

Removing the Constraints to Coverage of Gender-Confirming Healthcare by State Medicaid Programs

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ABSTRACT: In April of 2010, the United States Tax Court in O’Donnabhain v. Commissioner held that sex reassignment surgery and hormone therapy are tax-deductible medical expenses under the Internal Revenue Code. In the course of reaching its decision, the court found that sex reassignment surgery is a medically necessary treatment for gender identity disorder and that the medical community generally agrees that sex reassignment is both an appropriate and effective treatment for gender identity disorder. While these findings were reached in a case interpreting the Internal Revenue Code, they still have the potential to influence whether these forms of treatment are covered under the Federal Medicaid Act. Currently, individuals diagnosed with gender identity disorder face a great deal of difficulty getting Medicaid or private insurance to cover most gender-confirming treatment, particularly sex reassignment surgery. This Note focuses on state Medicaid coverage of sex reassignment surgery and other gender-confirming healthcare and argues that courts reviewing denials of coverage for these treatments should adopt the findings in O’Donnabhain. Further, this Note argues that states with regulatory and statutory provisions explicitly excluding coverage of sex reassignment surgery and other gender-confirming healthcare should repeal them or, in the alternative, that the courts in these jurisdictions should judicially invalidate these provisions because they no longer comply with the requirements imposed by the Federal Medicaid Act.

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I. INTRODUCTION

Although mental health practitioners and physicians have long recognized the existence of gender identity disorder (“GID”), albeit not necessarily by that name, and have treated GID in the same manner for over fifty years, persons diagnosed with GID still face a number of legal consequences as a result of their diagnosis.¹ While the stories of persons diagnosed with GID vary considerably, the following is a description of an individual with GID who had experiences commonly faced by persons with GID:

Appellant . . . was born physically a male on January 1, 1948. At a very early age, she developed many female characteristics which became more obvious as she grew older. The evidence presented at the hearing was that appellant has never experienced an erection or had sexual relations and has failed to develop secondary male sex characteristics, such as facial hair and a deepening of the voice. Her mother and father were unable to accept this. Appellant’s childhood was unstable and she developed a drinking problem in late adolescence. As a result of family problems, appellant moved to San Francisco at age 20, adopted a female name and started living completely as a woman. She obtained employment at various places but was unable to continue in these jobs more than a month or so and then she would be fired or would quit due to her failure to undergo physical examinations because of her fear of having her genital identity discovered. She has suffered severe depression and has attempted suicide on several occasions.²

The appellant was seeking coverage for sex reassignment surgery (“SRS”)—a treatment her physician testified was medically necessary to treat her GID—under California’s state Medicaid plan.³ While the appellant in this case received a favorable ruling, many state Medicaid programs, Medicare, and private insurance providers deny similarly situated persons coverage for gender-confirming healthcare,⁴ despite the fact that their physician recommended the treatment.⁵

1. The legal issues faced by transsexuals are expansive and generally include issues associated with bathroom usage, marriage, obtaining identification, birth certificate reissuance, employment discrimination, incarceration (including the right to continue treatment and placement in either a male or female facility), and the determination of parental rights following a divorce.

2. *J.D. v. Lackner*, 145 Cal. Rptr. 570, 570–71 (Ct. App. 1978).

3. *Id.* at 571.

4. This Note adopts Dean Spade’s phrase *gender-confirming healthcare* as a way to refer to the various procedures, therapies, and surgeries physicians and mental health professionals use to treat persons with GID, which includes SRS and hormone therapy. See Dean Spade, *Medicaid*

This Note addresses the barriers existing in state Medicaid programs that prevent persons diagnosed with GID from obtaining coverage of gender-confirming healthcare, including SRS. This Note also argues that because the medical and mental health communities recognize gender-confirming healthcare as a medically necessary treatment for GID in some cases, under existing case law, the federal Medicaid program requires participating states to cover this form of treatment. This Note then argues that since the federal act requires coverage, state statutory and regulatory provisions that explicitly preclude coverage for SRS are in conflict with the existing federal statutory framework, and thus the respective state legislatures and Medicaid agencies should repeal these provisions or, in the alternative, courts should find these provisions invalid.

Part II of this Note first traces the relevant historical events that led to the recognition of GID and the development of the current mode of treatment. Part II then reviews relevant definitions and outlines the current diagnostic criteria and treatment for GID. Part III discusses the federal and state laws that govern the distribution of federal Medicaid funds to eligible recipients and reviews the existing cases addressing the coverage of gender-confirming healthcare under federally funded state Medicaid programs. Part IV of this Note discusses *O'Donnabhain v. Commissioner*, a recent tax court case holding that SRS and hormone therapy may be tax-deductible medical expenses. Part V of this Note explores the impact of *O'Donnabhain* and the medical community's changing perception regarding the medical necessity of SRS on existing statutory and regulatory provisions excluding coverage for SRS.

II. DIAGNOSING AND TREATING GENDER IDENTITY DISORDER

Relative to the longstanding recognition of transgendered individuals, the diagnosis and treatment of individuals with GID is a relatively new phenomenon and mostly unfamiliar to the general population. This Part

Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates, 8 SEATTLE J. SOC. JUST. 497 (2010).

5. See *id.* at 498; Liza Khan, Note, *Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform*, 11 YALE J. HEALTH POL'Y L. & ETHICS 375, 380–81, 387–402 (2011); Medicare Program; National Coverage Decisions, 54 Fed. Reg. 34,555, 34,572 (Aug. 21, 1989) (“Transsexual surgery for sex reassignment of transsexuals is controversial. Because of the lack of well controlled, long-term studies of the safety and effectiveness of the surgical procedures and attendant therapies for transsexualism, the treatment is considered experimental. Moreover, there is a high rate of serious complications of these surgical procedures. For these reasons, transsexual surgery is not covered.”); see also *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001) (rejecting plaintiff's claim for coverage of gender-confirming treatment under Medicaid); *Rush v. Parham*, 625 F.2d 1150 (5th Cir. 1980) (same), *remanded to sub nom. Rush v. Johnson*, 565 F. Supp. 856 (N.D. Ga. 1983); *Ravenwood v. Daines*, No. 06-CV-6355-CJS, 2009 WL 2163105 (W.D.N.Y. July 17, 2009) (same); *Casillas v. Daines*, 580 F. Supp. 2d 235 (S.D.N.Y. 2008) (same); *Denise R. v. Lavine*, 347 N.E.2d 893 (N.Y. 1976) (same).

undertakes to familiarize the reader with this process by first providing an overview of the historical events that led to the initial recognition and treatment of GID. Next, this Part defines relevant terminology and provides the current diagnostic criteria used for GID. Finally, this Part outlines the recognized method of treating GID—triadic therapy—as provided in the Harry Benjamin Standards of Care.

A. *HISTORICAL BACKGROUND LEADING TO THE DIAGNOSIS AND TREATMENT OF GENDER IDENTITY DISORDER*

Although many consider the existence of transgendered people to be a relatively new phenomenon, substantial historical evidence indicates that persons exhibiting transgender qualities, although not identified as such, have existed in various cultures since at least the time of the Greeks and Romans.⁶ Various stories dating from that time and ranging up through the present reveal that transgendered persons have existed throughout history in a variety of manifestations.⁷ Some cultures even outwardly celebrated and respected persons who exhibited transgender qualities.⁸

Although transgendered persons, in one form or another, have existed in society for thousands of years, formal recognition of transgendered persons, as well as the various subgroups falling under that term, did not begin to occur until the late 1800s.⁹ Magnus Hirschfeld, a Berlin physician, pioneered most of the initial work in this area.¹⁰ One of Hirschfeld's major contributions was the founding of the Institute for Sexual Science, which studied, among other things, "intersex and transgender conditions."¹¹ Eventually the term "transsexual," which refers to a subcategory of persons who are transgendered, was coined by David Cauldwell in 1949.¹² However, this term was not widely used until Harry Benjamin, a later pioneer in

6. See DEBORAH RUDACILLE, *THE RIDDLE OF GENDER: SCIENCE, ACTIVISM, AND TRANSGENDER RIGHTS* 3 (2005); STEPHEN WHITTLE, *RESPECT AND EQUALITY: TRANSEXUAL AND TRANSGENDER RIGHTS* 22 (2002).

7. WHITTLE, *supra* note 6, at 21–26.

8. RUDACILLE, *supra* note 6, at 3, 11.

9. WHITTLE, *supra* note 6, at 35. For example, at that time Krafft-Ebbing, Professor of Psychiatry at Vienna, began to recognize various subcategories of homosexuality such as "Eviration and Defemination" and "Effemination and Viraginity." *Id.* (internal quotation marks omitted).

10. See RUDACILLE, *supra* note 6, at 30–51 (describing Hirschfeld's contributions to this line of research). Hirschfeld's goals were "the reduction of suffering through a scientific understanding of sex" and "to bring an end to the persecution of what he called 'sexual intermediaries,' people who lived somewhere between the boundaries of male and female." *Id.* at 34.

11. *Id.* at 33. Intersex conditions include conditions "such as congenital adrenal hyperplasia, an anomaly of the genitalia, or a chromosomal abnormality." DSM-IV-TR MENTAL DISORDERS: DIAGNOSIS, ETIOLOGY, AND TREATMENT 1081 (Michael B. First & Allan Tasman eds., 2004) [hereinafter DSM-IV-TR MENTAL DISORDERS].

12. WHITTLE, *supra* note 6, at 21; see also *infra* Part II.B.

transsexual studies, adopted the term in a paper he wrote on the topic approximately four years later.¹³

Several years after writing this paper, Benjamin founded the Harry Benjamin International Gender Dysphoria Association (now known as the World Professional Association for Transgender Health or “WPATH”),¹⁴ which in 1979 developed a set of standards of care (“SOC”) for persons diagnosed with gender dysphoria.¹⁵ About a year after Benjamin released the SOC, the American Psychiatric Association (“APA”) first recognized the diagnosis of GID in the third edition of the Diagnostic and Statistical Manual (“DSM-III”).¹⁶ Since that time, WPATH has revised the SOC five times, publishing the most recent revision in 2001.¹⁷ Currently, the APA’s most recent edition of the DSM, the DSM-IV-TR, and the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems each list sets of diagnostic criteria for GID that are, for the most part, similar in content.¹⁸ This Note will focus on the APA’s diagnostic

13. WHITTLE, *supra* note 6, at 21. Benjamin’s work was significant because it distinguished transsexuals from other subgroups of transgendered persons, such as transvestites. RUDACILLE, *supra* note 6, at 13.

14. WPATH “is an international association devoted to the understanding and treatment of individuals with gender identity disorders,” which currently has “over 300 physician, psychologist, social scientist, and legal professional members, all of whom are engaged in research and/or clinical practice that affects the lives of transgender and transsexual people.” THE WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, WPATH CLARIFICATION ON MEDICAL NECESSITY OF TREATMENT, SEX REASSIGNMENT, AND INSURANCE COVERAGE IN THE U.S.A. 1 (2008) [hereinafter WPATH CLARIFICATION ON MEDICAL NECESSITY].

15. Anne A. Lawrence, *Gender Identity Disorders in Adults: Diagnosis and Treatment*, in HANDBOOK OF SEXUAL AND GENDER IDENTITY DISORDERS 423, 424 (David L. Rowland & Luca Inrocci eds., 2008); WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, <http://www.wpath.org> (last visited Jan. 30, 2012). Gender dysphoria is now known as gender identity disorder; however, as is discussed in note 30 below, the American Psychiatric Association may again change the name of this diagnosis back to gender dysphoria in its newest revision of the Diagnostic and Statistical Manual, the DSM-V.

