STATE OF CONNECTICUT
COMMISSION ON HUMAN RIGHTS AND OPPORTUNITIES

DECLARATORY RULING ON PETITION REGARDING HEALTH INSURERS' CATEGORIZATION OF CERTAIN GENDER-CONFIRMING PROCEDURES AS COSMETIC

I. INTRODUCTION

On November 4, 2019, the Commission on Human Rights and Opportunities ("the Commission") filed a petition for declaratory ruling with regard to health insurance policies offered by the State of Connecticut and municipalities that preclude coverage for certain treatments related to gender dysphoria.

At its regular meeting on November 13, 2019, the Commission voted to issue a declaratory ruling in response to the petition by May 2, 2020. The Commission had a Notice published in the Hartford Courant from November 23 through 25, 2019. The Notice as published announced – pursuant to Conn. Gen. Stat. § 4-176(c) – the filing of the petition, the issues presented, and that any person seeking to become a party or intervene in the proceedings could do so through December 13, 2019.

Applications for intervenor status, as well as for permission to appear and file a brief as amicus curiae, were received within the specified timeframe. At its regular meeting on January 8, 2020, the Commission voted to grant intervenor status as herein enumerated, pursuant to Conn. Gen. Stat. § 4-176(d) and Regs. Conn. State Agencies § 46a-54-125. Participation of the intervenors was limited to the submission of written argument and documentary evidence. Permission was granted to the Connecticut TransAdvocacy Coalition to appear and file a brief as amicus curiae.

Pursuant to Conn. Gen. Stat. § 4-176(e) and Regs. Conn. State Agencies § 46a-54-126(c)(1), the Commission now issues this declaratory ruling.

II. PARTIES AND INTERVENORS

The Commission is the sole party to this declaratory ruling.

The following were granted intervenor status, and submitted briefs accordingly:

Ms. Rylie Robillard
GLBTQ Legal Advocates and Defenders
The National Center for Transgender Equality
Connecticut Women's Education and Legal Fund
Cigna Health and Life Insurance Company ("Cigna")

The Connecticut TransAdvocacy Coalition submitted a brief as amicus curiae.

III. FACTS PRESENTED

A. Gender Dysphoria is a Medical Condition Unique to Transgender People.

At birth, infants are assigned a sex of "male" or "female." Ettner Aff., ¶ 5.[1] Some of those infants will later intuit that they are not the sex doctors assigned and labeled them at birth. Id., at ¶ 5. Some will come to identify with the "opposite" assigned sex. Eli Coleman et al., Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, World Professional Association for Transgender Health, 96 (7th ed. 2012) (hereinafter "Stds. of Care"). Others will reject a binary understanding of sex altogether, identifying with both – or neither. Stds. of Care, 96. These people are all commonly described as "transgender". Stds. of Care, 97.

[1] Dr. Randi Ettner, whose Affidavit was included with the submission of Robillard, et al., has been recognized and relied on by courts across the nation as an expert in the field of gender dysphoria. See, e.g., Edmo v. Corizon, Inc., 935 F.3d 757, 775 (9th Cir. 2019); Good v. Iowa Dept. of Human Servs., 924 N.W.2d 853, 857 (Iowa 2019); Kothmann v. Rosario, 558 Fed. Appx. 907, 909 (11th Cir. 2014); Sundstrom v. Frank, 630 F. Supp. 2d 974, 986 (E.D. Wis. 2007) ("Dr. Ettner's experience speaks for itself.").

"Gender identity" is a medical concept describing an individual's sense of their own gender. Ettner Aff., ¶ 4.[2] One whose gender identity is different than their assigned sex is generally referred to as transgender. Id., at ¶ 6.[3] Most transgender people experience gender dysphoria, "a serious medical condition characterized by clinically significant and persistent distress and discomfort with one's assigned birth sex." Id., at ¶ 7. The condition is a mental disability recognized in the American Psychiatry Association's ("APA") Diagnostic and Statistical Manual of Mental Disorders ("DSM 5"), which sets out diagnostic criteria. Id., at ¶ 9.[4]

The criteria listed in the DSM 5 reveal that, speaking broadly, gender dysphoria is characterized by an individual's conviction that they are another gender and a strong desire to be seen and treated as that other gender. Id. Consequently,

> [a] key component of medical treatment for people with gender dysphoria is to live, function in society, and be regarded by others consistent with their gender identity. Because the essence of gender dysphoria is incongruence of the body and one's identity, the goal of gender transition is to establish an authentic appearance in a person's affirmed gender in order to eliminate the debilitating symptoms of gender dysphoria.

Ettner Aff., ¶ 13. This goal is reflected in the standards of care for transgender patients.

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[2] Gender identity is also a protected class under Connecticut law. See, e.g., Conn. Gen. Stat. §§ 46a-51(21), 46a-58, 46a-60, 46a-64, 46a-70, and 46a-71. See CHRO v. City of Hartford, 138 Conn. App. 141, 161–62 (2012) (recognizing mental disability), and CHRO v. City of Hartford, 50 Conn. L. Rptr. 750, 2010 WL 4612700, *12 (Conn. Super. Ct. Oct. 27, 2010) (recognizing physical disability).

[3] By contrast, "a person whose gender identity corresponds with the sex the person had or was identified as having at birth" is cisgender. Kadel v. Folwell, Docket No. 1:19-CV-272, 2020 WL 1169271, *2 n.2 (M.D.N.C. March 11, 2020) (quoting Merriam-Webster Online Dictionary). See also, Doe v. Boyertown Area Sch. Dist., 897 F.3d 518, 522 (3d Cir. 2018), cert. denied, 139 S. Ct. 2636 (2019).

[4] The mental disabilities protected under state antidiscrimination law are those "defined in the most recent edition of the American Psychiatry Association's "Diagnostic and Statistical Manual of Mental Disorders". Conn. Gen. Stat. § 46a-51(20).

B. The Treatment Needs of Transgender Patients Under Generally Accepted Standards of Care Must be Assessed on a Case-by-Case Basis.

The World Professional Association for Transgender Health ("WPATH") publishes the Standards of Care. WPATH "is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transsexual and transgender health." Stds. of Care, 1. WPATH's authority on transgender healthcare is recognized throughout the medical,[5] insurance,[6] and legal fields.[7]

WPATH's Standards of Care outline how to treat transgender and gender nonconforming patients based on research in the field of transgender medicine. See Stds. of Care, 71-93, 107-09.[8] The clinical guidelines "are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender non-

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[5] See Hicklin v. Precynthe, Docket No. 4:16-CV-01357 (NCC), 2018 WL 806764, *2 (E.D. Mo. Feb. 9, 2018) (WPATH Standards of Care "have been endorsed by numerous professional medical organizations including the American Medical Association, the American Psychological Association, the American Psychiatric Association, the World Health Organization, and the National Commission of Correctional Health Care").

[6] For instance, Anthem Blue Cross bases its medical necessity criteria for treatment of gender dysphoria on the WPATH Standards of Care. Petition Ex. A, 7. The State of Connecticut's own Husky Health Program also cites to WPATH as an authority on transgender healthcare. Petition Ex. G, 8.

[7] See, e.g., Monroe v. Baldwin, Docket No. 18-CV-00156 (NJR) (MAB), 2019 WL 6918474,*2 (S.D. Ill. Dec. 19, 2019) ("WPATH dictates medically-accepted Standards of Care for treating gender dysphoria"); Fields v. Smith, 712 F. Supp. 2d 830, 838 n.2 (E.D. Wis. 2010) (WPATH publishes "the worldwide acceptable protocol" for treating gender dysphoria), aff'd, 653 F.3d 550 (7th Cir. 2011).

