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: March 30, 2021

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 is 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 dysphoria.

¹ Andreas Kyriakou et al., Current Approach to the Clinical Care of Adolescents With Gender Dysphoria, 91 Acta BioMedica: Atenei Parmensis 165-175 (2020).
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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 and 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 . . . .

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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-Langner 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, 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.”).


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).


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.”).
[R]elief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence.”

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.

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 the experience of dysphoria in social interactions. It also allows people to be recognized as male by others and facilitates living in accordance with a male or non-binary social role. In a 2017 study, the satisfaction rate for trans men receiving mastectomies was 94%. Additionally, the results showed that “satisfied respondents reported a relatively positive QoL [quality of life]. This confirm[ed] that medical transition alleviates feelings of gender dysphoria and improves life satisfaction to normative levels.” A 2018 study also found improved quality of life,

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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).

12 Id. at 16. See also Christina Richards & J. Barrett, The case for bilateral mastectomy and male chest contouring for the female-to-male transgender, 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
reduced gender dysphoria, and no regret aside from a few aesthetic concerns.\textsuperscript{13}

The prevailing opinion among transgender specialists both nationally and globally is that mastectomy is 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.\textsuperscript{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.

B. 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 youth\textsuperscript{15} and that is not possible to change gender identity.\textsuperscript{16} The American Academy of Pediatrics notes that gender identity is stable

\textsuperscript{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 RECONSTRUCT. 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”).

\textsuperscript{14} TLDEF, Health Insurance Medical Policies, https://transhealthproject.org/resources/health-insurance-medical-policies.

\textsuperscript{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).

\textsuperscript{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).
by age four.\textsuperscript{17} Nearly all transgender adults report first experiencing gender dysphoria by age 7.\textsuperscript{18} In one study of transgender youth, 8.3 years was the mean age they realized their gender differed from their assigned gender.\textsuperscript{19} Transgender children know and express their genders as clearly and consistently as cisgender children express their genders,\textsuperscript{20} and transgender youth report body dissatisfaction with their genitals and chest.\textsuperscript{21}

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.\textsuperscript{22} The regions affected play a role in body perception and self-awareness.\textsuperscript{23} Separately, family and twin studies indicate a strong genetic component.\textsuperscript{24} This biological origin is reflected in

\begin{itemize}
\item \textsuperscript{17} David A. Levine and the Committee on Adolescence, \textit{Office-Based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth}, 132 \textit{Pediatrics} e297, e299 (2013).
\item \textsuperscript{18} Michael Zaliznyak et al., \textit{Age at First Experience of Gender Dysphoria Among Transgender Adults Seeking Gender-Affirming Surgery}, 3 \textit{JAMA Network Open} e201236.
\item \textsuperscript{19} Johanna Olson et al., \textit{Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria}, 57 \textit{The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine} 374, 378 (2015) (reporting an age range of 2-22).
\item \textsuperscript{20} Kristina R. Olson et al., \textit{Gender cognition in transgender children}, 26 \textit{Psychological Science}, 467–474 (2015); Selin Gülgöz et al., \textit{Similarity in Transgender and Cisgender Children’s Gender Development}, 116 \textit{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).
\item \textsuperscript{21} Anisha Gohil et al., \textit{Baseline Body Satisfaction in Gender-Diverse Youth}, 4 \textit{J. Endocrine Soc.} SUN-079 (May 8, 2020).
\item \textsuperscript{22} Elyse Pine-Twaddle, \textit{Medical Management Updates for Gender Minority Youth and Difficult Cases}, 29 \textit{Adolescent Medicine: State of The Art Reviews} 97, 98 (2018) (compiling the literature).
\item \textsuperscript{23} Id.
\item \textsuperscript{24} Id.
\end{itemize}
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 for GnRH analog treatment at the start of puberty\(^{26}\) 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.\(^{27}\)

**C. **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

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\(^{25}\) 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.”).


make the procedure any less effective or any less medically necessary in resolving those symptoms.\textsuperscript{28}

Surgeons are focusing more attention to gender reassignment surgeries in minors.\textsuperscript{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.\textsuperscript{30} Nearly all surgeons relied on the term “maturity” rather than chronological age to determine patients’ readiness for the procedure.\textsuperscript{31} Only one third of the surgeons thought that age 18 was an appropriate criterion.\textsuperscript{32} Concerning the less controversial chest surgery, one study simply noted that patients who were 16 or older could be considered for virilizing mammoplasty.\textsuperscript{33} The authors of this study, Laura 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.\textsuperscript{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

\textsuperscript{28} See generally Olson-Kennedy, supra note 4.


\textsuperscript{30} Milrod, Age Is Just a Number, supra note 29, at 626.

