

5-1-2010

Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates

Dean Spade

Follow this and additional works at: <https://digitalcommons.law.seattleu.edu/sjsj>

Recommended Citation

Spade, Dean (2010) "Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates," *Seattle Journal for Social Justice*: Vol. 8: Iss. 2, Article 4.
Available at: <https://digitalcommons.law.seattleu.edu/sjsj/vol8/iss2/4>

This Article is brought to you for free and open access by the Student Publications and Programs at Seattle University School of Law Digital Commons. It has been accepted for inclusion in Seattle Journal for Social Justice by an authorized editor of Seattle University School of Law Digital Commons.

Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates

Dean Spade

Introduction Author and Interview Facilitator

Gabriel Arkles

Phil Duran

Pooja Gehi

Huy Nguyen

Transgender Advocates

INTRODUCTION¹

Access to healthcare is a significant issue in the United States, especially for populations facing disproportionate poverty, medical abuse, and discriminatory denial of treatment. Trans people live at a complex crossroads—the law defines us through medical norms by requiring medical evidence of our gender at every turn, yet many laws and policies deny that our medical needs are real or that the care we seek is legitimate.² Gender-confirming healthcare for transgender people is widely misunderstood, and some of the most popular misunderstandings are reflected in administrative regulations. Perhaps the most common misunderstanding is the belief that all transgender people undergo genital surgery as the primary medical treatment for changing gender. In fact, gender-confirming healthcare is an individualized treatment that differs according to the needs and pre-existing conditions of individual transgender people.³ Some transgender people undergo no medical care related to their expression of a gender identity that

differs from their birth-assigned sex.⁴ Others undergo only hormone therapy treatment or any of a number of surgical procedures.

There are several reasons why the majority of transgender people do not undergo surgeries. Obviously, people have different aims and desires for their bodies and express gendered characteristics in ways that make the most sense to those needs and desires.⁵ For those who wish to enhance the masculinization or feminization of their appearance, changing external gender expressions such as hairstyle, clothing, and accessories is often an effective and affordable way to alter how they are perceived in day-to-day life. For those who seek medical treatment, the most common medical treatment is not surgery but masculinizing or feminizing hormone therapy, which is an effective step for enhancing feminine or masculine secondary-sex characteristics (e.g., voice, facial hair, breast tissue, muscle mass).⁶ For surviving daily life—work, school, street interactions—these external markers of gender are far more important than genital appearance, which is usually only known to one's closest intimates. Additionally, genital surgeries are not recommended medical treatment for all transgender people. Many do not want to undergo such procedures, or because of other medical issues, are not eligible. Finally, genital surgeries are more expensive procedures than other options and are still not covered by a majority of private insurance or Medicaid programs in the United States. For that reason, they remain inaccessible to most transgender people.⁷

The denial of gender-confirming healthcare and the popular belief that most transgender people *do* undergo surgery results in several negative consequences for trans people. First, the inability to receive this care has negative health consequences for those who need it. Depression, anxiety, and suicidality are conditions commonly tied to the unmet need for gender-confirming medical care.⁸ According to the few studies that have been done on the issue, rates of HIV infection are also extremely high among transgender people.⁹ One study found seroprevalence of 63 percent among African American trans women.¹⁰ A contributing factor to this may be the

fact that many people seek treatments through the informal market and receive care without medical supervision because it is not available through more legitimate means. This avenue to care may result in inappropriate dosage, nerve damage, and HIV and hepatitis infection resulting from injecting without medical supervision or clean needles.¹¹

In addition to these health consequences, the lack of access to identification (ID) that reflects a transgender person's current gender is a consequence of popular misunderstandings about gender-confirming healthcare. Many ID-issuing agencies have rules that reflect the popular myth that all transgender people undergo genital surgery to confirm their gender.¹² Because many ID-issuing agencies will not change gender markers on ID for transgender people without evidence that the person has undergone surgery,¹³ and most people do not or cannot undergo surgery, the employment consequences related to lack of accurate ID are directly connected to healthcare access issues. Lack of accurate ID is certainly one contributing factor in the high rates of unemployment several studies have found for transgender people.¹⁴ ID policies that require proof of surgery to change gender markers, combined with policies that deny insurance coverage for gender-confirming health care for trans people result in many trans people being unable to obtain an ID that indicates their current gender.

Additionally, research has shown that the inability to receive this type of health care may be a contributing factor to the high rates of imprisonment of transgender youth and adults.¹⁵ Because they are marginalized in employment, and may feel that such healthcare is urgent, many transgender people engage in criminalized activities such as sex work in order to raise money to purchase hormones from informal sources.¹⁶ Getting healthcare needs met through unauthorized sources produces vulnerability for trans people to both negative health outcomes and criminalization.

