Insurance coverage of medical treatments for “sex changes” is very controversial. Medicaid coverage of gender identity related conditions is practically a legal field of study unto itself. Like the various definitions of “gender identity,” the rules that control driver’s license and birth certificate amendments, and whether violence against someone is considered a hate crime; health insurance is governed differently in every state.

In Oregon, the Insurance Division of the Department of Consumer and Business Services (division) recently issued a comprehensive bulletin (INS 2012-01) about health insurance coverage of medical treatments for gender identity/gender dysphoria (GI/GD) (see discussion of meaning below, Principle #4). I will use the framework of this guidance to highlight some of the legal and practical inconsistencnes that concern me about the socially constructed intersection of sex and gender and what it means to consider gender non-conformity a medical anomaly. Insurance coverage of GI/GD is strategically oversimplified in political discourse as a matter of "fairness" and "equality" (an emotional appeal to our collective sense of justice), but the issues are actually much more complicated and have serious implications for biological determinism and sex stereotyping.

TO: All Insurers Transacting Insurance in Oregon (December 19, 2012)

RE: Application of Senate Bill 2 (2007 Legislative Session) to Gender Identity Issues in the Transaction and Regulation of Insurance in Oregon

The bulletin contains six guiding principles interpreting the proper application of the state’s "gender identity" anti-discrimination protections to health insurance policies. In short, medical treatments for GI/GD—from mental health counseling and synthetic hormone replacement to surgeries—must be covered at all times and without restriction.

**Principle #1:** An insurer may not discriminate on the basis of an insured’s or prospective insured’s actual or perceived gender identity, or on the basis that the insured or prospective insured is a transgender person.
Principle #1 is broken down into 4 finer points, including the mandate that an insurer may not "designate GI/GD as a preexisting condition for which coverage will be denied or limited." I agree with this. Preexisting condition exclusions and limitations should be illegal. Life is a preexisting condition! The industry standardization of these exclusions represents widespread profiteering at the expense of human dignity and health. They concern me, especially when inconsistently applied.

As I was researching preexisting conditions in Oregon, I discovered that the state has a program called the Oregon Medical Insurance Pool (OMIP). It's a health insurance plan for people with preexisting medical conditions for whom private insurance premiums are prohibitively expensive. Ironically, the OMIP itself limits coverage for preexisting conditions in the first six months of enrollment. These preexisting conditions include pregnancy, a female-specific condition. From their website:

**Q. I have not had insurance for years. I am pregnant and need insurance coverage. Can OMIP help me?**

**A. Maybe. Again, the OMIP benefit plans have a six-month limitation for pre-existing conditions (except HCTC), including pregnancy. Therefore, depending on when your baby is delivered (regardless of when the due date is), you may be covered. If the baby is delivered after you have had your policy in force for six months or more, you would be covered for that delivery.**

Pretty harsh. Even if you have a high-risk pregnancy or a premature birth, OMIP will not cover you in the first six months of your policy. So, according to the state of Oregon, pregnancy can be designated as a preexisting condition, but GI/GD cannot be. This arrangement doesn't make sense for a number of reasons. Pregnancy is a temporary condition with a known end (it is often defined as a short term disability). Within the biologically limited timeframe of gestation, pregnancy is an escalating condition that commonly requires treatment more urgently in its later stages than its early ones. Pregnancy can be physically, urgently life-threatening. GI/GD, on the other hand, is a long term, chronic condition. The medical treatment for GI/GD, including plans for "sex change" surgery, is an evolutionary process, often taking years. GI/GD is not directly, physically life-threatening. But Oregon’s legal priorities have been clearly established: it is more important to ensure immediate, continuous medical coverage for GI/GD than for a common, female-specific health condition that represents the main event of human reproduction. I think that is a human rights violation.
**Principle #2:** A health insurer may not deny or limit coverage or deny a claim for a procedure provided for GI/GD if the same procedure is allowed in the treatment of another non-GI/GD-related condition.

This attempt at “equality” may sound reasonable on first read, but let’s back it up a step: payment of health insurance benefits always turns on the meaning and application of medical necessity for any particular treatment. The bulletin further explains:

> For example, if an insurer provided coverage for breast reduction surgery to alleviate back pain, the insurer could not deny breast reduction surgery for gender reassignment purposes so long as the treatment is deemed medically necessary. This places an insured who is seeking coverage of a condition related to GI/GD on equal footing with any other person by basing the decision about coverage on medical necessity, not on GI/GD. . .

