

**RESOLUTION 12-01-08**

**DIGEST**

Civil Rights: Fairness in Medical Coverage Provided to Transgendered Individuals

Amends Health and Safety Code section 1367.63 to require healthcare providers to cover the special needs of persons with medically diagnosed gender identity disorder.

**RESOLUTIONS COMMITTEE RECOMMENDATION  
DISAPPROVE**

History:

No similar resolutions found.

Reasons:

This resolution amends Health and Safety Code section 1367.63 to require healthcare providers to cover the special needs of persons with medically diagnosed gender identity disorder. This resolution should be disapproved because it fails to provide statutory definitions of “medically-diagnosed gender identity disorder” or of “transgender,” which are necessary since the amendments and additions are based on these medical conditions/definitions.

Amendments to sections 1367.64, 1367.65, 1367.66, requiring health care service plans to cover prostate, cervical, and breast screenings for transgendered people who remain as their birth sex seem fair and address a serious need in this community. However, the costs associated with health care service providers establishing a dual tracking system (physically one gender but psychologically identify as another gender) may outweigh the number of affected transgendered persons.

The additions of sections 1367.666 and 1367.667 for health care service providers to cover “all surgical procedures necessary” is burdensome and requires the absent definitions mentioned above.

**TEXT OF RESOLUTION**

RESOLVED, that the Conference of Delegates of California Bar Associations recommends that legislation be sponsored to amend Health and Safety Code sections 1367.63, 1367.64, 1367.65, and 1367.66 and to add sections 1367.666 and 1367.667 to the Health and Safety Code as follows:

- 1    § 1367.63
- 2           (a) Every health care service plan contract, except a specialized health care
- 3    service plan contract, that is issued, amended, renewed, or delivered in this state on or
- 4    after July 1, 1999, shall cover reconstructive surgery, as defined in subdivision (c), that is
- 5    necessary to achieve the purposes specified in paragraphs (1) or (2) of subdivision (c).
- 6    Nothing in this section shall be construed to require a plan to provide coverage for
- 7    cosmetic surgery, as defined in subdivision (d).

8 (b) No individual, other than a licensed physician competent to evaluate the  
9 specific clinical issues involved in the care requested, may deny initial requests for  
10 authorization of coverage for treatment pursuant to this section. For a treatment  
11 authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the  
12 request may be reviewed by a similarly licensed individual, competent to evaluate the  
13 specific clinical issues involved in the care requested.

14 (c) "Reconstructive surgery" means surgery performed to correct or repair  
15 abnormal structures of the body caused by congenital defects, developmental  
16 abnormalities, trauma, infection, tumors, gender identity disorder or disease to do either  
17 of the following:

18 (1) To improve function.

19 (2) To create a normal appearance, to the extent possible.

20 (d) "Cosmetic surgery" means surgery that is performed to alter or reshape normal  
21 structures of the body in order to improve appearance.

22 (e) In interpreting the definition of reconstructive surgery, a health care service  
23 plan may utilize prior authorization and utilization review that may include, but need not  
24 be limited to, any  
25 of the following:

26 (1) Denial of the proposed surgery if there is another more appropriate surgical  
27 procedure that will be approved for the enrollee.

28 (2) Denial of the proposed surgery or surgeries if the procedure or procedures, in  
29 accordance with the standard of care as practiced by physicians specializing in  
30 reconstructive surgery, offer only a minimal improvement in the appearance of the  
31 enrollee.

32 (3) Denial of payment for procedures performed without prior authorization.

33 (4) For services provided under the Medi-Cal program (Chapter 7 (commencing  
34 with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), denial  
35 of the proposed surgery if the procedure offers only a minimal improvement in the  
36 appearance of the  
37 enrollee, as may be defined in any regulations that may be promulgated by the State  
38 Department of Health Services.

39  
40 § 1367.64.

41 (a) Every individual or group health care service plan contract, except for a  
42 specialized health care service plan contract, that is issued, amended, or renewed on or  
43 after January 1, 1999,  
44 shall be deemed to provide coverage for the screening and diagnosis of prostate cancer,  
45 including, but not limited to, prostate-specific antigen testing and digital rectal  
46 examinations, when medically necessary and consistent with good professional practice.

47 (b) The medical procedures and testing described in this section will not be denied  
48 to any male-to-female transgender enrollee solely on the basis of the enrollee's

49 identification as a woman. Any administrative processes or procedures necessary to  
50 ensure compliance with this provision shall be promptly instituted.

51 (c) Nothing in this section shall be construed to establish a new mandated benefit  
52 or to prevent application of deductible or copayment provisions in a policy or plan, nor  
53 shall this section be construed to require that a policy or plan be extended to cover any  
54 other procedures under an individual or a group health care service plan contract.  
55 Nothing in this section shall be construed to authorize an enrollee to receive the services  
56 required to be covered by this section if those services are furnished by a nonparticipating  
57 provider, unless the enrollee is referred to that provider by a participating physician or  
58 nurse practitioner providing care.