[8] The Stds. of Care lays out the basic competencies necessary for doctors to assess transgender patients' gender dysphoria as well as the competencies necessary for surgeons to perform certain gender-affirming procedures. Stds. of Care, 13-16, 22-25, 61-62. It also guides treatment for such surgeries and treatments; id., at 26-28, 104-06; and lists the criteria that must be met for referral of the same. Id., at 58-61, 104-106. It further lays out potential complications of surgeries and other treatments; id., at 62-63, 97-104; and summarizes postoperative and lifelong primary care. Id., at 64-65.

conforming people." Id., at 2. While some transgender people do not experience gender dysphoria, the overwhelming majority do and require some kind of medical treatment to alleviate the distress it creates – whether that treatment be therapeutic, hormonal, surgical, or all of the above. Id., at 8 ("As the field [of transgender medicine] matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither."). See also Jamie Grant, et al, Injustice at Every Turn: A Report of the National Transgender Discrimination Survey 77-79 (2011) (graphs depicting how many transgender people want specific treatments related to gender dysphoria) (hereinafter "The Transgender Discrimination Survey").[9]

There is no standardized, one-size-fits-all treatment plan for gender dysphoria because "[w]hat helps one person alleviate gender dysphoria might be very different from what helps another person." Stds. of Care, 5. "In other words, treatment for gender dysphoria has become more individualized." Id., at 9. Because "[t]he gender identity of transgender people differs to varying degrees from the sex they were assigned at birth[,]"; Id., at 97; the severity of gender dysphoria that each individual experiences – and the course of treatment to be prescribed thereto – must be assessed on a case-by-case basis. Ettner Aff., ¶ 35; see also Stds. of Care, 3 ("Clinically appropriate treatments must be determined on an individualized and contextual basis, in consultation with the patient's

[9] "Sixty-two percent (62%) of respondents have had hormone therapy, with the likelihood increasing with age; an additional 23% hope to have it in the future. Transgender-identified respondents accessed hormonal therapy (76%) at much higher rates than their gender non-conforming peers, with transgender women more likely to have accessed hormone therapy (80%) than transgender men (69%). Almost all respondents who reported undertaking transition-related surgeries also reported receiving hormone therapy (93%)." The Transgender Discrimination Survey, 78.

medical providers."). While some transgender patients are able to manage their gender identity with only minor medical interventions (or none at all), "[o]ther patients will require more intensive services." Stds. of Care, 2. This includes a number of procedures affecting secondary sex characteristics.

For example, "[n]on-genital surgical procedures... are often of greater practical significance in the patient's daily life than reconstruction of the genitals." WPATH Position Statement 3 (quoting Randi Ettner et al., Principles of Transgender Medicine and Surgery (2007)). The gender-affirming results of non-genital surgeries that alter a transgender patient's appearance

> are visible to others on a daily basis. They affect the social perception of gender that determines how a transgender person functions in the world.... [A]n individual with gender dysphoria who is not able to establish an authentic appearance will be at significant risk of interpersonal violence and discrimination, which threaten not only one's psychological well-being, but also one's bodily integrity.

Ettner Aff., ¶ 17. The Standards of Care provide examples of non-genital treatments that may alleviate gender dysphoria. Transgender women may need "reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid)." Stds. of Care, 63. Transgender men may need "liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective." Id., at 64.

But "[a]esthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient." Id., at 58. "Typical elective

procedures involve only a private mutually consenting contract between a patient and a surgeon." Id., at 55.

> In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by... insurance companies….
>
> Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.
>
> While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

Id., at 58, 63-64. Certain procedures that are considered "cosmetic" for cisgender people may, "in an individual with severe gender dysphoria... be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures." Id.

In 2016, WPATH published a statement further clarifying and strengthening its position on the issue of providing coverage for these kinds of treatments. "The medical procedures attendant to gender affirming/confirming surgeries are not 'cosmetic' or 'elective' or 'for the mere convenience of the patient.' These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for treatment of the diagnosed condition." WPATH 2016 Position Statement. Dr. Randi

Ettner, Ph.D. flatly opined in an affidavit submitted to the Commission that "[n]o treatment for gender dysphoria can be deemed cosmetic." Ettner Aff., ¶ 7. This is because procedures altering the appearance of transgender patients for treatment of gender dysphoria are not for the purpose of "enhancing" cosmetic beauty – they are medically indicated for the purpose of bringing a transgender patient's appearance in accordance with their gender identity to eliminate the stress caused by incongruence of the same. Id., at ¶ 16 (the goal is "to modify ... characteristics from [one sex to another] in order to allow a person to live and function in their affirmed gender, thereby reducing or eliminating their gender dysphoria.").[10]

The evidence before the Commission demonstrates that, pursuant to the Standards of Care, doctors must engage in interactive dialogues with their transgender patients to determine the source of the patient's gender dysphoria. They may then begin a course of treatment designed to change the patient's appearance to reflect their individual gender identity. Because the procedures medically necessary to bring one's appearance in accordance with their gender identity are different from patient to patient, each must be considered on a case-by-case basis. Some will need hormone treatment, others will need surgery, and still others will need more intensive procedures. There is no one-size-fits-all method for treating gender dysphoria. Instead, physicians must analyze

[10] In support of the assertion that so-called "cosmetic" surgeries are actually medically necessary procedures to treat gender dysphoria, Dr. Ettner pointed to both literature reviews and cutting-edge research. Ettner Aff., ¶¶ 20-28. The former generally showed that facial feminization surgery dramatically improved the lives of female transgender patients. Id., at ¶ 28. The latter effectively demonstrates *why* that is the case: proper gender recognition helps transgender patients avoid "being 'misgendered' in social, family, work and other settings, [which] amplif[ies] their dysphoria and exacerbate[s] psychological harm and dysfunction…." Id., at ¶ 17.

their patients on a case-by-case basis to determine whether a specific treatment will alleviate the gender dysphoria suffered by a particular patient.

C. The Connecticut Insurance Department Prohibits Categorical Exclusions for Gender Transition and Related Services.

The Connecticut Insurance Department found in 2013 that the legislative intent to prohibit discrimination on the basis of gender identity or expression in employment, public accommodations, and state contracts extended to health insurance practices. "Based on Public Act 11-55," the bill that added gender identity as a protected class under Connecticut law, "licensed [insurance] entities are prohibited from using an exclusion based solely on gender identity or expression, including an exclusion for gender reassignment and related services, or otherwise discriminating against insured individuals with gender dysphoria." Ins. Dept. Bulletin, IC-34 (Dec. 19, 2013).[11]

The Department decided on the basis of Connecticut law.[12] State statutes covering individual and group health insurance policies require insurers to cover medical conditions listed in the DSM 5. Id. They also require insurers "to pay 'covered expenses' for treatment provided to individuals with gender dysphoria where the treatment is deemed necessary under generally accepted medical standards." Id. The Department found that "a blanket policy exclusion for gender transition and related services is prohibited". Id. In so finding, the Department did not tie insurers' hands by requiring them to cover any and all requests by their insureds. The Department specifically permitted insurers to "perform medical necessity determinations on a case by case basis with respect to **an** insured's request for transgender services." (Emphasis added.) Id.

[11] The bulletin was originally numbered IC-37.
[12] Albeit through the lens of their own statutes.

D. Some Health Insurers Exclude Coverage for Certain Medically Necessary Procedures When Used to Treat Gender Dysphoria.

Nonetheless, some health insurance companies do not provide coverage for many treatments related to gender dysphoria under any circumstances. Surgeries that alter primary sex characteristics – like vaginoplasty or phalloplasty (a procedure that reconstructs male genitalia for transgender men) – are typically covered,[13] so long as an insured submits sufficient documentation to demonstrate the medical necessity of their request.[14] In that circumstance, insurers consider whether a surgery is medically necessary through a case-by-case analysis.

But many non-genital procedures that affect dysphoria-inducing secondary sex characteristics are never covered for *any* transgender patients because insurers do not perform a case-by-case analysis for certain procedures. For example, one insurer categorically refuses to cover the following procedures related to gender transition: breast implants, pectoral implants, voice surgery and therapy, non-genital hair removal, removal of the Adam's apple, rhinoplasty, body contouring, and facial feminization. Petition Ex. B, 1-2. The insurer's reasoning for excluding these treatments from coverage is that

[13] See Petition Ex. A (finding the following procedures medically necessary on a case-by-case basis: hysterectomy, salpingo-oophorectomy, ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethoplsaty, and prosthetics); Petition Ex. B (covering the same as well as vulvectomy and hair removal in advance of genital reconstruction); Petition Ex. C (the same); Petition Ex. G (the same).

[14] This requirement is consistent with the Standards of Care: "While the [Standards of Care] allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional." Stds. of Care, 58.

"[c]ertain ancillary procedures ... are considered cosmetic and not medically necessary, when performed as part of gender reassignment". Id., at 1.[15]

According to the record before the Commission, other insurers also appear to maintain extensive lists of procedures they consider always cosmetic when related to gender dysphoria.[16] While forgoing the case-by-case analysis required for transgender patients' requests for care related to gender transition and, instead, categorically denying

[15] But the medical community, including WPATH, has pushed back on framing these treatments as purely cosmetic rather than acknowledging their medical necessity. See Ettner Aff., ¶ 38 (noting that excluding certain procedures from coverage on the basis that they are cosmetic "fail[s] to take into account the robust body of research that these procedures alleviate or eliminate gender dysphoria."); See also supra Part III(B).