First, a finding of medical necessary to relieve the symptoms of one condition does not logically validate or lend credence to the idea that the same intervention is medically necessary and/or effective at treating a wholly different condition. But secondly, in this example, major surgery on the physical source of back pain is analogized to the use of major surgery on the same body part to relieve a physically unrelated mental condition. GI/GD seems to be the singular exception to the rule that establishing medical necessity for physical interventions on otherwise healthy body parts is logically inconsistent. The “brain sex” theory of transsexualism has been thoroughly debunked, but social and legal opinion has been slow to catch up because political power and money is concentrated in the hands of people who stand to benefit from medicalizing GI/GD.

Female transsexuals undergo mastectomies, but a common “treatment” for male transsexualism (or GI/GD) is breast implants. I want to ask what would happen if Oregon’s mandate were applied to Medicare (which it doesn’t because Medicare is a federal program). Medicare is a bit more discerning in its coverage rules:

> Medicare doesn’t cover cosmetic surgery unless it’s needed because of accidental injury or to improve the function of a malformed body part. Medicare covers breast prostheses if you had a mastectomy because of breast cancer.
By comparison, Oregon’s bulletin effectively requires coverage of breast prostheses for everyone, not just those females who have suffered physically objective health problems so extreme that they ultimately required a mastectomy. Instead of being able to limit coverage to instances of breast reconstruction (following the medically necessary removal of naturally formed breasts for life-saving purposes), the state of Oregon now expects private health insurance carriers to cover breast prostheses for anyone who “needs” breasts for the first time as a result of their aberrant “gender identity” even while the body itself functions normally and naturally.

I’m concerned about how medical necessity is applied to current conceptions of gender identity. If gender identity and/or gender dysphoria (GI/GD) medically necessitates physical changes to the body, then certain “gender identities” are medically consistent with particular kinds of bodies. In other words, there is a “right” and a “wrong” way to embody gender. Depending on one’s “gender identity,” certain sex-specific body parts can be diagnosed as erroneous and, therefore, in need of medical treatment or correction. Contrast this with the radical idea that gender non-conformity is a sociologically foreseeable departure from, and/or individually calculated resistance to, rigid gendered conditioning.

The medicalization of gender non-conformity is consistent with and legitimizes compulsory heteronormativity. Changing the sexed appearance of one’s body to accommodate society’s expectations of “man” or “woman” does not challenge the status quo; it is capitulation to and reinforcement of the stereotypes that limit these social categories in the first place. As a female who violates gender norms, and as a woman who cares about women’s freedom to express themselves without “gender” related limitations, the medicalization of gender non-conformity deeply concerns me.

**Principle #3:** Although a health insurer may categorically exclude coverage for a particular condition or treatment, the insurer may not base such exclusion on gender identity.

A health insurer may exclude coverage for specific conditions (like pregnancy!), but it cannot do so on the basis of gender identity. See Principle #1.

Principle #3 continues:

*An insurer cannot simply exclude "Gender Identity Disorders" or "Treatment for Gender Identity Disorder" because this is on its face discrimination based on sexual orientation.*
Please read that again. Excluding treatment for “gender identity” is on its face discrimination based on sexual orientation. This is made possible because Oregon statute defines “gender identity, appearance, expression or behavior” as a legally recognized subset of “sexual orientation.”

“Sexual orientation” means an individual’s actual or perceived heterosexuality, homosexuality, bisexuality or gender identity, regardless of whether the individual’s gender identity, appearance, expression or behavior differs from that traditionally associated with the individual’s sex at birth.  

But everyone knows “gender identity” and sexual orientation are different things! To quote Ilona Turner, Legal Director of the Transgender Law Center: “It is inaccurate to conflate sexual orientation with gender nonconformity, and such semantic sloppiness has no place in the law.” I just love that sentence.

“Gender identity” and sexual orientation differ in many ways, but specific to insurance coverage, sexual orientation is not a medically diagnosable disorder that requires specialized treatment, including but not limited to major surgery and long term hormone maintenance therapy. Homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM) decades ago. Gay and lesbian people are not “sick” or in need of medical correction because of their homosexuality. The state of California passed a law in 2011 outlawing gay youth conversion therapy. Concerns about the practice included “the use of shame, verbal abuse, and aversion therapy, that place youth at high risk of depression and suicide.” The legislation was co-sponsored by the National Center for Lesbian Rights, Equality California, Gaylesta, Courage Campaign, Lambda Legal, and Mental Health America of Northern California, and supported by dozens of other organizations. A similar law has been proposed in Pennsylvania and the Southern Poverty Law Center recently filed a law suit against a religious organization in New Jersey alleging that homosexual conversion therapy is a fraudulent practice.

