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Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People

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Abstract: This article explores how Medicaid policies excluding or limiting coverage for transition-related health care for transgender people reproduce hierarchies of race and class. In many legal contexts, a medical model informs views of transgender experience(s), often requiring proof of specific types of surgery prior to legal recognition of transgender people's identity and rights. Simultaneously, state Medicaid programs disregard the medical evidence supporting the necessity of transition-related care when considering whether to cover it. In this article, the authors analyze the contradiction between the medicalization of trans experience(s) and government's refusal to recognize the legitimacy and necessity of trans health care. The authors examine the social, economic, legal, political, medical, and mental health impact of these policies on low-income trans communities, paying particular attention to the disproportionate impact on communities of color. The authors conclude with recommendations for legal and health care systems to improve access to transition-related health care for low-income trans people.

Key words: transsexual; gender identity; economic justice; sex reassignment; health care disparities

This article explores how Medicaid policies that exclude or limit coverage for transition-related health care[1] for transgender people reproduce hierarchies of race and class. The authors examine Medicaid policies that exclude transition-related health care, looking at such policies through the lens of social, medical, and legal systems. These systems are intimately intertwined not only in determining when transgender[2] people's identities are or are not recognized in society but also in how these systems support race and class hierarchies.

Legal sources of authority often disregard the wealth of medical information that demonstrates the necessity of transition-related health care for many transgender people. Many of these same legal systems rely heavily on medical information to the exclusion of virtually all else prior to recognition of the gender identities and civil rights of

1 We use the term *transition-related health care* to broadly describe the medical care trans people seek in relation to their gender identity. The term may be used in specific instances to describe specific types of care. However, unless specified, we use it to encompass the supportive psychotherapy, hormonal therapies, surgical procedures, voice therapy, and electrolysis or laser hair removal that trans people seek in relation to their gender. In medical and legal literature, these treatments are also referred to *as gender reassignment, sex reassignment, sex change,* or *sexual conversion*. Some health care professionals have started shifting to using terms such as *gender confirming* or *gender affirming* to refer to these treatments. *Transgender health care* is another term used to refer generally to such treatments. Like other types of health care, transition-related health care is individualized. Some trans people want and need certain treatments, whereas other trans people want and need other treatments. Still other trans people do not want or need any health care specifically related to their gender—but their gender identity is still legitimate and should be recognized and respected. There is no single, universal transgender experience or narrative (Spade, 2003).

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transgender people. Because of this senseless, damaging dichotomy, Medicaid exclusions of transition-related health care often not only deny low-income transgender people their only means of access to necessary treatment but also deny their only means of access to legal recognition of their identity and rights. This dynamic is strikingly similar to the one that the disability rights movement has fought for years. Although not all trans people need, want, or should be required to receive specific health care, the many other trans people who do want and need it should be able to receive such care. The authors envision an alternative world in which all people, regardless of income, can obtain the consensual medical care they need to improve their health, well-being, quality of life, and length of life without having their autonomy robbed or identities pathologized.

Because of the state's denial of transition-related health care coverage, low-income transgender people face barriers that lead to further psychological, physical, political, social, and economic damage and disenfranchisement in a system in which they are already precariously positioned. These effects of Medicaid exclusions disproportionately affect low-income people because Medicaid is usually their only health insurance option. Furthermore, people of color are particularly affected because they are more likely to have low income (Kijakazi, 1999). People of color also face more severe social and health consequences from lack of Medicaid coverage because of the more intense surveillance they experience from various state systems and the racism they encounter when trying to gain access to health care. States' exclusions of transition-related health care are also generally in violation of other state and federal laws—particularly the very laws designed to protect the rights of low-income people, people of color, and other marginalized groups: the federal Medicaid statute, its implementing regulations, and the federal Constitutional protections of civil rights.

In this analysis, we first provide an overview of the states with specific regulatory Medicaid exclusions of transition-related health care coverage. To anchor the analysis, we then explore the results of Medicaid's statutory and regulatory exclusions of transition-related health care in affected people and communities. Next, we examine the medicalization of trans people in various legal systems and how these systems seek to legitimize or delegitimize trans people based on the medical care they receive. We also look at the government's contradictory disregard of medical evidence in the context of coverage of transition-related health care. For low-income trans people, this legal catch-22—being required to show proof of medical care for legal recognition of their identities but being denied that care by Medicaid—places them in a perpetual state of illegitimacy. Next, we examine the illegality of these exclusions by looking more closely at some of the laws with which they are in conflict. We also take a brief, critical look at the limitations of access to transition-related health care even when such care is included in state Medicaid plans. Finally, we provide recommendations for addressing these problems and creating systems that are more just.

This article is coauthored by two attorneys who represent transgender, gender-nonconforming, and *intersex*[3] low-income people and people of color in New York City. Our organization, the Sylvia Rivera Law Project (SRLP), has represented more than 700 individuals over the past 4 years. SRLP provides direct legal assistance to people dealing with Medicaid, access to identity documents, immigration, and discrimination in sex-segregated facilities. In addition, SRLP attorneys work on impact litigation in behalf of low-income people of color who are experiencing or have experienced discriminatory treatment by and in state agencies because they are trans, intersex, or gender nonconforming. The organization also works on policy initiatives and engages in public education to further the rights of the communities SRLP represents. Throughout this article, we occasionally refer to clients with whom we have worked directly. We also draw on our own observations and firsthand reports from clients as we explore Medicaid exclusions of transition-related health care, the negative impact of such exclusions on communities, and how these exclusions work with other

2 We use *transgender* and *trans* as umbrella terms to describe individuals whose gender identity or gender expression differs from that traditionally associated with their assigned sex at birth. Individuals may identify with the term *trans* or *transgender,* as well as or along with another term such as *man, woman, transsexual, two spirit, aggressive, femme queen,* or *genderqueer*. We generalize and use the terms *trans women* to discuss all people who were assigned male at birth and seek transition-related health care and *trans men* to discuss all people who were assigned female at birth and seek transition-related health care. These general terms are inadequate, however, because not all people in those categories identify as trans, as women, or as men. We employ our choice in language to include the broadest possible identities. Legal and medical sources use various other terms to describe trans people including, but not limited to, *transsexual, pre-* or *postoperative female-to-male* or *male-to-female, persons suffering from gender dysphoria,* or *people diagnosed with gender identity disorder*.

3 *Intersex* is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that does not seem to fit the typical definitions of female or male (Intersex Society of North America, n.d.).

state policies to erase trans experience and trans people. Although this article gives a national overview of these issues, we will draw many of our examples from New York State, given the depth of our experience there.

National Overview

Despite the fact that transition-related health care is accepted by health care providers to be medically necessary (Brown, 2001; Gordon, 1991; Meyer et al., 2001; Pfäfflin & Junge, 1992/1998), no state has a regulation that explicitly provides for Medicaid coverage of transition-related treatment.[4] Rather, state Medicaid regulations with regard to transition-related health care fall into one of two categories: those that explicitly prohibit coverage of transition-related care and those that do not.

Twenty-four states explicitly exclude coverage for transition-related health care by regulation (see Table 1). These exclusions are described in various ways, some of them more sweeping than others. For example, Arizona's administrative code (2007) 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. Reg.). Connecticut regulations (2006a) state: "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.).

In those states that do not have an explicit exclusion, coverage for transition-related care may still be denied based on interpretation and application of a more general exclusion, such as for so-called experimental or cosmetic treatments (see Table 2). Virtually every state not listed in Table 1 excludes experimental and cosmetic procedures from Medicaid coverage. However, the terms *experimental* and *cosmetic* are not always defined. When they are, the definition often leaves a great deal open to interpretation. For example, the Vermont administrative code (2001) states:

> Experimental surgery and expenses incurred in connection with such surgery are not covered. Experimental surgery encompasses any surgical procedure not proven to be clinically efficacious by literature and experts in the field. (Vt. Code R.)

Table 1. States With Explicit Exclusions for Transition-Related Health Care

State	Source of authority
Alaska	Alaska Admin. Code tit. 7, § 43.010(11), 2006
Arizona	Ariz. Admin. Reg. R9-27-203(A)(7), 2007
Connecticut	Conn. Agencies Regs. § 17b-262-442 (a); § 17b-262-456(c)(4); § 17b-262-612(k), 2006
Delaware	Code Del. Regs. 40 800 115.11
Georgia	*Rush v. Johnson,* 1983
Hawaii	Haw. Admin. Rules § 17-1728-19 (10); § 17-1737-84 (22)(a)
Illinois	Ill. Admin. Code tit. 89, § 140.6 (11),2007
Iowa	Iowa Admin. Code 441-78.1(249A)(4), 2007
Maine	Code Me. R. 10-144 Ch. 101, Ch. II, § 90.07(C)(8), 2006
Maryland	MD Health & Men. 10.09.02.05 (A)(21), 2006
Massachusetts	Mass. Regs. Code tit. 130, § 405.418 (A); Mass. Regs. Code tit. 130, § 406.413 (c)(2)(C)[a]
Minnesota	Minn. Stat. § 256B.0625 (2006)[b]
Missouri	22 Mo. Code Regs. Ann. Tit. 22, § 10-2.060(46); § 10-2.067, 2007
Montana	Mont. Admin. R. 37.79.303(1)(q), 2006
Nebraska	Neb. Admin. Code tit. 471, Ch. 18, § 003.03, 2006[c]
New Hampshire	N.H. Code Admin. R. Ann. He-W 530.05(b)(5); 531.06(g), 2006
New Mexico	N.M. Admin. Code 8.306.7.13(f)
New York	N.Y. Comp. Codes R. & Regs. tit. 18, § 505.2(l), 2006
Ohio	Ohio Admin. Code § 5101:3-13-05(c), 2006
Oregon	Or. Admin. r. 410-120-1200 (2)(z), 2006
Pennsylvania	55 Pa. Code § 1121.54; § 1126.54(a)(7); § 1141.59(11); § 1163.59(a)(1); § 1221.59(a), 2007
Tennessee	Tenn. Comp. R. & Regs. 1200-13-13-.10(3)(b)(63); 1200-13-14-.10, 2007
Wisconsin	Wis. Adm. Code s. HFS 107.03(23)(24), 2006
Wyoming	Wyo. R. & Regs. Ch 26 s 6(i)(xvii), 2006

[a]According to the regulation, Massachusetts does, however, continue to pay for any post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993. [b]The Minnesota statute states that gender-reassignment surgery and other gender-reassignment medical procedures, including drug therapy for gender reassignment, are not covered unless the individual began receiving gender-reassignment services prior to July 1, 1998. [c]Regulations imply that coverage is not available for transition-related health care, although they state that payment for treatment of complications from this and other noncovered care may be available.

4 Although California does list gender identity disorder among other conditions that, together with other requirements, qualify individuals for certain mental health services, the regulations still do not explicitly provide for coverage of transition-related health care (Cal Code Regs., 2007).