16. Lawrence, *supra* note 15, at 425. While this Note does not address whether it is appropriate for the APA to list GID as a mental illness, it is significant to note that “[t]he designation of gender identity disorders as mental disorders is not a license for stigmatization, or for the deprivation of gender patients’ civil rights. The use of a formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments.” THE HARRY BENJAMIN INT’L GENDER DYSPHORIA ASS’N, STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS 6 (6th ed. 2001), available at <http://www.wpath.org/documents2/socv6.pdf> [hereinafter THE HARRY BENJAMIN STANDARDS OF CARE]. For a discussion of the arguments against designating GID as a medical condition, see Kari E. Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 COLUM. J. GENDER & L. 88, 104–07 (2002); Khan, *supra* note 5, at 386–87, 402; Jonathan L. Koenig, Note, *Distributive Consequences of the Medical Model*, 46 HARV. C.R.-C.L. L. REV. 619 (2011).

17. *Standards of Care*, WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, http://www.wpath.org/publications_standards.cfm (last visited Jan. 30, 2012).

18. Lawrence, *supra* note 15, at 425.

criteria, which are the criteria primarily used by mental health practitioners in the United States.¹⁹

Although WPATH did not release formal standards for treating GID until 1979, German physicians performed the first partial SRS in 1912, more than sixty-five years before WPATH's release of the first SOC.²⁰ Fifteen to twenty years later, physicians in Germany performed the first full sex reassignment operation.²¹ Despite these early procedures, however, neither the condition nor the treatment for GID gained public attention until 1953, when Christine Jorgensen returned to the United States after undergoing SRS in Denmark.²² Approximately thirteen years later, in 1966, Johns Hopkins Hospital performed the first SRS in the United States.²³

While the precise number of persons with GID in the United States is currently unknown, epidemiological studies performed in smaller European countries have revealed that approximately one in 30,000 adult males and one in 100,000 adult females seek SRS.²⁴ Additionally, Professor Lynn Conway of the University of Michigan estimates that the prevalence of SRS in the United States for males and females combined is at least one in 2500.²⁵ However, regardless of the exact number of people with GID, researchers generally agree that the number of individuals diagnosed with GID is on the rise.²⁶

B. DEFINITIONS AND DIAGNOSTIC CRITERIA

"Transgender" is "an umbrella term that [in part] includes . . . all persons whose perceived gender or anatomic sex may be incongruent with their gender expression."²⁷ Transsexuals are a subgroup of transgendered

19. See *infra* Part II.B.

20. WHITTLE, *supra* note 6, at 36.

21. RUDACILLE, *supra* note 6, at 44; Lawrence, *supra* note 15, at 423.

22. WHITTLE, *supra* note 6, at 19. For a comprehensive account of Christine Jorgensen's life before and after the surgery, see RUDACILLE, *supra* note 6, at 62–90.

23. Lawrence, *supra* note 15, at 423–24.

24. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 579 (4th ed., text rev. 2000) [hereinafter APA, DSM-IV-TR]. Notably, these prevalence rates only account for persons who have applied for SRS and thus do not include all individuals with GID. THE HARRY BENJAMIN STANDARDS OF CARE, *supra* note 16, at 2. Consequently, a Dutch study estimated that the prevalence for transsexualism was one out of 11,900 males and one out of 30,400 females. *Id.* A Belgian study with similar results revealed that one out of 12,900 males and one out of 33,800 females have undergone SRS. Lawrence, *supra* note 15, at 433.

25. RUDACILLE, *supra* note 6, at 14.

26. *Id.* at 13; Lawrence, *supra* note 15, at 434. Notably, this increase may not represent an actual increase in the prevalence of persons with GID, but rather merely reflect the greater recognition and diagnosis of GID.

27. Hastings Wyman, *Transgender and Bisexual Issues in Public Administration and Policy*, in HANDBOOK OF GAY, LESBIAN, BISEXUAL, AND TRANSGENDER ADMINISTRATION AND POLICY 125, 126 (Wallace Swan ed., 2004) (quoting S.F., CAL., POLICE CODE art. 33 (1998)) (internal quotation marks omitted).

persons who have “a strong, persistent preference for living as a person of the other sex” and who “desire to have the body of the other sex.”²⁸ The SOC further divides transsexuals into male-to-female transsexuals and female-to-male transsexuals.²⁹

According to the APA’s DSM-IV-TR, a psychologist or psychiatrist may diagnose an individual with GID if the individual exhibits *all* of the following criteria:

- A. A strong and persistent cross-gender identification

 . . . manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
- B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

 . . . manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.
- C. The disturbance is not concurrent with a physical intersex condition.

The San Francisco municipal code defines *transgender* as “an umbrella term that includes female and male cross-dressers, transvestites, drag queens or kings, female and male impersonators, intersexed individuals, preoperative, postoperative, and nonoperative transsexuals, masculine females, feminine males, all persons whose perceived gender or anatomic sex may be incongruent with their gender expression, and all persons exhibiting gender characteristics and identities that are perceived to be androgynous.”

Id. (quoting S.F., CAL., POLICE CODE art. 33 (1998)).

28. KAPLAN & SADOCK’S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1979 (Benjamin J. Sadock & Virginia A. Sadock eds., 8th ed. 2005).

29. THE HARRY BENJAMIN STANDARDS OF CARE, *supra* note 16, at 2. The APA uses a different method of classification under which persons with GID are divided in accordance with their sexual attraction. APA, DSM-IV-TR, *supra* note 24, at 578. The APA method includes four main categories: (1) sexually attracted to males, (2) sexually attracted to females, (3) sexually attracted to both, and (4) sexually attracted to neither. *Id.* The APA uses this method of classification because of the existence of some commonalities amongst persons in each of these categories. *See id.*

- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.³⁰

While the DSM-IV-TR no longer uses “transsexualism” as a category of GID,³¹ psychologists and psychiatrists continue to use the term to describe persons with severe GID and, more specifically, those persons who wish to undergo SRS.³²

C. *TREATMENT OF GENDER IDENTITY DISORDER: GENDER-CONFIRMING HEALTHCARE*

Practitioners treating persons with GID overwhelmingly follow the SOC.³³ According to the SOC, “[t]he general goal of [treatment] . . . for persons with gender identity disorders is lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.”³⁴ In order to effectuate this general goal, the SOC utilizes a three-step approach to treating GID called triadic therapy: (1) the real-life experience, (2) hormone therapy, and (3) surgery for the purpose of sex reassignment and the alteration of other sex-specific characteristics.³⁵ However, within this framework, the SOC recognizes, and emphasizes, that

30. APA, DSM-IV-TR, *supra* note 24, at 581. The APA is in the process of revising the DSM and is set to publish the revised DSM in 2013. *Timeline*, AM. PSYCHIATRIC ASS’N DSM-5 DEV., <http://www.dsm5.org/about/Pages/Timeline.aspx> (last visited Jan. 30, 2012). The APA’s proposed revision of GID includes a change in the name of the condition back to gender dysphoria. *P 01 Gender Dysphoria in Adolescents or Adults (Proposed Revision)*, AM. PSYCHIATRIC ASS’N DSM-5 DEV., <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=482> (last updated May 4, 2011). In addition to the name change, the APA has proposed a revision to the diagnostic criteria, which includes modifications to the indicators and a reduction in the number of indicators required for diagnosis. *Id.* Finally, the proposed revision also adds an additional requirement—that “[t]he condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability.” *Id.* This website also discusses the APA’s rationales for these changes, one of which was that the APA “chose not to make any decision between its categorization as a psychiatric or a medical condition and wished to avoid jeopardizing either insurance coverage or treatment access.” *P 01 Gender Dysphoria in Adolescents or Adults (Rationale)*, AM. PSYCHIATRIC ASS’N DSM-5 DEV., <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=482#> (last visited Jan. 30, 2012).

31. The previous edition of the DSM had two diagnostic categories for GID: (1) transsexualism, which included persons who wanted to live as the opposite sex and also wished to undergo SRS; and (2) atypical GID, which served as a catchall for other persons with GID. Lawrence, *supra* note 15, at 425.

32. See *O’Donnabhain v. Comm’r*, 134 T.C. 34, 37 n.7 (2010), *acq.* 2011-47 I.R.B. 789; Lawrence, *supra* note 15, at 425.

33. DSM-IV-TR MENTAL DISORDERS, *supra* note 11, at 1083; see *infra* note 127 and accompanying text.

34. THE HARRY BENJAMIN STANDARDS OF CARE, *supra* note 16, at 1.

35. *Id.* at 3.

not all persons diagnosed with GID “need or want all three elements of triadic therapy,” and that the precise order of treatment may also vary.³⁶

The first element of triadic therapy, the real-life experience, involves the individual “fully adopting a new or evolving gender role or gender presentation in everyday life.”³⁷ The real-life experience is an important aspect of triadic therapy because it “tests the person’s resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports.”³⁸ Prior to or during this stage of the treatment, male-to-female transsexuals may also employ electrolysis to remove facial and other unwanted hair.³⁹

The second element of triadic therapy, hormone therapy, consists of female-to-male transsexuals taking androgens and male-to-female transsexuals taking estrogen, progesterone, and testosterone-blocking agents.⁴⁰ These hormones physically change the bodies of the recipients in both permanent and reversible ways.⁴¹ The resulting changes generally help those individuals to “feel and appear more like members of their preferred gender.”⁴² Treating physicians often consider this stage of treatment to be “medically necessary for successful living in the new gender.”⁴³ Further, this stage of treatment has the potential to “provide significant comfort to gender patients who do not wish to cross live or undergo surgery, or who are unable to do so.”⁴⁴ In fact, hormone therapy may, in some cases, be a

36. *Id.*

37. *Id.* at 17.

38. *Id.* at 18.

39. *Id.*

40. *Id.* at 13.

41. Biologic males taking estrogen hormones generally experience the following reversible physical changes: “some redistribution of body fat to approximate a female body habitus, decreased upper body strength, softening of skin, decrease in body hair, slowing or stopping the loss of scalp hair, decreased fertility and testicular size, and less frequent, less firm erections.” *Id.* at 14. In addition to these reversible changes, biologic males may also experience breast enlargement, which may not entirely subside after hormone treatment is stopped. *Id.*

Biologic females taking testosterone experience several permanent changes, including: “a deepening of the voice, clitoral enlargement, mild breast atrophy, increased facial and body hair and male pattern baldness.” *Id.* In addition to these permanent changes, biologic females taking testosterone may also experience the following reversible changes: “increased upper body strength, weight gain, increased social and sexual interest and arousability, and decreased hip fat.” *Id.*

42. *Id.* at 13.

43. *Id.*

44. *Id.* at 14. The potential impact of hormone therapy is aptly described in the following passage recounting Christine Jorgensen’s first experience taking hormones:

Within two weeks of beginning daily doses of ethynyl estradiol in 1949, Jorgensen noticed physical effects (“sensitivity in my breast area and a noticeable development”) and emotional ones. “The great feeling of listlessness and fatigue, which often seemed to be with me even after a full night’s sleep, had disappeared.

sufficient remedy for some patients with GID, thus removing the need for either the real-life experience, SRS, or both.⁴⁵

In the final phase of triadic therapy, the individual may undergo breast and genital surgery. Breast surgery typically involves breast augmentation for male-to-female transsexuals or a mastectomy for female-to-male transsexuals.⁴⁶ Female-to-male transsexuals often will undergo a mastectomy during the hormone-therapy stage and in some cases may not seek genital surgery.⁴⁷ However, breast surgery may be unnecessary for male-to-female transsexuals if the prescribing physician determines hormone-induced breast growth is “sufficient for comfort in the social gender role.”⁴⁸

Genital surgery for both male-to-female transsexuals and female-to-male transsexuals involves several different surgical procedures aimed at reforming the genitals of the individual into those of the opposite sex.⁴⁹ Due to the irreversible nature of genital surgery, the SOC places several eligibility requirements on individuals seeking genital surgery, including at least twelve months of hormone therapy and real-life experience.⁵⁰ In addition to hormone therapy and breast and genital surgery, a person diagnosed with

I was refreshed and alive and no longer felt the need to take little cat naps during the day.”