But back in Oregon, where GI/GD is a subset of sexual orientation:
The Oregon Equality Act (Senate Bill 2, 2007 Legislative Session) uses the term, "gender identity" when addressing the civil right and prohibition against discrimination set forth in that Act. However, the emerging term of art and the term that will likely be used in the revised DSM-5 when discussing treatment is "gender dysphoria" so for purposes of this bulletin we use, "GI/GD" to encompass both terms.

If GI/GD is defined as a unique kind of mental health disorder in the DSM, mental health counseling and treatment are appropriate, I agree. But my concern is that this continues to problematize the individual, not the rigidity of the gendered social roles that prescribe our behavior. In most cases, gender non-conformity simply represents the healthy expression of a wider range of human characteristics, emotions, and desires than most people are comfortable with because we have so deeply internalized-as-natural mutually exclusive sex-specific behavior. Enforcing sex-based behavior is fundamentally unreasonable. We should focus on eliminating the prejudice, discrimination, and oppression inherent to enforcing sex-role limitations. We should not pathologize as deviant those who violate sex role behavior or who wish to express gender “variance.”

The Iranian government promotes a parallel agenda by encouraging the use of "sex change" surgeries for gender non-conforming people with the purpose of "curing" homosexuality, a religiously ordained evil. And it’s not because sex-roles are bad--sex roles are good!-- but it’s because only people with certain genitalia are allowed to do certain things, such as engaging in sex-acts with females (you must be male) and wearing skirts (you must be female). If an individual defies these social rules, she is censured.

Disturbingly, "sex change" surgeries cause irreversible sterilization. As Sheila Jeffreys has argued, these medical interventions operate as a form of eugenics. Purporting to “treat” GI/GD with cross-sex hormones and genital surgeries effectively screens gender non-conforming people out of the collective gene pool. It does this by problematizing gender non-conforming bodies, which are then "treated“ with “medically necessary” physical modifications that cause sterilization or infertility-- a common side effect of cross-sex hormone usage--- ultimately ensuring that these individuals do not reproduce. This is the logical end of ideology that formalizes a mistaken connection between “gender identity” and genitals (or between gender non-conformity and sexual orientation, as in Iran) with “medically necessary” “sex changes.”

What’s more upsetting is that these “side effects” are often strategically ignored or downplayed in discussions about the rights of “transgender” identified people. The solution is not to bypass
medicalization by legally redefining “sex” as something so meaningless that any person can identify as either “sex” just because they want to. A more effective and sustainable and solution to sterilization-as-eugenics would be to stop confusing sex with gender by demedicalizing gender non-conformity as a unique health condition.

Again, brain sex theories of transsexualism have been debunked (see endnotes 6, 7, and 8). Long term follow up studies of transsexuals have further suggested that sex reassignment surgery does not resolve suicidal behavior. The relentless focus on making physical changes to the body obscures treatment of underlying psychological issues. If a gender non-conforming person is depressed, treat depression. If a gender non-conforming person has anxiety, treat anxiety. If a gender non-conforming person is suicidal, treat suicidal ideations and compulsion to self-harm. Pathologizing gender non-conformity as a separate and distinct mental disorder that requires special physical “correction” is just as scary as what Iran does to gay people.

The oppressive limitations of socially imposed sex roles are everyone’s concern. Gender non-conformity is not a character flaw or a moral failing that needs to be “treated” or corrected. In fact, just as believing that there is something wrong with a homosexual person is the very definition of homophobia; believing that there is something wrong with a gender non-conforming person’s mind, body, or behavior is the very definition of transphobia. Framing the individual as aberrant legitimizes conformity to sex roles as the correct way of being; it normalizes oppressive social conditions that are intolerant of any diversion from heteronormativity.

**Principle #5:** The perceived gender identity of a person should not prevent appropriate treatment.

Clearly perceived gender identity should not prevent appropriate treatment. But this is where replacing sex with gender becomes undeniably nonsensical. Principle #5 uses terminology we haven’t seen before. The bulletin goes on to make a distinction between biological sex and self-identified sex. In particular treatment situations insurance carriers are instructed to disregard “self-identified sex” in favor of “biological sex.”

The division will interpret the policy set forth in SB 2 to require an insurer to cover any sex-specific mandated coverage, if medically necessary, regardless of whether a person is biologically or self-identified as the sex identified in the statute. In other words, we would view the Pap...
smear mandate (ORS 743A.104) as applicable to a biological female who self-identifies as male, and we would view the prostate screening mandate (ORS 743A.120) as applicable to a biological male who self-identifies as female.