\textsuperscript{31} Id. at 631.

\textsuperscript{32} Id. at 630.

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

\textsuperscript{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).
care."\textsuperscript{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.\textsuperscript{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.\textsuperscript{37}

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.”\textsuperscript{38} WPATH publishes the \textit{Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People},\textsuperscript{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.\(^4\)

PATH released a statement on medically necessary therapy and treatment for trans people that specifically listed mastectomy and chest reconstruction as medically necessary surgeries.\(^4\)

PATH supports social transition for transgender youth, including puberty suppression, hormones, and surgeries where appropriate.\(^4\) The criteria for adults includes the age of majority to medical treatment, but “if younger, follow the SOC for children and adolescents.”\(^4\) Specifically, PATH 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.”\(^4\)

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 PATH standards, it is not the patient’s

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\(^4\) AMA House of Delegates’ Resolution 122, Removing Financial Barriers to Care for Transgender Patients at 1, ¶¶ 16-20 (April 18, 2008).


\(^4\) WPATH Standards of Care supra note 39 at 10-21.

\(^4\) Id. at 59.

\(^4\) Id. at 21.
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.\textsuperscript{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 fallen.\textsuperscript{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.\textsuperscript{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.\textsuperscript{48} Increased physician awareness due to the publi-


\textsuperscript{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.”).

\textsuperscript{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
cation of clinical guidelines, such as the publication of the 2009 Endocrine Society guidelines and the 2011 version of the SOC itself also likely contributed to the increase in referrals to gender clinics. A final factor is the increased number of clinical care options, including youth-specific clinics. 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.

The SOC recognize that the field of gender care evolves rapidly. 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. When Version 7 of the

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.


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).

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.”).

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.”

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

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. 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. Tellingly, the most recent document issued by WPATH is its June 2018 list of services—based on the SOC—that it recommends


56 Bizic, *supra* note 47, at 3.

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


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

61 *Id.*
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 recommend medical treatment for adolescents, including puberty suppression\(^{65}\) 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

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\(^{64}\) *Id.* at 26.

\(^{65}\) *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.”).
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.”\textsuperscript{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 require-
ment.”\textsuperscript{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.\textsuperscript{70}

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 in-
fants, children, adolescents and young adults.\textsuperscript{71}

The AAP endorses both WPATH and Endocrine Society approaches
noting that their standards “integrate the best available evidence with

\textsuperscript{68} Wylie C. Hembree et al., \textit{Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Per-
sons: An Endocrine Society Clinical Practice Guideline}, 102 \textit{J. Clinical Endocrinology}
& \textit{Metabolism} 1, 26 (2017).

\textsuperscript{69} Id. at 26.


\textsuperscript{71} American Academy of Pediatrics, \textit{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-Adoles-
cents.aspx.
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.

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

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).

75 Id. at 6.
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 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

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), http://transhealth.ucsf.edu/trans?page=guidelines-home.

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.” 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. In the final results of the study, 100% of postsurgical participants affirmed the statement, “It was a good decision to undergo chest reconstruction” and 67 out of 68 participants reported no regret. There is no evidence of statistically significant regret or adverse outcomes in minors who undergo this procedure.

A qualitative review of youth at the Children’s Hospital of Philadelphia found that youth reported that chest dysphoria triggered strong negative emotions and suicidal ideation, caused a myriad of functional limitations, and was inadequately relieved by testosterone therapy alone. All youth

80 Id.
82. Id.
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.
who underwent surgery reported near or total resolution of chest dysphoria, lack of regret, and improved quality of life and functioning.\textsuperscript{86}

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.\textsuperscript{87} 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.\textsuperscript{88} 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.”\textsuperscript{89} All subjects reported a high personal satisfaction with the surgical outcome, with the average score being 4.9 out of 5.\textsuperscript{90} Subjects experienced improvements in depression and anxiety, and none reported regret.\textsuperscript{91}

Similarly, researchers from the Children’s Hospital of Pittsburgh of UPMC reported on 25 patients who underwent bilateral mastectomy over a 17-month period.\textsuperscript{92} Six patients were under 18 years. All patients expressed satisfaction at postoperative visits.