In recent years, significant victories have emerged in two related policy arenas that confront these issues: the quest to increase health insurance coverage of gender-confirming healthcare and the quest to reduce medical

evidence requirements for changing gender classifications on government records. City and state authorities in a number of jurisdictions have eliminated surgery requirements for changing certain identity documentation to reflect a new gender marker, and some new policies have recognized self-identification as the only reasonable test of gender for certain governmental purposes.¹⁷ At the same time, many large employers, including public employers, have begun to include gender-related healthcare for trans people in their employee health coverage.¹⁸ While these hopeful developments have been occurring, however, a disturbing trend in the realm of Medicaid coverage has become apparent. More states, it seems, are eliminating coverage of gender-related healthcare for trans people¹⁹ or are increasing enforcement of policies that exclude coverage. Federal Medicaid regulations provide no guidance as to whether gender-confirming healthcare for transgender people should be covered or not. State programs differ in how they approach this question. No state's Medicaid regulations explicitly include this care. Instead, twenty-eight states have no explicit regulations regarding this care, and either accept or reject claims for reimbursement on a case-by-case basis, while at least twenty-one states have explicit regulations excluding coverage of this care.²⁰ States without explicit exclusions of gender-confirming healthcare for transgender people frequently have exclusions of "cosmetic" or "experimental" care that are used, on a case-by-case basis, to deny claims for reimbursement by transgender people seeking certain therapies or procedures.²¹

Two central arguments have consistently been advanced for coverage of this care, with varying success in courts.²² The first argument is that gender-confirming healthcare for trans people is a medically necessary, non-experimental treatment that is proven to be safe and effective. This healthcare has successfully been used for more than sixty years to treat people who experience a persistent desire to live in a gender different from that they were assigned at birth.²³ Furthermore, lack of access to this care results in serious physical and mental health consequences. The argument

goes, then, that because this care has been used effectively to treat transgender people, is medically necessary, and creates severe risks if denied, Medicaid should cover the care.

The second argument asserts that denial of this care is diagnosis discrimination that violates Federal Medicaid regulations. The Federal Medicaid regulations make it clear that once a state has decided to provide coverage through a Medicaid program, it cannot pick and choose amongst groups of people to give coverage based on diagnosis.²⁴ It can make a variety of other types of decisions regarding what to cover and not cover, but it cannot forgo coverage of a group based solely on diagnosis. For example, a state could not decide to treat diabetics while refusing care to people with HIV just because the legislature or state administrators had animus towards people with HIV.

The argument follows that Medicaid already provides all of these procedures and medications, and only denies them to people who seek them based on a transgender diagnostic profile. For example, testosterone and estrogens are frequently prescribed to non-transgender people for a variety of conditions including hypogonadism, menopause, late onset of puberty, vulvular atrophy, atrophic vaginitis, ovary problems (including lack of ovaries), intersex conditions, breast cancer or prostate cancer, and to help prevent osteoporosis.²⁵ Similarly, the chest surgery that transgender men often seek, removing breast tissue to create a flat chest, may be provided and insured for non-trans men who develop the common condition gynecomastia, where breast tissue grows in abnormal amounts. Non-transgender women who are diagnosed with hirsutism—where facial or body hair grows in abnormal amounts—are frequently treated for this condition with Medicaid coverage. In addition, reconstruction of breasts, testicles, penises, or other tissues lost to illness or accident is routinely performed and covered. Further, treatments designed to help create genitals that meet social norms of appearance are frequently provided and covered for children born with intersex conditions.²⁶

Advocates point out that every type of care that a transgender Medicaid recipient might seek is already provided by Medicaid, except to transgender people seeking the care to confirm gender. This is particularly significant considering that much of the care provided has the sole purpose of confirming the gender of non-transgender patients. Reconstruction of breasts or testicles lost to cancer, hormone treatment to eliminate hair that is considered gender inappropriate, chest surgery for gynecomastia, and other treatments are provided solely because of the mental health and social consequences faced by people who have physical attributes that do not comport with their self-identity and social gender. Thus, the distinction made in refusing this care to transgender people appears to be based solely on diagnosis. Denying care to a politically unpopular group that is provided to others in need of such care appears to violate the letter and spirit of the federal Medicaid statute and regulations.²⁷

The recent trend of reduced access to gender-related healthcare for trans Medicaid recipients is concerning, especially given the successes in other realms where advocates are battling with the double-binds of the medicalization of trans identity and the exclusion of this care. It would be concerning, indeed, if access to legal recognition and healthcare were being won for trans people who have access to private health insurance through employers but lost for those who rely on public health systems. In 2010, the interview below was conducted with attorneys currently working on these issues to get a sense of the current trends and find out what may be in store on these issues. These advocates, working on the front lines of poverty and transphobic public policy, provide a sense of the troubling changes of the last few years as well as the inspiring work that is being done to confront them.

Dean Spade: What is happening in your region regarding Medicaid coverage for gender-related healthcare for trans people?

Huy Nguyen.²⁸ No gender-confirming healthcare for trans people was explicitly excluded from Medicaid coverage in Washington State until very recently. Prior to 2007, this care was a covered service under the Medicaid program.²⁹ Medicaid recipients were required to establish that surgeries or other services related to the “gender identity disorder” (GID) diagnosis were medically necessary; recipients were also required to provide a multi-disciplinary evaluation from a urologist, psychiatrist, and endocrinologist.

