

# Beyond Categorical Exclusions: Access to Transgender Healthcare in State Medicaid Programs

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*This Note addresses a major barrier to care that transgender individuals face: “categorical exclusions” barring payment for healthcare related to gender transition in state Medicaid programs, along with policies prohibiting payment for such care when deemed “cosmetic.” It first argues that because the dysphoria and discrimination that transgender individuals experience affect their quality of life and mental well-being, and derive from a discord between their appearance and gender identity, those considerations should be taken into account in the legal determination of medical necessity. As medical studies and the views of major medical associations demonstrate, healthcare for gender transition has been found medically necessary for some individuals to mitigate their gender dysphoria.*

*This Note then describes the arguments for and against the invalidity of categorical exclusions and other policies that deny transgender individuals access to medically necessary care, focusing on Section 1557 of the Affordable Care Act as well as more general provisions of federal Medicaid law. It then examines these issues in the context of litigation regarding New York’s limitations on transgender healthcare, which ultimately culminated in a medical necessity standard. Finally, it considers the arguments that Medicaid coverage for gender transition would be too costly, and that requiring states to cover such care would undermine principles of federalism.*

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## I. INTRODUCTION

“Cosmetic” and “experimental” are words of choice for health insurers seeking to deny claims for transgender individuals hoping to undergo medical transition.<sup>1</sup> There is a long history of deeming medical care for transgender people seeking to transition as unneeded or unproven treatment, medically unnecessary and not worth payment by private insurance premiums or the public treasury. This tactic has taken two forms: as a means to justify a categorical ban on any transition coverage, or more recently a way of cordoning off a set of specific procedures as cosmetic or unproven.

Wholesale categorical exclusions are increasingly viewed as invalid, whether under Affordable Care Act regulations or as a matter of Medicare coverage determinations or federal Medicaid law.<sup>2</sup> Even among jurisdictions that have repealed categorical exclusions in their Medicaid programs, however, many still place restrictions on procedures deemed cosmetic. These states assert that those procedures, among them electrolysis, facial reconstruction, voice therapy, and sexual reassignment surgery, are not properly considered medically necessary treatment for gender dysphoria.<sup>3</sup> The medical and scientific consensus, however, stands in contrast to that view. In particular, medical studies now demonstrate that these transition-related procedures can be medically necessary for transgender individuals as a way to mitigate their gender dysphoria. Moreover, access to such treatment can substantially advance their acceptance by society as a whole, and thus reduce the pervasive discrimination — a known health risk — still faced by transgender people.

As a result, this Note argues that statutes, regulations or policies that bar payment for procedures considered “cosmetic” should therefore be understood to violate the Affordable Care Act, as well as federal Medicaid law, by discriminating on the basis of diagnosis and by failing to provide medically necessary treatment. New York’s experience could serve as a bellwether for other states, with an iterative development of regulatory policy in response to litigation in the case of *Cruz v. Zucker*, ultimately

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1. See *infra* Part II and notes 23 & 26.

2. See *infra* Part III, and note 113 and accompanying text.

3. See, e.g., *infra* note 126.

leading to a medical necessity standard for transgender healthcare.<sup>4</sup>

This Note proceeds in four parts. Part II sets forth the scientific literature on gender dysphoria and the medical treatment often prescribed to alleviate it, and explores the link between the discrimination that transgender individuals face and access to transition-related medical care. Part III discusses the existence of “categorical exclusions” banning all insurance coverage for gender transition in state Medicaid programs, along with other specific restrictions on such care. It then discusses arguments for and against their invalidity on the basis of Section 1557 of the Affordable Care Act (which prohibits categorical exclusions and forbids discrimination in treating gender dysphoria), as well as more general federal Medicaid law. Part IV examines these issues in the context of litigation against New York’s categorical exclusion and the gradual transition to a medical necessity standard. Finally, Part V considers policy arguments against covering transition-related healthcare.

## II. BEING TRANSGENDER: HEALTHCARE AND DISCRIMINATION

For many though not all transgender people — individuals whose gender identity differs from their sex assigned at birth — the transition from their natal sex to living in accord with their gender identity is inextricably tied to medical services.<sup>5</sup> According to one survey, 62% of transgender people take cross-sex hormones, and an additional 23% wish to receive such treatment.<sup>6</sup> Transgender people also often wish to pursue surgical interventions but are more rarely able to do so, due to barriers to care and the expense of such procedures. For example, according to a survey by the National Transgender Task Force, 18% of transgender women<sup>7</sup> have had breast augmentation surgery, while an addi-

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4. Cruz v. Zucker, 195 F. Supp. 3d 554 (S.D.N.Y. 2016).