59  
60 § 1367.65.

61 (a) On or after January 1, 2000, every health care service plan contract, except a  
62 specialized health care service plan contract, that is issued, amended, delivered, or  
63 renewed shall be deemed to provide coverage for mammography for screening or  
64 diagnostic purposes upon referral by a participating nurse practitioner, participating  
65 certified nurse midwife, or participating physician, providing care to the patient and  
66 operating within the scope of practice provided under existing law.

67 (b) The medical procedures and testing described in this section will not be denied  
68 to any transgender enrollee solely on the basis of the enrollee's identification as a man.  
69 Any administrative processes or procedures necessary to ensure compliance with this  
70 provision shall be promptly instituted.

71 (c) Nothing in this section shall be construed to prevent application of copayment  
72 or deductible provisions in a plan, nor shall this section be construed to require that a plan  
73 be extended to cover any other procedures under an individual or a group health care  
74 service plan contract. Nothing in this section shall be construed to authorize a plan  
75 enrollee to receive the services required to be covered by this section if those services are  
76 furnished by a nonparticipating provider, unless the plan enrollee is referred to that  
77 provider by a participating physician, nurse practitioner, or certified nurse midwife  
78 providing care.

79  
80 § 1367.66.

81 (a) Every individual or group health care service plan contract, except for a  
82 specialized health care service plan, that is issued, amended, or renewed, on or after  
83 January 1, 2002, and that includes coverage for treatment or surgery of cervical cancer  
84 shall also be deemed to provide coverage for an annual cervical cancer screening test  
85 upon the referral of the patient's physician and surgeon, a nurse practitioner, or certified  
86 nurse midwife, providing care to the patient and operating within the scope of practice  
87 otherwise permitted for the licensee.

88 (b) The coverage for an annual cervical cancer screening test provided pursuant to  
89 this section shall include the conventional Pap test, a human papillomavirus screening

90 test that is approved by the federal Food and Drug Administration, and the option of any  
91 cervical cancer screening test approved by the federal Food and Drug Administration,  
92 upon the referral of the patient's health care provider.

93 (c) The medical procedures and testing described in this section will not be denied  
94 to any female-to-male transgender enrollee solely on the basis of the enrollee's  
95 identification as a man. Any administrative processes or procedures necessary to ensure  
96 compliance with this provision shall be promptly instituted.

97 (d) Nothing in this section shall be construed to establish a new mandated benefit  
98 or to prevent application of deductible or copayment provisions in an existing plan  
99 contract. The Legislature intends in this section to provide that cervical cancer screening  
100 services are deemed to be covered if the plan contract includes coverage for cervical  
101 cancer treatment or surgery.

102

103 § 1367.666.

104 Every individual or group health care service plan contract, except for a  
105 specialized health care service plan contract, that is issued, amended, delivered, or  
106 renewed on or after January 1, 2009, will provide coverage for all surgical procedures  
107 necessary to treat medically-diagnosed gender identity disorder.

108

109 § 1367.667.

110 Every individual or group health care service plan contract, except for a  
111 specialized health care service plan contract, that is issued, amended, delivered, or  
112 renewed on or after January 1, 2009, will provide coverage for all prescribed hormone  
113 treatments for medically-diagnosed gender identity disorder.

(Proposed new language underlined; language to be deleted stricken.)

**PROPONENT:** Bay Area Lawyers for Individual Freedom

**STATEMENT OF REASONS:**

Existing Law: Allows discrimination in the provision of healthcare on the basis of an individual's identification with a gender other than his or her birth gender.

This Resolution: Would require health care service plans to provide care for transgender enrollees on an equal basis with non-transgender enrollees.

The Problem: Transgender individuals face tremendous difficulties in obtaining quality healthcare that includes treatment for health concerns related to gender identity disorder. Virtually all health insurance providers and health maintenance organizations exclude sex-change surgeries to treat gender identity disorder as either pre-existing conditions or as "cosmetic" surgery. Contrast this with the fact that these same insurers and health maintenance organizations cover surgery to (re-)assign a sex to an infant who is born intersexed, as well as cover hormone therapy for non-transgender individuals. See San Francisco Human Rights

Commission, A HUMAN RIGHTS INVESTIGATION INTO THE MEDICAL “NORMALIZATION” OF INTERSEX PEOPLE, April 28, 2005. This exclusion of coverage for a serious medical condition is irrational and patently unfair.

In addition, healthcare providers often refuse to provide screening for potentially life-threatening medical conditions arising from the birth gender of the transgender individual. For example, male-to-female transgender individuals are often denied coverage and/or testing and screening for prostate cancer. Likewise, female-to-male transgender individuals are often denied coverage and/or testing and screening for cervical cancer as well as for breast cancer. These denials are due at least in part to the fact that the insurance codes used (on both electronic and paper forms) to refer patients for screening and testing are restricted to the gender declared by the individual subscriber of the insurance contract. If a female-to-male transgender individual has enrolled with his insurer as a male, or transitioned to maleness while enrolled and informed his insurer of this fact, the health care codes attached to his medical record will only reflect male anatomical parts and conditions. Currently, health care service plans are under no onus to correct this problem. This resolution will address the problems discussed by allowing transgender individuals to obtain the healthcare that they need.

