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Transgender Health Care Lawsuit Moves Forward

A federal judge found that a blanket exclusion for "gender-confirming health care" and related services in the state of West Virginia's Medicaid program and the state's health plan for government employees violates the nondiscrimination clause of Section 1557 of the Affordable Care Act (ACA). Therefore, the health plans' motion to dismiss is denied and plaintiffs' claims may proceed.

Plaintiffs were two transgender males, one covered by the state government employee health plan, and the other covered under the state's Medicaid program. Both were diagnosed with gender dysphoria, "the clinically significant distress that can result from the dissonance between an individual's gender identity and sex assigned at birth." Both were denied coverage for hormone replacement therapy and surgery for the treatment of gender dysphoria and, as a

result, they sued, charging that these treatments are denied to transgender individuals despite being available to cisgender individuals (people whose gender identity matches their sex assigned at birth).

Section 1557 of the ACA prohibits discrimination by recipients of federal financial assistance. It states: ". . . [A]n individual shall not . . . be excluded from participation in, be denied benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving federal financial assistance, including credits, subsidies, or contracts of insurance . . .

Plaintiffs alleged that the state government employee health plan contracted with a private-sector HMO to provide health plan coverage to some state government employees (including one of the plaintiffs). And because that HMO also offered a Medicare Advantage plan in its product portfolio, the HMO received federal financial assistance. Therefore, the HMO was required to comply with Section 1557 of the ACA.

The HMO argued that the Section 1557 language referring to "any health program or activity" should be equated to individual health plans rather than entities. If Congress had intended Section 1557 to apply to entities, the HMO asserted, it would have used language like "health insurance issuer" or "health maintenance organization." Here, the court disagreed, finding that Congress intended the phrase to apply broadly. Therefore, the court concluded that the HMO is a "health program or activity" under Section 1557 and, because it accepts federal financial assistance under the Medicare Advantage program, the HMO must comply with Section 1557 in its entire portfolio of products.

Full text of Fain v. Crouch, 3:20-0740 (S.D. W. Va. May 19, 2021) (Scholar.Google.com)

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Full text of Fain v. Crouch, 3:20-0740 (S.D. W. Va. June 28, 2021) (Casetext.com)

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