[16] Anthem considers the following procedures cosmetic for treating gender dysphoria: abdominoplasty, blepharoplasty, breast augmentation, brow lift, calf implants, face lift, facial bone reconstruction, facial implants, gluteal augmentation, hair removal and hairplasty, jaw reduction, lip reduction or enhancement, lipofilling or collagen injections, liposuction, nose implants, pectoral implants, rhinoplasty, thyroid cartilage reduction (chondroplasty), voice modification surgery, and voice therapy. Petition Ex. A, 3. UnitedHealthcare Oxford sports a similar list, finding the following always cosmetic: abdominoplasty, blepharoplasty, body contouring (fat transfer, lipoplasty, panniculectomy), breast enlargement, brow lift, calf implants, cheek, chin and nose implants, injection of fillers or neurotoxins (botox), face/forehead lift and/or neck tightening, facial bone remodeling for facial feminization, laser hair removal not related to genital reconstruction, hair transplants, lip augmentation or reduction, liposuction, mastopexy, pectoral implants for chest masculinization, rhinoplasty, skin resurfacing, removal of the Adam's apple, voice modification surgery, and voice therapy. Petition Ex. B, 1-2. Regence, a subsidiary of Anthem BlueCross Blue Shield, also sports its own list of gender dysphoria treatments that are always cosmetic: adominoplasty, blepharoplasty, brow lift, calf implants, cheek/malar implants, chin/nose implants, collagen injections, face-lift, facial bone reduction, forehead lift, lip reduction, liposuction, neck tightening, pectoral implants, reduction thyroid chondroplasty, rhinoplasty, suction-assisted lipoplasty of the waist, voice modification surgery, and voice therapy/lessons. Petition Ex. C, 3. The University of Connecticut Student Health Plan, administered by Wellfleet Group, LLC, excludes "[c]osmetic procedures *related to Gender Reassignment* including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chrondoplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, [and] nose implants." (emphasis added) Petition Ex. I, 3.

them, these insurers individually consider the requests of other patients for the *same* procedures – for care *unrelated* to gender transition – on a case-by-case basis.

An example of this apparent differential treatment is rhinoplasty. An insurer may not consider rhinoplasty ever medically necessary for a transgender patient seeking treatment of gender dysphoria,[17] but *will* consider rhinoplasty medically necessary to treat a condition unrelated to gender dysphoria, such as difficulty breathing or some form of physical trauma.[18] Similarly, at least one insurer always denies as cosmetic face lifts for transgender patients seeking treatment related to gender dysphoria, but considers the procedures on a case-by-case basis for those who have suffered accidental injury, disease, or trauma.[19] Some have observed insurers denying hair removal services for treatment related to gender dysphoria but granting the same for a physical condition, hirsutism. Lombardi Aff., ¶ 11.

E. <u>The State and Municipalities Contract with Insurers to Provide These Plans.</u>

The State of Connecticut and municipalities are prominent employers.[20] Both offer their employees health insurance plans like those at issue in the petition.

In the Medical Benefit Plan Document for state employees, a number of gender dysphoria-related "surgeries are considered cosmetic when used to improve the gender

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[17] <u>See</u> Petition Ex. A, 3; Petition Ex. B, 3; Petition Ex. C, 3; Petition Ex. I, 3.
[18] <u>See</u> Petition Ex. D, 2-3; Petition Ex. E, 1-3; Petition Ex. F, 1-2; Petition Ex. I, 3.
[19] <u>See</u> Petition Ex. A, 3; Petition Ex. D, 2-3. Anthem describes medical necessity in its document for cosmetic and reconstructive services of the head and neck: "[i]n this document, procedures are considered medically necessary if there is a significant physical functional impairment AND the procedure can be reasonably expected to improve the physical functional impairment."
[20] More than fifty thousand people work for the State of Connecticut, and our cities, towns, and municipalities employ another one hundred and fifty thousand. <u>Connecticut Labor Market Information – State of Connecticut Nonfarm Employment</u>, Conn. Dep't of Labor, http://www1.ctdol.state.ct.us/lmi/ces/nfstatcm.asp (last accessed April 1, 2020).

specific appearance of an individual who has undergone or is planning to undergo gender reassignment surgery and are not covered". Petition Ex. H, 51.[21] "The State has contracted with two insurance [carriers]… to provide claims processing, disease management and other administrative services". Id., at 1.[22] The carriers in question also use the exclusions at issue in the petition in their own public-facing policy documents. Petition Ex. A, 3; Petition Ex. B, 1-3. In addition, at least one municipality – the City of Waterbury – offered city firefighters (both current employees and retirees) health insurance through a provider that uses these exclusions.[23]

The State of Connecticut also offers plans containing these exclusions to students in state universities. See, e.g., Petition Ex. I, 1-4. More than sixty thousand students attend the University of Connecticut or one of four regional Connecticut state universities.[24] The University of Connecticut even supports its own Health Center providing healthcare to students on campus – both those with their own insurance and those who get it from the University.

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[21] It identifies liposuction and body contouring, rhinoplasty, facial bone reconstruction, voice modification surgery, hair removal, face lift, blepharoplasty, reversal of genital surgery, sperm preservation, cryopreservation, and surgery under the age of 18 as cosmetic procedures not covered under the plan. Id.

[22] The carriers are Anthem Blue Cross and Blue Shield and UnitedHealthcare Oxford.

[23] See Petition Ex. J; see also Open Enrollment 2019 – City of Waterbury, https://www.waterburyct.org/oe2019 (Last visited March 31, 2020) (providing this document as the Enrollment/Change Form for currently employed firefighters).

[24] See Headcount by Race/Ethnicity for Connecticut State Colleges & Universities, State Department Of Education, https://www.ct.edu/files/opr/WEB%20Enrollment-by-Race-Ethnicity-through-F2017.pdf (2017) (last accessed Mar. 31, 2020); University of Connecticut 2019 Fact Sheet, https://uconn.edu/content/uploads/2019/01/INS-004-Fact-Sheet-NewDesign-011719-FY19.pdf (last accessed Mar. 31, 2020).

With more than 250,000 members of the Connecticut public – about 7%[25] of the state's total population – falling under State and municipal umbrellas as employees and students, plans containing exclusions related to treatment of will be offered to more than 850 transgender people across the state by State and municipal entities.[26] Given that "the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available"; Stds. of Care, 6; and "[t]he existence of a diagnosis for such treatment often facilitates access to health care"; id.; many of those people are likely to accept the insurance offered to them to receive the treatment they can for gender dysphoria.[27] And some will be denied medically necessary care related to their dysphoria because it is categorized as "cosmetic" under the plan.[28]

[25] Based on 2019 Census data; U.S. Census Bureau QuickFacts: Connecticut, https://www.census.gov/quickfacts/CT (showing a population of 3.565 million).

[26] Based on an estimated Connecticut transgender population of 12,400 from data gathered in 2014. Andrew Flores et al., How Many Adults Identify As Transgender in the United States?, Williams Institute, https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Adults-US-Aug-2016.pdf (2016).

[27] Given that "employer-based insurance was most common [in 2017], covering 56.0 percent of the population"; Health Insurance Coverage in the United States: 2017, https://www.census.gov/library/publications/2018/demo/p60-264.html; one can presume that many transgender people will become members of State and municipal offered health insurance plans and be exposed to these exclusions.

[28] This is in contrast with the State's own insurance program, Husky Health. Petition Ex. G. The Husky plan, similar to the others, does have a section that refers to cosmetic procedures that it considers "not reconstructive and therefore… *typically*... cosmetic and not medically necessary." (emphasis added) Petition Ex. G, 5. While the plan *presumes* that the procedures are "typically" cosmetic, which may contradict the Standards of Care, it does not categorically exclude them from coverage. The plan begins with a message that it is a set of "guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail." (emphasis in original) Petition Ex. G, 1. This is materially different than the plans the State offers to employees and students, which are not considered on a case-by-case analysis, as requests made by those on Husky Health insurance *are*.

IV. ANALYSIS OF THE ISSUES PRESENTED BY THE PETITION

The Petition requests that the Commission answer the following questions:

1. Does the State of Connecticut, or a municipality as defined under state law, engage in a discriminatory practice in violation of statutes enforced by the Commission – including but not limited to Conn. Gen. Stat. §§ 46a-60, 46a-71, or 46a-64 – by offering and administering insurance plans that categorically deny certain treatments for gender dysphoria?

2. Does the State of Connecticut, or a municipality as defined under state law, engage in a discriminatory practice in violation of statutes enforced by the Commission by offering and administering an insurance plan that considers certain procedures medically necessary to treat certain conditions, but considers the same procedures cosmetic for gender dysphoria?

3. Does an insurer that sells health insurance plans pursuant to (1) and/or (2) engage in a discriminatory practice in violation of statutes enforced by the Commission?

The Commission answers "yes" to all three questions.