Table 2. State Exclusions for Experimental or Cosmetic Care

State	Source of authority
Alabama	Ala. Admin. Code r. 560-X-6-.13, 2006
Arkansas	Code Ark. R. 016 06 024
California	Cal. Admin. Code tit. 22, § 51303(g); § 51305(i), 2007
Florida	Fla. Admin. Code Ann. R. 59G-1.010, 2006
Idaho	Idaho Admin. Code 16.03.09.390.02(g), 2006
Indiana	Ind. Admin. Code tit. 405, r. 5-29-1, 2007
Kansas	Kan. Admin. Regs. 30-5-88, 2006
Kentucky	907 Ky. Admin. Regs. 3:005, 2006
Mississippi	State of Mississippi Division of Medicaid, 2007
New Jersey	N.J. Admin. Code tit. 10, § 49-5.7(c)(2), 2007
North Carolina	N.C. Admin. Code tit. 10A, r. 220.0301; r. 39A.1104(b)(3), 2006
North Dakota	N.D. Admin. Code § 75-02-02-03.2, 2006
Oklahoma	Okla. Admin. Code 317:30-3-59, 2007
Rhode Island	R.I. Code R. 15 040 004 (III)(A)(1); 15 020 007 (III)
South Carolina	South Carolina Medicaid Program Hospital Services Provider Manual, 2006
South Dakota	SD Admin. R. 67:16:14:05, 2006
Texas	1 Tex. Admin. Code § 354.1149, 2006
Utah	Utah Admin. Code. § 414-1A; § 414-3A-6(4), 2006
Vermont	Vt. Code R. 13 170 008, 2001
Virginia	12 Va Admin. Code, § 30-50-140, 2006
Washington	Wash. Admin. Code § 388-501-0050, 2006

Due to the vagueness of such wording, whether procedures are or are not covered is frequently determined through agency and court decision.

A few states—Louisiana, Michigan, and West Virginia—were not included in Tables 1 and 2 because we could find no directly relevant information regarding transition-related health care in state regulations. We also left out Colorado and Nevada because information about exclusions of trans health care was ambiguous. Colorado excluded coverage for transition-related health care in 1998, but it is not clear whether an explicit exclusion is currently in effect (Colorado Department of Health Care Policy and Financing, 1998). We were unable to locate specific statutory or regulatory exclusion in Nevada, but it seems that transition-related care is generally not provided pursuant to the specific Medicaid plans (Health Plan of Nevada Inc., 2005).

Impact on Trans Communities

Any discussion of access to transition-related health care must center on the lived experiences of trans people and communities to illuminate the urgency of the need for these services. Lack of access to transition-related medical care causes profound negative mental, physical, social, legal, and economic consequences in low-income trans communities.[5] All of these consequences are intimately interrelated.

The statistics available with regard to trans people are extremely limited, but all available evidence suggests that transgender people have disproportionately low incomes. One needs assessment of transgender people conducted in the Washington, DC, area (Xavier, 2000) showed that only 58% were employed in paid positions; 29% reported no source of income and another 31% reported annual income less than $10,000. Another assessment conducted in San Francisco (Minter & Daley, 2003) found that 64% of participants reported annual incomes in the range of $0–$25,000. SRLP provides free legal services to trans people of color of all income levels. Of the trans people of color SRLP has served, 85% live under the 2005 federal poverty level, with annual income less than $9,570 a year.

This disproportionate poverty for trans people of color is caused by persistent and severe discrimination in every aspect of life (Sylvia Rivera Law Project [SRLP], 2007b). Trans people are expelled from school and thrown out of their parents' homes at a young age; asked to leave their partners' homes when they are adults; fired from their jobs because of their gender identity and gender expression; or forced to leave school, home, or work because of harassment and abuse (Minter & Daley; SRLP, 2007b; Xavier, 2000). Many trans people cannot gain access even to the meager state and federal supports generally available to low-income people because transgender individuals are so often discriminatorily denied

5 Our intention in this section is to reveal some of the great damage to many trans people and communities resulting from discriminatory actions such as the exclusion of transition-related health care, not to imply that most or all trans people experience every form of the damage we describe. The experiences of some trans people are often universalized, supporting incorrect assumptions about the uniformity of trans people and their experiences. Worse, these nonuniversal experiences are sometimes seized on as standards for deservingness or suitability for access to transition-related health care. In fact, all individuals should have access to the services that help them fully self-determine their gender—people need not be suicidal, for example, and need not experience intense negative feelings in relation to their bodies to qualify for such care (Spade, 2003).

benefits and access to homeless shelters and other services (SRLP, 2007b). Trans people are also disproportionately arrested and incarcerated because of their gender identity and expression, an occurrence that further contributes to the overwhelming poverty in trans communities (Lee, 2003; SRLP, 2007a). Because of this high rate of poverty in trans communities, Medicaid health care coverage is of particular importance as one of the only available forms of health insurance. Medicaid programs throughout the United States continue to discriminate against trans people in the coverage such programs provide. For transgender individuals, the dire consequences of not having health care coverage are sweeping. Following are some examples of how Medicaid's denial of transition-related health care negatively affects low-income transgender people.

Criminalization

When Medicaid recipients cannot pay for transition-related health care through Medicaid, they must seek other ways of paying for their treatments. Often, the only adequate source of income available to low-income trans people is engaging in prostitution or other survival crimes (Clements, Wilkinson, Kitano, & Marx, 1999). Trans people may also turn to criminalized sources for medication, such as buying hormones from the black market, for example (Lunievicz, 1996; Raverdyke, 2002). People who commit these types of survival crimes are far more likely to experience police harassment, arrest, and incarceration.

Without having access to transition-related health care, trans people are often unable to obtain identification (ID) that shows their correct gender and, in some cases, cannot get ID at all. Police sometimes request ID when they are deciding whether to make an arrest, and people without valid ID are more likely to be arrested. Once arrested, people without proper ID are more likely to be held and processed through the system rather than released with a summons or desk appearance ticket (Murray, 2004; LexisNexis, 2005).

Those who have not had access to transition-related medical care generally cannot acquire official recognition of their gender identity, and they are also less often viewed in accordance with their gender identity and more often perceived as being transgender or gender nonconforming. Police routinely profile trans women of color as prostitutes and also falsely arrest trans people for using the restroom (Amnesty International, 2005; Osborne, 2003). These false arrests are more common for people who have not had access to transition-related health care because these individuals are more easily singled out as being trans.

Poverty

For transgender people who have a criminal record, obtaining housing, employment, benefits, and appropriate identity documents becomes even more difficult (Barnett, 2004). These social consequences contribute to deepened and prolonged poverty (Waysdorf, 1996). Without identity documents that match their gender identity and presentation, trans people's ability to travel, visit government or office buildings, find employment, make purchases, or do anything else that involves showing ID is massively curtailed, again deepening the poverty already disproportionately affecting trans communities. Paying out of pocket for expenses such as the cost of hormones also has a huge impact on the economic well-being of trans Medicaid recipients. In New York City, the total nonshelter monthly allowance for an individual receiving public assistance is $137 (New York State Office of Temporary and Disability Assistance, 2003). Even if just a fraction of that goes toward hormones, very little is left over for groceries, transportation, or other necessities. Because trans people who have not received transition-related health care are more easily perceived as trans, they are also more vulnerable to discrimination when they seek education or employment, another factor contributing to poverty in trans communities.

Violence

Lack of access to transition-related health care increases trans communities' exposure to violence in several ways. Some of this violence flows from criminalization: People who are supporting themselves through survival crimes often have extremely dangerous work conditions. Low-income sex workers can be attacked, harassed, raped, beaten, or killed on the job (Sex Workers Project at the Urban Justice Center, 2005; Thukral, 2005). Those trans people who are incarcerated as a result of their survival crimes are also likely to experience further violence. Jails and prisons are dehumanizing institutions for anyone, and nontrans inmates and correction officers disproportionately target trans inmates for intense harassment, rape, and assault (Arkles, 2005; Lee, 2003; Spade, 2005). Trans people are also, again, routinely denied access to the health care they need while incarcerated (Lee).

Trans people's placement in appropriate gender-segregated facilities such as foster care group homes, residential drug treatment facilities, jails, prisons, homeless shelters, and domestic violence shelters can also be contingent on their having access to transition-related health care such as surgery. Decisions about placement occur

either directly, as a result of an institution's policy, or indirectly, through a facility's reliance on the gender reflected on identity documents or the person's physical appearance (Dasti, 2002; Lee, 2003; Mottet & Ohle, 2003). Besides causing emotional distress and inhibiting trans people's ability to self-determine their gender, being placed in inappropriate gender-segregated facilities can often be exceptionally physically dangerous, particularly for trans women placed in men's prisons or homeless shelters (Lee; Mottet & Ohle). Many homeless trans people remain on the street rather than going to shelter systems, where sexual or other violent assault would be near certain (Mottet & Ohle; SRLP, 2007c). Those who do enter the homeless shelter system often experience these forms of violence.

Furthermore, the increased likelihood that people who have not had access to transition-related health care will be perceived as trans puts them at greater risk for interpersonal violence. Those who are visibly gender nonconforming often must walk down the street in fear of being subject to hate crimes, violence, and harassment (National Coalition of Anti-Violence Programs, 2006). The Washington, DC, needs assessment found that 43% of the transgender individuals surveyed had been victims of violence or crime, with 75% of those attributing a motive of transphobia or homophobia to the violence (Xavier, 2000).

Disenfranchisement

The ability of trans Medicaid recipients to participate in the political process is also severely affected by the denial of transition-related health care. On one level, when people are not getting the health care they need and are suffering the consequences of that denial in their lives, they are less able to take the time, attention, or energy to participate in community organizing or other political activities. The higher levels of poverty we have described profoundly limit any financial resources that trans people could leverage to make their voices heard politically through contributing to candidates' campaigns, community organizing groups, or lobbying groups; traveling to speak to an elected representative; or running for office. The related disproportionate homelessness in the trans community can create an insurmountable obstacle to exercising the right to vote (National Coalition for the Homeless & National Law Center on Homelessness and Poverty, 2007). The increased criminalization that results from denial of transition-related health care also limits the political participation of trans communities in profound ways. Felon disenfranchisement laws can strip people who have been convicted of crimes of the right to vote (Fellner & Mauer, 1998). Furthermore, people who have criminal records or who are on parole or probation are often particularly wary of participating in political activities such as protests or marches because of the increased severity of the consequences should they be arrested for exercising their First Amendment rights. Finally, the inability to obtain ID with the correct gender can also prevent people from exercising their right to vote, due to the potential for harassment and humiliation at the polls.

Negative Health Consequences

When people are denied access to health care through doctors and pharmacies because of a lack of Medicaid coverage, they have two options—go without the health care they need or resort to alternative sources of treatment. Both of these options have profound negative health consequences and have created a health crisis in low-income trans communities, with disproportionate impact on trans people of color. The deepened poverty and increased exposure to verbal, physical, and sexual violence that transgender people experience also profoundly affect the physical and mental health of trans communities.