RUDACILLE, *supra* note 6, at 76.

45. THE HARRY BENJAMIN STANDARDS OF CARE, *supra* note 16, at 14.

46. *Id.* at 19–20.

47. *Id.* at 20.

48. *Id.*

49. *See id.* at 21. Male-to-female transsexual genital surgery may include an “orchietomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty.” *Id.* Female-to-male transsexual genital surgery may include a “hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty.” *Id.*

50. *Id.* at 20–21. The full eligibility criteria for genital surgery include:

1. Legal age of majority in the patient’s nation;
2. Usually 12 months of continuous hormonal therapy for those without a medical contraindication . . . ;
3. 12 months of successful continuous full time real-life experience. Periods of returning to the original gender may indicate ambivalence about proceeding and generally should not be used to fulfill this criterion;
4. If required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional. Psychotherapy per se is not an absolute eligibility criterion for surgery;
5. Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches;
6. Awareness of different competent surgeons.

Id. at 20.

GID may also require other surgical procedures in order to help the individual conform to the new gender role.⁵¹ These procedures generally involve plastic surgery, which aids the individual in further feminizing or masculinizing her or his features.⁵²

State Medicaid programs typically deny coverage for treatments falling under the last two stages of triadic therapy: hormone therapy and surgical procedures.⁵³ Although Medicaid rarely covers these two aspects of the treatment, in many cases both are essential to the effective treatment of GID. Like most surgical procedures, the effectiveness and benefits of SRS depend on a number of factors, some specific to the patient, and others dependent upon the outcome of the surgery.⁵⁴ However,

[t]he consensus of most experts is that sex reassignment generally, and SRS specifically, is associated with a high degree of patient satisfaction, a low prevalence of regrets, significant relief of gender dysphoria, and aggregate psychosocial outcomes that are usually no worse and are often substantially better than before sex reassignment.⁵⁵

A study examining the reported satisfaction rates of post-surgery patients supports this conclusion and specifically found that post-surgery male-to-female transsexuals have an average satisfaction rate of 87% and post-surgery female-to-male transsexuals have an average satisfaction rate of 97%.⁵⁶ Further, practitioners in the field recognize that persons with GID

51. *Id.* at 21–22.

52. *Id.* (“Other surgeries that may be performed to assist feminization include reduction thyroid chondroplasty, suction-assisted lipoplasty of the waist, rhinoplasty, facial bone reduction, face-lift, and blepharoplasty. . . . Other surgeries that may be performed to assist masculinization include liposuction to reduce fat in hips, thighs and buttocks.”).

53. At least part of the reason state Medicaid programs do not cover these final two stages of triadic therapy is probably because they both entail the potential for irreversible physiological change to the body, unlike the real-life experience, which often only involves temporary changes to a person’s way of life.

54. *See* Lawrence, *supra* note 15, at 448 (“Good surgical results and an absence of complications are associated with better psychosocial outcomes and higher levels of patient satisfaction.”).

55. *Id.* at 449; *see also* Eric B. Gordon, *Transsexual Healing: Medicaid Funding of Sex Reassignment Surgery*, 20 ARCHIVES SEXUAL BEHAV. 61, 68–71 (1991); Khan, *supra* note 5, at 395 n.102. In one study, Pfäfflin and Junge examined results from studies conducted from 1961 to 1991 and “found that subjective satisfaction was high in most studies, that patients’ mental health improved more often than it declined, that effects on socioeconomic functioning were generally positive (albeit with some instances of decline in employment status and social isolation among [male-to-female] transsexuals), and that patients’ sexual satisfaction generally improved.” Lawrence, *supra* note 15, at 449 (citing FRIEDEMANN PFÄFFLIN & ASTRID JUNGE, SEX REASSIGNMENT: THIRTY YEARS OF INTERNATIONAL FOLLOW-UP STUDIES AFTER SEX REASSIGNMENT SURGERY: A COMPREHENSIVE REVIEW, 1961–1991 (Roberta B. Jacobson & Alf B. Meier trans., 1998) (1992)); *see also* WPATH CLARIFICATION ON MEDICAL NECESSITY, *supra* note 14, at 3.

56. Lawrence, *supra* note 15, at 450 (citing R. Green & D. T. Fleming, *Transsexual Surgery Follow-Up: Status in the 1990s*, 1 ANN. REV. SEX RES. 163, 163–74 (1990)).

who are unable to receive gender-confirming healthcare often suffer negative health consequences, including depression, anxiety, and, in some cases, suicidality.⁵⁷

III. COVERAGE OF GENDER-CONFIRMING HEALTHCARE UNDER MEDICAID

This Part will discuss the interaction between the Federal Medicaid Act and state Medicaid programs, as well as the methods used by those state programs to deny coverage of SRS and other gender-confirming healthcare. First, this Part reviews the federal statutory framework that establishes the Medicaid program. Second, this Part examines the different types of exclusionary provisions states use to exclude SRS and other gender-confirming healthcare from coverage under their respective state Medicaid programs. Third, this Part reviews cases addressing state denials of Medicaid coverage for SRS.

A. THE FEDERAL MEDICAID ACT

This Subpart describes the federal statutory provisions and federal regulations that govern state Medicaid programs. Title XIX of the Social Security Act (hereinafter “Federal Medicaid Act”) establishes a federally funded medical assistance program, under which participating states receive federal funds in exchange for enacting a program that fulfills the purposes of the Federal Medicaid Act.⁵⁸ The Federal Medicaid Act sets out the basic requirements that a state Medicaid program must meet in order to be eligible for federal funding.⁵⁹ In addition to these basic requirements, a state Medicaid program must also abide by the regulations interpreting these statutory provisions, which are promulgated by the Department of Health.⁶⁰

Under the federal statutory and regulatory requirements, participating states must provide medical assistance to persons designated as categorically needy and may, at the state’s option, provide services to persons designated

57. Spade, *supra* note 4, at 498; *see also* RUDACILLE, *supra* note 6, at 12 (“Public prejudices make it difficult for visibly transgendered or transsexual people to gain an education, employment, housing or health care, and acute [GID] leaves people at high risk for drug abuse, depression, and suicide.”).

58. 42 U.S.C. § 1396-1 (Supp. 2009); *Id.* §§ 1396 to 1396w-5 (2006); *see* Doe v. Minn. Dep’t of Pub. Welfare, 257 N.W.2d 816, 819 (Minn. 1977) (“It can be generally described as a venture in what is commonly referred to as ‘cooperative federalism’ in that the state administered program as a condition to receiving Federal funds is required to conform to applicable Federal statutes and regulations.”).

59. Smith v. Rasmussen, 249 F.3d 755, 757 (8th Cir. 2001); *see* 42 U.S.C. §§ 1396 to 1396w-5.

60. Pinneke v. Preisser, 623 F.2d 546, 549 (8th Cir. 1980); *see* 42 C.F.R. §§ 440.1–440.390 (2010).

as medically needy.⁶¹ If a state Medicaid plan includes coverage for the medically needy, then the plan must provide certain designated services to those individuals; however, the required services are substantially limited and would not likely include coverage of gender-confirming procedures.⁶² This Note will focus on coverage of gender-confirming care for the categorically needy; however, the same analysis would likely apply in the states that elect to provide the same or similar coverage to the medically needy as they do for the categorically needy. With respect to the categorically needy, the Federal Medicaid Act requires participating states to provide them with services falling under five broad categories, including inpatient and outpatient hospital services, laboratory and x-ray services, nursing facility services, physicians' services, and home health services.⁶³ Further, the state "plan must specify the amount, duration, and scope of each service that it provides" to the categorically needy and the medically needy.⁶⁴ The regulations further delimit this coverage and acknowledge that states are not required to cover all procedures within each category and thus "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."⁶⁵

While the Federal Medicaid Act does not explicitly require states to cover all medically necessary treatment, the Supreme Court has suggested in dictum that "statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage . . ."⁶⁶ Several courts have interpreted this portion of the Supreme Court's opinion to require participating states to provide the categorically needy with medically necessary treatment that falls within the five required categories of care.⁶⁷ One court specifically identified two levels of medical necessity:

61. See 42 U.S.C. § 1396a(a)(10)(A)(i)-(ii); *Smith*, 249 F.3d at 757. Subsection (i) defines who is categorically needy and subsection (ii) defines who is medically needy for the purposes of Medicaid. 42 U.S.C. § 1396a(a)(10)(A)(i)-(ii).

62. See 42 C.F.R. § 440.220 (requiring that a state plan provide certain pregnancy-related care, ambulatory services, and home health services).

63. 42 U.S.C. § 1396a(a)(10)(A) (referring to services outlined in 42 U.S.C. § 1396d(a)(1)-(5), (17), and (21)); see also 42 C.F.R. § 440.210 (referring to services detailed in 42 C.F.R. §§ 440.10-440.50 and 440.70); *Beal v. Doe*, 432 U.S. 438, 440-41 (1977) (citing 42 U.S.C. §§ 1396a(a)(13)(B), 1396a(a)(1)-(5) (1970)).

64. 42 C.F.R. § 440.230(a)(1)-(2).

65. *Id.* § 440.230(d).

66. *Beal v. Doe*, 432 U.S. at 444-45.

67. See, e.g., *Hern v. Beye*, 57 F.3d 906, 911 (10th Cir. 1995) ("The purpose of Medicaid as stated in the Act is to enable states to provide medical treatment to needy persons 'whose income and resources are insufficient to meet the cost of *necessary medical services*.'" (quoting 42 U.S.C. § 1396 (1994))); *Weaver v. Reagen*, 886 F.2d 194, 198 (8th Cir. 1989) ("This provision[, 42 U.S.C. § 1396a(a)(17),] has been interpreted to require that a state Medicaid plan provide treatment that is deemed 'medically necessary' in order to comport with the objectives of the Act."); *Pinneke v. Preisser*, 623 F.2d 546, 548 n.2 (8th Cir. 1980) (citing *Beal v. Doe*, 432 U.S. at 444-45 & n.9) ("This standard of medical necessity is not explicit in the

The first is the macro-decision by the legislature that only certain kinds of medical assistance are deemed sufficiently necessary to come under the coverage of its plan. The second is the micro-decision of the physician, that the condition of his patient warrants the administering of a type of medical assistance which that plan makes available.⁶⁸

Under this theory of medical necessity, the legislature is responsible for determining the first level of medical necessity (“general medical necessity”).⁶⁹ However, in making this determination, the legislature must act in accordance with the restrictions of the Federal Medicaid Act and its accompanying regulations.⁷⁰ One such restriction is that the state’s plan must “include reasonable standards . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [the Federal Medicaid Act].”⁷¹ Some courts have held that they will measure the reasonableness of the legislature’s standards by examining whether the specified treatment is “generally accepted by the professional medical community as an effective and proven treatment.”⁷² Notably, this standard does not require absolute unanimity, but rather a general consensus.⁷³ In addition to these requirements, the state Medicaid plan or governing agency, in defining the services covered by the five categories,

statute, but has become judicially accepted as implicit to the legislative scheme and is apparently endorsed by the Supreme Court.”). *But see* *Preterm, Inc. v. Dukakis*, 591 F.2d 121, 124 (1st Cir. 1979) (“It does not seem, however, that the words ‘necessary medical services’ are properly read as a substantive requirement imposed on the states. Instead, this section merely specifies for whose benefit federal funds are to be appropriated—those ‘individuals, whose income and resources are insufficient to meet the costs of necessary medical services.’” (quoting 42 U.S.C. § 1396 (1976))).