Now, in most cases, “gender identity” operates as a replacement for “sex” rendering it legally discriminatory to treat someone according to their biological sex. Yes, this happens. But in very specific situations, insurance companies are required to provide treatment according to biological sex regardless of self-identified sex.

I dare to ask, if biological sex cannot be "changed" by medical standards, why are we creating a fictional self-identified sex, or gender identity, that overrides biological sex for legal purposes? Gender identity and sex are different. This is terminological dissonance of the highest order. It is confusing, it is unnecessary, and it should be eliminated as a matter of logical necessity and legal integrity.

**Principle #6:** The Insurance Division expects insurers' forms to comply with the policy expressed in SB 2 as it is incorporated into insurance regulation with this bulletin.

I love consistent documentation, so I applaud standardization of insurance forms. It’s the underlying policy reasoning that I object to.

An obvious example would be that of a form submitted for approval that included exclusions based on treating gender identity as a preexisting condition. The division would disapprove this both because it is unjust, unfair and inequitable under ORS 742.005 and because it violates the policy and intent of SB 2.

Preexisting condition exclusions are discussed above, under Principle #1. If it is unjust, unfair, and inequitable exclude coverage for treatment of gender identity/self-identified sex; then it is also unjust, unfair, and inequitable to exclude coverage for treatment relating to biological sex, including the main event of human reproduction: pregnancy. Sex-based conditions should never be less important than gender identity-based ones.

It is also unjust, unfair and inequitable to continue insisting that there is no difference between biological sex and “gender identity/gender dysphoria/self-identified sex.” This creates unnecessary medical and legal absurdities. Worse, it naturalizes binary gender roles, and therefore naturalizes female
oppression, at the expense of pathologizing all of those for whom gender non-conformity does not create psychological discord about biological sex or physical appearance.

CONCLUSION

Instead of isolating gender non-conforming and gender dysphoric people as a disordered class of persons whose defining characteristic is their departure from normative sex role behavior or appearance, we should recognize enforcement of sex role limitations as universal violations of our human rights—even when they are supported by medical professionals. Considering gender dysphoria on an individual level, as special kind of medical condition, evades examination of the oppressive psychological effects of mutually exclusive sex roles. This is particularly disturbing when the suggested medical treatments for gender dysphoria cause infertility and other permanent physical changes to the body.

Stigmatizing gender non-conformity as a special kind of mental illness is not progressive. It is dangerous to gender non-conforming children. It is dangerous to female liberation from sex role stereotypes about our “gender.” And it must be more closely examined before it is further entrenched in our cultural lexicon.

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2. Oregon Insurance Division Bulletin INS 2012-01 can be found in full, here: [http://www.cbs.state.or.us/ins/bulletins/bulletin2012-01.html](http://www.cbs.state.or.us/ins/bulletins/bulletin2012-01.html)

3. Employer sponsored health insurance overview on the Oregon.gov website: [http://www.cbs.state.or.us/ins/consumer/health-insurance/consumerguide_2a.html](http://www.cbs.state.or.us/ins/consumer/health-insurance/consumerguide_2a.html)


http://www.hup.harvard.edu/catalog.php?isbn=9780674057302 and 
http://www.slate.com/articles/double_x/doublex/2010/10/the_last_word_on_fetal.html

9 Pharmaceutical companies, insurance companies, hospitals, clinics, and every other entity that profits from 
gender-identity related medical “treatments.”


11 Oregon’s statutory definitions: http://www.leg.state.or.us/ors/174.html

12 Ilona Turner: http://transgenderlawcenter.org/about/staff-and-board/ilona-turner

13 Discussion of state laws that define “gender identity” as a subset of “sexual orientation:” 
http://sexnotgender.com/2012/06/28/it-is-inaccurate-to-conflate-sexual-orientation-with-gender-nonconformity- 
and-such-semantic-sloppiness-has-no-place-in-the-law/

14 *Sex Stereotyping Per Se: Transgender Employees and Title VII*; Turner, Ilona M. 95 Cal. L. Rev. 561 (2007). 
http://scholarship.law.berkeley.edu/cgi/viewcontent.cgi?article=1227&context=californialawreview

15 The History of Psychiatry & Homosexuality: http://www.aglp.org/gap/1_history/

16 “The longstanding consensus of the behavioral and social sciences and the health and mental health professions
is that homosexuality per se is a normal and positive variation of human sexual orientation,” the [American
Psychiatric Association] says.”
News article http://www.cnn.com/2012/10/01/us/california-gay-therapy-ban/index.html