Health Consequences of No Treatment

Discriminatory denial of medical care people need inevitably exacts *dignitary harm* (Goode & Johnson, 2003; Shultz, 1985). Dignitary harm is the insult to the dignity, autonomy, and personhood of an individual that results from discriminatory or harassing acts (Ehrenreich, 1999). Although this harm is not always easily quantifiable as emotional distress or psychological or physical injury, recognizing it is vital to understanding the full impact of discriminatory policies. The denial of coverage for transition-related health care represents a refusal to recognize the humanity of trans people, frustrates their ability to self-determine their gender, infringes on their personal autonomy, and adds to the cumulative effects of the constant discrimination they confront. The emotional distress that results from facing these denials—manifested as anger, frustration, stress, hopelessness, distrust, and sadness—is a common response that negatively affects the overall mental health of trans people.

In addition, severe mental health consequences—such as dysphoria—specific to trans people who are not able to gain access to transition-related health care have been well documented. The term *dysphoria,* in this context, refers to the discomfort that some trans people feel in regard to parts of their bodies in relation to their gender identities. Not all trans people experience dysphoria, but for many, it is an intense and painful reality. The negative feelings associated with dysphoria can manifest as

depression, anxiety, disorientation, sadness, confusion, shame, discomfort, a sense of wrongness, pain, withdrawal, self-hatred, insecurity, despair, desperation, suicidal thoughts, and disassociation (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders [4th ed., text revision; *DSM-IV-TR*], 2000; Goulart, 1999; Morris, 1974; The Transgender Network of Parents, Families and Friends of Lesbians and Gays, 2004). Trans people with dysphoria have described their bodies as shells, as machines, as alien things, as divorced from themselves, as nonexistent (Califia, 1997; Morris; Richards, 1992).

The ways in which dysphoria affects people's behavior are diverse. One person may remove all of the mirrors from his home and remain fully clothed as close to always as possible. Another may not have sex at all or may not have sex as often or in the ways she would otherwise like (Rees, 1999). Still another may minimize speaking to avoid the sound of *hir*[6] voice (Neumann, Welzel, Gonnermann, & Wolfradt, 2002). The responses of individuals and society to trans bodies and incorrect perceptions of trans people's genders also cause serious discomfort for some trans people, magnifying dysphoria. Enduring interactions in which one is being treated as a gender not matching one's gender identity can be exceptionally painful and anxiety provoking, causing some trans people to withdraw from situations in which they must interact with others (*DSM-IV-TR*, 2000; Feldman & Bockting, 2003; Morris, 1974).

For many people, transition-related treatment such as hormones, electrolysis or laser hair removal, and surgeries can relieve dysphoria, increase positive feelings about the body, and improve their freedom to live life fully (Martino, 1977; Morris, 1974; Pfäfflin & Junge, 1992/1998; Xcalibur, 1998). Without these treatments, dysphoria continues unabated and can intensify. In addition, untreated trans people's bodies continue to be misinterpreted by others and their emotional well-being and ability to move in the world continue to be impaired, often severely (Neumann et al., 2002).

The health consequences that flow from a lack of transition-related treatment affect not only mental health but also physical well-being. To many trans people, the continued existence of the physical attributes that transition-related health services would alter, or the return of these features after discontinuance of hormone therapy, constitutes negative physical health consequences. The medical community commonly acknowledges that certain physical features, which would be perfectly acceptable on one person, are health problems on another because of gender.

Some trans people who are unable to gain access to hormones or surgeries injure themselves, often while trying to perform their own surgeries without the benefit of anesthesia, a sterile environment, or medical expertise (Brown, 2001; Brown & Rounsley, 1996; *G.B. v. Lackner*, 1978; Richards, 1992; "Transgender Health," 2004). Physical injuries including lacerations, infections, blood loss, urinary and sexual dysfunction, and severe pain result directly from these actions, which people undertake due to being denied transition-related medical care.

Some transgender individuals who are unable to gain access to hormones or surgeries kill themselves as a result (Brown, 2001; *DSM-IV-TR*, 2000). A more severe physical effect of lack of access to transition-related health care could hardly be imagined. Suicide attempt rates are exceptionally high among trans people who have not had access to transition-related care. One study found suicidal tendencies among 20% of trans people diagnosed with gender identity disorder (GID)[7] before transition-related treatment (Michel, Ansseau, Legros, Pitchot, & Mormont, 2002). Research also has shown that transition-related health care is an effective treatment for ameliorating these suicidal tendencies (Rehman, Lazer, Benet, Schaefer, & Melman, 1999). One study found suicide attempts among 12% of trans women and 21% of trans men who had not begun transition-related treatment and no suicide attempts among the same patients after having begun treatment (Cole, O'Boyle, Emory, & Meyer, 1997). Clearly, deaths would be prevented by offering equitable access to transition-related health care.

6 *Hir* is a gender-neutral pronoun equivalent to the words *him* and *her*.

7 The American Psychiatric Association first listed transsexualism as an official disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.), published in 1980. The most recent version of the manual refers to transsexualism as gender identity disorder (GID; American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* [4th ed., text revision; *DSM-IV-TR*], 2000). According to the *DSM-IV-TR*, two basic symptoms are required to sustain a diagnosis of GID: (a) "strong and persistent cross-gender identification" (p. 581) and (b) persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role corresponding to one's assigned sex that causes "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (p. 581). The way health care professionals have framed GID is controversial among some in trans communities, but the diagnosis is widely used and accepted in the medical community.

Other serious effects include the physical and mental withdrawal symptoms that can result if hormone therapy is discontinued abruptly. Affected trans people have reported nausea, vomiting, cramps, dizziness, weakness, bruising, depression, suicidal feelings, hot flashes, and reversal of some of the effects of hormones, among other symptoms (*Phillips v. Michigan Dep't of Corr.*, 1990; *Wolfe v. Horn*, 2001). This sudden discontinuation of hormones can occur in the context of Medicaid in several situations, such as when a formerly higher-income person experiences a loss of income and enrolls in Medicaid, when a person discontinues use of illicit hormones and attempts to find coverage through Medicaid, when a person who received hormones while incarcerated seeks care through Medicaid upon release, or when an exclusion of coverage for this care is newly enforced.

In New York, members of low-income trans communities, mostly communities of color, experienced this level of intense withdrawal with the sudden enforcement in 2002 of the 1998 exclusion of transition-related care from Medicaid. Most trans people were cut off entirely from the hormone treatment they had been relying on, in some cases for decades, to maintain their health. The sudden discontinuation led to grave negative psychological and physical repercussions for transgender individuals and a health crisis in New York trans communities. SRLP has received countless calls from people who are suffering because of their inability to gain access to health care. Many of our clients had been receiving hormones for years or decades prior to the 1998 exclusionary amendment and are currently in desperate situations because of the physical and psychological reactions stemming from being unable to get the treatment they need.

Health Consequences of Alternative Means of Treatment

Rather than endure going entirely without the health care they need, many trans people seek out alternative forms of treatment. The limited options for these alternative forms of treatment unfortunately also cause great unnecessary harm to the health of the trans people using them. In the following sections, we will discuss four general types of treatments that are not medically supervised, as well as the health consequences that can result from using these treatments instead of doctor-supervised therapies.

Illicit hormones. Trans people in need of hormones who cannot get them through ordinary medical channels commonly acquire them from the black market, networks of friends, other countries with less stringent regulations, and doctors or pharmacists who sell hormones for cash without doing any screening, monitoring, or supervision (Lunievicz, 1996). Some trans people share needles to inject hormones and thus risk bacterial infection and transmission of blood-borne diseases such as HIV and hepatitis ("Crossing to Safety," 2002). Needle exchange programs often do not have needles that are the right size for intramuscular hormone injections (Namaste, 1999). HIV rates are, in fact, extremely high among trans people according to the few studies that have been done (Clements et al., 1999). One study (Clements-Nolle, Marx, Guzman, & Katz, 2001) found HIV seroprevalence of 63% among African American trans women. Also, without medical instruction or supervision, some people inject incorrectly, risking nerve damage (Rodger & King, 2000). Furthermore, lack of medical monitoring, unregulated dosages, and dubious quality of the products obtained create significant risk of complications when trans people self-administer hormones ("Crossing to Safety"; "FIERCE! and SRLP Team Up," 2004; Kammerer, Mason, Connors, & Durkee, 2001).

Silicone. Some trans women who cannot gain access to hormones or surgeries to change the shape of their bodies instead have industrial-grade silicone injected directly into body parts such as breasts, lips, hips, and buttocks. This practice is sometimes referred to as *getting pumped*. The same injection risks described for hormones apply here, in addition to severe health consequences specific to silicone injections. These injections can cause pulmonary emboli, silicone pneumonitis, acute respiratory distress syndrome, abscesses, liver disease, septic shock, and puncture of internal organs (Fox, Geyer, Husain, Della-Latta, & Grossman, 2004; Komenaka, Ditkoff, Schnabel, Marboe, & Mercado, 2004). In a particularly sad case, one woman helped inject silicone into another woman's body at a pumping party. The one who received the injection died as a result; the one who administered it was sentenced to 5 years in prison for practicing medicine without a license ("Two Sentenced in Silicone Death," 2003).

Binding and tucking. Some trans men who have not had chest reconstruction surgery physically flatten their chests using devices such as compression vests, Ace bandages, duct tape, sports bras, or back braces. In the short term, binding tightly or with certain materials can cause pain, dizziness, shortness of breath, cuts, or sores. In the long term, some suggest that binding can change bone structure, cause rash or yeast infection, reduce lung capacity, and cause chronic pain (Feldman & Goldberg, 2006; For Ourselves: Reworking Gender Expression, 2003).

Trans women who have not had an orchiectomy or a vaginoplasty sometimes tuck their genitals on a daily or near-daily basis, using tape, multiple pairs of tight underwear, or other strategies. Tucking can be quite uncomfortable or even painful, especially when sitting, and can also cause bruising, cuts, or hernia (de Vries, Cohen-Kettenis, & Delemarre-Van de Waal, 2006; Feldman & Goldberg, 2006). These types of pain, discomfort, and health risks are utterly unnecessary for those trans people who would undergo chest reconstruction surgery or orchiectomy if they had access to it.

In summary, lack of access to transition-related medical care has profound health consequences for many in transgender communities, including high risks of depression, anxiety, suicide, self-injury, HIV and other infections, liver damage, stroke, trauma from assault and rape, and health concerns aggravated or created by deepened and prolonged poverty and homelessness. The reality is that all of these consequences are extremely common in low-income trans communities of color.

Misuse of Medicalization in Legal Analysis of Trans Issues

As we have explained, transition-related health care is necessary for many individuals—and, for many, lack of treatment can lead to very severe negative consequences. It is important to note that transition-related health care must be individualized. For some people, certain procedures are required, whereas for other individuals, they are not. Under no circumstances, however, should medical treatment define people's identity.