68. *Preterm*, 591 F.2d at 125.

69. *Id.*

70. *See id.*

71. 42 U.S.C. § 1396a(a)(17) (2006); *see also* *Beal v. Doe*, 432 U.S. at 444 (“This language confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be ‘reasonable’ and ‘consistent with the objectives’ of the Act.”).

72. *Weaver*, 886 F.2d at 198 (quoting *Rush v. Parham*, 625 F.2d 1150, 1156 n.11 (5th Cir. 1980), *remanded to sub nom.* *Rush v. Johnson*, 565 F. Supp. 856 (N.D. Ga. 1983)) (internal quotation marks omitted). In *Weaver*, the Missouri legislature limited coverage of AZT to AZT prescribed in accordance with the approved usages provided for by the FDA. *Id.* at 199. The *Weaver* court noted,

In the face of widespread recognition by the medical community and the scientific and medical literature that AZT is the only available treatment for most persons with AIDS, we find that Missouri Medicaid’s approach to its coverage of the drug AZT is unreasonable and inconsistent with the objectives of the Medicaid Act.

Id. at 200; *see also* *Rush v. Parham*, 625 F.2d at 1156 (adopting the procedure Medicare uses to determine whether a particular treatment will be covered).

73. *O’Donnabhain v. Comm’r*, 134 T.C. 34, 69 (2010), *acq.* 2011-47 I.R.B. 789 (“[A] complete consensus on the advisability or efficacy of a procedure is not necessary.”).

“may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.”⁷⁴

After the first determination is made by the legislature, the individual’s physician is responsible for making the secondary determination of medical necessity (“specific medical necessity”).⁷⁵ Other courts have found that “[t]he Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.”⁷⁶ The Federal Medicaid Act’s legislative history supports these courts’ interpretation that the physician should play a central role in determining the medical necessity of a particular treatment for a particular patient.⁷⁷

B. STATE LAWS EXCLUDING COVERAGE OF GENDER-CONFIRMING HEALTHCARE

This Subpart outlines the different types of statutory and regulatory exclusions states utilize to deny gender-confirming healthcare to persons diagnosed with GID. States generally use two types of laws: (1) laws that specifically exclude SRS or care related to treating GID and (2) laws that exclude SRS and related procedures as cosmetic or experimental surgery. The first group of provisions used to deny coverage of SRS may be applied either narrowly or broadly. The narrow laws only exclude coverage for SRS itself and make no mention of related gender-confirming healthcare.⁷⁸ However, the broad laws may preclude coverage for related forms of gender-confirming treatment.⁷⁹

74. 42 C.F.R. § 440.230(c) (2010); *see also* *White v. Beal*, 555 F.2d 1146, 1152 (3d Cir. 1977) (“The regulations permit discrimination in benefits based upon the degree of medical necessity but not upon the medical disorder from which the person suffers.”).

75. *Preterm*, 591 F.2d at 125.

76. *Smith v. Rasmussen*, 249 F.3d 755, 759 (8th Cir. 2001) (quoting *Weaver*, 886 F.2d at 200) (internal quotation marks omitted); *see* *Rush v. Parham*, 625 F.2d at 1156.

77. *See* S. REP. NO. 89-404, pt. 1, at 46 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1986-89. (“The committee’s bill provides that the physician is to be the key figure in determining utilization of health services—and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. For this reason the bill would require that payment could be made only if a physician certifies to the medical necessity of the services furnished.”).

78. *See, e.g.*, MINN. STAT. § 256B.0625, subdiv. 3a (2008) (amended 2011) (“Sex reassignment surgery is not covered.”); MONT. ADMIN. R. 37-79-303(q) (2010) (“In addition to any exclusions noted elsewhere in these rules, the following services are not covered benefits . . . transsexual surgery.”); 471 NEB. ADMIN. CODE. § 18-003.01(30) (2010) (“NMAP does not cover . . . sex change procedures.”).

79. *See, e.g.*, ILL. ADMIN. CODE tit. 89, § 140.6(l) (2010) (“The following services are not covered under the Department’s medical assistance programs . . . [m]edical or surgical transsexual treatment.”); MO. CODE REGS. ANN. tit. 22, § 10-2.060(30) (2010) (amended 2011) (excluding from coverage under the Missouri Medicaid Plan “[g]ender reassignment—health services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to

The second group of laws that deny coverage for gender-confirming healthcare are hybrid laws that couch the denial of services in the terms of experimental or cosmetic surgery. This type of law generally states that Medicaid does not cover experimental procedures and then provides a list of procedures considered to be experimental, which usually includes SRS.⁸⁰ Iowa's regulation, for example, defines cosmetic procedures as "surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions."⁸¹ The regulation then goes on to state, "Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage."⁸² The law also specifically excludes procedures related to certain diagnoses, including "[p]rocedures related to transsexualism . . . [and] gender identity disorders."⁸³ While many states have exclusionary provisions that fall under one of these two types, very few of them have faced a formal challenge. The next Subpart explores the few cases that have addressed formal challenges to denials of coverage for SRS.

C. CASES ADDRESSING MEDICAID COVERAGE OF GENDER-CONFIRMING HEALTHCARE

This Subpart discusses the cases in which courts have addressed the question of whether the state Medicaid plan covers SRS and other gender-confirming healthcare. Of the five states that have faced challenges to a denial of coverage for SRS, a majority of them have upheld the denial of coverage under their respective state Medicaid statute.⁸⁴ Currently, only one

gender reassignment; also, hormonal support for gender reassignment"); N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l) (2010) ("Payment is not available for care, services, drugs, or supplies rendered for the purpose of gender reassignment (also known as transsexual surgery) or any care, services, drugs, or supplies intended to promote such treatment.").

80. See, e.g., IOWA ADMIN. CODE r. 441-78.1(4) (2010); 130 MASS. CODE REGS. 405.418(A) (2006) ("MassHealth does not pay a CHC for performing, administering, or dispensing experimental, unproven, or otherwise medically unnecessary procedures . . . including . . . sex-reassignment surgery . . . and any other related surgeries and treatments including pre- and post-sex-reassignment surgery hormone therapy.").

81. IOWA ADMIN. CODE r. 441-78.1(4).

82. *Id.*

83. *Id.* r. 441-78.1(4)(b)(2).

84. A number of states have addressed this issue, including California, Georgia, Iowa, Minnesota, and New York. See, e.g., *J.D. v. Lackner*, 145 Cal. Rptr. 570 (Ct. App. 1978) (California permitting coverage); *G.B. v. Lackner*, 145 Cal. Rptr. 555 (Ct. App. 1978) (same); *Rush v. Parham*, 625 F.2d 1150 (5th Cir. 1980) (Georgia denying coverage on remand), *remanded to sub nom.* *Rush v. Johnson*, 565 F. Supp. 856 (N.D. Ga. 1983); *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001) (Iowa denying coverage); *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980) (Iowa permitting coverage); *Doe v. Minn. Dep't of Pub. Welfare*, 257 N.W.2d 816 (Minn. 1977) (Minnesota permitting coverage); *Ravenwood v. Daines*, No. 06-CV-6355-CJS, 2009 WL 2163105 (W.D.N.Y. July 17, 2009) (New York denying coverage); *Casillas v. Daines*, 580 F. Supp. 2d 235 (S.D.N.Y. 2008) (same); *Denise R. v. Lavine*, 347 N.E.2d 893 (N.Y. 1976) (same).

of these states, California, permits coverage of SRS under its Medicaid program.⁸⁵ All of the courts to uphold the denial did so in accordance with a state regulation excluding SRS or other gender-confirming care from coverage under the state Medicaid act.⁸⁶ This Subpart first discusses the cases that were decided in the absence of an official statute or regulation explicitly excluding coverage of SRS. Second, this Subpart discusses the cases addressing Medicaid coverage of SRS in states that had an explicit statute or regulation excluding coverage.

1. Cases Decided in the Absence of an Exclusionary Statute or Regulation

In the absence of a statute or other regulation explicitly denying coverage, courts addressing whether Medicaid covers SRS have uniformly found that state Medicaid programs should cover it.⁸⁷ This was true even when the Medicaid agency making the decision relied on an unofficial policy that mandated the denial of coverage for SRS and related gender-confirming care.⁸⁸

85. *J.D.*, 145 Cal. Rptr. at 572; *G.B.*, 145 Cal. Rptr. at 559.

86. *See, e.g., Smith*, 249 F.3d at 760; *Rush v. Parham*, 625 F.2d at 1152; *Casillas*, 580 F. Supp. 2d at 237.

87. *See, e.g., Pinneke*, 623 F.2d at 550; *J.D.*, 145 Cal. Rptr. at 572 (concluding SRS is medically “necessary and reasonable” and rejecting the conclusion that the surgery is cosmetic); *G.B.*, 145 Cal. Rptr. at 559 (same); *Minn. Dep’t of Pub. Welfare*, 257 N.W.2d at 821 (same). *But see Denise R.*, 347 N.E.2d at 895 (upholding the denial of coverage based upon the testimony of plaintiff’s treating physicians regarding the medical necessity of the procedure). In *Denise R.*, the court relied on a provision in the New York Medicaid Act that limited coverage to procedures that were medically necessary in upholding the commissioner’s denial of the plaintiff’s request for coverage. *Id.* (“[E]ligible persons are entitled to medical assistance which is ‘necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with his capacity for normal activity, or threaten some significant handicap.’” (footnote omitted) (quoting N.Y. SOC. SERV. LAW § 365-a, subdiv. 2)). The court determined the commissioner did not act arbitrarily in determining the procedure was not medically necessary, and thus not covered, because the commissioner relied upon the testimony of the plaintiff’s physicians, who had conflicting opinions on whether the procedure was medically necessary. *Id.* One of the plaintiff’s physicians testified that “petitioner [should] not be encouraged or misled into thinking that the operation could be performed at [his] [h]ospital” because the plaintiff suffered from severe psychopathology, but had “no formal disturbance of thinking, nor suicidal inclination.” *Id.* at 894. In 1998, New York promulgated a rule that requires the Department of Health to deny claims for coverage of SRS under the state Medicaid act. *See* N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l) (1998) (“Payment is not available for care, services, drugs, or supplies rendered for the purpose of gender reassignment (also known as transsexual surgery) or any care, services, drugs, or supplies intended to promote such treatment.”).

88. *See, e.g., Pinneke*, 623 F.2d at 549 (“Without any formal rulemaking proceedings or hearings, the Iowa Department of Social Services established an irrebutable presumption that the procedure of sex reassignment surgery can never be medically necessary when the surgery is a treatment for transsexualism”); *Minn. Dep’t of Pub. Welfare*, 257 N.W.2d at 818 (“The DPW Physician’s Handbook . . . states that the cost of transsexual surgery is not payable under the Medical Assistance Program.” (internal quotation marks omitted)); *G.B.*, 145 Cal. Rptr. at 556 (“[A] Medi-Cal bulletin . . . contained the following announcement: ‘All medical services

For example, in *Pinneke v. Preisser*, Pinneke, a male-to-female transsexual, sought coverage of her SRS under Iowa's Medicaid program.⁸⁹ At the time Pinneke requested coverage, the State had an unofficial policy of automatically denying coverage for SRS.⁹⁰ The Eighth Circuit found that Iowa's broad policy of exclusion was inconsistent with the purposes of the Federal Medicaid Act because the policy was enacted in the absence of a formal rulemaking procedure.⁹¹ The court further emphasized that the Medicaid agency should base its decision of whether Medicaid should cover a particular treatment on medical necessity rather than diagnosis.⁹² Finally, the Eighth Circuit underscored that the Medicaid recipient's physician, and not "clerical personnel or government officials," should determine whether a particular procedure is medically necessary for the recipient.⁹³ Courts in California and Minnesota have reached similar conclusions.⁹⁴

In California, Medi-Cal recipients continue to receive coverage for gender-confirming healthcare.⁹⁵ However, in Iowa and Minnesota, the decisions in *Pinneke* and *Doe v. Minnesota Department of Public Welfare* have been left with relatively little weight because both states have subsequently added provisions explicitly excluding SRS from coverage under their Medicaid programs.⁹⁶ As mentioned previously, the relevant Iowa administrative rule, which was enacted after *Pinneke*, excludes SRS as a form of cosmetic, reconstructive, or plastic surgery, which is defined as "surgery which can be expected primarily to improve physical appearance or which is

directly related to the diagnostic workup, surgical procedure, hormonal therapy or psychiatric care involved in trans-sexual surgery are not payable under the Medi-Cal Program."); *J.D.*, 145 Cal. Rptr. at 572 (same).