In 2005, the Washington State Department of Social and Health Services (DSHS) implemented new regulations that detailed the process by which DSHS weighed medical opinions and evidence to determine coverage of a requested procedure.³⁰ Under this new system that emphasized evidence-based medicine, credible evidence from a recipient’s medical provider was given less weight in helping DSHS determine whether a requested procedure was medically necessary. DSHS later commissioned a report from the Winfred S. Hayes, Inc., (Hayes Corporation) entitled, “Sex Reassignment Surgery³¹ and Associated Therapies for the Treatment of Gender Identity” (Hayes Report), to question the safety and effectiveness of surgical treatment and to make individualized medical-necessity determinations for transgender clients seeking coverage for these surgeries. Generally, the Hayes Report concluded that surgical gender-confirming treatments for trans people had potential but unproven benefit.³² The Hayes Report’s methodology and conclusions as to safety and efficacy for these surgeries have been disputed by some within the medical community as being flawed and biased.³³

Despite the Hayes Report’s conclusions about the safety and efficacy of surgical gender-confirming treatments for trans people, Northwest Justice Project successfully represented individual clients in administrative hearings who were denied coverage for such care. Medicaid recipients who did not have access to the correct type of medical information or access to

legal services often found their denied requests for coverage upheld in the administrative hearing process.

In 2006, controversy erupted after local media coverage highlighted the State Auditor's Office 2004 report that questioned the use of Medicaid dollars to provide coverage for gender-confirming treatments for trans people and other procedures that were considered to be "cosmetic" such as breast augmentation.³⁴ As a direct result of intense media scrutiny, Republicans in the state legislature attempted to ban coverage for gender-confirming surgical treatments for trans people, but were unsuccessful.³⁵ During this time, much of the debate focused on whether this care was a "cosmetic" or "experimental" procedure, with less focus on why this would be medically necessary on a case-by-case basis.³⁶ In response to this controversy, DSHS proposed new regulations that explicitly excluded from coverage gender-confirming surgeries for trans Medicaid recipients.

Legal organizations and medical experts from around the country rallied to pull together comments during the notice and comment period to oppose the new exclusions. Advocates submitted comments pointing out the overwhelming number of medical studies indicating that gender-confirming healthcare for trans people is safe and effective.³⁷ However, despite these collaborative efforts, the regulation went into effect. Today, transgender Medicaid recipients cannot receive coverage for gender-confirming surgeries as they are now noncovered services.³⁸ Hormone coverage and other nonsurgical treatments are still covered services.

Phil Duran.³⁹ In Minnesota, the state's Medical Assistance (MA) program covered gender-confirming healthcare for trans people following a Minnesota Supreme Court decision in 1977. The decision directed the Department of Public Welfare (now the Department of Human Services) to review each applicant on a case-by-case basis and cover those surgeries deemed "medically necessary" (i.e., those that satisfied the Benjamin/WPATH Standards).⁴⁰ In the mid-1990s, the legislature began restricting coverage. In the MA context, a 1998 amendment essentially

“grandfathered in” those individuals who had begun “receiving gender reassignment services” prior to July 1, 1998.⁴¹ Several cases followed that explored exactly what it meant to have begun “receiving services” prior to that date, and the cases tended to interpret that language broadly.⁴² In response, in 2005, the legislature enacted a flat prohibition on funding gender-confirming surgical care for trans people in the MA program; this is codified as Minn. Stat. 256B.0625, subd. 3a. Due to financial constraints and a difficult governor, no progress has been made in reinstating coverage. The changes in policy have not impacted coverage for hormones and other non-surgical gender-confirming treatment for trans Medicaid recipients.

Pooja Gehi and Gabriel Arkles:⁴³ In New York, all gender-confirming healthcare for trans people is excluded from coverage through Medicaid pursuant to N.Y. Comp. Codes R. & Regs. title 18, §505.2(l).⁴⁴ This regulation was proposed in 1997⁴⁵ and promulgated in 1998⁴⁶ by the New York State Department of Health. The justification for this regulation was a “lack of evidence about the long-term safety and effectiveness of this care.”⁴⁷ No hearing was held about the proposed regulation. The only two comments submitted were from surgeons who opposed its adoption on the grounds that “gender reassignment is an appropriate, effective and safe treatment for persons with gender dysphoria.”⁴⁸ Nevertheless, the Department of Health dismissed their comments and adopted the amendment, stating that “there are equally compelling arguments indicating that gender reassignment, involving the ablation of normal organs for which there is no medical necessity because of underlying disease or pathology in the organ, remains an experimental treatment, associated with serious complications.”⁴⁹ The new regulation was not enforced for hormone treatment until around 2002⁵⁰ when we (at the Sylvia Rivera Law Project) encountered a crisis among our clients, many of whom had been relying on the coverage of their healthcare for a very long time, being suddenly cut off without explanation. The agency began matching people’s gender markers

on their identification with the hormones they were receiving and then blocking them if the two—in its opinion—did not match.⁵¹