Nevertheless, in many contexts, the legal system views transgender people primarily, if not exclusively, through the lens of the medical model.[8] Having undertaken transition-related health care and being able to produce medical evidence of that care is, in many cases, a prerequisite to any possible recognition of the civil rights or identity of transgender people through the law. At the same time, the legal system often denies access to transition-related health care in spite of the medical evidence confirming the necessity of such care. This double bind demeans all transgender people, but the consequences are most likely to be life or death for low-income transgender people of color. In the following section, we will first examine how the legal system medicalizes transgender experience and requires or defers to medical evidence, then look at when the legal system refuses to acknowledge the legitimacy of transition-related health care and disregards medical evidence, and, last, discuss what the implications of this contradiction mean for trans people.

The Medicalization of Trans Experience

The medical model in many ways has a similar impact when used to view trans people as it does when used to perceive disabled people. This model, although it does have some value, permits dominant society to rest secure in its privilege by pathologizing and *othering* the individuals who do not fit easily into the way society has been set up. The medical model locates a problem within trans or disabled bodies and minds, rather than in a transphobic and ableist society. Thus, a medical model labels trans and disabled people as sick and tries to cure each individual's body or mind instead of labeling society as discriminatory and fixing the problem by changing institutions so disabled and trans people can gain access to them with safety, equality, and dignity.[9] Trans and disabled people are often transformed into narratives of tragedy and objects of pity, seen as a phenomenon that would be desirable to cure out of existence, considered incapable of making their own decisions, and viewed as always somehow less than so-called normal people. In this model, health care providers are deferred to as appropriate guardians of the rights of trans and disabled people and as decision makers for the course of these individuals' lives. Although important differences exist between transphobia and ableism, when viewed exclusively through the medical model, trans and disabled

8 We use the term *medical model* to refer to the framework that examines and understands differences primarily in terms of pathology and diagnosis, treatment, and cure of illness and that establishes medical professionals as having particular expertise concerning these differences. When we criticize the use of the medical model, we do not in any way imply that medical treatment is not of tremendous importance to all those who need and want it, trans and nontrans; that medical science is not a valuable tool for understanding medical needs and treatment; or that medical professionals do not do important work when they provide treatment to those who need and consent to it. Instead, we challenge the notion that the framework of the medical model is appropriate to use as a primary means of understanding trans and disabled communities or of determining an individual's identity or civil rights.

9 According to Clare (1999):

> [H]aving particular medical needs differs from labeling a person with multiple sclerosis as sick, or thinking of quadriplegia as a disease. The disability rights movement, like other social change movements, names systems of oppression as the problem, not individual bodies.… Rather than a medical cure, we want civil rights, equal access, gainful employment, the opportunity to live independently, good and respectful healthcare, unsegregated education. (p. 106)

people are collectively perceived as anything but individual human beings with whole lives and valid identities and desires, deserving of respect, access to health care, and recognition of civil rights.

Of course, other ways of approaching both trans and disability issues exist, including the social model of disability, as well as antioppression, human rights, and self-determination approaches, which strive to acknowledge diversity among bodies and identities without valuing some over others. These alternative models can acknowledge that some, but not all, trans people and disabled people need health care related to their gender identities or disabilities and appreciate the importance of a system in which all people have access to quality, respectful, and free or affordable health care when they need it. Such models simultaneously acknowledge that trans or disabled people themselves, rather than their health care providers, should be the ones making decisions about how to lead their own lives. These approaches identify the primary problem not as residing in individuals and communities that are uncomfortably different or even sick, but as stemming from a coercive, violent binary gender system or an intolerant, inaccessible, and ableist society. Therefore, for the following discussion, it is helpful to keep in mind that when agencies, courts, or other entities choose to invoke a medical model when describing trans experience—including those times when trans people are conceived of as people with disabilities—it is indeed a choice, not a necessity.

Ironically, government bodies often disregard medical evidence when its consideration would be most appropriate for cases involving transgender people, such as when deciding whether to cover transition-related health care. On the other hand, when transgender people go to court or administrative agencies to enforce their rights or seek recognition of their gender, medical evidence is almost always essential to the process and the outcome. This requirement comes into play whether a trans person is seeking to be free from rape in prison (*Farmer v. Brennan*, 1994); obtain damages for being harassed at a job due to gender (*Maffei v. Kolaeton Indus. Inc.,* 1995); change the gender designation on a driver's license (Adduci, 1987); or apply for immigration status in the United States (*In re Lovo-Lara*, 2005). Even if the transgender individual brings medical evidence, of course, recognition is anything but guaranteed—but in many cases, having medical evidence of transition is a minimum for a possibility of success. We will focus on three contexts here: ID, access to sex-segregated facilities and institutions, and discrimination.

Identity Documentation

Official recognition of a trans person's gender identity is almost always contingent on some form of medical evidence. Most often, such recognition requires evidence of transition-related surgery (Dasti, 2002; Spade, 2003).[10] Identity documents and government records such as Social Security cards, state ID or driver's licenses, birth certificates, passports, green cards, employment authorization documents, and benefits cards all reflect a gender for the holder. The minimum requirements for ID set out in the Real ID Act of 2005 in fact require state ID to show a gender if that ID is to be accepted for federal purposes. Particularly in the post–September 11 world, ID is a necessity for gaining access to practically any services or opportunities. One must show ID to get a new job (U.S. Citizenship and Immigration Services [U.S.C.I.S.], 2007), to apply for public benefits (Code Me. R, 2006b; 9 Colo. Code Regs., 2006; 25 Tex. Admin. Code, 2006), to travel (Amtrak, 2006; ATA Airlines, 2006; U.S. Airways, 2006), to make purchases (Greyhound Lines Inc., n.d.; New York State Department of Motor Vehicles, 2006), to get housing (National Law Center on Homelessness and Poverty, 2004; Pera, 2006), and sometimes even to walk down the street or enter a building (Sharkey, 2006). ID also is concretely helpful in interactions with law enforcement and avoiding arrest (*U.S. v. Spivey,* 1995) and, increasingly, is required to vote (Help America Vote Act, 2002).

When trans people show ID with a gender that is different from the gender they are presenting in other ways, they often are accused groundlessly of having stolen or forged their ID. They are also often revealed to be trans and thus subjected to discrimination, harassment, humiliation, violence, and denial of services and opportunities (Arkles, 2006; Osborne, 2003). Therefore, for many trans

10 Some of these policies mandate particular surgical procedures, other policies mandate other specific surgical procedures, and still other policies simply mandate surgery. It is a common myth that there is one surgery—the surgery—that all transgender people get. In reality, transgender people may undergo a wide variety of different possible surgical procedures, such as orchiectomy, vaginoplasty, phalloplasty, vaginectomy, hysterectomy, mastectomy, breast augmentation, tracheal shave, plastic surgery on the hips or buttocks, and facial feminization surgery. Surgery may or may not be a part of the treatment plan of an individual transgender person. Hormonal therapy, electrolysis or laser hair removal, voice coaching, and supportive psychotherapy may also be aspects of necessary treatment.

individuals, it is a matter of fundamental importance to change the gender on their ID.

State and federal government agencies have different, often inconsistent standards for when gender may be changed in records and on ID. These standards virtually all require medical evidence, although the type and amount of evidence and the specific medical fact or facts the evidence needs to prove vary. For example, to change gender on state ID or driver's licenses, New York State requires a letter from a physician, psychologist, or psychiatrist stating that one gender predominates over the other (Adduci, 1987). To change the gender on a birth certificate, New York State requires an original operative report showing that trans women have had a penectomy and that trans men have had a hysterectomy and mastectomy, a postoperative psychiatric evaluation, a physician's letter, and a name-change order (P. Carucci, personal communications, November 4, 2003; June 24, 2004; June 28, 2005). To change gender on a Social Security card, one needs a letter from a physician indicating that sex-reassignment surgery has been completed (U.S. Social Security Administration, 2006).

This dependence on medical evidence is not mandated by practical concerns. If the government's concern is to facilitate identification of individuals, what is most important is clearly not, for example, whether someone has had organs that are never or rarely visible in everyday interactions (such as ovaries or testicles) removed. In the context of identity documents, the government, when it acknowledges the gender of trans people at all,[11] will do so only when medical authorities give legitimacy to the genders of transgender people.

Sex-Segregated Settings

Sex-segregated settings, such as restrooms, locker rooms, dormitories, foster care group homes, drug treatment facilities, jails, and prisons present some of the most intense discrimination and violence against transgender people. As a practical matter, transgender people can sometimes obtain access to sex-segregated facilities in accordance with their gender identity when they have had enough transition-related health care that they either meet a facility's medically based policy or are visually identified as nontransgender members of their gender. The intensity of scrutiny varies from facility to facility—in a setting with no privacy, such as a prison, genitals will be observed as well. When transgender people seek access to sex-segregated facilities based on gender identity in the courts, they rarely meet with success (*Goins v. West Group*, 2001; *Hispanic AIDS Forum v. Estate of Bruno*, 2005). Although the United States has some excellent policies and laws regarding the right of transgender people to gain access to sex-segregated facilities appropriate for their gender identity, such regulations are still in the minority (Mottet & Ohle, 2003; New York City Department of Homeless Services, 2006). Again, when these cases go to court, medical evidence is often critical if a court is to take a transgender person's position at all seriously.

Johnson v. Fresh Mark Inc. (2003) is one example of a court's deference to medical authority when inquiring into whether a trans person ought to be able to use the restroom matching hir gender identity. In this case, when an employer in Ohio realized that a trans woman's driver's license identified her as male, the employer told her that she had to stop working until she provided evidence of her sex from her doctor. The employee refused to provide medical evidence, at which point her employer told her that she was not permitted to use the women's restroom anymore. Afraid for her safety, the employee did not return to work and was soon fired. She sued her employer for discrimination and lost. The court described the demand for medical information prior to allowing the employee to use the restroom that matched her gender identity not as invasive, but rather as a reasonable, good faith effort on the part of the employer. The court in fact found fault with the plaintiff for not responding to the demand. The court stated that applying a genital standard to determine access to gender-segregated restrooms was not discriminatory and ruled against the transgender employee.

In *Crosby v. Reynolds* (1991), a federal court in Maine upheld the decision of prison officials with regard to a transgender person in a sex-segregated facility because the decision was based on medical advice. Based on the counsel of the prison physician, the officials placed a transgender woman appropriately in a women's prison rather than a men's prison. This case is extremely unique; in the vast majority of cases, prison officials place transgender women with men, where they are exposed to a great deal of violence (Arkles, 2005; Spade, 2005). The nontransgender woman who was the trans woman's cell mate sued prison officials, alleging a violation of her right to privacy. The court ruled on behalf of the prison officials, finding that particularly given their reliance on medical advice, they were entitled to qualified immunity.

11 Three states never permit any sort of amendment to birth certificates to reflect the current sex of transgender people: Ohio (*In re Ladrach*, 1987); Tennessee (Tenn. Comp. R. & Regs., 2006e); and Idaho (Idaho Admin. Code, 2006a).