89. *Pinneke*, 623 F.2d at 547.

90. *Id.*

91. *Id.* at 549.

92. *Id.* at 549-50 (citing *White v. Beal*, 555 F.2d 1146, 1152 (3d Cir. 1977)).

93. *Id.* at 550.

94. See *Doe v. Minn. Dep't of Pub. Welfare*, 257 N.W.2d 816, 820 (Minn. 1977); *J.D. v. Lackner*, 145 Cal. Rptr. 570, 572 (Ct. App. 1978); *G.B. v. Lackner*, 145 Cal. Rptr. 555, 556 (Ct. App. 1978). In *J.D.*, the court made a broader statement about the medical necessity of SRS. The court determined that the state Medi-Cal program should cover SRS because "the proposed surgery is medically reasonable and necessary and that there is no other effective treatment method." 145 Cal. Rptr. at 572. The court further rejected the State's argument that the surgery is cosmetic or experimental. *Id.* ("We do not believe, by the wildest stretch of the imagination, that such surgery can reasonably and logically be characterized as cosmetic.").

95. THE TRANSGENDER LAW CTR. & THE CMTY. HEALTH ADVOCACY PROJECT, *MEDI-CAL AND GENDER REASSIGNMENT PROCEDURES 1* (2002), available at <http://www.transgenderlawcenter.org/pdf/MediCal%20Fact%20Sheet.pdf>.

96. See IOWA ADMIN. CODE r. 441-78.1(4) (2010); MINN. STAT. § 256B.0625, subdiv. 3a (2008) (amended 2011) ("Sex reassignment surgery is not covered."). As subsequently discussed in greater detail, the Eighth Circuit later held the Iowa regulatory provisions to be valid. *Smith v. Rasmussen*, 249 F.3d 755, 761 (8th Cir. 2001). Similar provisions exist in at least twenty-two other states. See Spade, *supra* note 4, at 511 n.20.

performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions.”⁹⁷

2. Cases Decided Under an Exclusionary Statute or Regulation

Turning to the cases decided under a specific prohibitory regulation or statute, to date, all of the courts that have been presented with an existing statutory or regulatory prohibition on the coverage of SRS have upheld the exclusionary provision and affirmed the denial of coverage.⁹⁸ The facts in these denial-of-coverage cases are generally consistent across the board. First, the plaintiff is seeking, at a minimum, either coverage of or reimbursement for SRS.⁹⁹ Second, the plaintiff seeking coverage qualifies as a categorically needy person under the Federal Medicaid Act and thus is entitled to the most expansive coverage.¹⁰⁰ Finally, the state has either a regulatory or statutory provision explicitly prohibiting coverage of SRS by the state Medicaid program.¹⁰¹

For example, in *Smith v. Rasmussen*, the Eighth Circuit upheld the Iowa Department of Human Services’ denial of the plaintiff’s request for coverage of SRS in accordance with an existing regulation that explicitly excluded coverage for surgeries performed as treatment for GID.¹⁰² The court specifically upheld the regulation as a reasonable “standard[] for

97. IOWA ADMIN. CODE r. 441-78.1(4).

98. See, e.g., *Smith*, 249 F.3d at 760; *Rush v. Parham*, 625 F.2d 1150, 1153 (5th Cir. 1980), *remanded to sub nom.* *Rush v. Johnson*, 565 F. Supp. 856 (N.D. Ga. 1983); *Ravenwood v. Daines*, No. 06-CV-6355-CJS, 2009 WL 2163105, at *13 (W.D.N.Y. July 17, 2009); *Casillas v. Daines*, 580 F. Supp. 2d 235, 247 (S.D.N.Y. 2008).

99. See, e.g., *Smith*, 249 F.3d at 757 (SRS); *Rush v. Parham*, 625 F.2d at 1152 (same); *Ravenwood*, 2009 WL 2163105, at *1 (electrolysis and SRS); *Casillas*, 580 F. Supp. 2d at 237 (hormones and SRS).

100. See, e.g., *Rush v. Parham*, 625 F.2d at 1153 (recipient of Supplemental Security Assistance); *Ravenwood*, 2009 WL 2163105, at *1 (same); *Casillas*, 580 F. Supp. 2d at 237 (same). *But see Smith*, 249 F.3d at 757 (medically needy). The court in *Smith* failed to address this distinction when rejecting the analysis in *Pinneke*. *Id.* at 760. The Federal Medicaid Act requires the participating states that elect to provide coverage to the medically needy to provide substantially less coverage to those persons in comparison to the categorically needy. See *supra* text accompanying notes 61–62. Accordingly, this distinction may provide a rationale for the court’s departure from its decision in *Pinneke*, which the Eighth Circuit never explicitly overruled in *Smith*.

101. See, e.g., *Smith*, 249 F.3d at 760 (citing IOWA ADMIN. CODE r. 441-78.1(4)(b)); *Ravenwood*, 2009 WL 2163105, at *1 (citing N.Y. COMP. CODES R. & REGS. tit. 18 § 505.2(d)(2009)); *Casillas*, 580 F. Supp. 2d at 237 (same). *Rush v. Parham* involved a slightly different situation because Georgia did not have a regulatory or statutory provision that explicitly excluded coverage of SRS, but rather relied upon a provision that excluded all experimental treatments. *Rush v. Parham*, 625 F.2d at 1153. Ultimately, the Fifth Circuit remanded the case to the federal district court to determine whether SRS could reasonably be classified as an experimental treatment. *Id.* at 1156–57, *remanded to sub nom.* *Rush v. Johnson*, 565 F. Supp. 856. The lower court ultimately determined that the state’s classification of the procedure as experimental was reasonable. *Rush v. Johnson*, 565 F. Supp. at 868.

102. *Smith*, 249 F.3d at 760–62.

determining the extent of medical assistance”¹⁰³ because “the Department . . . followed a rulemaking process and [had] considered the knowledge of the medical community.”¹⁰⁴ In its decision, the court rejected the plaintiff’s argument that the procedures used in determining the medical community’s perspective were inadequate because the Department failed to obtain opinions from medical professionals with actual experience treating individuals with GID.¹⁰⁵ However, as discussed in the next Part, a recent U.S. Tax Court decision may provide a basis for rejecting the validity of these statutes and regulations in future cases.

IV. OPENING THE DOOR TO THE FORMAL RECOGNITION OF THE MEDICAL NECESSITY OF GENDER-CONFIRMING HEALTHCARE

In *O’Donnabhain v. Commissioner*, the United States Tax Court concluded that O’Donnabhain’s expenses for hormone therapy and SRS, which she received as treatment for GID, were tax-deductible medical expenses.¹⁰⁶ O’Donnabhain’s psychotherapist diagnosed her with severe GID, as defined in the DSM-IV-TR, and treated her in accordance with the SOC.¹⁰⁷ O’Donnabhain’s triadic therapy consisted of hormone therapy, the real-life experience, and concluded with both sex reassignment and breast augmentation surgeries.¹⁰⁸ Although O’Donnabhain responded positively to hormone therapy and the real-life experience, her psychotherapist determined that O’Donnabhain’s continued “anxiety over the lack of congruence between her perceived gender and her anatomical sex . . . would impair her ability to function normally in society” and thus recommended SRS to treat her GID.¹⁰⁹ During the course of her triadic therapy, O’Donnabhain underwent a number of medical procedures, including electrolysis, plastic surgery to feminize her facial features,

103. *Id.* at 759 (quoting *Beal v. Doe*, 432 U.S. 438, 444 (1977)) (internal quotation marks omitted). The court specifically found the regulation reasonable because “the Department’s research demonstrated the evolving nature of the diagnosis and treatment of gender identity disorder and the disagreement regarding the efficacy of sex reassignment surgery.” *Id.* at 761.

104. *Id.* at 760. It was on this basis that the court distinguished the case from its holding in *Pinneke*, which invalidated an existing prohibition on coverage. *Id.* The court noted in particular that the Department “had not followed a formal rulemaking process, had not consulted medical professionals, and had disregarded the current accumulated knowledge of the medical community.” *Id.*

105. *Id.* at 761 (“‘Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs,’ as long as the care and services that the states provide ‘are provided in the best interests of the recipients.’” (quoting *Alexander v. Choate*, 469 U.S. 287, 303 (1985))).

106. *O’Donnabhain v. Comm’r*, 134 T.C. 34, 34 (2010), *acq.* 2011-47 I.R.B. 789. For a detailed analysis of *O’Donnabhain*, see Susan L. Megaard, *Scope of the Medical Expense Deduction Clarified and Broadened by New Tax Court Decision*, 112 J. TAX’N 353 (2010).

107. *O’Donnabhain*, 134 T.C. at 36.

108. *Id.* at 38.

109. *Id.* at 40.

hormone therapy, SRS, and breast augmentation surgery.¹¹⁰ O'Donnabhain listed her expenses associated with the hormone therapy, SRS, and breast augmentation as tax-deductible medical expenses on her tax return.¹¹¹ The Internal Revenue Service determined these expenses were not tax deductible, and O'Donnabhain appealed this decision.¹¹²

The court found that O'Donnabhain's expenses for SRS and hormone therapy were tax-deductible medical expenses because the procedures treated O'Donnabhain's GID.¹¹³ In reaching this conclusion, the court found that the medical community generally accepts triadic therapy as an appropriate and effective treatment for GID.¹¹⁴ The court further explicitly rejected the government's contention that the surgery was a non-deductible cosmetic surgery as defined by the Internal Revenue Code.¹¹⁵ Specifically, the court concluded that hormone therapy and SRS were medically necessary treatments because the patient's psychotherapist determined the procedures were medically necessary, a substantial proportion of professionals at the time agreed the procedures were medically necessary to treat GID, and experts from both sides agreed that "untreated GID can result in self-mutilation and suicide."¹¹⁶

While the court rejected the contention that O'Donnabhain's breast augmentation surgery was a tax-deductible medical expense, the applicability of this finding appears to be limited to the particular facts of this case. The court acknowledged that under the SOC, the treating mental health practitioner will recommend breast augmentation surgery for male-to-female transsexuals when hormone therapy does not result in sufficient breast development.¹¹⁷ Accordingly, the court found that because O'Donnabhain exhibited sufficient breast growth as a result of the hormone

110. *Id.* at 41-42.

111. *Id.* at 42.

112. *Id.*

113. *Id.* at 65.

114. *Id.* at 65-67.

115. *Id.* In the course of reaching this result, the court also determined that GID is a disease for the purpose of the Internal Revenue Code because of:

(1) GID's widely recognized status in diagnostic and psychiatric reference texts as a legitimate diagnosis, (2) the seriousness of the condition as described in learned treatises in evidence and as acknowledged by all three experts in this case; . . . [and] (4) the consensus in the U.S. Courts of Appeals that GID constitutes a serious medical need for purposes of the Eighth Amendment . . .