In 2007 SLRP, along with the New York Legal Assistance Group and Orrick, Herrington and Sutcliff LLP, brought a federal lawsuit challenging § 505(l) through 42 U.S.C. § 1983.⁵² Our complaint alleged that the regulation was violating the federal Medicaid statute, under the federal regulation that prohibits discrimination on the basis of diagnosis, among other grounds. Since New York Medicaid covers hormones and gender-confirming surgeries for other diagnoses, but not for gender identity disorder, 505(l) is deliberately discriminating against transgender individuals. Unfortunately, we lost our case when the judge ruled that no private right of action existed under §1983.⁵³ While we believe the case was wrongly decided, after consulting with other Medicaid litigators we decided against an appeal because of the risk of setting bad precedent. If the decision were affirmed on appeal there could be serious negative consequences on the ability of poor people to access the courts.

The regulation continues to create a crisis for the communities with which we work, and we continue to fight against it. We believe the regulation should be repealed on the grounds that it discriminates against transgender people and on the grounds that medical experts agree that gender-confirming healthcare is, in fact, medically necessary.

Dean Spade: What efforts have you made or are you preparing to make to address these issues?

Huy Nguyen: Northwest Justice Project will continue to discuss, strategize, and collaborate with other advocacy groups and community partners on the issue of evidence-based medicine and noncovered Medicaid services. The standard for coverage for any medical procedure should be based on medical necessity, and each request for coverage should be reviewed through the lens of medical necessity.⁵⁴

Phil Duran: OutFront Minnesota was the primary organization taking on appeals for transgender people denied gender-confirming surgical care in Minnesota from 1998 through 2005, to the best of my knowledge. OutFront Minnesota is the only organization even seriously discussing the notion of reinstating coverage. We generally do not believe that a state constitutional facial challenge to the current statute would be successful, but we mull the idea of an as-applied challenge; though, resources for undertaking such an effort are close to nonexistent.

Pooja Gehi and Gabriel Arkles: As stated above, we have tried a federal lawsuit. We have been strategizing with advocates and other community members around a way to fight against this very damaging regulation. As of late, many attorneys who do not practice in the specific area of transgender rights have approached us with concern about the regulation's damaging effect on their clients and communities. This development is promising given the fact that many of these organizations are well-funded, mainstream, legal rights organizations that are more than willing to fight against the regulation with us. We do not believe it would be conducive to our efforts to publicly share details at this stage, but generally we continue to explore alternative litigation approaches, possibly based on state law, as well as other potential strategies. We also continue to educate community members and other service providers about these issues.

Dean Spade: Do you have ideas about a local or national strategy you want to share? Have you seen a particular approach that works well?

Huy Nguyen: I think it is crucial for legal aid agencies to identify and competently serve the diverse needs of the community. This would include ensuring that low-income individuals within the transgender community have equal access to healthcare and access to legal aid services when they experience problems with Medicaid coverage, such as a denial, termination, or reduction of Medicaid services. This will require a targeted and focused effort by legal aid agencies to provide outreach, education, and training to

the community on Medicaid issues. By doing so, legal aid advocates can help provide a client-focused perspective when discussing strategy with other legal advocates who are working on impact litigation in this area.

Phil Duran: It is plausible that working to educate the private insurance industry about gender-confirming health care for transgender people and the appropriateness of its coverage could help to establish an environment where its inclusion is simply the prevailing norm, which could in turn shift the discussion related to public insurance programs.

Pooja Gehi and Gabriel Arkles: As an agency focused on economic injustice, we believe it is important to prioritize Medicaid and other public insurance programs in advocacy. However, we agree with Phil that making change in the private insurance industry is also important and can help with overall norm shifting. Recent statements from groups such as the American Psychological Association⁵⁵ and American Medical Association⁵⁶ acknowledging the medical necessity of this care provide us with a great opportunity to leverage that support to make policy change. We do not think that a federal legislative strategy would be helpful at this time. We think that locally-based strategies will be most effective and that people in those communities are best situated to evaluate whether litigation, legislative, regulatory, or other approaches will be most effective in their state. Community organizing can also be important in this work and community accountability is always vital.

Dean Spade: What implications do you see for the national conversation about healthcare reform, if any?

Huy Nguyen: In Washington State, we are experiencing a devastating budget crisis, and in an attempt to balance the budget, there have been ongoing discussions about reducing the scope of Medicaid services or possibly eliminating healthcare coverage programs for low-income individuals.⁵⁷ There have been discussions about the possibility of scaling back Medicaid coverage for vision and dental services. Given the current

economic situation, any discussion related to the scope of coverage for Medicaid services will be even more challenging. Access to healthcare will definitely be an ongoing issue.