The court's factual discussion concerning the transgender prisoner was made up almost entirely of the physician's opinion.[12] The transgender woman's own articulation of her gender identity or need for a greater level of physical safety while serving her sentence did not enter into the court's decision. Without the prison physician's testimony, it seems unlikely that the court would have reached the same decision, even if the transgender woman's identity and need for safety and dignity were exactly the same.

In *Richards v. U.S. Tennis Assoc.* (1977), a New York court addressed a decision of the United States Tennis Association (hereafter, the association) to institute a chromosome test to determine the sex of contestants. A transgender woman who sought to compete as a woman sued the association, alleging that this test was discrimination on the basis of her sex. The court reviewed a slew of medical opinions, all of which stated that the plaintiff, Ms. Richards, was now a woman, particularly given the genital surgery and hormonal treatment she had received (*Richards v. U.S. Tennis Assoc.*). The court carefully explored the medical expert testimony concerning the medical definition of sex and the experts' assessment of the plaintiff's sex in particular before deciding that applying the chromosome test to Ms. Richards was "grossly unfair, discriminatory and inequitable, and violative of her rights under the Human Rights Law of this State" (*Richards v. U.S. Tennis Assoc.* at 721). The medical opinions were absolutely key to the court's finding that the plaintiff's rights had been violated.

Discrimination

Trans people face pervasive and severe discrimination in all aspects of public and private life (Minter & Daley, 2003). With no obvious reason why the medical history of a transgender person would be particularly relevant to most discrimination litigation, medical evidence nonetheless is often advanced in these types of cases and seized on by the courts in their decisions.

For example, in *Doe v. Bell* (2002), a young transgender woman in the New York City foster care system brought a lawsuit against the commissioner of New York. She was housed in a group home where she was not permitted to wear girls' clothing. Her lawsuit challenged the foster care agency's decision to force her to wear boys' clothing. She advanced numerous claims, including arguments that the actions were unlawful discrimination on the basis of gender, sex, and disability; that they were arbitrary and capricious; and that they violated her due process rights and right to free speech (verified petition, *Doe v. Bell,* 2002). The court ruled in favor of the young woman on the state disability law claim, relying heavily on the testimony of the young woman's psychologist that wearing girls' clothing was a necessary part of her treatment for GID (*Doe v. Bell*).

Disability antidiscrimination laws are an important, hard-won victory of the disability rights movement in large part because they leave behind a medical model of disability in favor of a model that focuses on societal discrimination. Of course, ableism and the medical model have not disappeared even in decisions based on these laws. Although *Doe v. Bell* is without doubt a great victory advancing the rights of transgender youth, it nonetheless invokes the medical model and undermines the agency of the young woman through its reliance on the testimony of mental health professionals to determine the ways in which she had a right to express her gender.

In *Maffei v. Kolaeton* (1995), another New York court denied a motion to dismiss by the defendants, who were claiming that state and local sex-discrimination law did not prohibit discrimination against transgender people. The plaintiff, a transgender man, transitioned at his job and then was subjected to constant harassment and humiliation by his supervisor. The court found that state and local law did prohibit this form of discrimination, after first discussing medical understandings of gender and listing seven variables the medical community considered factors in determining an individual's sex. Again, in an important case based on a law that does not require reliance on a medical model, the court apparently considered the opinion of health care professionals of great importance in recognizing the rights of the transgender person, in this case the right to be free from harassment at work.

Thus, in both of these landmark positive cases on behalf of transgender people experiencing discrimination, the courts employed the medical model in their opinions. Of course, medical evidence does not necessarily mean that trans people's civil rights will be

12 As quoted in *Crosby v. Reynolds* (1991):
> According to the Jail's contract physician, Richard Sagall, M.D., Lamson receives hormone treatments and has developed tissue resembling female breasts as a result. Though Lamson's male genitalia remain anatomically intact, Lamson has virtually no capacity to function sexually as a male. In Dr. Sagall's opinion, Lamson was psychologically a female throughout 1989.…Dr. Sagall told Jail authorities that he approved of this housing situation from a medical standpoint. He did not want Lamson housed with the male inmates because of both the physical and psychological harm that Lamson would likely suffer. (at 667)

protected.[13] Nonetheless, the fact that medical evidence seemed to be required for the court to accept a position favorable to the rights of transgender people in these cases is disturbing. If these litigants had not received medical or psychological treatment related to their gender identity, did not have access to the funds to produce expert testimony, or did not have a sympathetic health care professional treating them, the outcome of the cases may well have been different.

Implications of the Centrality of the Medical Model in Legal Understanding of the Trans Experience

As we have documented, the legal system frequently views transgender experience with deference to medical professionals. Because the legal system has established this highly medicalized framework, tr ansgender people frequently need to produce evidence from health care professionals about their transition in order to do things as simple as using a restroom or wearing the clothes that match their gender, or getting a driver's license that shows who they are.

The effect of this medicalization is not the same for all trans people. Transgender individuals who have a particularly hard time getting health care in general—such as trans people who are also uninsured (Wyn, Teleki, & Brown, 2000); immigrants (Ku & Matani, 2001); not fluent speakers of English (Association of Community Organizations for Reform Now, 2004); low income (Davis, 1991; Freeman et al., 1987); people of color (Phillips, Mayer, & Aday, 2000; U.S. Commission on Civil Rights, 2004); intersex;[14] disabled (Reis, Breslin, Iezzoni, & Kirschner, 2004); fat;[15] lesbian, gay, or bisexual;[16] or without a traditional binary gender identity[17]—have the most difficulty gaining access to the medical treatment and evidence required for affirming their identity and protecting their rights.

Furthermore, the impact of not having access to these forms of official recognition of identity and rights affects some trans people more than others. In the case of ID, certain trans individuals are hard hit by this barrier: low-income people who need to produce a birth certificate when they apply for public benefits to get the money they need to pay for food and shelter, people of color who are singled out by poll workers and police to show ID, and immigrants who often find their ID greeted with suspicion in the best of circumstances, for example. In the case of sex-segregated facilities, people of color, youth, people with disabilities, and low-income people are all overrepresented in many of the most intensely regulated sex-segregated facilities, such as homeless shelters, jails, prisons, foster care group homes, juvenile justice facilities, and inpatient drug treatment. Finally, in the context of discrimination, trans people who have less privilege and education and who experience more forms of discrimination are less likely to be able to find employment, housing, or other opportunities elsewhere if they are discriminated against without redress.

13 According to the undisputed facts in one discrimination case, a man was fired from his job as a truck driver after his employer discovered that he occasionally dressed as a woman during the evening when he was not at work (*Oiler v. Winn Dixie*, 2002). The plaintiff offered evidence that he had a diagnosis of transvestic fetishism with gender dysphoria. The court seized on this diagnosis and ruled against the man, holding that his circumstances differed entirely from those of a woman, such as the plaintiff in *Price Waterhouse v. Hopkins*, who was fired for not dressing or acting feminine enough.

14 Intersex people commonly experience abuse, shaming, and secrecy from the medical profession (Koyama, 2006b). Some intersex trans people have an easier time gaining access to transition-related health care than nonintersex trans people. For example, in some states, Medicaid coverage for transition-related health care is available if a physical intersex condition is present. Other times, though, intersex people actually have more difficulty getting transition-related care. For example, intersex trans people are sometimes told that their physicians do not have enough expertise to treat an intersex trans person, that they should get further normalizing treatments rather than transition, or that they cannot be treated because they do not meet the criteria of gender identity disorder due to their intersex condition (Kaldera, 2003; Koyama, 2006a).

15 Fat people generally face enormous barriers to access to health care (K., 1983; Mabel-Lois, 1983; McAfee, 1998). Overweight trans people in particular are sometimes denied transition-related treatment because of their weight (Gooren, 1999).

16 Trans people are commonly assumed to be heterosexual (attracted to people of a gender other than their gender identity). Those trans people who are lesbian, gay, or bisexual often face specific barriers to care. In the context of transition-related health care, they are generally seen as less likely to need this health care, probably because success of transition-related surgery is often measured by heterosexist standards (Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005). For example, in one study, outcomes were measured by a point system and points were actually deducted for gay or lesbian relationships after transition (Meyer & Reter, 1979). Barriers to health care for lesbian, gay, and bisexual people generally are common (Clark, Landers, Linde, & Sperber, 2001).

17 To be diagnosed with gender identity disorder and hence to gain access to transition-related health care, trans people's level of conformity to gender stereotypes for the gender trans people identify with must often be very high (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* [4th ed., text revision], 2000; Spade, 2003). Trans people who do not identify with either gender or who do not match rigid gender stereotypes have reported to us that they have been denied health care for that reason.

Disregard of Medical Evidence Concerning Legitimacy of Transition-Related Health Care

Medical Evidence Generally

At the same time that the legal system frequently defers to medical evidence when it comes to evaluating transgender people's right to ID, access to sex-segregated settings, or nondiscrimination, the legal system frequently ignores medical evidence when it comes to evaluating the need for transition-related health care. Ironically, the latter is the context in which careful consideration of medical evidence is by far the most appropriate and logically merited. In addition to the context of Medicaid, transgender people also face state denial of access to this care while in state custody such as prison (Joslin, 2006; Wis. Stat., 2005) or foster care (*Brian L. v. Admin. Children's Serv.,* 2006).[18]

The purported justifications for the Medicaid exclusions of transition-related care—that the care is either experimental or cosmetic—have been disproved in the medical literature (Brown, 2001; Cole, Emory, Huang, & Meyer, 1994; Snaith & Hohberger, 1994). The evidence is overwhelming that these procedures are well established, widely accepted, nonexperimental, and noncosmetic. Therefore, in the contexts in which the state excludes transition-related health care from coverage, the state is choosing to go against the vast weight of medical evidence.

For at least the last 75 years, the medical community has provided and studied transition-related health care (Abraham, 1931/1998), and experts in the field (Brown, 2001; Cole et al., 1994; Snaith & Hohberger, 1994) consider such care a standardized, safe, and effective treatment for GID. In considering the risks, side effects, and success rates of the treatment, the medical community long ago concluded that these treatments are not experimental. A scholarly review of the relevant medical history (Gordon, 1991) concluded that sex-reassignment surgery ceased being an experimental treatment following the publication of a seminal medical text in 1969. Pfäfflin and Junge (1992/1998) did a comprehensive review of 30 years of research from 1961 to 1991 and found evidence of lessened suffering, increased subjective satisfaction, improved partnership and sexual experiences, increased mental stability, and improved socioeconomic functioning among trans people with GID who received transition-related treatment. A long-term study of morbidity and mortality among transgender people treated with hormone therapy (van Kesteren, Asscheman, Megens, & Gooren, 1997) found no increased mortality and concluded that the risks from such treatment were acceptable in light of the benefits. Studies and scientific review articles supporting transition-related treatment have been published in some of the most widely respected medical journals in the world (Wylie, 2004).