Id. at 63. The Internal Revenue Code defines *cosmetic surgery* as "any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease." I.R.C. § 213(d)(9)(B) (2006).

116. *O'Donnabhain*, 134 T.C. at 76. Because the court found that the SRS and hormone therapy were medically necessary, it declined to address whether the tax code required tax-deductible treatments to be medically necessary. *Id.* at 75-76.

117. *Id.* at 72.

therapy, her breast augmentation surgery was unnecessary to treat her GID and thus was a non-deductible cosmetic expense.¹¹⁸ However, considering the weight the court gave to the SOC in its analysis, the court likely would reach a different result if presented with a case where the individual did not have substantial breast development and the patient's physician has properly documented that fact in accordance with the SOC.¹¹⁹

O'Donnabhain sets forth a number of findings that bear on whether state Medicaid plans should cover SRS and other gender-confirming healthcare. The next Part will examine the potential effect these findings could have on the coverage of treatment for GID.

V. REMOVING THE CONSTRAINTS TO MEDICAID COVERAGE OF GENDER-CONFIRMING HEALTHCARE

This Part explores the potential impact of *O'Donnabhain* and other recent developments on the coverage of SRS and related gender-confirming healthcare by Medicaid. First, this Part examines *O'Donnabhain's* possible effect on the courts' recognition that SRS and other gender-confirming healthcare may be medically necessary in some circumstances. Second, this Part analyzes how the increasing medical and judicial recognition of the medical necessity of these procedures impacts the validity of state laws explicitly excluding coverage of SRS and other gender-confirming healthcare under the standards set forth in the Federal Medicaid Act.

A. MOVING TOWARDS THE FORMAL RECOGNITION OF THE MEDICAL NECESSITY OF SEX REASSIGNMENT SURGERY AND OTHER GENDER-CONFIRMING HEALTHCARE

As discussed above, several federal courts construe the Federal Medicaid Act to require states to provide the categorically needy with medically necessary treatment falling under five specific categories.¹²⁰ Courts have further found that this medical necessity designation encompasses two separate levels: general medical necessity, which is determined by state legislatures or agencies; and specific medical necessity, which is determined by the treating physician in accordance with reasonable guidelines.¹²¹

First, this Subpart argues that in light of *O'Donnabhain's* findings and the growing consensus in the medical community regarding the

118. *Id.* at 72–73.

119. *See id.* at 73 (“[G]iven the contemporaneous documentation of the breasts’ apparent normalcy and the failure to adhere to the Benjamin standards’ requirement to document breast-engendered anxiety to justify the surgery, we find that petitioner’s breast augmentation surgery did not fall within the treatment protocols of the Benjamin standards and therefore did not ‘treat’ GID within the meaning of section 213(d)(9)(B).”); *see also* Megaard, *supra* note 106, at 360 (“The majority’s reasoning here leaves the door open for persons with GID who do produce such evidence to deduct the cost of their breast surgery because it treats their disease.”).

120. *See supra* notes 59–60, 63–64 and accompanying text.

121. *See supra* text accompanying notes 67–68.

appropriateness of SRS and other gender-confirming healthcare as treatments for GID, courts, legislatures, and state Medicaid agencies should recognize that these procedures are generally medically necessary to treat some cases of GID. Second, this Subpart argues that Medicaid agencies and courts reviewing claims for coverage should use the SOC as a guideline for reviewing a physician's assessment of an individual's specific medical need for the treatment in question.

1. The General Medical Necessity of Sex Reassignment Surgery and Other Gender-Confirming Healthcare

In reviewing whether a form of treatment is generally medically necessary for the purposes of Medicaid, courts focus on whether the medical community generally accepts the specified treatment “as an effective and proven treatment.”¹²² Past cases and the statutory and regulatory provisions explicitly excluding coverage indicate that state Medicaid agencies are, for the most part, unwilling to recognize the general medical necessity of SRS and other gender-confirming healthcare.¹²³ In support of their conclusion that SRS and other forms of gender-confirming care are not medically necessary, state agencies and legislatures have provided three basic rationales. The first is that SRS is not generally medically necessary because the medical community does not agree that SRS is an appropriate and effective treatment for GID.¹²⁴ The second justification is that these GID treatments are experimental treatments that are potentially dangerous to the patient.¹²⁵ The third and final justification courts point to in rejecting claims for coverage of these treatments is the availability of alternative forms of treatment for GID—especially hormone therapy and psychotherapy.¹²⁶ Although these rationales may have been true at one time, they now ring hollow in light of the shift in the perspective of the greater medical

122. *Weaver v. Reagen*, 886 F.2d 194, 199 (8th Cir. 1989); *accord* *Hern v. Beye*, 57 F.3d 906, 911 (10th Cir. 1995); *see supra* notes 71–72 and accompanying text.

123. *See* statutes and regulations cited *supra* notes 78–80. All courts having the opportunity to review these provisions have upheld them as reasonable under the Federal Medicaid Act. *See, e.g.,* *Smith v. Rasmussen*, 249 F.3d 755, 761 (8th Cir. 2001) (Iowa's regulation); *Casillas v. Daines*, 580 F. Supp. 2d 235, 238 (S.D.N.Y. 2008) (New York's regulation); *Rush v. Johnson*, 565 F. Supp. 856, 866–68 (N.D. Ga. 1983) (holding that the state properly denied coverage of Rush's SRS under Georgia's regulation denying coverage for experimental treatments). Two previous courts recognized the general medical necessity of SRS; however, these cases currently have little weight given that the states subsequently passed statutory and regulatory provisions explicitly excluding coverage of SRS. *See* *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980); *Doe v. Minn. Dep't of Pub. Welfare*, 257 N.W.2d 816, 819 (Minn. 1977). As discussed in Part III.B, not all states have statutory or regulatory provisions that preclude coverage for hormone therapy, but rather some limit the exclusion solely to SRS.

124. *See* *Smith*, 249 F.3d at 760; *Rush v. Johnson*, 565 F. Supp. at 868.

125. *See* *Casillas*, 580 F. Supp. 2d at 238; *Rush v. Johnson*, 565 F. Supp. at 868. *But see* *Smith*, 249 F.3d at 760 (acknowledging that SRS is not an experimental form of treatment).

126. *See* *Smith*, 249 F.3d at 760–61.

community with respect to the medical necessity of SRS and recent judicial examination of the appropriateness of this treatment in contexts other than Medicaid coverage. These rationales will be discussed in turn.

With respect to the first rationale, courts, legislatures, and state Medicaid agencies should recognize the medical necessity of these treatments because the medical community has, in fact, arrived at the general consensus that SRS, and more broadly those treatments included in the SOC, may be an appropriate and effective treatment for GID in some cases. One way in which the medical community has acknowledged that these forms of treatment are appropriate and effective for treating GID is by consistently citing the SOC as an authoritative source for effectively treating GID in psychiatric and medical texts.¹²⁷ Additionally, the AMA itself published a resolution that explicitly recommends that public and private insurers cover treatment for GID.¹²⁸ The medical and psychiatric communities have also acknowledged that SRS is an appropriate and effective treatment for GID through their publication of several scientific studies, each of which demonstrates the overall effectiveness of SRS.¹²⁹

The existence of this general consensus is further evidenced by the fact that the courts, albeit in other contexts, have increasingly recognized its existence and have thus found that SRS and other forms of gender-confirming healthcare may be medically necessary in some cases. For example, in *O'Donnabhain*, the United States Tax Court specifically found that the medical profession broadly accepts the treatment sequence outlined

127. *O'Donnabhain v. Comm'r*, 134 T.C. 34, 65 (2010), *acq.* 2011-47 I.R.B. 789 (“The Benjamin standards are widely accepted in the psychiatric profession, as evidenced by the recognition of the standards’ triadic therapy sequence as the appropriate treatment for GID and transsexualism in numerous psychiatric and medical reference texts.”); *id.* at nn.44-45; *see, e.g.*, DSM-IV-TR MENTAL DISORDERS, *supra* note 11, at 1083 (“The treatment of these conditions, although not as well based on scientific evidence as some psychiatric disorders, has been carefully scrutinized by multidisciplinary committees of specialists within the Harry Benjamin International Gender Dysphoria Association for over 20 years.”); KAPLAN & SADOCK’S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, *supra* note 28, at 1988 (“An extensive set of clinical management guidelines for treatment of adults with gender identity disorder is published by the Harry Benjamin International Gender Dysphoria Association.”); AM. MED. ASS’N HOUSE OF DELEGATES, RESOLUTION: 122 (A-08), REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS 1, 2-3 n.7 (2008), *available at* http://www.tgender.net/taw/ama_resolutions.pdf (“An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID”); Lawrence, *supra* note 15, at 449-50.

128. *See* AM. MED. ASS’N HOUSE OF DELEGATES, *supra* note 127, at 2 (“[It is resolved] [t]hat the AMA support public and private health insurance coverage for treatment of gender identity disorder”).

129. *See supra* notes 54-55 and accompanying text; *see also* AM. MED. ASS’N HOUSE OF DELEGATES, *supra* note 127, at 2-3 n.7 (citing numerous medical research studies demonstrating the effectiveness of various types of gender-confirming healthcare, including SRS and hormone therapy).

in the SOC—which includes the option of SRS—as being an effective and proven treatment for GID.¹³⁰ In its opinion the court stated,

[T]he evidence establishes that cross-gender hormone therapy and sex reassignment surgery are well-recognized and accepted treatments for severe GID. The evidence demonstrates that hormone therapy and sex reassignment surgery to alter appearance (and, to some degree, function) are undertaken by GID sufferers in an effort to alleviate the distress and suffering occasioned by GID, and that the procedures have positive results in this regard in the opinion of many in the psychiatric profession, including petitioner's and respondent's experts.¹³¹

In addition, the United States Tax Court acknowledged that a number of other courts “have also concluded in a variety of contexts that sex reassignment surgery for severe GID or transsexualism is medically necessary.”¹³² The court also recognized that a number of courts have identified the SOC “as representing the consensus of the medical profession regarding the appropriate treatment for GID or transsexualism.”¹³³

Second, the medical profession no longer views SRS and other gender-confirming healthcare as experimental and thus as a potentially dangerous form of treatment for GID.¹³⁴ As mentioned in Part II.A, the first full SRS was performed in Germany approximately eighty years ago.¹³⁵ Since that time, physicians have continued to treat persons diagnosed with GID in the same manner—with hormone therapy, SRS, or a combination thereof. Further, the SOC, and by extension its component parts, has persisted as the most utilized treatment regimen for GID for nearly forty years, with only minor revisions.¹³⁶ Given that the medical community has continued to consistently use SRS and hormone therapy to treat persons with GID, it

130. *O'Donnabhain*, 134 T.C. at 64–71.

131. *Id.* at 70 (footnote omitted).

132. *Id.* at 75–76 (citing *Meriwether v. Faulkner*, 821 F.2d 408, 412 (7th Cir. 1987); *Pinneke v. Preisser*, 623 F.2d 546, 548 (8th Cir. 1980); *Sommers v. Iowa Civil Rights Comm'n*, 337 N.W.2d 470, 473 (Iowa 1983); *Doe v. Minn. Dep't of Pub. Welfare*, 257 N.W.2d 816, 819 (Minn. 1977); *Davidson v. Aetna Life & Cas. Ins. Co.*, 420 N.Y.S.2d 450, 453 (Sup. Ct. 1979)).