THE COMMISSION'S AUTHORITY AND JURISDICTION

As a threshold matter, Cigna has challenged whether the Commission may properly issue a ruling at all. It first suggests that to answer the insurance-related questions presented in the Petition would exceed the Commission's statutory authority, which Cigna characterizes as being limited to "employment, housing, public accommodations, and credit transactions." Cigna Submission, 3-4. Cigna also suggests that because, in its view, insurers are not places of public accommodation, the Commission lacks jurisdiction to issue a ruling that applies to them. Id., at 9.

The Commission's "authority to act pursuant to a statute is different from its subject matter jurisdiction. The power of the [agency] to hear and determine, which is implicit in jurisdiction, is not to be confused with the way in which that power must be exercised in order to comply with the terms of the statute." Amodio v. Amodio, 247 Conn. 724, 728

(1999). The Commission must therefore address two distinct but related issues: first, whether it has statutory authority to issue a declaratory ruling on matters related to insurance; and second, whether it has jurisdiction to issue a ruling that applies to insurers even if, as Cigna argues, they are not places of public accommodation.

The Commission has statutory authority to seek and issue a declaratory ruling regarding the applicability of its statutes to specific facts. See Conn. Gen. Stat. § 4-176(a) ("an agency may on its own motion initiate a proceeding, for a declaratory ruling as to… the applicability to specified circumstances of a provision of the general statutes"); Regs. Conn. State Agencies § 46a-54-122(a)(2) ("Commission… may petition for a declaratory ruling as to… the applicability to specified factual circumstances of any provision of the Connecticut General Statutes [it] enforce[s]"). There is no exception to this authority for matters relating to insurance. "[I]n the face of language that is clear, precise and unequivocal, this [Commission] is not inclined to smuggle in muffled words"; Mulligan v. Goodrich, 28 Conn. Supp. 11, 14 (Conn. Super. Ct. Sept. 9, 1968); particularly where doing so would create an exception. See Gay & Lesbian Law Students Ass'n v. Bd. of Trustees, 236 Conn. 453, 473–74 (1996) ("exceptions to statutes are to be strictly construed with doubts resolved in favor of the general rule rather than the exception").

Cigna cites a number of statutes and regulations delineating authority to the Insurance Commissioner or Insurance Department. Cigna Submission, 3-4. Nothing in those provisions indicates that such authority is exclusive, however, or that agencies such as the Commission are precluded from acting on matters that may relate to insurance. In fact, just the opposite. Conn. Gen. Stat. § 38a-8(a) provides that

> The [insurance] commissioner shall see that all laws respecting insurance companies… are faithfully executed and shall administer and enforce the

> provisions **of this title**. The commissioner shall have all powers specifically granted, and all further powers that are reasonable and necessary to enable the commissioner to protect the public interest **in accordance with the duties imposed by this title**.[29]

(Emphasis added.) "Undoubtedly, this [statute] vests [the Insurance Commissioner] with a wide range of discretion." Allyn v. Hull, 140 Conn. 222, 226 (1953). "That discretion, however, cannot be exercised on everything bearing directly or indirectly upon the subject of insurance…. The legislative mandate which we have quoted does not endow [the Commissioner] with limitless authority…. The statute does not speak of laws **relating to insurance.**" (Emphasis added.) Id. Even the Insurance Department's external review procedure – which Cigna asserts is the process that must be utilized to address insurance concerns – explicitly envisions that parties may have "other remedies available under federal or state law". Conn. Gen. Stat. § 38a-591g(a)(4).

On this issue the Connecticut Supreme Court's decision in CHRO v. Bd. of Ed. of Cheshire, 270 Conn. 665 (2004) is directly on point. There, the Cheshire Board of Education argued that the State Department of Education had exclusive jurisdiction over discrimination in public schools, and that the Commission lacked authority to act on the issue. Id., at 706. The Court disagreed. "Although there is no talismanic phrase that is necessary to establish exclusive statutory jurisdiction over a particular subject matter, we are ordinarily reluctant to infer exclusivity of remedy from an ambiguous remedial statute." Id., at 719. The Court cited "numerous instances in which the legislature has made clear by explicit legislative language its intention to confer exclusive jurisdiction in various

[29] The "title" referred to is Title 38a of the General Statutes.

contexts." Id., at 719-20.[30] The Court also noted separate and distinct remedies available through each agency's respective process. Id., at 722.

The Court ultimately concluded that the Commission had statutory authority to vindicate the right to be free from discrimination in the context of public schools; id., at 706; and that the Commission's jurisdiction was concurrent with that of the State Department of Education. Id., at 722. The same is true here: the Commission's statutory authority over discrimination arising in the realm of certain insurance practices is coextensive with, and not displaced by, the statutory authority of the Insurance Commissioner or Insurance Department.[31] Courts have therefore been correct to permit the Commission to exercise its statutory authority over insurance companies. See Blue Cross & Blue Shield of Connecticut, Inc. v. CHRO, 2 Conn. L. Rptr. 769, 1990 WL 261918,

[30] "See… General Statutes § 13b–26 (b) ("[commissioner of transportation] shall exercise exclusive jurisdiction over all such highways"); General Statutes § 15–121(a) ("Commissioner of Environmental Protection shall... have exclusive jurisdiction of all waters of the state"); … General Statutes § 16–243 ("[t]he Department of Public Utility Control shall have exclusive jurisdiction... over the method of construction"); … General Statutes § 22a–348 (a) ("the [commissioner of environmental protection] shall have exclusive jurisdiction over any encroachments"); General Statutes § 26–103 ("wildlife habitats and shall be under the exclusive jurisdiction and control of the Commissioner of Environmental Protection"); … General Statutes § 29–349(a) ("[t]he Commissioner of Public Safety shall have exclusive jurisdiction in the preparation of... explosives and blasting agents")". Bd. of Ed. of Cheshire, 270 Conn. at 719-20.

[31] Cigna's brief reference to the authority of the Insurance and Real Estate Committee of the General Assembly does not alter this outcome. See Cigna Submission, 6. A legislative committee's cognizance of a subject area does not, in itself, preclude an administrative agency's authority to act with regard to that subject. Indeed, some of the fundamental underpinnings of administrative law are "grounded in deference to [the legislature's] delegation of authority to coordinate branches of [g]overnment," and specifically to administrative agencies. Piteau v. Bd. of Ed. of Hartford, 300 Conn. 667, 679 (2011). Moreover, delegation of authority by the Education Committee to the State Department Education did not preclude the Commission from having authority to act in to eliminate discrimination in education. Bd. of Ed. of Cheshire, 270 Conn. at 244-45.

*1 (Conn. Super. Ct. Nov. 5, 1990) (recognizing Commission's statutory authority to enforce subpoena against insurance company accused of discriminatory practice).

This brings us to Cigna's jurisdictional challenge. Whether or not specific entities are places of public accommodation is wholly distinct from whether the Commission has jurisdiction to decide. "[I]t is the general rule that an administrative agency may and must determine whether it has jurisdiction in a particular situation. When a particular statute authorizes an administrative agency to act in a particular situation it necessarily confers upon such agency authority to determine… the coverage of the statute". Johnson v. Dep't of Pub. Health, 48 Conn. App. 102, 110 (1998). The Commission is "charged with the primary responsibility of determining whether discriminatory practices have occurred and what the appropriate remedy for such discrimination must be." Dept. of Health Servs. v. CHRO ex rel. Mason, 198 Conn. 479, 488 (1986). Implicit in the authority to determine that discriminatory practices have occurred is the authority to determine whether parties engaged in particular courses of conduct are covered by our statutes. Whether or not an insurer may be a place of public accommodation by virtue of its offering insurance to the State of Connecticut or municipalities,[32] the Commission certainly has jurisdiction to issue a ruling that addresses the issue.

QUESTIONS 1 AND 2: THE STATE OF CONNECTICUT AND MUNICIPALITIES

The first and second questions posed to the Commission focus on the conduct of the State of Connecticut and its municipalities. The first asks whether it is a discriminatory practice for such entities to offer or administer health insurance plans that categorically deny coverage for certain gender dysphoria treatments. The second asks whether it is

[32] A question we discuss in further detail later in this ruling.

discriminatory for such entities to offer or administer plans that preclude coverage of certain treatments for gender dysphoria, but permit coverage of the same treatment for other conditions. These questions implicate the role of the State of Connecticut and municipalities as employers, through which many public employees obtain their health insurance. For the State of Connecticut, the questions also implicate its role as a provider of educational services, through which many students also obtain health insurance.

A. The State of Connecticut and Municipalities as Employers

The Connecticut Fair Employment Practices Act ("CFEPA") "defines important rights designed to rid the workplace of discrimination". Sullivan v. Bd. of Police Com'rs of Waterbury, 196 Conn. 208, 216 (1985). To that end, the CFEPA "is composed of remedial statutes, which are to be construed liberally to effectuate their beneficent purposes." (Internal quotation marks omitted.) Vollemans v. Town of Wallingford, 103 Conn. App. 188, 197 (2007), aff'd, 289 Conn. 57 (2008).