Phil Duran: I am concerned that the experiences of states like Minnesota regarding the enactment of exclusions for gender-confirming healthcare for transgender people in public programs could influence federal legislators to try the same thing.

Pooja Gehi and Gabriel Arkles: We share Phil's concern about federal legislators and generally think that now is not the time to raise these issues at a federal government level. We do think that at a grassroots, state, or local level, though, it is important to connect different struggles for access to health care in our messaging. It may be helpful when talking to local officials about trans healthcare issues to bring up the national focus on expanding healthcare access. We should be building strong coalitions with others working on healthcare access generally, whether it is reproductive healthcare, HIV prevention and treatment, immigrant access to healthcare, disability justice in healthcare provision, or access to healthcare for poor and working class people.

¹ Some of the ideas in this introduction are more fully developed in, Dean Spade, *Documenting Gender*, 59 *Hastings L.J.* 731 (2008) [hereinafter Spade, *Documenting Gender*].

² See Pooja S. Gehi & Gabriel Arkles, *Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People*, 4 *SEXUALITY RES. AND SOC. POL'Y* 7, 7–9 (2007); Spade, *Documenting Gender*, *supra* note 1, at 736; Dean Spade, *Resisting Medicine, Remodeling Gender*, 18 *BERKELEY WOMEN'S L.J.* 15, 17–18 (2003) [hereinafter Spade, *Resisting Medicine*].

³ See Sylvia Rivera Law Project, *The Fight for Fair Access to Birth Certificates Continues*, Jan. 15, 2008, <http://srlp.org/node/89>.

⁴ See Dylan Vade, *Expanding Gender and Expanding the Law: Toward a Social and Legal Conceptualization of Gender That Is More Inclusive of Transgender People*, 11 *MICH. J. GENDER & L.* 253, 260–61 (2005); Gehi & Arkles, *supra* note 2, at 8; Spade, *Documenting Gender*, *supra* note 1.

⁵ Elsewhere, I have discussed more fully the overreliance on medical authority in legal determinations of the gender of transgender people, as well as the intense scrutiny that

transgender people face in general and at the hands of medical providers regarding choices to express gender that matches or does not match stereotypical understandings of masculinity and femininity. See Spade, *Resisting Medicine*, *supra* note 2, at 25–26.

⁶ See Sylvia Rivera Law Project, *supra* note 3.

⁷ AM. FRIENDS SERV. COMM., WORKPLACE TRANSITIONS: EFFECTIVE ADVOCACY FOR TRANSGENDER-INCLUSIVE EMPLOYEE HEALTH BENEFIT PLANS 5 (2005).

⁸ See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR 576–82 (4th ed. text rev. 2000); MARIO MARTINO, EMERGENCE: A TRANSEXUAL AUTOBIOGRAPHY 168–69, 190 (1977); JAN MORRIS, CONUNDRUM 40–135 (Harcourt Brace Jovanovich 1974) (1926); Karen M. Goulart, *Trans 101: Trans Communities Face Myriad Issues*, 23 PHILADELPHIA GAY NEWS, Sept. 17–23, 1999, at 1, http://www.queertheory.com/articles/articles_goulart_trans101.htm; Jamil Rehman et al., *The Reported Sex and Surgery Satisfaction of 28 Postoperative Male-to-Female Transsexual Patients*, 28 ARCHIVES SEXUAL BEHAV. 71, 81 (1999); Friedemann Pfäfflin & Astrid Junge, *Sex Reassignment. Thirty Years of International Follow-up Studies After Sex Reassignment Surgery: A Comprehensive Review 1961-1991* (Roberta B. Jacobson & Alf B. Meier trans., 1992), <http://web.archive.org/web/20061230125838/www.symposion.com/ijt/pfaefflin/6002-7.htm#Differential%20Indication>.

One study found suicide attempts among 12 percent of trans women and 21 percent of trans men who had not begun treatment and no suicide attempts among the same patients after having begun treatment. Collier M. Cole et al., *Comorbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses*, 26 ARCHIVES OF SEXUAL BEHAV. 13, 19 (1997).

⁹ See generally, Kristen Clements-Nolle, et al., *HIV Prevention and Health Service Needs of the Transgender Community in San Francisco*, 3 INT'L J. TRANSGENDERISM 1 (1999).

¹⁰ Kristen Clements-Nolle et al., *HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention*, 91 AM. J. PUB. HEALTH 915, 917 (2001).

¹¹ *Crossing to Safety: Transgender Health and Homelessness*, 6 HEALING HANDS, June 2002, at 1, available at <http://transhealth.transadvocacy.org/Newsletters/June2002HealingHands.pdf>; Nina Kammerer et al., *Transgender Health and Social Science Needs in the Context of HIV Risk*, in TRANSGENDER AND HIV: RISKS, PREVENTION, AND CARE 39, 41 (2001); Michael Rodger & Lindy King, *Drawing Up and Administering Intramuscular Injections: A Review of the Literature*, 31 J. Advanced Nursing 574, 577 (2000); Joe Luniewicz, *Transgender Positive*, THEBODY.COM, Nov. 1996, available at <http://www.thebody.com/content/whatis/art30598.html>.