133. *Id.* at 66–67 (citing *Gammatt v. Idaho State Bd. of Corr.*, No. CV05-257-S-MHW, 2007 WL 2186896, at *8 (D. Idaho July 27, 2007); *Houston v. Trella*, No. 04-1393(JLL), 2006 WL 2772748, at *20 (D.N.J. Sept. 25, 2006); *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 158 (D. Mass. 2002); *Farmer v. Hawk-Sawyer*, 69 F. Supp. 2d 120, 121 n.3 (D.D.C. 1999)).

134. AM. MED. ASS'N HOUSE OF DELEGATES, *supra* note 127, at 1 (“Health experts in GID, including WPATH, have rejected the myth that such treatments are ‘cosmetic’ or ‘experimental’ and have recognized that these treatments can provide *safe* and effective treatment for a serious health condition . . .” (emphasis added)).

135. RUDACILLE, *supra* note 6, at 44; Lawrence, *supra* note 15, at 423.

136. See *Standards of Care*, *supra* note 17; sources cited *supra* note 127.

defies common sense to categorize these forms of treatment as experimental.¹³⁷

Finally, the availability of alternative forms of treatment, including hormone therapy and psychotherapy, should be dismissed as a viable rationale because SRS is medically necessary to treat some persons with GID. It is significant to note that persons with GID “have different aims and desires for their bodies and express gendered characteristics in ways that make the most sense to those needs and desires.”¹³⁸ Consequently, while it is true that hormone therapy or psychotherapy may be sufficient alone to treat *some* persons with GID, it is not a one-size-fits-all treatment, and thus many persons with severe GID find hormone therapy or psychotherapy alone to be ineffective.¹³⁹

2. The Standards of Care as a Guideline for Specific Medical Necessity

In light of the recognized authority of the SOC within the medical community and in many courts, the Medicaid agencies and courts should use these standards to test whether a physician’s determination that a specific treatment is medically necessary is well grounded in reasonable standards. In determining the specific medical necessity of a particular procedure under the Medicaid Act, courts generally defer to the opinion of the treating physician.¹⁴⁰ *O’Donnabhain* followed this approach and deferred to the physician’s opinion of the medical necessity of the hormone treatments and SRS.¹⁴¹ However, when considering the specific medical necessity of the breast augmentation surgery, the court required that the procedure be medically necessary under the SOC.¹⁴² While this approach seems more restrictive for GID patients, it may strike an appropriate balance between broadening the procedures Medicaid recognizes as medically necessary for treating GID, while at the same time ensuring that individuals ground their claims in the standards the medical community recognizes as delineating the appropriate treatment for GID.

Although judicial recognition of the medical necessity of gender-confirming healthcare for persons diagnosed with GID, as discussed above,

137. See sources cited *supra* note 127.

138. Spade, *supra* note 4, at 498.

139. *O’Donnabhain v. Comm’r*, 134 T.C. 34, 67 (2010), *acq.* 2011-47 I.R.B. 789 (“[P]etitioner’s expert Dr. Brown contends that in the case of severe GID, sex reassignment surgery is the *only* known effective treatment; indeed, Dr. Brown was unaware of any case where psychotherapy alone had been effective in treating severe GID.” (emphasis added)); KAPLAN & SADOCK’S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, *supra* note 28, at 1988 (“When patient gender dysphoria is severe and intractable, sex reassignment may be the best solution.”); Lawrence, *supra* note 15, at 443 (“Individual psychotherapy is unlikely to lead to remission of gender dysphoria . . .”).

140. See *supra* notes 75–76.

141. *O’Donnabhain*, 134 T.C. at 74–76.

142. *Id.* at 72–73.

would go a long way toward ensuring Medicaid coverage in states without statutory or regulatory provisions excluding care, this type of recognition will likely not function as a cure-all in the states with existing exclusionary regulatory and statutory provisions. In these states, courts faced with challenges to denials of coverage have universally upheld the denial of coverage in accordance with the exclusionary provision.¹⁴³ This is true even when a court has previously found SRS to be a medically necessary procedure that the Medicaid agency may not refuse to cover on the theory that the procedure is cosmetic or experimental.¹⁴⁴ In the next Subpart, this Note will argue that either the states should repeal these statutory and regulatory provisions prohibiting coverage of SRS and other gender-confirming healthcare, or, in the alternative, the courts should declare these provisions judicially invalid under the Federal Medicaid Act because the underlying rationale for these provisions is no longer reasonable.

B. REMOVING THE CONSTRAINTS TO MEDICAID COVERAGE OF GENDER-CONFIRMING HEALTHCARE THROUGH THE REPEAL OF THE EXCLUSIONARY PROVISIONS

Ideally, the state legislatures and administrative agencies that enacted the statutory and regulatory provisions explicitly excluding coverage of SRS and other gender-confirming healthcare would repeal them in order to come into compliance with the Federal Medicaid Act. In passing these statutes and regulations, the state legislatures and agencies relied upon the conclusion that there was no medical consensus supporting the fact that SRS is an appropriate and effective treatment for persons diagnosed with GID, the procedure was experimental, or that alternative forms of treatment existed.¹⁴⁵ Further, in many cases, the legislature or agency enacted these statutory or regulatory provisions several years ago and did not include a process under which it could reexamine the basis for the statute or regulation in the event that the medical community changed its view of the appropriateness and effectiveness of this form of treatment.

For example, Iowa passed its regulation approximately fifteen years ago after the Iowa Foundation for Medical Care, under a contract with the Iowa Department of Health, performed a medical literature review and contacted various organizations regarding treatment for GID.¹⁴⁶ At the conclusion of its review, the Foundation determined that there was “a lack of consensus on

143. See *supra* note 98.

144. Compare *Pinneke v. Preisser*, 623 F.2d 546, 549–50 (8th Cir. 1980) (finding SRS to be a medically necessary treatment for GID), with *Smith v. Rasmussen*, 249 F.3d 755, 761 (8th Cir. 2001) (upholding a regulation excluding coverage of SRS).

145. See, e.g., *Smith*, 249 F.3d at 760.

146. *Id.* The Iowa Foundation for Medical Care “is a federally designated medical peer review organization that, among other things, monitors the quality of care and the appropriateness of certain medical procedures for payment under Medicare and Medicaid programs.” *Id.*

definition, diagnosis, and treatment” of GID.¹⁴⁷ The basis for this determination, at least in part, was the Foundation’s review of “research that indicated that hormone treatments, psychotherapy, and situational treatment may be more appropriate, and at times more effective, than [SRS].”¹⁴⁸ While this is certainly true, even today, the Foundation reported that “[t]he literature also revealed that the surgery can be appropriate and medically necessary for some people and that the procedure was not considered experimental.”¹⁴⁹ Ultimately, the Foundation recommended that the Iowa Medicaid program not cover SRS because of “the lack of consensus in the medical community and the availability of other treatment options.”¹⁵⁰

In addition to this report, the Department of Health relied on a survey of state Medicaid agencies indicating the number of state Medicaid plans that covered SRS when deciding to exclude SRS from coverage.¹⁵¹ Only eight of the forty-four states that responded to the survey indicated their Medicaid program covered SRS.¹⁵² Thus, while the report from the Foundation acknowledged that SRS may be medically necessary for some and that the medical community does not consider the procedure to be experimental, the State, relying in part on the survey of state Medicaid programs, ultimately elected to exclude the procedure as a “cosmetic” procedure.¹⁵³

While the Iowa Department of Health appropriately followed rulemaking procedure at the time it enacted the regulation, the state failed to consider the potential for changes in the medical community’s view of what constitutes appropriate treatment for GID. Indeed, there is no indication that the Department of Health even reconsidered the medical basis it offered for its exclusion when the plaintiff in *Smith* challenged the regulation in 2000.¹⁵⁴ This is particularly troubling in light of the fact that, given the courts’ increasing recognition of the medical necessity of various forms of gender-confirming healthcare, it is not clear that the original basis for this regulation still holds true.

Further militating against the current validity of Iowa’s medical basis for exclusion is the fact that, in some respects, it appears that Iowa relied on the lack of an *absolute* consensus, something the *O’Donnabhain* court dismissed as

147. *Id.*

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.* at 760–61.

152. *Id.* at 761.

153. *See id.* at 760–61; IOWA ADMIN. CODE r. 441-78.1(4) (2010).

154. *Smith*, 249 F.3d at 761. The state did resurvey the state Medicaid agencies, and the results of this survey revealed that only seven of the forty-seven responding states covered SRS. *Id.* at 761 n.5.

a basis for rejecting the medical necessity of this form of treatment.¹⁵⁵ Even without the judicial finding that absolute consensus is unnecessary, the mere fact that the medical community and the SOC recognize that SRS is not appropriate for all persons diagnosed with GID does not detract from the fact that the medical community generally agrees that SRS is the only effective treatment for many individuals with severe GID.¹⁵⁶ This type of variation in treatment for the same disorder is not uncommon for psychological disorders or medical diagnoses—even those with clear biological etiologies, such as schizophrenia or environmental allergies.¹⁵⁷ Further, studies have demonstrated the effectiveness of this mode of treatment for persons with severe GID.¹⁵⁸ In light of all these factors, legislatures and agencies in states with statutory or regulatory provisions excluding coverage of these forms of treatment for GID should repeal such provisions in order to comply with the requirements of the Federal Medicaid Act.

C. *REMOVING THE CONSTRAINTS TO MEDICAID COVERAGE OF GENDER-CONFIRMING HEALTHCARE THROUGH THE JUDICIAL INVALIDATION OF THE EXCLUSIONARY PROVISIONS*

Given the likely unpopularity of repealing these prohibitions,¹⁵⁹ this Subpart addresses the possible challenges a plaintiff could make to these

155. *O'Donnabhain v. Comm'r*, 134 T.C. 34, 69 (2010), *acq.* 2011-47 I.R.B. 789 (“[A] complete consensus on the advisability or efficacy of a procedure is not necessary . . .”).

156. *See id.* at 68 (citing *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997); *Sommers v. Iowa Civil Rights Comm’n*, 337 N.W.2d 470, 473 (Iowa 1983); *Doe v. Minn. Dep’t of Pub. Welfare*, 257 N.W.2d 816, 819 (Minn. 1977)); *supra* note 138 and accompanying text.

157. *See* NAT’L GUIDELINE CLEARINGHOUSE, PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA (2d ed. 2009), *available at* <http://www.guideline.gov/content.aspx?id=5217> (identifying several other ways of treating schizophrenia beyond medication, including various forms of psychosocial intervention and somatic therapies, such as electroconvulsive therapy); NAT’L INST. OF MENTAL HEALTH, SCHIZOPHRENIA 6–9 (2009), *available at* <http://www.nimh.nih.gov/health/publications/schizophrenia/schizophrenia-booklet-2009.pdf> (identifying genetics as one of the underlying causes of schizophrenia and listing several medications used to treat schizophrenia); De-Yun Wang, *Risk Factors of Allergic Rhinitis: Genetic or Environmental?*, 1 THERAPEUTICS & CLINICAL RISK MGMT. 115, 116 (2005) (“A genetic background in terms of a family history of atopic disease has been the strongest risk factor for the development of allergic symptoms, irrespective of the varying prevalence and environmental risk factors in different societies.”); *Allergic Rhinitis*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/000813.htm> (last visited Mar. 17, 2012) (listing several ways of treating allergic rhinitis, including lifestyle changes and avoidance techniques, allergy shots, and various medications).

158. *See supra* note 130 and accompanying text.