This consensus has emerged as the medical community rejected older and now discredited forms of treatment, such as efforts to alter a person's core gender identity. Such treatments are now regarded by the medical community as futile and unethical; the goal of treatment has shifted "to facilitating acceptance and management of a gender role transition" (Mallon, 1999, p. 55; also see Bockting & Coleman, 1992; Israel & Tarver, 1997). As early as 1972, the American Medical Association Committee on Human Sexuality acknowledged that "[p]sychotherapy has been largely ineffective for adult transsexuals and surgical reassignment of sex is frequently employed" (p. 136). Today's treatments are the product of medical consensus based on an established history of treating GID.

The 2001 Standards of Care for Treatment of Gender Identity Disorders[19] of the World Professional Transgender Health Association (formerly the Harry Benjamin International Gender Dysphoria Association) described transition-related treatment as a necessary and effective treatment for people with GID:

> In persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. *Sex reassignment is not 'experimental', 'investigational', 'elective', 'cosmetic', or optional in any meaningful sense.* It constitutes very effective and appropriate treatment for transsexualism or profound GID. (Meyer et al., 2001, p. 18)

Indeed, several of the courts that have reviewed state agency decisions to deny coverage for transition-related health care have found that the state determination was contrary to the overwhelming medical evidence. For example,

18 Transgender people also face discriminatory denials of transition-related health care through private insurance companies. However, increasing numbers of insurance companies and employers are providing benefits for this care (Aetna, 2002; Human Rights Campaign, 2007).

19 These standards for transition-related care have been formulated by an international organization of interested professionals and have been sharply criticized as overly conservative by the trans community. Other groups have developed alternate standards of care, particularly regarding hormonal treatments (International Conference on Transgender Law and Employment Policy Inc., 1993; Tom Waddell Health Center Transgender Team, 2001). However, all of these professionals agree that transition-related health care is medically necessary for certain people.

in *G.B. v. Lackner* (1978), California had classified the transition-related surgery the plaintiff needed as cosmetic. The court reviewed medical evidence that described hormones and surgery as the only effective treatment available for transsexuals; outlined the danger of self-mutilation and suicide for people who do not receive such treatment; and documented the improved psychological, vocational, and social functioning of people who received the treatment. The court concluded that "[t]he only evidence presented in this case was that the surgery was necessary and reasonable" (*G.B. v. Lackner*, at 71). The court held the same in a companion case, reasoning: "The evidence presented in these proceedings establishes that J. D. 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" (*G.B. v. Lackner*, at 95). The Supreme Court of Minnesota reached a similar conclusion about the state agency's exclusion of this type of care. The court ordered a state Medicaid plan to pay for a trans woman's surgery, stating that "it is not unreasonable to conclude that transsexualism is a very complex medical and psychological problem…the only successful treatment known to medical science is sex conversion surgery" (*Doe v. Dep't of Pub. Welfare*, 1977, at 819).

The method of adoption of the New York State exclusion shows the lack of attention that government often pays to medical evidence when denying coverage for this care. In 1997, the New York State Department of Health (DOH) announced a proposed amendment to the regulations implementing the state Medicaid program that would exclude coverage for transition-related health care. The DOH's stated justification for the rule was a lack of evidence about the long-term safety and effectiveness of this care (N.Y. St. Reg., 1997). The only source cited for any of the statements was "the Department's knowledge" (N.Y. St. Reg., 1998, p. 11). No hearing was held.

The only two comments on the proposed regulation were from physicians who opposed its adoption on the grounds that "gender reassignment is an appropriate, effective and safe treatment for persons with gender dysphoria" (N.Y. St. Reg., 1998, p. 5). The DOH 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" (N.Y. St. Reg., p. 5). Again, the DOH offered no support for these conclusions. The exclusion was adopted as N.Y. Comp. Codes R. & Regs. tit. 18, § 505.2(l).

Courts also must disregard the weight of the medical evidence when deciding in favor of state agencies in cases challenging Medicaid exclusions of transition-related care. In *Smith v. Rasmussen* (2001), the court referred somewhat elusively to findings of the agency that the efficacy of transition-related surgery had been questioned in the medical community while also admitting that the agency found that "the surgery can be appropriate and medically necessary for some people and that the procedure was not considered experimental" (*Smith v. Rasmussen,* at 760). The court relied in part on the availability of hormones and the agency's consideration of costs in making its decision to allow an exclusion of transition-related surgery to stand.

Gender-Related Care for Transgender People Versus Nontransgender People

The fact that the exclusions of coverage for transition-related health care are not based on medical evidence or the needs of trans communities is particularly clear when one considers how differently gender-related health care is treated when it affirms or transgresses gender norms. In general, gender-related health care is easily acknowledged as medically necessary—whenever it supports more normative gendering. A range of medical diagnoses identifies physical gender variance and the same services that trans people seek are available to treat those types of variance. Hypogonadism identifies abnormally low testosterone levels in people assigned male at birth and abnormally low estrogen levels in people assigned female at birth (Medline Plus Merriam-Webster Medical Dictionary, 2005c). Gynecomastia identifies abnormal amounts of breast tissue in people assigned male at birth (Medline Plus Merriam-Webster Medical Dictionary, 2005a). Hirsutism identifies abnormal amounts of body or facial hair growth, particularly for people assigned female at birth (Medline Plus Merriam-Webster Medical Dictionary, 2005b). These conditions may not present the slightest problem for the person affected. On the other hand, they could cause truly severe emotional distress and barriers to functioning in society. Regardless, medical services are readily available to treat them if they wish to be treated for these conditions. Furthermore, reconstruction of breasts, penises, and testicles lost due to illness or injury is also available. In fact, in the case of intersex children, some gender-related medical services are seen as not only medically necessary but also emergent, and thus these procedures are imposed on people who are far too young to consent to them and who may experience severe complications as a result (Tamar-Mattis, 2006).

The compounds that trans people receive for transition-related health care, which include androgens,

estrogens, testosterone antagonists, and progesterone, are specifically listed as reimbursable prescription drugs in some Medicaid state plans (N.J. Admin. Code, 2007a; N.Y. Comp. Codes R.. & Regs., 2006a). Many states specifically list only exclusions, not covered drugs, in their regulations. Thus, the hormones commonly prescribed as a part of transition-related health care are presumably covered unless the reason for which they are prescribed falls under an exclusion. The most common exclusions relevant to this discussion are those excluding transition-related health care and health care solely designed to promote fertility (Tenn. Comp. R. & Regs., 2007b).

Aside from treatment related to a trans woman's gender identity, estrogens are prescribed for many reasons, including to bring hormone levels into normal ranges for women (for example, during menopause or when puberty is late); to treat vulvular atrophy, atrophic vaginitis, hypogonadism, ovary problems (including lack of ovaries), intersex conditions, breast cancer, or prostate cancer; and to help prevent osteoporosis (Medline Plus, U.S. National Library of Medicine and National Institutes of Health, 2006a).

Besides treatment related to a trans woman's gender identity, progesterone is prescribed to regulate the menstrual cycle; to treat unusual stopping of menstrual periods, endometriosis, breast cancer, kidney cancer, uterine cancer, carcinoma of the prostate, corpus luteum insufficiency, endometrial hyperplasia, hot flashes, precocious puberty, polycystic ovarian syndrome, intersex conditions, and loss of appetite and severe weight or muscle loss in people with AIDS or cancer; to prevent pregnancy; to help a pregnancy occur during certain procedures; to prevent endometrial hyperplasia in menopausal people who are being treated with estrogen; and to test the body's production of other hormones (Medline Plus, U.S. National Library of Medicine and National Institutes of Health, 2005a).

Other than treatment related to a trans woman's gender identity, spironolactone, a testosterone antagonist, is used to treat high blood pressure, fluid retention, low potassium levels, hyperaldosteronism, intersex conditions, myasthenia gravis, precocious puberty, and abnormal amounts of facial hair for women (Medline Plus, U.S. National Library of Medicine and National Institutes of Health, 2006b).

Aside from treatment related to a trans man's gender identity, testosterone is prescribed to bring hormone levels into normal ranges for men; to stimulate the beginning of puberty or a growth spurt when it is late; and to treat muscle wasting from HIV or cancer, hypogonadism, breast cancer, and certain intersex conditions (Medline Plus, U.S. National Library of Medicine and National Institutes of Health, 2005b; WebMD, 2007a).

Included in the aforementioned lists of uses for these compounds are several reasons for treatment designed solely to bring a person's hormones, secondary sex characteristics, or both in line with what is considered normal for that person's gender. Of course, that is exactly the purpose of transition-related hormone therapy. The only difference is that trans people's gender is not the same as the sex they were assigned at birth and, because of that, their transition is seen as transgressing a societal gender norm. Therefore, the diagnosis is considered GID and coverage for the treatment is commonly excluded from Medicaid plans. For both trans people and nontrans people, these forms of treatment may be absolutely critical for their mental health and social functioning or might not be necessary at all, depending on the needs of the individual. No evidence supports the notion that the side effects or safety of hormones would be worse when used to treat trans individuals as opposed to nontrans people, or that such treatment is somehow less necessary for transgender people than for those who are nontrans.

Many of the same and similar surgeries trans people need are listed on many states' schedules for Medicaid reimbursement or otherwise included as covered services in state Medicaid plans, including complete and partial mastectomy, mammoplasty, plastic operation on breasts, breast prostheses, breast reduction, reconstructive surgery of the genitalia, amputation of the penis, plastic operation on penis, orchiectomy, scrotoplasty, plastic operation on scrotum, vulvectomy, episioplasty, salpingo-oophorectomy, and hysterectomy (Ala. Admin. Code, 2006; Idaho Admin. Code, 2006b; Minn. R., 2006; Mont. Admin. Reg., 2006b; N.J. Admin. Code, 2007b; N.Y. Comp. Codes R. & Regs., 2006c; Or. Admin. R., 2006b; Tenn. Comp. R. & Regs., 2007a; 12 Va. Admin. Code, 2006a; 12 Va. Admin. Code, 2006b). Similar to hormone therapy, many of these surgical procedures could also be performed with Medicaid coverage for gender identity–related purposes, but they are excluded in those cases based on the patient's diagnosis. For example, removal of breast tissue for gynecomastia is specifically listed on New York's schedule for Medicaid reimbursement (N.Y. Comp. Codes R. & Regs., 2006c). Thus, the cost of surgery to make a patient's chest appear more typically male is covered for a man who was assigned male at birth, but not for a transgender man. In other words, Medicaid will fund the procedure if the condition the doctor would be treating is construed as gynecomastia, but not if the diagnosis is GID.

The arbitrary distinction between those diagnosed with intersex conditions and those diagnosed with GID is also particularly striking. If a baby whom a doctor assessed

as female at birth and who was raised as a girl ended up identifying as male and seeking a double mastectomy to affirm his male gender identity, he would be able to have the operation with funding from New York's Medicaid program if he had a diagnosed intersex condition—but not if he was diagnosed with GID. Because of the perceived difference in these conditions, a person diagnosed as intersex would get the care the medical community considers necessary but a person diagnosed with GID would not get that exact same medically necessary care.