An \textit{Adolescent Medicine: State of the Art Review (AM:STARS)} on \textit{LGBTQ Youth: Enhancing Care for Gender and Sexual Minorities} indicates that surgery—is appropriate for people under 18 and that individual readiness,

\begin{itemize}
  \item \textsuperscript{86} \textit{Id.}
  \item \textsuperscript{87} Maja Marinkovic and Ron S. Newfield, \textit{Chest reconstructive surgeries in transmasculine youth: Experience from one pediatric center}, 18 \textsc{Int’l J of Transgenderism} 376, 376 (2017).
  \item \textsuperscript{88} \textit{Id.} at 378.
  \item \textsuperscript{89} \textit{Id.} at 381.
  \item \textsuperscript{90} \textit{Id.} at 379.
  \item \textsuperscript{91} \textit{Id.} at 379.
  \item \textsuperscript{92} Jessica A. Lee et al., \textit{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.
\end{itemize}
maturity, and timing should be considered instead of simply chronological age. 93 The preface indicates that the volume “provides new information and resources and promotes best practices.”94

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.95 No subjects reported regret.96 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.97 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.98

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

95 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.”).
96 Id. at 267.
97 Id.
98 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. That is, indeed, part of the purpose of such treatments.

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.

In this emerging field, “care is often based on expert opinion.” Practicing clinicians and specialists agree on the necessity of chest surgery for transgender patients, including people under 18. A case-by-case approach is what is currently recommended when deciding to perform surgery on a patient who is under 18. Clinicians note that “decisions in such cases must necessarily be individualized.” 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. Private 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 private insurance companies recognize the medical necessity of mastectomy for


100 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.”).

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

102 Lee Ann E. Conard et al., Caring for Transgender and Gender-Nonconforming Youth, 6 Current Pediatrics Reports, 139, 139 (2018).

103 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.”).

104 Colebunders, supra note 47, at 229.

105 Scott F. Leibowitz & John D. Lantos, Affirming, Balanced, and Comprehensive Care for Transgender Teenagers, 143 Pediatrics e20190995 (June 2019).
trans men under age 18.106 Government health plans such as Medicaid will also cover surgery for minors.107 In cases where insurers do deny this

106 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.28lC (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. The California Department of Insurance has clarified that under California law,

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health insurance companies may not deny coverage for male chest reconstruction surgery for patients undergoing gender-affirming care for gender dysphoria based solely on a patient’s age.109

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.110 Delayed eligibility for medical interventions is associated with increased psychiatric comorbidity in transgender adolescents.111 Transgender youth are already demonstrated to be at disproportionate risk for depression, suicidal ideation and life-threatening behaviors attributable to their transgender status.112 Like its adult counterpart, untreated gender dysphoria in adolescents is strongly correlated with negative health outcomes such as depression and anxiety.113 Transgender


112 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).

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

prevailing 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).


114 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”).

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.\textsuperscript{116} 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), reflux, dermatosis, and skin infections."\textsuperscript{117} Studies on the health consequences of binding found that nearly every respondent experienced at least one negative health effect.\textsuperscript{118} 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."\textsuperscript{119} 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 dysphoria\textsuperscript{120} 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.\textsuperscript{121} The need to bind would be alleviated permanently through mastectomy whereas delaying surgery will only prolong and worsen these physical consequences of binding.

\textsuperscript{116} Marinkovic, supra note 87, at 376.

\textsuperscript{117} Id.


\textsuperscript{119} Id. at 72.

\textsuperscript{120} Id. at 73.

\textsuperscript{121} Laura Bond Maycock and Holly Powell Kennedy, Breast Care in the Transgender Individual, 59 J. of Midwifery \& Women’s Health 74, 78 (2014).
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.\textsuperscript{122} 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 testosterone therapy but not undergone chest surgery, chest dysphoria increases over time.\textsuperscript{123} 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.”\textsuperscript{124} 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

\textsuperscript{122} Olson-Kennedy, \textit{supra} note 4, at 435.
\textsuperscript{123} \textit{Id.}
emotional problems.” 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.” In the context of puberty 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.”

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. This appeal includes published research

125 Id.


128 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
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”). 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. Courts have and continue to find that § 1557 itself— independent of any regulation—protects transgender individuals from discrimination in health care in general, and that transgender insurance denials in particular trigger sex discrimination protections under § 1557.

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130 See Bostock v. Clayton Cty., Georgia, 140 S. Ct. 1731, 1747 (2020) (holding under Title VII that “discrimination based on … transgender status necessarily entails discrimination based on sex”).

131 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.”).

132 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
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.\(^{133}\) Courts are beginning to recognize that denying medically necessary treatment to gender dysphoric minors is unlawful.\(^{134}\) 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.”\(^{135}\) The arbitrary denial of necessary medical treatment targets—without justification—persons below the age of majority and therefore constitutes unlawful age discrimination.

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\(^{133}\) 42 U.S.C. § 18116; 45 C.F.R. § 92.2.


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 the basis of disability, as does the Americans with Disabilities Act (ADA), and the Rehabilitation Act. Gender dysphoria is a disability. 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 treat-


137 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.


ment 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 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.