¹² Spade, *Documenting Gender*, *supra* note 1, at 736. While this interview was being edited, the U.S. State Department announced a significant change in federal policy. U.S. citizen passport holders will now be able to change gender on passports without showing proof of having undergone surgery. Many transgender advocates are hopeful that this policy change will lead to similar elimination of surgery requirements in other key federal, state and local government recordkeeping and ID systems. Press Release, U.S. Dept. of State, *New Policy on Gender Change in Passports Announced* (June 9, 2010), available at <http://www.state.gov/r/pa/prs/ps/2010/06/142922.htm>.

¹³ Spade, *Documenting Gender*, *supra* note 1, at 736.

¹⁴ Masen Davis & Kristina Wertz, *When Laws Are Not Enough: A Study of the Economic Health of Transgender People and the Need for a Multidisciplinary Approach to Economic Justice*, 8 SEATTLE J. SOC. JUST. 467 (2010); Spade, *Documenting Gender*, *supra* note 1, at 736.

¹⁵ Gehi & Arkles, *supra* note 2, at 7, 11; See Alexander L. Lee, *Nowhere to Go but out: The Collision Between Transgender and Gender-Variant Prisoners and the Gender Binary in America's Prisons*, at 9 (Spring 2003) (unpublished note, University of Berkeley School of Law) (*available at* http://www.srlp.org/documents/alex_lees_paper_2.pdf); Franklin H. Romeo, *Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law*, 36 COLUM. HUM. RTS. L. REV. 713, 730–38 (2005).

¹⁶ Gehi & Arkles, *supra* note 2, at 13; Spade, *Documenting Gender*, *supra* note 1, at 757.

¹⁷ In 2006, after years of negotiation, activists in New York City (NYC) won a policy in the Department of Homeless Services that establishes that trans people must be placed according to gender identity. NYC Dep't of Homeless Servs. Proc. No. 06-1-31, at 2 (Jan. 31, 2006), *available at* http://coalhome.3cdn.net/c7a840f68c28233a37_8qm6bngdv.pdf; Boston and San Francisco have similar policies in their homeless services systems. San Francisco Commission on Hum. Rts., *Transgender Policy for City Funded Shelters* (Oct. 23, 2003) (on file with the author) (“Clients must be sheltered according to their expressed gender identity, regardless of surgical or hormonal status or conformity to gender stereotypes. Transgender women must not be singled-out or treated differently than other women.”); Boston, Mass., *An Ordinance Regarding Discrimination Based on Gender Identity or Expression* (2002), *available at* http://www.masstpc.org/pubs/Boston_TG_Ordinance.pdf; Jurisdictions like WA, NY, and the District of Columbia now allow applicants to change the gender on their DMV ID without proving surgery, although a letter from a physician is still required. Spade, *Documenting Gender*, *supra* note 1, at 822 (Appendix I: DMV Requirements for Gender Reclassification (Detailed)).

¹⁸ See, e.g., City of SF coverage, University of CA system coverage, Harvard recent coverage, U of MI coverage. MB – THIS WAS FROM JENI'S MEMO--> In recent years, several major public systems have added coverage of this care to their employee benefits packages. Spade, *Documenting Gender*, *supra* note 1, at 755 n.107. This includes the City of San Francisco, the University of California, and the University of Michigan. *Id.*; R. Nick Gorton, *Transgender Health Benefits: Collateral Damage in the Resolution of the National Health Care Financing Dilemma*, 4 SEXUALITY RES. & SOC. POL. 81, 85–86 (2007).

¹⁹ See, e.g., WASH. ADMIN. CODE § 388-501-0070(4)(i) (2010); Minn. Stat. 256B.0625, subd. 3a; N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l) (2010).

²⁰ At least twenty-two states explicitly exclude coverage for gender-confirming health care for transgender people. Ariz. Admin. Code § 9-27-203(A)(7) (2007); Conn. Agencies Regs. §§ 17b-262-456(c)(4), -612(k) (2006); Haw. Code R. §§ 17-1728-19(10), -1737-84(22)(a) (Weil 2006); Ill. Admin. Code tit. 89, § 140.6(l) (2007); Iowa Admin. Code r. 441-78.1(249A)(4) (2007); 10-144-101 Me. Code R. § 90.07(8) (Weil 2006); Md.