One such remedial statute is Conn. Gen. Stat. § 46a-60(b)(1), which in relevant part makes it a discriminatory employment practice for "an employer, by the employer or the employer's agent… to discriminate against [any] individual in compensation or in terms, conditions or privileges of employment because of the individual's… sex… [or] gender identity". As used in this statute, the term "employer" is defined to include "the state and all political subdivisions thereof." See Conn. Gen. Stat. § 46a-51(10) (defining "employer"); Hall v. Gallo, 50 Conn. Supp. 420, 428 (Conn. Super. Ct. 2007) ("§ 46a–51 applies… to § 46a–60"). Conn. Gen. Stat. § 46a-60(b)(1) therefore applies to "all employers whether municipal, private or agencies or subunits of state or local government". Id.

"Health insurance and other fringe benefits are compensation, terms, conditions, or privileges of employment." Newport News Shipbuilding & Dry Dock Co. v. E.E.O.C., 462 U.S. 669, 682 (1983). The prohibition on employers discriminating in terms or conditions of employment therefore "extends to discrimination in providing health insurance". Saks v. Franklin Covey, Co., 316 F.3d 337, 343 (2d Cir. 2003).[33] This applies to the State of Connecticut and municipalities as employers, as well as to any entities acting as their agents. The issue here, then, is whether the exclusions or disparities for gender dysphoria are discriminatory when found in a plan offered or administered by the State of Connecticut or municipality as an employer.

"Blanket exclusions, no matter how well motivated, fly in the face of the command to individuate that is central to fair employment practices." Connecticut Inst. for the Blind v. CHRO, 176 Conn. 88, 96 (1978). "The very act of classifying individuals by means of criteria irrelevant to the ultimate end sought to be accomplished operates in a discriminatory manner." Evening Sentinel v. Nat'l Org. for Women, 168 Conn. 26, 35 (1975). For that reason, the focus of the CFEPA on the *individual* – prohibiting employment discrimination against "any individual" on the basis of "that individual's" protected class – is so important. Such "unambiguous" language "precludes treatment of individuals as simply components of a [protected] class… [for e]ven a true generalization about the class is an insufficient reason for disqualifying an individual to whom the generalization does not apply." City of Los Angeles v. Manhart, 435 U.S. 702, 708 (1978).

[33] Given such unambiguous pronouncements as these, it is unclear why Cigna would suggest we lack authority to rule on questions presented here, particularly as they relate to any rights or obligations under the CFEPA.

"[W]hen a policy facially discriminates on the basis of the protected trait, in certain circumstances it may constitute per se or explicit… discrimination." Erie County Retirees Ass'n v. County of Erie, 220 F.3d 193, 211 n.9 (3d Cir. 2000). A determination that a policy or practice is facially discriminatory per se "does not depend on why the employer discriminates but rather on the explicit terms of the discrimination. This is because, in a facial disparate treatment case, the protected trait by definition plays a role in the decision-making process, inasmuch as the policy explicitly classifies people on that basis." Id.

Courts have held for decades that categorical exclusions in the coverage offered by employer-sponsored insurance may be discriminatory when it is tied to a protected class. In Newport News, an employer's health insurance plan fully covered hospital charges equally for men and women, *except* when those charges were incurred by reason of pregnancy. Newport News, 462 U.S. at 671-74. Because pregnancy is so closely tied to biological sex, the United States Supreme Court held that the categorical exclusion of pregnancy-related hospital charges from the employer's plan was discriminatory on the basis of sex, in violation of Title VII. Id., at 683-85.[34]

The Second Circuit expanded on this point in Saks, which similarly dealt with a claim of discrimination in employer-provided health insurance. The plaintiff alleged that her employer-provided insurance plan was discriminatory because every fertility procedure that could only be performed on males was covered, but certain fertility procedures that could only be performed on females were not covered. Saks, 316 F.3d at 341-42. The court concluded that the plan did not violate Title VII because neither the

[34] Congress had recently clarified for purposes of Title VII that actions taken "because of sex" included actions taken because of pregnancy. Newport News, 462 U.S. at 678-79.

condition of infertility, nor coverage for the condition under the plan, was sex-specific. Id., at 346-47. The court made clear, however, that "[i]n a different context the exclusion of surgeries that are performed solely on women from an otherwise comprehensive plan might arguably constitute a violation of Title VII." Id., at 347.

In reaching its conclusion in Saks, the Second Circuit distilled the holding of Newport News as follows: "Under Title VII the proper inquiry in reviewing a sex discrimination challenge to a health benefits plan is whether sex-specific conditions exist, and if so, whether exclusion of benefits for those conditions results in a plan that provides inferior coverage to one sex." Id., at 344. "Although we are not bound by federal interpretation of Title VII provisions," Connecticut courts and this Commission "have often looked to federal employment discrimination law for guidance in enforcing our own antidiscrimination statute." State v. CHRO, 211 Conn. 464, 470 (1989).

Guided by Newport News and Saks, the categorical exclusions at issue in Question 1 should be evaluated based on whether class-specific conditions exist, and if so, whether exclusion of certain benefits for those conditions results in a plan that provides inferior coverage to members of that class. We conclude that the condition of gender dysphoria is class-specific. It directly implicates the gender identity and assigned sex of individuals who are transgender, or who are otherwise not cisgender.

While "[g]ender dysphoria and the status of being transgender are not synonymous… they are correlated…. Gender dysphoria is the clinically significant distress experienced by transgender individuals." (Internal quotation marks and citations omitted.) M.A.B. v. Bd. of Ed. of Talbot County, 286 F. Supp. 3d 704, 708 (D. Md. 2018). See also, Doe v. Boyertown Area Sch. Dist., 897 F.3d 518, 522 (3d Cir. 2018) (noting that

transgender individuals can experience gender dysphoria "as a result of their birth-determined sex being different from their gender identity"), cert. denied, 139 S. Ct. 2636 (2019). In other words, while not every non-cisgender person will have gender dysphoria, by definition *only* non-cisgender people *can* have gender dysphoria.[35] Gender dysphoria is therefore so inexorably linked to an individual's non-cisgender status that it can be considered a "proxy" for it when used as a classification. See Doe 2 v. Mattis, 322 F. Supp. 3d 92, 97 (D.D.C. 2018) (noting "gender dysphoria" among concepts that are "proxies for transgender status"). See generally, Erie County Retirees Ass'n, 220 F.3d at 211 (noting that "Medicare status is a direct proxy for age"). Like the categorical exclusion of certain expenses for pregnancy in Newport News, which provided inferior coverage for a female-specific condition, the categorical exclusion of certain treatments for gender dysphoria provides inferior coverage for a condition specific to individuals who are not cisgender. It therefore discriminates on the basis of gender identity.

Such an exclusion can also amount to discrimination on the basis of assigned sex. Depending on the policy or plan, the categorical exclusion of certain procedures for gender dysphoria may mean that individuals of certain sexes are entirely precluded from being able to obtain such procedures under an employer's plan. Such an exclusion discriminates on the basis of sex by "denying equal access to certain medical procedures,

[35] In passing Public Act 11-55, which added gender identity to the Commission's statutes, the General Assembly knew that this was the case. The legislative history of Public Act 11-55 reveals that the legislature knew full well that protections on the basis of gender identity specifically referred to transgender (or "transsexual") people as a class. 54 S. Proc., Pt. 16, 2011 Sess., p. 617-24. It also shows that they knew that this class of people suffers from a unique condition in the DSM called gender dysphoria (sometimes referred to as "gender identity disorder"). Public Act 11-55: Conn. Joint Standing Committee Hearings, Judiciary Pt. 2, 2011 Sess., 418-433.

depending on whether an individual's assigned sex is male or female." Kadel v. Folwell, Docket No. 1:19-CV-272, 2020 WL 1169271, *7 (M.D.N.C. March 11, 2020). Until quite recently it may not have been so widely considered that a male-assigned individual might require a vaginoplasty, for example, or a female-assigned individual a phalloplasty. But "[t]he nature of injustice is that we may not always see it in our own times." Obergefell v. Hodges, 135 S. Ct. 2584, 2598 (2015). It can no longer be said that the need for such procedures is limited to individuals of a particular assigned sex. The same holds true for numerous other procedures, which for some might be purely cosmetic, but for others might be medically necessary due to gender dysphoria.[36]