What the Double Bind Means for Trans Communities

In summary, the courts often defer to medical evidence with regard to transgender people in a wide variety of contexts but then often disregard or implausibly explain away the overwhelming weight of medical evidence when considering the necessity of transgender health care. The state often requires transgender people to have been evaluated and treated by transgender health experts or to have received specific forms of transition-related health care before giving them access to gender-matched ID, appropriate sex-segregated systems, or remedies for discrimination. At the same time, the state often denies access to transition-related health care to Medicaid recipients and people in state custody. This double bind assaults the dignity of transgender people and has a profound impact on trans communities, with disproportionate effects on those who face other forms of marginalization, such as racism and poverty. State systems that deny coverage for transition-related health care while requiring this care in other contexts thereby create a hierarchy of race and class in which rich, predominantly White trans people—because they do not need to rely on the state for health care—are the only transgender individuals able to gain access to a wide variety of basic services and opportunities on anything approaching an equal basis with nontransgender people.

Illegality of Exclusions of Coverage for Transition-Related Health Care

The Medicaid exclusions of transition-related health care are in violation of federal and state law, particularly of those regulations designed to protect low-income people and people of color.

Exclusions Violate Federal Statutory and Regulatory Scheme

Congress created the Medicaid program in 1965 with Title XIX of the Social Security Act in order to provide

> medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, [and to] help such families and individuals attain or retain capability for independence or self-care. (42 U.S.C.A., 2006b)

In the federal Medicaid scheme, the federal government and state governments share the cost of Medicaid and state governments administer the program. States are not obligated to participate in the federal Medicaid program. If, however, a state opts to participate in Medicaid, then the state develops its own plan proposing how to meet the needs of those enrolled. The state plan must comply with federal guidelines. Title XIX requires participating states to provide the categorically needy with financial assistance for certain general categories of medical treatment, including physician services and hospital services. Federal regulations do not require that states cover particular services within these broad categories, leaving states with some discretion in deciding which procedures to cover. However, this discretion is limited by important statutory and regulatory restrictions that provide a strong basis for the position that exclusions of coverage for transition-related health care are invalid.

Under the Supreme Court's decision in *Beal v. Doe* (1977), state Medicaid programs need not cover care that is not medically necessary. At the same time, the court stated that "serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage" (*Beal v. Doe,* at 444). Since then, some courts have found that state Medicaid programs must, in fact, provide for coverage of all medically necessary care within the relevant categories of care for eligible individuals or else be in violation of the federal Medicaid Act. One of these decisions (*Pinneke v. Preisser*, 1980), in fact, occurred in the context of invalidating an exclusion for transition-related health care.

Other courts, however, have taken a different approach. For example, in *DeSario v. Thomas* (1998), the Second Circuit found that a position requiring state Medicaid programs to cover all medically necessary care within the covered categories was "baseless" (*DeSario v. Thomas,* at 94). The court reasoned that

> a state may impose coverage limitations that result in denial of medically necessary services to an individual Medicaid recipient, so long as the health care provided is adequate with respect to the needs of the Medicaid population as a whole. (*DeSario v. Thomas,* at 94)

In *Slekis v. Thomas* (1999), however, the Supreme Court vacated the Second Circuit's decision in *DeSario* (1998) in light of interpretive guidance issued by the Health Care Financing Administration (HCFA) that mitigated the ruling in *DeSario*. The guidance letter stipulated that the state must provide a reasonable and meaningful procedure for requesting items that do not appear on a preapproved list and that the state cannot use a *Medicaid population as a whole* test (Richardson, 1998). However, the scope of the interpretive guidance by its terms is limited to medical equipment coverage, and the Supreme Court has yet to squarely decide whether excluding some medically necessary health care from coverage under state Medicaid programs can ever be legal.

The Supreme Court also has yet to provide a clear legal definition for the term *medically necessary*. When the term has been defined in any way, various courts, agencies, and legislatures have defined it differently. New York State defines medical necessity based on whether the treatment is

> required to prevent or cure a handicap [and necessary] to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. (N.Y. Comp. Codes R. & Regs., 2006d)

North Carolina regulations, on the other hand, state: "Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants" (N.C. Admin. Code, 2006).

Although there is overwhelming support in the medical community for the position that transition-related care is safe, effective, and often necessary, many states continue to label such care as experimental (Mass. Regs. Code, 2006a) or cosmetic (Iowa Admin. Code, 2007). Given the complete lack of support for this position in the medical literature or the general practice of health care providers who treat transgender people, there is no legitimate basis for such positions, almost regardless of the precise definition of medical necessity one is using. Transition-related health care is necessary for many transgender people, and any failure to acknowledge that fact is more likely based on the overwhelming prejudice against transgender people in society than on any scientific evidence.

In this unsettled area of law, the question of whether a particular form of health care is medically necessary may be dispositive on the question of a violation of the federal Medicaid Act (1965): If treatment is necessary, excluding it from coverage may violate the act. At the very least, however, it is a threshold inquiry: If treatment is not necessary, excluding it from coverage does not violate the act. Having found medical necessity, some further reason may be needed to determine that an exclusion violates the federal Medicaid Act, depending on the interpretation of the act. Many such further reasons are available in the statutory and regulatory scheme.

For example, states must adopt standards for determining the extent of medical assistance Medicaid will grant that is "reasonable" and "consistent with the objectives" of the federal statute (42 U.S.C.A., 2006a, at (a)(17); see *Beal v. Doe,* 1977, at 441) and ensure that eligibility for and provision of care and services will be determined in accordance with "the best interests of the recipients" (42 U.S.C.A., at (a)(19)). A denial of a medically necessary treatment because the group in need of such care is politically unpopular is anything but reasonable and is not a determination made with the best interests of recipients in mind.

42 U.S.C.A. § 1396a(a)(10)(A) (2006) and its implementing regulation, 42 C.F.R. § 440.210, mandate that a state must provide certain required services, including inpatient and outpatient hospital services, X-ray and other laboratory services, and physicians' services to all categorically needy Medicaid recipients. In addition, 42 U.S.C. § 1396(a)(10)(B)(i) and its implementing regulation, 42 C.F.R. § 440.230(b), mandate that medical assistance made available to any categorically needy Medicaid recipient shall not be less in "amount, duration, and scope than the medical assistance made available to any other categorically needy Medicaid recipient." Transgender Medicaid recipients who are categorically needy therefore are just as entitled to the services of physicians and hospitals, as well as any other services they need (including prescription drugs), as other, nontransgender categorically needy recipients. Medicaid already covers most of the same hormones, therapy, and surgeries for nontrans people that it explicitly denies for trans people—a clear violation of the aforementioned provision.

Also, 42 U.S.C. § 1396a(a)(17) and its implementing regulation, 42 C.F.R. § 440.230(b), mandate that "each service must be sufficient in amount, duration or scope to reasonably achieve its purpose." For many individuals, achieving the purpose of transition-related surgery (i.e., relief of distress and dysphoria, living fully according to one's gender identity) is dependent on the administration of hormone therapy both before and after surgical procedures, as well as the performance of surgical procedures in addition to hormone therapy, because certain procedures require specific regimens. For example, metaoidioplasty

cannot be performed on trans men who have not received testosterone therapy for a significant period of time (Hage, 1996) and breast augmentation surgery is not recommended for trans women who have not had at least 18 months of estrogen therapy (Meyer et al., 2001). Hormones and one or more forms of surgery are all necessary together to maintain the physical effects that allow many transgender people to live their lives fully and experience the health benefits of the treatment. Therefore, any exclusions that affect only some portion of the care are also a violation of federal law.

Furthermore, 42 U.S.C. § 1396a(a)(17) and its implementing regulation, 42 C.F.R. § 440.230(c), mandate that "[t]he 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." This regulation is perhaps the most obviously violated by the exclusions, because the services are not covered in cases of GID diagnosis. By excluding transition-related health care from Medicaid coverage, states are excluding an entire subgroup of people based on their diagnoses.

This argument has, in fact, been successful in at least one case. In *Pinneke v. Preisser* (1980), the court concluded that the state Medicaid program absolutely excluded the only available treatment known for a particular condition and therefore made an "arbitrary denial of benefits based solely on the diagnosis, type of illness or condition" (623 F.2d, at 549) in violation of the federal regulation. The court ordered Medicaid compensation for the plaintiff's surgery, as well as damages for mental anguish. However, in a disappointing change of direction in 2001, the same court of appeals distinguished Pinneke and accepted as not unreasonable or arbitrary the agency's regulation mandating coverage for transition-related psychotherapy and hormones but not surgery (*Smith v. Rasmussen,* 2001).

Thus, the exclusions of transition-related health care violate law designed to protect the rights of the low-income and disproportionately elderly and disabled people who qualify for federal Medicaid. This law can be successfully used as a means to challenge these exclusions.

Exclusions Violate Federal Constitutional Law

The Equal Protection Clause of the Fourteenth Amendment (1868) requires that all people similarly situated be treated alike under the law (*City of Cleburne, Texas, et al. v. Cleburne Living Center Inc.,* 1985) and prohibits states from treating people differently under their laws on an arbitrary basis (*State v. Williams*, 2000). When a suspect class or a fundamental right is at issue, a court must apply strict scrutiny. If the government act is not narrowly tailored to achieve a compelling state purpose, then the government has acted unconstitutionally (*Miller v. Johnson*, 1995).

A strong argument can be made that as a class, transgender people generally, or low-income transgender people more particularly, should received a heightened level of scrutiny as a suspect class. In *Frontiero v. Richardson* (1973), the U.S. Supreme Court described the characteristics that mark a suspect class, such as pervasive discrimination and marginalization throughout society—characteristics that certainly apply to transgender people and, even more so, to low-income transgender people. Another sign of a suspect class is that discrimination occurs on the basis of a characteristic unrelated to ability to perform or contribute to society. Low-income transgender people are, in fact, just as capable of performing as nontransgender people and have made incredible contributions to society over the centuries (Feinberg, 1997). Another piece of the argument is that the characteristic triggering discrimination is immutable. For transgender individuals, this arguments holds because evidence supports that a person's gender identity is a deeply felt, internal sense of self that cannot be changed by force of will or any medical treatment. The court in *In re Heilig* (2003) stated that "[b]ecause transsexualism is universally recognized as inherent, rather than chosen, psychotherapy will never succeed in 'curing' the patient" (p. 708). Despite the logic of seeing transgender people or low-income transgender people as a suspect class, to date courts have declined to adopt this position (*Holloway v. Arthur Andersen & Co*., 1977).