**IMPACT STATEMENT:**

This resolution does not affect any other law, statute or rule.

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**RESPONSIBLE FLOOR DELEGATE:**

## RESOLUTION 12-02-08

### DIGEST

#### Insurance: Definitions in Policies

Amends Insurance Code, section 41, to state that all terms in an insurance policy are governed by the terms defined in the Insurance Code.

### RESOLUTIONS COMMITTEE RECOMMENDATION DISAPPROVE

#### History:

No similar resolutions found.

#### Reasons:

This resolution amends Insurance Code, section 41, to state that all terms in an insurance policy are governed by the terms defined in the Insurance Code. This resolution should be disapproved because the defined terms in the Insurance Code relate to the terms of the Insurance Code, not the terms of insurance policies.

In contract law, words or phrases requiring definitions generally are defined according to their plain meaning. The same is true of insurance policies. This resolution would replace the plain meaning of terms to coincide with definitions contained within the Insurance Code. This change likely would benefit insurance carriers and not policy holders, for whom the plain meaning of terms is a more reasonable standard.

### TEXT OF RESOLUTION

RESOLVED, that the Conference of Delegates of California Bar Associations recommends that legislation be sponsored to amend Insurance Code §41 to read as follows:

- 1 § 41
- 2 All insurance in this State is governed by the provisions of this code, including the
- 3 meaning of any undefined word, term or phrase in the policy.

(Proposed new language underlined; language to be deleted stricken.)

**PROPONENT:** San Fernando Valley Bar Association

### STATEMENT OF REASONS:

Existing Law: A frequent dispute between insurers and policyholders continuously reappears: what does a particular word, or term, or phrase in the policy mean. *Insurance Code* §19<sup>1</sup> defines

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<sup>1</sup> “§ 19. ‘Person’

‘Person’ means any person, association, organization, partnership, business trust, limited liability company, or corporation.”

the word “person” to include non-natural entities. Section 41 provides all insurance is subject to that code.

This Resolution: Amending *Insurance Code* §41 to state that the meaning of any undefined word, term, or phrase in a policy would be determined by the provisions of the *Insurance Code*, including a comment stating the amendment is declaratory of existing law.

The Problem: One court refused to apply §19 to a corporate tenant’s dispute with its landlord, holding that “person” in a landlord’s liability policy covering interference with a person’s rights to occupy a premises meant *only* natural people. (*Mirpad vs. CIGA* (2005) 132 Cal.App.4th 1058, 1070-1071.) The trial court’s ruling that the undefined word “person” meant any of the entities defined in §19 was reversed. (*Id.* at 1065-1066, and fn. 10.) Its rationale was that §19 only applied to construe other insurance statutes. (*Mirpad, supra*, 132 Cal.App.4th at 1073-1074.) The landlord had no insurance coverage.

The *Mirpad* court reached the same result in *Golden Eagle vs. Cen-Fed* (2007) 148 Cal.App.4th 976, again holding that the landlord’s general liability policy’s personal injury coverage did *not* apply because *only suits by natural person-tenants were within the policy’s coverage*. (*Id.* at 990.) That policy also did not define the word “person,” yet the court ruled that the insurer had no duty to defend, nor to indemnify, the insured landlord against the corporate tenant’s claims.

This issue is not limited to landlord-tenant disputes; it has been applied in situations where no privity of contract or estate exists. A business whose dust from its grinding operations interfered with a neighboring landowner’s business was uninsured for its interference (negligence, nuisance, trespass) with a neighbor’s use of its property. (*Stonelight Tile vs. CIGA* (2007) 150 Cal.App.4th 19, 40.)

California insureds who are sued by a non-natural tort plaintiff (tenant, lessee, or otherwise) for interfering with the use of plaintiff’s real property (negligence, nuisance, trespass), is only insured, including a duty to defend, if the plaintiff is a natural person.

This amendment would greatly reduce the level of litigation involving all kinds of insurance. Its clearest impact would be for the negligence, nuisance or trespass defendants who are insured under liability policies, including homeowners policies. Health insurance is an area which would definitely benefit from such an amendment, let alone the ordinary commercial businessman or homeowner or automobile driver. Leaving words undefined is a purposeful manner of ensuring that costly and prohibitive litigation is the only way an insured can obtain an impartial interpretation of the policy. This, of course, favors the insurer’s economic power. The amendment is soundly grounded, as definitions in the *Insurance Code* are readily available to everyone.

#### **IMPACT STATEMENT:**

This resolution does not affect any other law, statute or rule.

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**RESPONSIBLE FLOOR DELEGATE:**