Code Ann. Health-Gen. § 10.09.02.05(A)(21) (West 2006); 130 Mass. Code Regs. 405.418(A) (2006); Minn. Stat. § 256B.0625 subd. 3a (2006); Mo. Code Regs. Ann. tit. 22, §§ 10-2.060(52), -2.067 (2007); Mont. Admin. R. 37.79.303(1)(r) (2006); 471 Neb. Admin. Code § 18-003.01(30) (2006); N.H. Code Admin. R. Ann. He-W 530.05(b)(5), 531.06(g) (2006); N.M. Code R. § 8.306.7.13(f) (Weil 2006); N.Y. Comp. Codes R. & Regs. tit. 18, § 505.2(l) (2006); Ohio Admin. Code 5101:3-25-03(F)(2)(gg); Or. Admin. R. 410-120-1200(2)(z) (2006); 55 Pa. Code §§ 1121.54(16), 1126.54(a)(7), 1141.59(11), 1163.59(a)(1), 1221.59(a) (2007); Tenn. Comp. R. & Regs. 1200-13-13-.10(3)(b)(71), 1200-13-14-.10(3)(a)(71) (2007); Wis. Adm. Code HFS § 107.03(23)–(24) (2006); 048-130-026 Wyo. Code R. § 6(h)(iv)(xix) (2006); *Rush v. Johnson*, 565 F. Supp 856, 869 (N.D. Ga. 1983) (holding that gender-confirming healthcare surgeries are not medically necessary or proven effective and the state can exclude them from coverage); *see also* Gehi & Arkles, *supra* note 2, at 9–10; The language in the regulations excluding this coverage varies. For example, Arizona’s administrative code states: “An HCG Plan shall not cover the following: . . . Treatment of gender dysphoria including gender reassignment surgeries and reversal of voluntarily induced infertility (sterilization),” Ariz. Admin. Code § 9-27-203(A)(7) (2007), while Connecticut’s regulations read: “The department shall not pay for the following: . . . transsexual surgery or for a procedure which is performed as part of the process of preparing an individual for transsexual surgery, such as hormone therapy and electrolysis,” Conn. Agencies Regs. § 17b-262-342(1) (2006).

²¹ *Supra* note 20.

²² *See Pinneke v. Preisser*, 623 F.2d 546, 549–50 (8th Cir. 1980) (“We find that a state plan absolutely excluding the only available treatment known at this stage of the art for a particular condition must be considered an arbitrary denial of benefits based solely on the ‘diagnosis, type of illness, or condition.’”); *J.D. v. Lackner*, 80 Cal. App. 3d 90, 95 (Cal. Ct. App. 1978) (“J.S. has an illness and that as far as her illness affects her, the proposed surgery is medically reasonable and necessary and that there is no other effective treatment method.”); *Doe v. State*, 257 N.W.2d 816, 820 (Minn. 1977) (noting that sex reassignment surgery was “the only surgical treatment which, if recommended by a physician and related to a patient’s health is not covered by the [Minnesota Medicaid] program.”); *Beger v. Div. of Med. Assistance*, No. 99-4613H, 2000 Mass. Super. LEXIS 126, at 13 (2000) (finding that a transsexual woman who had undergone sex reassignment over twenty-five years earlier could not be denied medically necessary breast reconstruction surgery simply because she is transsexual). *But see* *Smith v. Rasmussen*, 249 F.3d 755, 761 (8th Cir. 2001) (reversing district court’s ruling and holding that Iowa’s rule denying coverage for sex reassignment surgery was not arbitrary or inconsistent with the Medicaid Act); *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980) (reversing district court’s ruling that Georgia’s Medicaid program could not categorically deny coverage for sex reassignment surgery).

²³ Courts in a variety of contexts have found that transgender health care is medically necessary. *See, e.g.,* *De’Lonta v. Angelone*, 330 F.3d 630 (4th Cir. 2003); *South v. Gomez*, 211 F.2d 1275 (9th Cir. 2000); *Kosilek v. Maloney*, 221 F. Supp. 2d 156 (D. Mass. 2002); *Phillips v. Mich. Dep’t of Corr.*, 731 F. Supp. 792 (W.D. Mich. 1990), *aff’d*, 932 F.2d 969 (6th Cir. 1991); *Brian L., aka Mariah L. v. Admin. for Children’s*

Servs., No. K-11554/96 (N.Y. Fam. Ct., Feb. 21, 2007). *But see* Preisser, 623 F.2d 546; Rasmussen, 249 F.3d 755; Wolfe v. Horn, 130 F. Supp. 2d 648 (E.D. Pa. 2001).

²⁴ “The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type or illness, or condition.” 42 C.F.R. § 440.230(c) (2002).

²⁵ Medline Plus, Estrogen, <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682922.html> (last visited April 6, 2010). *See also* Gehi & Arkles, *supra* note 2, at 24.

²⁶ These treatments have become increasingly controversial in recent years, as intersex advocacy organizations have brought attention to the fact that when performed on infants and young children, patients cannot meaningfully consent and these treatments often lead to loss of sexual and reproductive function. Intersex advocacy organizations advocate that these treatments not be performed on young children. In addition, children should be allowed to grow and develop and determine their desire for such treatments at a later age. The eagerness of the medical profession to bring intersex bodies in-line with gendered body norms, including providing payment for such care, while marginalizing and refusing treatment for adults whose medical needs are viewed as bringing their bodies away from gendered norms, indicates that Medicaid funding decisions are frequently made based on gender politics more than questions of legitimate medical necessity. *See generally* Noa Ben-Asher, *The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties*, 29 HARV. J.L. & GENDER 51 (2006).