17 National Center For Lesbian Rights (NCLR) press release, *CA Governor Brown Signs Bill To Protect LGBT Youth
http://nclrights.wordpress.com/2012/09/30/ca-governor-brown-signs-bill-to-protect-lgbt-youth-from-
psychological-abuse/

18 Southern Poverty Law Center web pages about the JONAH Conversion Therapy Case (Michael Ferguson, et al., v.
JONAH, et al.).
http://www.splcenter.org/get-informed/news/splc-files-groundbreaking-lawsuit-accusing-conversion-therapy-
organization-of-frau

19 Wikipedia entry for a movie entitled “Be Like Others.”
“Be Like Others (also known as Transsexual in Iran) is a 2008 documentary film written and directed by Tanaz
Eshaghian about transsexuals in Iran. It explores issues of gender and sexual identity while following the personal
stories of some of the patients at a Tehran gender reassignment clinic. The film played at the Sundance Film
Festival and the Berlin International Film Festival, winning three awards.”
http://en.wikipedia.org/wiki/Be_like_others

20 News article http://www.policymic.com/articles/22744/what-is-transgender-why-trans-people-are-no-longer-
subject-to-forced-sterilization

22 There is a statistically relevant correlation between gender non-conformity and homosexuality (see endnote 24), which makes childhood transition particularly dangerous from a lesbian point of view. Neither way of being is a medically diagnosable condition, however, and neither can be cured by a “sex change” treatments. I am arguing at the same time that gender identity and homosexuality are qualitatively distinct in the sense that one is not necessary for the other—you can be homosexual and gender conforming or heterosexual and gender non-conforming. Sexual orientation and gender non-conformity are not the same thing.

23 “The increased mortality in MtF in the 25–39 years of age group (SMR 4.47; 95% CI: 4.04–4.92) was mainly due to the relatively high numbers of suicides (in six), drugs-related death (in four), and death due to AIDS (in 13 subjects).” A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. Henk Asscheman, Erik J Giltay, Jos A J Megens, W (Pim) de Ronde, Michael A A van Trotsenburg and Louis J G Gooren. European Journal of Endocrinology 164 635–642 http://www.eje-online.org/content/164/4/635.full.pdf


26 See endnotes 22 and 25.

27 Colleen Francis’s exposure of male genitals in a women’s only locker room in Olympia, Washington was protected by the state’s anti-discrimination statute. Calls to regard Francis as a biological male were considered discriminatory behavior. http://dailycaller.com/2012/11/06/college-oks-transgender-mans-full-monty-to-underage-girls-in-womens-locker-room/

28 “The most important principle to apply in general prevention and screening is to provide care for the anatomy that is present, regardless of the patient’s self-description or identification, presenting gender, or legal status, and
always to provide that care in a sensitive, respectful, and affirming manner that recognizes and honors the patient's self-description or identification.”  http://www.transhealth.ucsf.edu/trans?page=protocol-screening

29 As another example of the significance of biological sex, explaining difference in heart attack and heart disease symptoms between males and females: http://www.mayoclinic.com/health/heart-disease/HB00040


31 See the History of Psychiatry & Homosexuality: http://www.aglp.org/gap/1_history/

32 See also the history of lobotomies, an example of Paul McHugh’s “mixture of a medical mistake lashed to a trendy idea.”

“The lobotomy was first performed on humans in the 1890s. About half a century later, it was being touted by some as a miracle cure for mental illness, and its use became widespread; during its heyday in the 1940s and ’50s, the lobotomy was performed on some 40,000 patients in the United States, and on around 10,000 in Western Europe. The procedure became popular because there was no alternative, and because it was seen to alleviate several social crises: overcrowding in psychiatric institutions, and the increasing cost of caring for mentally ill patients.”

33 See also: Psychiatric Misadventures by Paul R. McHugh. “Major psychiatric misdirections often share this intimidating mixture of a medical mistake lashed to a trendy idea. Any challenge to such a misdirection must confront simultaneously the professional authority of the proponents and the political power of fashionable convictions. Such challenges are not for the fainthearted or inexperienced. They seldom quickly succeed because they are often misrepresented as ignorant or, in the cant word of our day, uncaring.”
http://www.lhup.edu/~dsimanek/mchugh.htm

34 “Transgender Children”: Pathology of childhood is NOT LOVE, by Gallus Mag. August 17, 2012.