Furthermore, access to health care can be seen as a fundamental right. Certainly, for those who are in great need of health care, few rights would seem more inalienable. Hirschl (2005) argued that

> basic needs such as access to food, safe water, basic housing, education, and healthcare are both morally and practically more fundamental than any given classic negative right. One's ability to live a decent life, to be adequately nourished, and to have access to basic healthcare, education, and shelter are essential preconditions to the enjoyment of any other rights and freedoms. (p. 496)

However, U.S. constitutional jurisprudence has traditionally failed to recognize such positive rights (*Harris v. McRae*, 1980).

Even failing to recognize transgender people or low-income transgender people as a suspect class and failing to recognize access to health care as a fundamental right,

state exclusions of transition-related health care still should be subjected to strict scrutiny given how these exclusions support racial hierarchies and White supremacy. Race is the classic suspect class (*Frontiero v. Richardson*, 1973; *Loving v. Virginia*, 1967). The largest barrier in this case—unlike if transgender people or low-income transgender people were the suspect class—is the principle that has constrained Equal Protection doctrine to look at the conscious intent behind the government act rather than the actual impact of the act (*Arlington Heights v. Metropolitan Housing Development,* 1977). Many scholars (e.g., Lawrence, 1995) have harshly criticized this principle.

Classifications on the basis of gender have received *intermediate scrutiny,* which means that they must be substantially related to achievement of important governmental objectives to survive that constitutional scrutiny (*Craig v. Boren*, 1976). Without a doubt, transgender individuals as a group are distinguished and discriminated against because of their gender, and singling out care related to gender transition for exclusion from coverage is clearly a gender-based classification. Therefore, these exclusions ought to at least receive intermediate scrutiny.

Even when no suspect class or fundamental right is at issue, the Equal Protection clause requires that all state regulations bear a rational relationship to some legitimate state purpose (*Romer v. Evans*, 1996). There is no rational basis to denying care, services, drugs, and supplies to treat GID, particularly when the identical care, services, drugs, and supplies are provided for other categorically needy Medicaid recipients with different diagnoses but nearly identical medical needs. Denying medically necessary care to a politically unpopular group is not a legitimate state purpose (*Romer v. Evans*).

Exclusions Often Violate State Law

Many exclusions are also in violation of state laws. For example, state laws, executive orders, or constitutions prohibiting discrimination in government services; requiring care for low-income people; or requiring coverage of necessary mental health care, prescription drugs, physicians' services, and inpatient or outpatient hospital programs in the state Medicaid program may invalidate exclusions of transition-related care from Medicaid.

For all of the aforementioned reasons, state Medicaid exclusions to transition-related health care are in violation of laws designed to benefit or protect the rights of low-income people and people of color. By excluding treatment based on a specific diagnosis, these statutes discriminate against an entire group of categorically needy individuals who usually rely on Medicaid as their only source of health care coverage.

Recommendations

One key, obvious solution to the crisis caused in low-income trans communities by lack of access to transition-related health care is to make coverage for this care available through Medicaid. However, before imagining that this type of change will truly solve the problems for many transgender people, it is important to consider some of the limitations of such a solution.

Even where coverage for transition-related care has been purportedly available through Medicaid, low-income transgender people often have not had full and meaningful access to this health care—particularly for surgical interventions, which are far more expensive than hormones. The compensation Medicaid has offered for transition-related operations is many times lower than the rates surgeons can obtain from people who pay out of pocket (Community Health Advocacy Project & Transgender Law Center, 2007; Vade, 2003). Therefore, it is extremely rare that any surgeons who perform transition-related surgeries will accept Medicaid payment. This situation exists despite the fact that Title XIX requires payment that is sufficient "to enlist enough providers so that care and services are available under that plan at least to the extent that such care and services are available to the general population in the geographic area" (42 U.S.C.A. 1396a, 2006a, at (a)(30)). So far, no litigation has been attempted regarding such payment rates for transition-related health care. Thus, even when Medicaid does seemingly cover transition-related health care, that promise often proves false for trans Medicaid recipients.

Case-by-case denials of transition-related treatment are also possible. Before New York State had an explicit regulatory exclusion for transition-related health care, for example, many trans people were still denied coverage for transition-related treatment on the grounds that it was not necessary for them. In the two published cases concerning such denials, the courts upheld the agency's decision (*Denise R. v. Lavine*, 1976; *Vickers v. Toia*, 1978). These cases did not seem well reasoned based on the facts of transition-related care and its benefits for trans people. If these two cases are any indication, trans people will quite possibly continue to face hurdles to receiving coverage in individual instances even when coverage is generally available.

In the bigger picture, gaining access to Medicaid at all remains a barrier for many people. The federal Medicaid program is designed for families with dependent children, elders, and disabled people—groups sometimes called the deserving poor. Single adults who do not qualify

as disabled under federal standards are not eligible to receive federally funded Medicaid no matter how poverty stricken or desperately in need of health care they may be (Louisiana Department of Health and Hospitals, n.d.). New York is quite rare in that it has extended Medicaid benefits to certain individuals outside the federal Medicaid system by providing non–federally subsidized Medicaid benefits to residents between the ages of 21 and 65 who are eligible for assistance because of their low income and resources but who are not entitled to federal Medicaid (18 N.Y. Comp. Codes R. & Regs., 2006; N.Y. Soc. Servs. Law, 2007).

The devastating welfare rollbacks of 1996 have also drastically reduced Medicaid eligibility for low-income people throughout the United States (42 U.S.C.A. § 601). Welfare reform made receiving many benefits with federal funding contingent on complying with rigid work requirements, invasive child-support enforcement provisions, and other mandates. The reform also created strict time limits on how long families could receive many sorts of benefits, leaving low-income people with no means of support at all once those time limits have passed. Welfare reform also severely curtailed immigrant access to benefits, including Medicaid (42 U.S.C.A. § 601; Kaiser Commission on Medicaid and the Uninsured, 2003).

In addition, onerous application procedures, lack of information and outreach, and discriminatory and harassing treatment prevent many eligible people from obtaining Medicaid benefits. Staggering numbers of people who are eligible for Medicaid are not enrolled. In a recent article, Richard Pérez-Peña (2007) reported that two thirds of uninsured children are eligible for but not enrolled in Medicaid or a similar state-funded health insurance program. In interviewing and advocating for our clients, we at SRLP have encountered many instances of discrimination against our clients when they have tried to gain access to public benefits, including Medicaid. For example, one trans woman was not allowed to submit an application because she was wearing a skirt. The worker told her to come back when she was dressed like a man. A trans man was held to be noncompliant with his mandated job training program because he refused to wear a skirt. Trans people have been kicked out of welfare offices for using the wrong bathroom; have had their cases closed groundlessly with the explanation that the closure resulted from their so-called lifestyle choice; and have been harassed by being called such names as *faggot*, *thing*, and *it*. The high amounts of discretion vested in welfare agencies lead to biased decision making (Handler, 1986). Discrimination on other bases is also common and the application requirements are extremely onerous (Welfare Law Center, 2002).

Therefore, although removing exclusions to Medicaid coverage is critical for creating access to health care for low-income transgender communities, this step represents only one element of an overall approach. Many measures must be taken in order to decrease the harm to and the marginalization of trans communities, as well as to avoid reproducing hierarchies of race and class in the welfare system.

First, all blanket exclusions of coverage for transition-related health care, whether through explicit regulations or through practice in interpreting other limits on coverage, should be eliminated from state Medicaid plans. Transition-related health care—and health care generally—should be covered whenever it is consensual and necessary to improve or maintain an individual's health, well-being, or quality or length of life, with heavy deference given to the opinion of the individual and treating professional(s) rather than outside reviewers or formulae. Transgender individuals must, of course, also have access to appropriately qualified professionals.

These changes alone, however, are not enough. Medicaid workers and officials must be trained, educated, and guided by transpositive policies about trans health care issues to prevent discriminatory treatment during application processes or inappropriate case-by-case denials of coverage. The reimbursement rates must be set high enough in comparison to market rates to entice surgeons to accept Medicaid payment. Surgeons must accept as their responsibility not only taking payment through Medicaid but also giving all patients, including low-income clients, quality and respectful care. Providers throughout the United States generally need to be educated about transgender issues and health care needs so that qualified, knowledgeable, and respectful providers are available to prescribe necessary treatments and advocate for patients when necessary. Case managers and legal service providers should also be trained and ready to work with and represent low-income transgender people who encounter problems related to Medicaid and access to health care.

Every person deserves access to health care. Medicaid itself must be made far more widely available to low-income people generally, including trans people—an undertaking that would require changes in federal as well as local law to eliminate barriers to eligibility for immigrants, single adults, the working poor, and others. Application processes must be simplified, and Medicaid offices must be adequately staffed with well-compensated workers who are treated well. These workers should be given all the training, support, and supervision they require to understand how to respectfully and effectively

assist people with a great diversity of identities, backgrounds, and needs.

Finally, even if barriers to health care access were drastically reduced, the overreliance on medical evidence in the field of trans rights must be ended. Civil rights and acknowledgment of individuals' identities should not be dependent on notes from doctors, psychologists' opinions, or which medical procedures individuals have undergone. New, humane policies must be developed that allow changes to ID based on gender identity and that work to eliminate discrimination no matter what its manifestation and regardless of whether the victim has ever seen a doctor about hir gender.

Conclusion

The federal Medicaid scheme is intended to benefit low-income people in the United States who otherwise would not have access to health care coverage. This benefit is intended to cover all medically necessary care for all eligible people, including those who are low income, of color, or transgender. Nevertheless, as states implement their own Medicaid programs, an overwhelming number of them have formulated exclusions to transition-related health care that discriminate against transgender people.

Transgender people are already marginalized in U.S. society and thus are disproportionately low income, incarcerated, and homeless. Without access to appropriate health care, their lives are negatively affected in numerous ways that deepen the oppression they face. Low-income transgender people in communities throughout the United States experience profound negative mental and physical health consequences, disenfranchisement, criminalization, deepened poverty, and increased vulnerability resulting directly from Medicaid exclusions of transition-related health care. These consequences have a disproportionate impact on trans people of color, who are already likely to be profiled in the criminal justice system, disproportionately low income and unlikely to be able to pay for health care through other means, and confronted with racist barriers to health care and enfranchisement.

State reliance on an inappropriate medical model with regard to trans people also furthers the oppression they face. Because the law most often recognizes trans people's true identity or works to protect their rights only upon their presenting proof of having had specific, arbitrary transition-related medical procedures, the unavailability of state-funded coverage for those who cannot otherwise afford such treatments places low-income trans people in an untenable double bind. Thus, these exclusions of transition-related care reproduce and exacerbate the very race and class hierarchies that social services such as Medicaid presumably seek to eliminate or, at least, reduce.

We have made recommendations for change on a number of levels, including modification of eligibility requirements for Medicaid, training of health care providers and state employees and officials, and elimination of exclusions for transition-related health care. Overlapping interests make coalition work among trans activists, health care providers, social service and legal service providers, immigrant rights organizers, disability rights advocates, racial and economic justice leaders, and many others a powerful possibility. Working together for these changes would bring equality in health care access that much closer to reality.

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