²⁷ Gehi & Arkles, *supra* note 2, at 25–26.

²⁸ Huy Nguyen has worked as a staff attorney with the Northwest Justice Project since 2000. He has focused on public benefits issues (including TANF, Basic Food, Medicaid, & Long Term Care benefits) since 2004.

²⁹ WASH. ADMIN. CODE § 388-531-0100(5)(g) (2006) (amended 2007).

³⁰ WASH. ADMIN. CODE § 388-501-0165 (2010).

³¹ While the term “sex reassignment surgery” is often used in Medicaid policies and in popular discussion of these issues, many advocates working on discrimination facing trans people resist using this term. The term “sex reassignment surgery” is often used to suggest that such surgery is necessary for a person to change their gender, a myth which, as discussed in the introduction, has many harmful consequences for trans people including when it has been codified in law and policy. The term “gender-confirming healthcare for trans people” is used to indicate both that gender-confirming healthcare is often covered by insurance and Medicaid for non-trans people, highlighting the diagnosis discrimination issue, and that the care trans people seek ranges and is not always surgical or even medical.

³² HAYES DIRECTORY FOR SEX REASSIGNMENT SURGERY, RATINGS, UPDATE, AND REPORT (2004).

³³ R. Nick Gorton, *The Use and Misuse of Evidence Based Medicine* (Lyon-Martin Women’s Health Services, Working Paper).

³⁴ Chris McGann, *State’s Taxpayers Paid for a Sex Change*, SEATTLE POST-INTELLIGENCER, Feb. 10, 2006, http://www.seattlepi.com/local/259076_sexchange10.html.

³⁵ Ralph Thomas, *Tax Dollars and a Sex Change: A Story of One Patient*, SEATTLE TIMES, Apr. 11, 2006, http://seattletimes.nwsourc.com/html/localnews/2002923955_sexchange10m.html.

³⁶ *Id.*

³⁷ See Ralph Thomas, *State Tries to Rule Out Aid for Sex-Change Surgery*, SEATTLE TIMES, Aug. 7, 2006, available at http://seattletimes.nwsourc.com/html/localnews/2003180336_sexchange07m.html.

³⁸ WASH. ADMIN. CODE § 388-501-0070(4)(iv)(i) (2010).

³⁹ Phil Duran has been OutFront Minnesota's Legal Director since 2000. As OutFront Minnesota's Legal Director, Phil focuses on legal information, referral, and education; state legislative research and analysis; state administrative agency and local government public policy; school-related issues; and direct representation in selected public assistance and human rights cases. Phil also is currently a member of the Minnesota Supreme Court's Gender Fairness Implementation Committee.

⁴⁰ *Doe v. Dept. of Pub. Welfare*, 257 N.W.2d 816, 820 (Minn. 1977).

⁴¹ See *Hare v. Dept. of Human Servs*, 666 N.W.2d 427, 430 (Minn. App. 2003).

⁴² *Id.* at 432-33.

⁴³ Pooja Gehi and Gabriel Arkles are staff attorneys at the Sylvia Rivera Law Project. At SRLP, Pooja and Gabriel are members of the direct service team representing low-income and/or people of color transgender, intersex, and gender-nonconforming people in the areas of immigration, attaining appropriate identification, attaining benefits, Medicaid, name changes, and discrimination.

⁴⁴ N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l) (2010).

⁴⁵ N.Y. REG., July 16, 1997.

⁴⁶ 20 N.Y. REG. 11 (Jan. 7, 1998).

⁴⁷ N.Y. REG., *supra* note 44.

⁴⁸ 20 N.Y. REG. 5 (Mar. 25, 1998).

⁴⁹ *Id.*

⁵⁰ In or around 2002, clients began seeking the assistance of SRLP because they could no longer access healthcare through Medicaid. As such, it is our belief that 505(l) was implemented at this time.

⁵¹ This is based on knowledge SRLP attorneys have gained from Medicaid workers, as well as our clients.

⁵² *Casillas v. Daines*, 580 F.Supp.2d 235 (S.D.N.Y. 2008).

⁵³ *Id.* at 241-46.

⁵⁴ WASH. ADMIN. CODE § 388-500-0005 (2010).

⁵⁵ American Psychological Association (APA), APA Policy Statement: Transgender, Gender Identity, & Gender Expression Non-Discrimination (2008), available at <http://www.apa.org/about/governance/council/policy/transgender.aspx>.

⁵⁶ American Medical Association, Resolution 122: Removing Financial Barriers to Care for Transgender Patients (2008).

⁵⁷ Associated Press, *Highlights of WA House, Senate Budget Proposals*, SEATTLE TIMES, Feb. 23, 2010, available at http://seattletimes.nwsourc.com/html/localnews/2011165739_apwaxgrbudgethighlights.html.