For these reasons, in the context of gender dysphoria, "[t]he decision of whether or not certain treatment or a particular type of surgery is 'medically necessary' [should] rest[] with the individual recipient's physician and not with clerical personnel or government officials." Pinneke v. Preisser, 623 F.2d 546, 550 (8th Cir. 1980) (finding state's categorical exclusion of certain gender affirming treatments as "cosmetic" to be unlawful). See also, Flack v. Wis. Dept. of Health Servs., 328 F. Supp. 3d 931, 951 (W.D. Wis. 2018) ("individuals should be allowed to decide in consultation with their treatment providers what treatment is best and then ultimately whether to pursue it"). This is what the Insurance Department concluded in 2013 with regard to gender dysphoria. See Ins. Dept. Bulletin IC-37 (Dec. 19, 2013) ("a blanket policy exclusion for gender transition and related services is prohibited, [but] a health insurer, HMO or other entity... may still

[36] This would not be the first time the Commission has been at the forefront of recognizing advancements in the rights of non-cisgender individuals through the lens of prohibitions on sex discrimination in the context of its declaratory rulings. See CHRO Declaratory Ruling on Petition Filed on Behalf of Jane/John Doe (Nov. 9, 2000) (recognizing that transgender individuals may assert claims of sex discrimination).

perform medical necessity determinations on a case by case basis with respect to… transgender services"). It is what we conclude here. [37]

The discriminatory nature of the policies at issue becomes even clearer when one considers Question 2 of the petition. Where the State of Connecticut or a municipality offers a plan that denies coverage for treatments related to gender dysphoria as cosmetic, but grants coverage for the same treatments when related to other conditions as medically necessary, that is facial discrimination on the basis of gender identity and sex. See Newport News, 462 U.S. at 684, 682-83 (noting, as an example, that it would be discriminatory to "provide[] complete hospitalization coverage for… female employees but.. not cover… male employees when they had broken bones").

Courts have recently illustrated precisely how this disparity manifests itself through the labelling of certain procedures as medically necessary for certain conditions, but "cosmetic" for gender dysphoria. For example, depending on the plan,

> a cisgender woman born without vagina may qualify for a vaginoplasty (the surgical creation of a vagina) to correct that congenital defect; however, a transgender woman (whose [assigned] sex is male) would not be able to

[37] We note the argument raised by Robillard et al., as intervenors, and the Connecticut TransAdvocacy Coalition, as amicus, that this disparity could also discriminate on the basis of gender dysphoria as both a mental and physical disability. Courts have recognized that an insurance plan may be discriminatory if it provides fewer benefits to individuals with certain disabilities than it does to individuals with other disabilities. See Fletcher v. Tufts Univ., 367 F. Supp. 2d 99, 111 (D. Mass. 2005). Some courts have specifically found policies which deny coverage of treatments for gender dysphoria but grant it for other conditions to be unlawful. See Fields v. Smith, 712 F. Supp. 2d 830, 867 (E.D. Wis. 2010), supplemented (July 9, 2010), aff'd, 653 F.3d 550 (7th Cir. 2011). At least one court has even gone so far as to apply a "never say never" rule to state determinations on the provision of healthcare coverage, precluding a state from "plac[ing] an outright ban on medically necessary treatments for a particular diagnosis." Cruz v. Zucker, 195 F. Supp. 3d 554, 571 (S.D.N.Y. 2016). Given our conclusion that the plans at issue here discriminate on the basis of gender identity and sex, we need not reach an issue that would require us to determine, in essence, whether categorical exclusions applied to procedures for any particular disability are per se discriminatory.

> seek the same procedure, even if deemed medically necessary to treat gender dysphoria. Likewise, while a cisgender woman may opt to undergo breast reconstruction after a cancer-related mastectomy, a person whose assigned sex is male cannot receive coverage for breast augmentation to aid in gender transition.

Kadel, 2020 WL 1169271, at *7. Thus, to the extent a plan provides greater coverage to cisgender individuals for whom the same treatment may be medically necessary, that plan is discriminating against individuals who are not cisgender, based on gender identity as well as assigned sex. Id. See also, Boyden v. Conlin, 341 F. Supp. 3d 979, 997 (W.D. Wis. 2018); Flack, 328 F. Supp. 3d, at 948.[38]

To the extent that the State of Connecticut or a municipality, either itself or through an agent, offers or administers an insurance plan to its employees that categorically excludes certain procedures for gender dysphoria, it is discriminating on the basis of gender identity and possibly sex, in violation of Conn. Gen. Stat. § 46a-60(b)(1). To the extent such entities offer or administer plans that consider procedures medically necessary to treat certain conditions, but consider the same procedures cosmetic for gender dysphoria, that too is discriminatory on the basis of gender identity and sex, in violation of Conn. Gen. Stat. § 46a-60(b)(1).[39]

[38] See, e.g., Petition Ex. A, 3 ("The following procedures are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo sex reassignment surgery…."); Petition Ex. B, 2 ("Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary, when performed as part of gender reassignment….").

[39] To the extent these plans would also deprive an individual of their rights under any other state or federal law on the basis of gender identity, sex, or another protected class, they may also violate Conn. Gen. Stat. § 46a-58(a). See, e.g., Conn. Gen. Stat. §§ 38a-488a(c) and 38a-514(c) ("[n]o such policy shall establish any terms, conditions or benefits that place a greater burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of… physical health conditions").

B. The State of Connecticut as Educator

Just as the State of Connecticut violates antidiscrimination law when it offers these plans to employees, it also violates the law when it offers them to the students attending its colleges and universities, including the flagship University of Connecticut. And just as the state must cease discriminating against its transgender employees, it must also cease discriminating against students who are not cisgender.

Connecticut law decrees that "[a]ll services of every state agency shall be performed without discrimination based upon... sex... [or] gender identity." Conn. Gen. Stat. § 46a-71(a). And "[n]o state facility may be used in the furtherance of any discrimination, nor may any state agency become a party to any agreement, arrangement or plan which has the effect of sanctioning discrimination." Conn. Gen. Stat. § 46a-71(b). State universities are state agencies. Gay & Lesbian Students Ass'n, 236 Conn. at 470. Thus, when the University of Connecticut or other state universities engage in any discrimination or enter into agreements that sanction such discrimination, the Commission must bring an end to the practice.

Here, the University of Connecticut has been provided as an example. Petition Ex. I, 1. Its 2019-2020 Student Health Plan contains the exclusions for treatment related to gender dysphoria at issue in the petition. Education is an essential service provided by the state in which there may be no discrimination. See Horton v. Meskill, 172 Conn. 615, 644-46 (1977) (holding that primary and secondary education are guaranteed state services as a fundamental right under the Connecticut Constitution). Consequently, offering students discriminatory health insurance in the course of providing post-secondary education violates Conn. Gen. Stat. § 46a-71(a). Given that the Commission

has concluded that the insurance plans in question are discriminatory, Conn. Gen. Stat. § 46a-71(b) is violated when the State of Connecticut contracts with an insurer to offer students these plans or contracts with an individual student to provide them such plans.

QUESTION 3: INSURERS

The final question presented requires a determination of whether an insurer that sells exclusionary plans to the State of Connecticut or a municipality engages in a discriminatory practice in violation of statutes enforced by the Commission. Based on the petition and the submissions of the intervenors, resolution of this question must focus on two areas within the Commission's jurisdiction: employment and public accommodations.

A. Insurers as Agents or Aiders and Abettors of Public Employers

For purposes of our analysis here, insurers are not strictly "employers" when they provide health insurance services to others. But the Commission is not limited to pursuing discriminatory practices by the employing entities themselves. For example, Conn. Gen. Stat. § 46a-60(b)(5) makes it unlawful "[f]or any person, whether an employer or an employee or not, to aid, abet, incite, compel or coerce the doing of any act declared to be a discriminatory employment practice or to attempt to do so." Conn. Gen. Stat. § 46a-51(14), in turn, defines person as "one or more individuals, partnerships, associations, corporations, limited liability companies, legal representatives, trustees, trustees in bankruptcy, receivers and the state and all political subdivisions and agencies thereof." Such language proclaims that the word "person" is meant to cast a wide net.[40] The

[40] See also Bd. of Ed. of Cheshire, 270 Conn. at 707. ("The repeated use in § 46a-58(a) of the word "any" – "any person," "any other person," and "any rights, privileges or immunities, secured or protected by the Constitution or laws of this state or of the United States" – indicates an intention to protect a broad and inclusive range of persons from broadly specified forms of discrimination by a broad and inclusive range of actors.").

Commission has determined that the State of Connecticut or a municipality as an employer commits a discriminatory practice through provision of health insurance plans that discriminate on the basis of gender identity and sex. Consequently, one question this raises is whether insurers aid, abet, or incite such entities to discriminate through contracting for these health insurance plans.

