2020 WL 1169271, at *7 (M.D.N.C. Mar. 11, 2020) (rejecting a motion to dismiss challenging transgender exclusion in the North Carolina state employee health plan under § 1557 and Title IX); *Flack v. Wisconsin Dep’t of Health Servs.*, 395 F. Supp. 3d 1001, 1015 (W.D. Wis. 2019) (finding a transgender exclusion in Medicaid discriminates on the basis of sex under § 1557 as detailed in *Flack v. Wis. Dep’t of Health Servs.*, 328 F. Supp. 3d 931, 951 (W.D. Wis. Jul. 25, 2018)); *Boyden v. Conlin*, 341 F. Supp. 3d 979, 997 (W.D. Wisc. 2018) (applying § 1557 to transgender exclusion in Wisconsin state employee health plan); *Tovar v. Essentia Health*, 342 F. Supp. 3d 947, 954 (D. Minn. 2018) (holding that employer and third-party administrator may be held liable under § 1557 for administering a self-funded plan containing an exclusion for “gender reassignment” treatment); *Cruz*

B. Unlawful age discrimination under § 1557

Refusing to cover medically necessary treatment solely because of someone's chronological age is age discrimination. Section 1557 prohibits discrimination based on age.¹³⁰ Courts are beginning to recognize that denying medically necessary treatment to gender dysphoric minors is unlawful.¹³¹ The medical records submitted in support of this procedure deem the procedure medically necessary and appropriate despite the minor's age. The insurance company does not dispute the diagnosis of gender dysphoria or the ability of the surgery to alleviate that dysphoria; the only explanation for denying coverage was age.

Age is not being used as a legitimate measure or approximation of another characteristic, such as maturity or an individual's readiness for treatment. The age of 18 might be the legal age of majority, but it is not a medically relevant category. As one expert in the field notes, "[t]he rationale of the arbitrary age of 18 years is probably based more on a fear of malpractice suits ... than on something intrinsically good for [sex reassignment] applicants... The age of psychological and somatic maturity varies largely inter-individually. Adhering to such limits would severely hamper the development of a mature adolescent."¹³² The arbitrary denial of necessary medical treatment targets—without justification—persons below the age of majority and therefore constitutes unlawful age discrimination.

C. Unlawful disability discrimination under § 1557, the ADA, and Rehabilitation Act

Failing to cover this procedure because the minor has gender dysphoria is also disability discrimination. Section 1557 prohibits discrimination on

v. Zucker, 116 F. Supp. 3d 334, 348 (S.D.N.Y. 2015) (entertaining a § 1557 sex discrimination claim for transgender people under Medicaid); *see also* *Bostock v.*

¹³⁰ 42 U.S.C. § 18116 (2017); 45 C.F.R. § 92.207(b)(1) (prohibiting denial or limitation of a health-related insurance plan or policy on the basis of age).

¹³¹ *Cf. Cruz v. Zucker*, 218 F. Supp. 3d 246, 248 (S.D.N.Y. 2016) (rejecting an age-based exclusion for hormones and surgery under Medicaid's availability provision).

¹³² Peggy T. Cohen-Kettenis & Friedemann Pfäfflin, *Legal Issues of Intersexuality and Transsexualism*, in *TRANSGENDERISM AND INTERSEXUALITY IN CHILDHOOD AND ADOLESCENCE: MAKING CHOICES* 155, 179 (2003).

the basis of disability,¹³³ as does the Americans with Disabilities Act (ADA),¹³⁴ and the Rehabilitation Act.¹³⁵ Gender dysphoria is a disability.¹³⁶ A medically necessary mastectomy would have been provided to a minor suffering from a different illness (i.e., breast cancer) regardless of age. Here, the same treatment was denied because of the diagnosis. This is a diagnosis-based exclusion that has no nondiscriminatory justification. As demonstrated above, the insurer denied coverage because of animus-based discriminatory treatment of gender dysphoria, not sound medical evidence. In denying this surgery, the insurer goes against the clinical judgment of the member's providers, established authority on the treatment of gender dysphoria, and is internally inconsistent even with the insurer's own policies regarding puberty suppression and cross-sex hormone therapy for minors. The insurer must cover this procedure to be in

¹³³ See 42 U.S.C. § 18116 (2017); 45 C.F.R. § 92.207(b)(1) (2017) (prohibiting denial or limitation of a health-related insurance plan or policy on the basis of disability).

¹³⁴ Title III of the ADA prohibits places of public accommodation, including insurance companies, from offering services that discriminate on the basis of disability. 42 U.S.C. § 12182(a); 28 C.F.R. §36.201(a). Title II prohibits state entities from engaging in discrimination. 42 U.S.C.A. § 12132.

¹³⁵ 29 U.S.C. § 794(a); 29 U.S.C. § 794(b)(1) (applying to entities that receive federal funding).

¹³⁶ See *Tay v. Dennison*, No. 19-CV-00501-NJR, 2020 WL 2100761, at *3 (S.D. Ill. May 1, 2020) (allowing incarcerated transgender woman's ADA failure to accommodate claim to proceed); *Shorter v. Barr*, No. 4:19-CV-108, 2020 WL 1942785, at *11 (N.D. Fl. Mar. 13, 2020) (declining to dismiss claim under Rehabilitation Act); *Iglesias v. True*, 403 F. Supp. 3d 680, 687 (S.D. Ill. 2019) (allowing a pro se incarcerated transgender woman's Rehabilitation Act claim to proceed); *Doe v. Mass. Dep't of Correction*, No. 1:17-cv-12255-RGS, 2018 WL 2994403, at *6-8 (D. Mass. June 14, 2018) (drawing a distinction between gender identity disorder and gender dysphoria and suggesting that there may be a physical etiology underlying gender dysphoria sufficient to take it out of "not resulting from physical impairments" category); *Edmo v. Idaho Dep't of Correction*, No. 1:17-CV-00151-BLW, 2018 WL 2745898, at *8 (D. Idaho June 7, 2018) (declining to dismiss Title II claim because whether plaintiff's "diagnosis falls under a specific exclusion of the ADA presents a genuine dispute of material fact in this case."); *Blatt v. Cabela's Retail*, No. 5:14-CV-04822, 2017 WL 2178123, at *4 (E.D. Pa. May 18, 2017) (denying a motion to dismiss by finding that "gender dysphoria" was not excluded by § 12211 of the Americans with Disabilities Act); *Darin B. v. McGettigan*, E.E.O.C. App. No. 0120161068, 2017 WL 1103712 (Mar. 6, 2017) (establishing that a claim may proceed under Section 501 of the Rehabilitation Act where a transgender man was denied nipple reconstruction under his federal employee health plan).

compliance with established medical standards of care as well as § 1557 and the ADA.

VI. Conclusion

Denying coverage for mastectomy in a minor with gender dysphoria is not only in contravention of terms of the plan, but it is also discrimination. In refusing medically necessary treatment on the basis of sex, disability, and age, the insurer is in violation of federal nondiscrimination law. Accordingly, the insurer should promptly reverse its denial of coverage and eliminate categorical age requirements in its clinical policy.