

Minutes of the Senate Anti-Discriminatory Policies Committee
8 April 2011
826 Cathedral of Learning

In Attendance: Mark Lynn Anderson, Deborah Brake (Chair), Jane Feuer, Rebecca Harmon, Randy Juhl, Noah Lewis (invited presenter), Kathy Humphrey, Carol Mohamed, Jesse Nicholson, Alexandra Oliver, Edward SanFilippo, Vijai Singh, and Steve Zupcic.

Absent Elected Members: Andrew Franz, Paolo Palmieri, Cindy Popovich, and Roy Smith.

Excused member: Bruce Venarde.

Deborah Brake called the meeting to order at 9:05 AM.

Chair Brake reminded the committee that the entire April meeting of the ADPC was devoted to a presentation by and discussion with Noah Lewis. Brake introduced Lewis to the committee: Lewis is a 2005 graduate of Harvard Law School, and he is currently an Attorney for the Transgender Legal Defense and Education Fund (TLDEF), specializing in issues of transgender health care. Lewis was an undergraduate at the University of Pittsburgh where he graduated *magna cum laude* with degrees in chemistry and in the history and philosophy of science. Lewis visited our campus to participate in a conference program on transgender legal issues at the School of Law, and he generously accepted our committee's request to talk with us as we continue to discuss ways of ending the University's exclusion of transsexual medical procedures from its employee and students insurance plans.

Lewis began his presentation with some general definitions and descriptions of transitioning and transitioning people. One important way of understanding the condition of transitioning people is that they are faced with a "mismatch" between the brain and the biological body, and Lewis pointed to current MRI research that indicates possible differences in the "brain sex" of men and women, with transitioning often people testing as having brain characteristics in counter-distinction to their biological sex. Lewis mentions that many insurance plans do not provide coverage for transitioning procedures, even though the need for reassignment has been recognized as a legitimate diagnosis requiring treatment by the American Medical Association, and even though many insurance companies do pay for "corrective surgeries" for intersexed infants who are routinely assigned a single anatomically sex through surgery shortly after birth. Lewis considers such assignments of intersexed infants bad practice since these procedures often result in reduced or absent sexual function and since they also impinge upon issues of consent.

Lewis distinguished transitioning people from other definitions of transgender identity, in part, by remarking how the majority of transitioning people identify as either a man or a woman, seeing themselves as always already the sex that is the objective target of their medical therapies. Lewis points out that roughly 85% of transitioning men and 90% of transitioning women have not had genital surgery. Vijai Singh asked Lewis about the rate of reconsideration by transitioning people who have had surgical reassignments. Lewis

said that long-term studies show that regret for reassignments is extremely rare. Regret, he said, is typically a function of the discrimination the person must face as a transitioning person.

Next, Lewis briefly discussed the types of medical procedures designed to change the primary and secondary characteristics. These include hormone therapies for trans men, and electrolysis for trans women, with the latter almost never covered, even by plans that pay for most transitioning procedures. Surgeries will include genital surgery, but also breast reduction for trans men, breast augmentation for trans women, facial feminization for trans women, puberty blockers for transitioning adolescents, etc. Each individual will have different medical needs.

Lewis then addressed the issue of why the exclusions from insurance coverage exist. His short answer is, “Because they [company’s] can get away with it.” Lewis points out that similar exclusions existed for pregnancies and for AIDS treatments, exclusions that unfairly targeted women and gay men, that is, until women, PLWAs (persons living with AIDS), and their allies were able to win recognition for the unfairness of these very types of targeted exclusions that are virtually unthinkable today. Lewis points out, though, that transsexual surgeries are not exactly new science. Reassignment surgeries were beginning to be routinely performed in the 1960s, and such procedures had sometimes been extensively covered by insurance in the past. Exclusions are currently enforced tacitly by physician agreement, a situation that creates a “cycle of exclusion” in which all transgender people suffer. There is a widespread belief that medical care is unnecessary, and only a handful of surgeons in the country currently perform reassignment. The lack of attention to transgender and transitioning healthcare in Medical Schools is a huge problem, and the relative noninterest in the health of transitioning individuals means that there is a lack of follow-up studies to track outcomes.

Rebecca Harmon asked Lewis what he thought of arguments coming from fiscal conservatives about this being an issue of self-satisfaction with body image, and a brief discussion followed of how numerous aging men and women might also benefit from facial surgeries or cosmetic procedures that shape their body into a more self-pleasing and comfortable appearance. Lewis responded that transitioning was different in that it was a reconstruction of the body determined by medical need, something that non-transsexuals have a very difficult time understanding. While Lewis acknowledges that there are psychological diagnoses for transitioning people, such as the GID (Gender Identity Disorder) of the *DSM-IV (Diagnostic and Statistical Manual of Mental Disorders)*, he doesn’t think transitioning should principally be a psychological diagnosis. Lewis pointed out that we accept the fact that, for example, reconstruction surgeries for burn patients are almost always covered by medical insurance, but no one would think to suggest that this is the equivalent of a facelift. Jane Feuer mentioned that her thinking about reassignment had been similarly casual, but that she now thinks about the medical necessity of these very serious surgeries and procedures. Brake said that transitioning is a medical condition and insurance companies need to treat it as such.

Lewis then addressed the expenditure issue that fiscal conservative were likely to advance. He pointed out that the cost of the coverage for these procedures in San Francisco, a city with an unusually high demographic of transitioning people, and one

that has a generous insurance benefit for transsexual therapies and procedures, is extraordinarily low because, given the overall number of participants in the plan, the rate of claims is very low. The insurance company maintains that the expense of tracing these procedures would cost more than the procedures themselves. Lewis says that, like our University, Blue Cross of Massachusetts has an explicit exclusion of coverage for trans-surgery and related procedures, but when asked for the rationale of the exclusion they cannot produce any data about costs. The only reason for the exclusion is prejudice.

Randy Juhl mentioned that transplant procedures and training at UMPC are subject to a variety of political, economic, and social determinations, and that it is difficult to isolate the medical rationale from these other factors, as much as we would like to do so. Steve Zupcic offered that public discussion is needed on these questions because the false issue of cost is used to defend exclusionary practices. What followed was an informal discussion of similar issues about the political context of adequately addressing the removal of the exclusion, including concerns about possibilities for circumventing diagnoses and fraud.

Ed SanFilippo ([a first-year student in the School of Law, invited to the meeting by Chair Brake](#)) responded to this series of concerns by saying that medical disorders require a medical response, that there was no slippery slope that would “open the door” to all sorts of other surgeries that weren’t medically necessary. The bodies of non-transitioning people who are unhappy with their appearance do not suffer the everyday social violence that trans bodies endure. The two cannot be equated. SanFilippo said that, as a trans man, he experiences discrimination in every context of his life. Alexandra Oliver offered that it might make sense to still consider the psychological contexts of the disorder, despite some of the problems of psychological diagnoses, since we commonly cover treatments for depression and other debilitating psychological problems. Zupcic mentioned that Canada’s coverage of reassignment was uneven and was subject to differing political climates across the provinces. Juhl observed that it might not only be questions of cost that prevent progressive changes in coverage, and he asked Lewis about outcome studies. To highlight the need for this health care, Lewis pointed out that 41% of trans people have attempted suicide as compared to 1.6% of the general population (These statistics are from the National Gay and Lesbian Task Force).

The meeting was adjourned at 10:03 AM.

Submitted by Mark Lynn Anderson, 9 May 2011.

Revised and resubmitted by Mark Lynn Anderson, 13 May 2011.