In answering, we do not write on a blank slate. In CHRO & Nat'l Org. for Women v. Evening Sentinel, CHRO Nos. FEP Sex 1-5 & 29-1 (June 30, 1972), a Commission hearing tribunal found that a newspaper aided and abetted an employer's discriminatory hiring practice by publishing job positions in sex-segregated columns. The Commission's decision was affirmed at the Court of Common Pleas and the Connecticut Supreme Court. Nat'l Org. for Women v. Evening Sentinel, Docket No. 25682, 1973 WL 2709, *5 (Conn. C.P. Sept 27, 1973), aff'd sub nom.. Evening Sentinel v. Nat'l Org. for Women, 168 Conn. 26, 38 (1975). Little distinguishes the newspaper in Evening Sentinel from the insurers with which the State contacts to provide health insurance plans.

In Evening Sentinel, the newspaper created advertising space that was facially discriminatory on the basis of sex. Evening Sentinel, 168 Conn. at 34-5 ("[S]ex-classification in help-wanted advertising constitutes a per se violation of Connecticut law..."). Here, insurers have created, marketed, and administered policies that are facially discriminatory on the basis of gender identity and sex. Employers routinely retain insurers' aid in developing and/or purchasing health insurance. In both instances, separate entities facilitated discriminatory practices by employers. In Evening Sentinel, the newspaper helped employers hire on a discriminatory basis. Here, insurers help the State of Connecticut and municipalities as employers to discriminate in the terms and conditions

of employment through provision of inferior health benefits to employees. Aiding and abetting such discriminatory practices violates Conn. Gen. Stat. § 46a-60(b)(5).

To the extent that during negotiations insurers provide example policies that contain categorical exclusions for health services related to treatment of gender dysphoria, which employers then elect to use, they go further than merely aiding and abetting a discriminatory practice – they incite such practices. See Kilduff v. Cosential, Inc., 289 F.Supp. 2d 12, 17-18 (D. Conn. 2003) (quoting Webster's Dictionary to define "incite" as "to move to a course of action: stir up: spur on: urge on… to bring into being: induce to exist or occur… incite may indicate both an initiating, a calling into being or action, and also a degree of prompting, furthering, encouraging, or nurturing of activity"). Insurers therefore violate Conn. Gen. Stat. § 46a-60(b)(5) by presenting discriminatory healthcare plan terms to the State of Connecticut or a municipality as an employer. See Samartin v. Metropolitan Life Ins. Co., MCAD No. 97-SPA-0383, 2005 WL 2993469, *2 (Aug. 18, 2005) (insurer could be liable for aiding and abetting employer's discrimination).

To the extent that an insurer may act as an agent of the State of Connecticut or a municipality in the provision or administration of insurance benefits, that insurer may also be liable under Conn. Gen. Stat. § 46a-60(b)(1), which prohibits conduct by itself, but also by "the employer's agent". See, e.g., Carparts Distribution Ctr., Inc. v. Auto. Wholesaler's Ass'n, 37 F.3d 12, 17-18 (1st Cir. 1994) (plan administrator could be liable under ADA as "agent" of employer to extent it "act[ed] on behalf of the [employer] in the matter of providing and administering employee health benefits"); Boots v. Nw. Mut. Life Ins. Co., 77 F. Supp. 2d 211, 214 (D.N.H. 1999) (denying motion to dismiss against administrator

of plan, in part on possibility that it could be agent of employer). See also, Manhart, 435 U.S. at 718 n. 33 ("Title VII applies to 'any agent' of a covered employer").

B. Insurers as Places of Public Accommodation

Conn. Gen. Stat. § 46a-64(a), Connecticut's public accommodation statute, states in part that it "shall be a discriminatory practice… [t]o deny any person within the jurisdiction of this state full and equal accommodations in any place of public accommodation… because of… sex, gender identity or expression... [or] to discriminate, segregate or separate on account of… sex, gender identity or expression…." For there to be a determination that this section has been violated, it must normally be shown that, in the context of a place of public accommodation, a person has been denied full and equal accommodations or otherwise been discriminated against on the basis of their protected class. See Quinnipiac Council v. CHRO, 204 Conn. 287, 298 (1987).

In Connecticut, "any establishment which caters or offers its services or facilities or goods to the general public" is a place of public accommodation. See Conn. Gen. Stat. § 46a-63(1). "Although no private organization is duty-bound to offer its services and facilities to all comers, once such an organization has determined to eschew selectivity, under our statute it may not discriminate among the general public." Quinnipiac Council, Boy Scouts of Am., Inc. v. CHRO, 204 Conn. 287, 299 (1987); Corcoran v. German Social Society Frohsinn, Inc., 99 Conn. App. 839, 844 (2007). See Marsh v. Alabama, 326 U.S. 501, 506 (1946) ("The more an owner, for his advantage, opens up his property for use by the public in general, the more do his rights become circumscribed by the statutory and constitutional rights of those who use it.").

The intervenors and amicus have offered arguments for and against our finding that insurers would be places of public accommodation by virtue of their offering insurance plans to certain consumers. A decision about whether a particular entity is a "place of public accommodation", and therefore covered by Conn. Gen. Stat. § 46a-64, "must reflect the legislative purpose of eliminating discriminatory conduct by those who serve the general public. From that vantage point, the organizational status of the enterprise that is the service provider cannot be the determinant of statutory coverage." Quinnipiac Council, 204 Conn. at 299. Instead, "coverage under the statute depends, in each case, upon the extent to which a particular establishment has maintained a private relationship with its own constituency or a general relationship with the public at large." Id., at 300. To this end, courts have typically "declined 'categorical judgment' as to what types of establishments are or are not public accommodations"; Collins v. Univ. of Bridgeport, 781 F. Supp. 2d 59, 66 (D. Conn. 2011); suggesting that the question is more readily one of fact than law. Quinnipiac Council, 204 Conn. at 300.

Courts have not, however, shied away from giving examples of instances in which otherwise private entities could eschew selectivity, thereby becoming places of public accommodation. "A hospital, for example, cannot refuse its services to a member of the general public simply because the hospital is a nonprofit corporation…. Similarly, a private university that opens its theater facilities for the entertainment of the general public cannot refuse admission for reasons of race or sex or other grounds made illegal by § [46a-64](a)." Id., at 299. It is therefore appropriate for us to consider whether an insurer *could be* a place of public accommodation subject to statutory coverage, even without finding that a *particular* insurer *is* a place of public accommodation.

An "establishment" includes, at the very least, business and commercial enterprises; Quinnipiac Council, 204 Conn. at 297-98; of which an insurer would certainly be one. Insurance may be both a "service" and a "good". See Webster Bank v. Oakley, 265 Conn. 539, 572 (2003) (citing Pallozzi v. Allstate Life Ins. Co., 198 F.3d 28, 30–33 (2d Cir. 1999)). For purposes of determining coverage under Connecticut law, then, the inquiry must focus on whether insurers offering insurance to the State of Connecticut or municipalities may be thought to be providing such services or goods to "the general public". The term "general public" has not been defined in statute, however. We must therefore "turn for interpretive guidance to [the statute's] legislative history, the circumstances surrounding its enactment, and the purpose the statute is to serve." Quinnipiac Council, 204 Conn. at 294–95.

The legislative history by itself does not provide us with a clear result in this instance. The bill which became Public Act 53-326 and enacted the current definition of "place of public accommodation" passed easily through both chambers of the legislature, with no debate. See 5 H.R. Proc., Pt. 6, 1953 Sess., p. 2120; 5 S. Proc., Pt. 4, 1953 Sess., p. 1498. The one hint that we can discern is from Harold Lewis of the NAACP, who testified before the Judiciary Committee in support of the bill, calling it a "measure to end discrimination in places which depend upon the patronage of the general public for support". Conn. Joint Standing Committee Hearings, Judiciary, Vol. 2, 1953 Sess., p. 455. While "testimony before legislative committees may be considered in determining the particular problem or issue that the legislature sought to address by the legislation"; Hatt v. Burlington Coat Factory, 263 Conn. 279, 314 (2003); we must be cautious in relying

too heavily on "ambiguous legislative history" if more instructive sources of interpretation exist. Cotto v. United Techs. Corp., 251 Conn. 1, 40 (1999) (Borden, J., concurring).

We next turn to the circumstances surrounding the enactment of Conn. Gen. Stat. § 46a-63(1)'s definition of "place of public accommodation". Perhaps the earliest case to address our then-fledgling public accommodations statute was Faulkner v. Solazzi, 79 Conn. 541, 65 A. 947 (1907), which analyzed whether a barber shop should be considered a "place of public accommodation". At the time, the statute provided only that "every person who deprives another of 'the full and equal enjoyment of the advantages, facilities, accommodations and privileges of any place of public accommodation or amusement or transportation' on account of race or color shall pay double damages to the person injured thereby." Fowler v. Benner, 23 Ohio Dec. 59, 64 (Ohio Com. Pl. 1912). As there was no statutory definition of "place of public accommodation", the Connecticut Supreme Court "was given wide latitude in construing the language and giving construction to the words". Id.