159. One criticism lodged by opponents in New York against a proposal aimed at expanding Medicaid coverage to include SRS was that that it would be “an outrageous abuse of taxpayer dollars.” Carl Campanile, *Let Taxpayers Foot Sex-Op Bill: Panel*, N.Y. POST (Sept. 29, 2011, 12:18 AM), http://www.nypost.com/p/news/local/let_taxpayers_foot_sex_op_bill_panel_syVzH88veFSKLnSXA76w9O (quoting state Conservative Party Chairman Mike Long) (internal quotation marks omitted). Another opponent of this effort stated simply that coverage

exclusionary provisions in court, which would allow the reviewing court to hold these provisions invalid as unreasonable and inconsistent with the Federal Medicaid Act. There are two potential claims a plaintiff could bring to challenge the validity of these provisions under the Federal Medicaid Act. First, a plaintiff could claim that the denial of coverage violates the plaintiff's right to medical assistance under the Federal Medicaid Act because the state plan discriminates on the basis of diagnosis in violation of 42 C.F.R. § 440.230(c) (hereinafter "Discrimination on the Basis of Diagnosis Claim").¹⁶⁰ Second, a plaintiff could allege that the denial of coverage violates the plaintiff's right to medical assistance under the Federal Medicaid Act because the state plan fails to provide medical assistance for medically necessary treatment, subject only to reasonable restrictions (hereinafter "Unreasonable Restrictions on Medically Necessary Treatment Claim").¹⁶¹

A Discrimination on the Basis of Diagnosis Claim would likely succeed given its success in previous cases. For example, the plaintiffs in *Doe v. Minnesota Department of Public Welfare* and *Pinneke v. Preisser* both successfully challenged their respective state Medicaid agency's denial of their claims under the theory that the state Medicaid agency's policy of denying these claims conflicted with the Federal Medicaid Act's prohibition on making coverage decisions based on diagnoses.¹⁶² However, the validity of these decisions was called into question after both the Iowa Department of Health and the Minnesota legislature enacted an official regulation and a law,

"doesn't seem to be appropriate." *Id.* (quoting Kemp Hannon, New York Senate Health Committee Chairman) (internal quotation marks omitted). Ultimately, the proposal to cover SRS under the New York Medicaid system failed. Carl Campanile, *Cuomo's Office Kills Plan for Taxpayer-Funded Sex-Change Surgeries*, N.Y. POST (Sept. 30, 2011, 1:13 PM), http://www.nypost.com/p/news/local/cuomo_office_kills_plan_for_taxpayer_gunUNXZ3BKLtcyLGbvtKVK. While the rationale for the opposition may not be immediately clear, it is evident that strong opposition to such coverage exists. *See A Transforming Debate*, MOD. HEALTHCARE, Aug. 14, 2006, at 36, 36 (noting that U.S. Senator Chuck Grassley, a republican from the State of Iowa, called the Governor of Washington, Christine Gregorie, to threaten a federal investigation after he learned that the Washington state appeals board had ordered Medicaid to reimburse two beneficiaries for their sex reassignment surgeries).

160. In bringing the first claim, the plaintiff could argue that the state plan provision is preempted by the Federal Medicaid Act under the Supremacy Clause of the United States Constitution. *See Pinneke v. Preisser*, 623 F.2d 546, 548 (8th Cir. 1980).

161. The plaintiff could potentially bring both of these claims under 42 U.S.C. § 1983 (2006). Currently, there is a split among the circuits as to whether the Federal Medicaid Act confers an individual right that the court may enforce under § 1983. For example, there is a split as to whether § 1396a(a)(10) confers an individual right that is enforceable under § 1983. *See, e.g., Watson v. Weeks*, 436 F.3d 1152, 1160 (9th Cir. 2006) (finding a right exists); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004) (same); *Casillas v. Daines*, 580 F. Supp. 2d 235, 246 (S.D.N.Y. 2008) (finding no individual right). While this Note acknowledges this split, this issue is beyond the scope of the Note, and thus, for the purposes of this Subpart, this Note assumes the Federal Medicaid Act confers an individual right that is enforceable under § 1983.

162. *Pinneke*, 623 F.2d at 549; *Doe v. Minn. Dep't of Pub. Welfare*, 257 N.W.2d 816, 820 (Minn. 1977).

respectively, excluding sex reassignment from coverage under their Medicaid plans.¹⁶³

While no plaintiff has challenged the Minnesota statutory provision excluding coverage of SRS under a Discrimination on the Basis of Diagnosis theory,¹⁶⁴ an Iowa plaintiff did unsuccessfully challenge the Iowa regulatory provision in *Smith v. Rasmussen*.¹⁶⁵ The plaintiff in *Smith* claimed that the new Iowa regulation discriminated on the basis of diagnosis and thus was invalid under the Federal Medicaid Aid.¹⁶⁶ The court, however, rejected this claim because the provision in the C.F.R. that prohibits states from denying coverage on the basis of diagnosis only applies to the services states are *required* to provide to the categorically and medically needy under the Federal Medicaid Act, and not necessarily to those services the state *elects* to provide to the medically needy.¹⁶⁷ Accordingly, the court found that because the Federal Medicaid Act does not require the state to provide the plaintiff—who was only medically needy—with physician’s services, which include SRS, the C.F.R. rule prohibiting denials based upon diagnosis did not apply to the state’s optional provision of such services.¹⁶⁸ However, given that Smith’s Discrimination on the Basis of Diagnosis Claim was dismissed because he was medically needy, rather than categorically needy, both *Pinneke* and *Doe v. Minnesota Department of Public Welfare* remain good law. Thus, if a categorically needy person challenged the existing exclusionary regulations in either state, he or she would likely be successful, especially in light of the judicially recognized medical necessity of SRS and other gender-confirming healthcare.

The second potential claim, the Unreasonable Restrictions on Medically Necessary Treatment Claim, has not been successfully raised in any case challenging an existing provision excluding coverage of SRS or other gender-confirming healthcare.¹⁶⁹ However, if a plaintiff could establish that

163. IOWA ADMIN. CODE r. 441-78.1(4) (2010); MINN. STAT. § 256B.0625, subdiv. 3a (2008) (amended 2011).

164. See generally *DeMare v. Minn. Dep’t of Human Servs.*, No. A06-803, 2006 WL 2533922 (Minn. Ct. App. Sept. 5, 2006) (no constitutional claim argued on appeal); *Hare v. Minn. Dep’t of Human Servs.*, 666 N.W.2d 427 (Minn. Ct. App. 2003) (decided on statutory grounds).

165. *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001).

166. *Id.* at 761–62.

167. *Id.* See generally *supra* notes 61–62 and accompanying text (outlining the Federal Medicaid Act’s differential treatment of the categorically needy and medically needy).

168. *Smith*, 249 F.3d at 757–58, 761–62. The Eighth Circuit has not addressed a case with an individual who is categorically needy, and thus the Eighth Circuit’s holding in *Pinneke* that such a denial amounts to an arbitrary denial on the basis of diagnosis in violation of 42 C.F.R. § 440.230(c) (2010) remains good law.

169. See, e.g., *Smith*, 249 F.3d at 756 (finding the regulation reasonable because the Department of Health passed the regulation in accordance with proper rulemaking procedure and based the regulation upon medical opinion); *Ravenwood v. Daines*, No. 06-CV-6355-CJS, 2009 WL 2163105, at *10–11 (W.D.N.Y. July 17, 2009) (denying the claim on the grounds that

the Federal Medicaid Act confers an individual right enforceable under § 1983,¹⁷⁰ this claim could still possibly prevail under the rationale used in *Weaver v. Reagen*.¹⁷¹ In *Weaver*, the plaintiffs challenged the state Medicaid agency's refusal to provide coverage for their AIDS treatment—a drug known as AZT.¹⁷² The state Medicaid agency based its denial on a state regulation, passed within a year of the plaintiff's request for coverage, which limited the covered uses of AZT to those approved by the Food and Drug Administration.¹⁷³ The Eighth Circuit ultimately found the regulation to be invalid, stating,

In the face of widespread recognition by the medical community and the scientific and medical literature that AZT is the only available treatment for most persons with AIDS, we find that Missouri Medicaid's approach to its coverage of the drug AZT is unreasonable and inconsistent with the objectives of the Medicaid Act. As in *Pinneke*, this approach “reflects inadequate solicitude for the applicant's diagnosed condition, the treatment prescribed by the applicant's physicians, and the accumulated knowledge of the medical community.”¹⁷⁴

Plaintiffs raising this second type of claim may draw several clear parallels to the *Weaver* case. First, the court in *Weaver* acknowledged that AZT was a necessary medical treatment for treating the plaintiffs' conditions.¹⁷⁵ Similarly, the medical community and several courts recognize SRS and other gender-confirming healthcare as being medically necessary for the treatment of some individuals diagnosed with GID.¹⁷⁶ Second, although the promulgating agency in *Weaver* considered medical knowledge in passing its regulation, the court still rejected the regulation because it did not represent the *current* consensus of the medical community.¹⁷⁷ *O'Donnabhain* acknowledged that the medical community generally recognizes SRS and other gender-confirming healthcare as acceptable and effective treatments

the plaintiff has no enforceable right and thus no claim under § 1983); *Casillas v. Daines*, 580 F. Supp. 2d 235, 241–46 (S.D.N.Y. 2008) (same).

170. See *supra* note 162.

171. *Weaver v. Reagen*, 886 F.2d 194, 198–99 (8th Cir. 1989).

172. *Id.* at 196.

173. *Id.*

174. *Id.* at 200 (quoting *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980)).

175. *Id.* at 198 (“It would be improper for the State of Missouri to interfere with a physician's judgment of medical necessity by limiting coverage of AZT based on criteria that admittedly do not reflect *current* medical knowledge or practice.” (emphasis added)).

176. See *supra* Part V.A.

177. *Weaver*, 886 F.2d at 198 (“It would be improper for the State of Missouri to interfere with a physician's judgment of medical necessity by limiting coverage of AZT based on criteria that admittedly do not reflect current medical knowledge or practice.”).

for persons with GID.¹⁷⁸ Finally, *O'Donnabhain* and other courts also recognize that SRS and other gender-confirming care may be the only effective treatment for some persons with severe GID.¹⁷⁹ Consequently, the Eighth Circuit's rationale in *Weaver* should also apply to the regulations and statutory provisions excluding SRS as a covered treatment for GID. In accordance with these theories, a reviewing court faced with either of these two challenges to exclusionary provisions should judicially invalidate the provisions because the initial rationales supporting exclusion no longer reflect the current consensus of the medical community and thus are unreasonable and inconsistent with the Federal Medicaid Act.

VI. CONCLUSION

The ruling in *O'Donnabhain* has the potential to have a widespread impact on the judicial recognition of the medical necessity of SRS and gender-confirming healthcare. *O'Donnabhain* laid the groundwork for courts, legislatures, and agencies to similarly recognize the current consensus in the medical community that SRS is not only an appropriate and effective treatment for GID in some cases, but that in many cases it is also the *only* effective form of treatment. States with statutory or regulatory provisions excluding coverage of SRS and other gender-confirming healthcare should repeal these provisions in accordance with the current state of medical knowledge. If the legislatures fail to repeal these statutes in order to come into compliance with the Federal Medicaid Act, courts should hold the provisions invalid when challenged because these regulations both conflict with the Federal Medicaid Act, as they constitute an arbitrary denial of services on the basis of diagnosis, and are unreasonable because they do not represent the current consensus of the medical community.

178. *O'Donnabhain v. Comm'r*, 134 T.C. 34, 68–69 (2010), *acq.* 2011-47 I.R.B. 789; *see also supra* note 127.

179. *O'Donnabhain*, 134 T.C. at 68 (citing *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997); *Sommers v. Iowa Civil Rights Comm'n*, 337 N.W.2d 470, 473 (Iowa 1983); *Doe v. Minn. Dep't of Pub. Welfare*, 257 N.W.2d 816, 819 (Minn. 1977)).