The test adopted by the Court was whether a particular kind of entity was "affected with the public interest," such that it was covered by "some power of [state] regulation in the interest of the public, or… certain duties as owed to the individual members of the public, or both." Faulkner, 65 A. at 947; Fowler, 23 Ohio Dec. at 64. In doing so the Court made no explicit reference to insurance, but one of the cases cited by the Court as providing an example "a public employment involving a public service for the public accommodation… without the power of discrimination" was New Jersey Steam Nav. Co. v. Merch.'s Bank of Boston, 47 U.S. 344 (1848). In that decision, the United States Supreme Court affirmed liability on shipping carriers, concluding that in transporting

goods such carriers were not only performing duties of a "public" nature, but were acting as "insurers" of those goods, and thus subject to similar obligations. Id., at 381-82.

The public's interest in insurers was made even more explicit by the United States Supreme Court 7 years after Faulkner. The issue in German All. Ins. Co. v. Lewis, 233 U.S. 389 (1914) was whether a state could legislatively regulate insurance rates. In concluding that states could properly do so, the Court commented at length on the public interest in the business of insurance: "The effect of insurance – indeed, it has been said to be its fundamental object – is to distribute the loss over as wide an area as possible. [T]he disaster to an individual is shared by many…. Contracts of insurance, therefore, have greater public consequence than contracts between individuals to do or not to do a particular thing whose effect stops with the individuals." Id., at 412-413. Viewed through this lens, insurers would have been "affected with the public interest" under Faulkner by virtue of their public nature, and the public interest in regulating their conduct.

By 1952, Connecticut had adopted a "specific list of enterprises offering [goods or services] to the general public". Quinnipiac Council, 204 Conn. at 290. But in 1953 the legislature "abandoned its laundry list approach", enacting the current more wide-ranging definition of "place of public accommodation". Id. The arc of this history shows that Connecticut, like many other states, "has progressively broadened the scope of its public accommodations laws in the years since they were first enacted, both with respect to the number and type of covered facilities and with respect to the groups against whom discrimination is forbidden." Roberts v. US Jaycees, 468 U.S. 609, 624 (1984); Quinnipiac Council, 204 Conn. at 296 ("our public accommodation statutes have repeatedly been amended to expand the categories of enterprises that are covered and the conduct that

is deemed discriminatory."). This suggests that the pool of entities covered by our public accommodations statutes should be *broader* than it was a century ago, not narrower.

We lastly may look to the purpose that our public accommodation statutes were intended to serve. "[P]ublic accommodation laws plainly serve compelling state interests of the highest order;" id., at 297; namely remedying "the deprivation of personal dignity that surely accompanies denials of equal access to public establishments." Heart of Atlanta Motel, Inc. v. U.S., 379 U.S. 241, 291–92 (1964) (Goldberg, J., concurring). See also, Thibodeau v. Design Group One Architects, LLC, 260 Conn. 691, 706 (2002) ("there exists a general public policy in this state to eliminate all forms of invidious discrimination"); Curry v. Allan S. Goodman, 286 Conn. 390, 412 (2008) ("the intent of the legislature is to stamp out discrimination"). The Connecticut Supreme Court has directed that statutes furthering such "remedial" goals be interpreted "liberally in order to effectuate the legislature's intent". CHRO v. Sullivan Associates, 250 Conn. 763, 782 (1999).

Based on "the unconditional language of the statute, the history of its steadily expanded coverage, and the compelling interest in eliminating discriminatory public accommodation practices"; Quinnipiac Council, 204 Conn. at 297; the term "general public" must be interpreted broadly, to encompass a wide array of recipients to whom an "establishment" may offer "services" or "goods". From Connecticut's earliest conception of "place of public accommodation", coverage under the statute has been tied not only to the interest of individual members of the public in particular services and goods, but also the public interest in certain industries as manifested through government oversight. We therefore conclude that "the general public" referred to in Conn. Gen. Stat. § 46a-63(1) includes public entities such as the State of Connecticut and municipalities. As a result,

an insurer that offers insurance to such entities is offering services and goods to "the general public" and could, if it has eschewed selectivity in doing so, be considered a "place of public accommodation".

In reaching this conclusion we join several other jurisdictions which have found insurers may be places of public accommodation in certain circumstances. See, e.g., Pallozzi, 198 F.3d 28 at 31; Carparts, 37 F.3d 12 at 20; Marques v. Harvard Pilgrim Healthcare of New England, Inc., 883 A.2d 742, 749–50 (R.I. 2005); Samartin, 2005 WL 2993469, at *8. We acknowledge that other jurisdictions have reached a contrary result, particularly under the ADA. See, e.g., Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1115 (9th Cir. 2000); Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1010 (6th Cir. 1997). Many of these contrary decisions, however, are based on an interpretation of by federal courts that "place of public accommodation" as used in the ADA refers to a physical location, which the Connecticut Supreme Court has rejected as a requirement for coverage under Connecticut's public accommodations statute. Quinnipiac Council, 204 Conn. at 297 ("physical situs is not today an essential element of our public accommodation law"). Moreover, federal law generally defines "the beginning and not the end of our approach" to discrimination, such that Connecticut courts often "have interpreted our statutes even more broadly than their federal counterparts, to provide greater protections to our citizens, especially in the area of civil rights." CHRO v. Savin Rock Condo. Ass'n, Inc., 273 Conn. 373, 386 n.11 (2005).

Based on the record here, the Commission cannot categorically state that any particular insurer is a place of public accommodation. That will still require a more "fact-bound" approach better suited to case-by-case analysis. Quinnipiac Council, 204 Conn.

at 300. For some insurers, the factual inquiry into whether they offer plans to the general public will be quite simple. See, e.g., Blue Cross of Idaho Health Serv., Inc. v. Atl. Mut. Ins. Co., Docket No. 1:09-CV-246 (CWD), 2011 WL 162283, *1 (D. Idaho Jan. 19, 2011) ("Blue Cross provides health insurance policies to the general public"). For other insurers, the inquiry may be more nuanced. See, e.g., Grunwald v. Physicians Health Services of New York, Inc., Docket No. 97-CIV-5654 (JGK), 1998 WL 146226, *1 (S.D.N.Y. March 25, 1998) ("Physicians Health Services of New York, Inc.… [is] licensed… to sell medical insurance to the general public"). Where the answer is not immediately apparent, the inquiry should, as a result of this ruling, explore whether the insurer offers insurance-related services or goods to the State of Connecticut or municipalities.

If a particular insurer does offer insurance-related services or goods to the State or municipalities, and has not eschewed selectivity, it will be found to constitute a public accommodation. If a particular insurer is so found, the question is whether the health insurance policy underlying the contract – whether self-funded by an employer or purchased through the insurer – would be discriminatory pursuant to our previous analysis. Just as a policy that provides inferior benefits to people on the basis of gender identity and sex is discriminatory in the terms and conditions of employment, so too is such a policy discriminatory in a public accommodations context. The plans deny non-cisgender people full and equal access to good and services offered by insurers to the general public. In so doing they facially and practically discriminate on the basis of gender identity and sex in violation of Conn. Gen. Stat. § 46a-64.

V. CONCLUSION

The complexity that transgender people face in evaluating their own gender identity and sex requires that doctors, insurers, and the State recognize them as the individuals that they are. Just as disregarding the individuality of a person on the basis of their skin color strikes at the heart of antidiscrimination policy, painting all transgender people with the same brush violates that same principle.

Insurance policies that categorically refuse to consider certain procedures for certain people on the basis of their race, sex, or sexual orientation are facially discriminatory. So too are such exclusions for transgender people on the basis of gender identity, a condition unique to them. Consequently, when the State or a municipality contracts for health insurance plans that contain categorical exclusions for treatments related to gender dysphoria – and especially when the same treatments are covered for treatment of other conditions – it commits a discriminatory practice, as does the insurer.

Transgender people are uniquely reliant on medical services to help them treat gender dysphoria – to avoid both personal distress as well as future violence and discrimination. The State cannot permit itself, its agents, and its municipalities to discriminate against this vulnerable group of people. Our understanding of sex and gender has evolved. It is time for the State to catch up, and reclaim its place on the front lines in the fight against discrimination on the basis of gender identity or expression.

COMMISSION ON HUMAN RIGHTS AND OPPORTUNITIES

Adopted by a majority vote of the members of the Commission on Human Rights and Opportunities present and voting at the regular monthly meeting held on April 15, 2020.

Cherron Payne

Cherron Payne, Chairperson

April 17, 2020
Date