5. Liza Khan, *Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform*, 11 YALE J. HEALTH POL’Y L. & ETHICS 375, 379 (2011).

6. Jaime Grant et al., *National Transgender Discrimination Survey Report on Health and Health Care*, NAT’L CTR. FOR TRANSGENDER EQUAL. & NAT’L GAY & TRANSGENDER TASKFORCE 10 (Oct. 2010), [http://www.thetaskforce.org/static\\_html/downloads/resources\\_and\\_tools/ntds\\_report\\_on\\_health.pdf](http://www.thetaskforce.org/static_html/downloads/resources_and_tools/ntds_report_on_health.pdf) [https://perma.cc/4QDW-RBT9].

7. Those assigned male at birth who identify as female. See NAT’L CTR. FOR TRANSGENDER EQUAL., *Transgender Terminology* (2014), <https://www.nawj.org/uploads/>

tional 54% wish to have that surgery someday.<sup>8</sup> 20% of transgender women have had genital surgery, while an additional 60% wish ultimately to undergo it.<sup>9</sup> For transgender men,<sup>10</sup> 41% have had chest surgery<sup>11</sup> and another 51% desire to do so, while 20% have had a hysterectomy and another 57% wish to undergo one.<sup>12</sup> Only a very small percentage (under 5%) of transgender men have had genital reconstructive surgery, while anywhere from one-quarter to one-half wish to have some variant of that surgery.<sup>13</sup>

These medical interventions are by now well-understood as medically necessary for at least some transgender individuals. All leading medical organizations, including the American Medical Association and the American Psychiatric Association, recognize gender dysphoria<sup>14</sup> as a serious medical problem requiring treatment in some form.<sup>15</sup> The Diagnostic and Statistical Manual of Mental Disorders — the definitive diagnostic guide for mental health practitioners<sup>16</sup> — recognizes gender dysphoria as a form of chronic distress and indicates that cross-sex hormones and vari-

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files/annual\_conference/session\_materials/transgender/transgender\_terminology-ncte.pdf [https://perma.cc/VRX3-P9V9].

8. Grant et al., *supra* note 6, at 11.

9. *Id.*

10. Those assigned female at birth who identify as male. See NAT'L CTR. FOR TRANSGENDER EQUAL., *Transgender Terminology*, *supra* note 7.

11. "Chest surgery" for a transgender man refers to a mastectomy and the creation of a male chest. WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH [WPATH], *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* 57 (2011), [https://s3.amazonaws.com/amo\\_hub\\_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20\(2\)\(1\).pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf) [https://perma.cc/AJ95-27W7].

12. Grant et al., *supra* note 6, at 12.

13. *Id.*

14. According to the American Psychiatric Association, "[g]ender dysphoria involves a conflict between a person's physical or assigned gender and the gender with which he/she/they identify." AM. PSYCHIATRIC ASS'N, *What is Gender Dysphoria* (2016), <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> [https://perma.cc/4FHR-VMSD].

15. *Id.* See also AM. MED. ASS'N HOUSE OF DELEGATES, *Resolution 122 (A-08): Removing Financial Barriers to Care for Transgender Patients*, at 10 (2008), [http://www.tgender.net/taw/ama\\_resolutions.pdf](http://www.tgender.net/taw/ama_resolutions.pdf) [https://perma.cc/CXE9-6AHG] (recognizing that "gender identity disorder is a serious medical condition" and that "delaying treatment for GID can cause and/or aggravate additional serious and expensive health problems, such as stress-related physical illnesses, depression, and substance abuse problems, which further endanger patients' health and strain the health care system").

16. *US Mental Health "Bible" DSM-5 Updated*, BBC (May 19, 2013), <http://www.bbc.com/news/health-22570857> [https://perma.cc/RKS4-H6SA].

ous forms of surgery can be appropriate treatment.<sup>17</sup> Notably, the World Professional Association for Transgender Health (WPATH), a group of physicians and other specialists in transgender healthcare, has since the 1970s developed and refined standards for the treatment of gender dysphoria; these “Standards of Care” are acknowledged to be the accepted and most comprehensive guidance for medical providers treating transgender patients.<sup>18</sup> As the Standards of Care note, the medical literature is clear that upon the satisfaction of certain preconditions,<sup>19</sup> various forms of medical treatment can be medically necessary to ameliorate gender dysphoria. Though the definition of “medical necessity” can be murky, insurers commonly define it as the services that a “prudent physician” would provide to a patient to prevent, diagnose, or treat a medical ailment, as deter-

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17. DSM-5 GUIDEBOOK: THE ESSENTIAL COMPANION TO THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION 283, 285–86 (Donald W. Black & Jon E. Grant eds., 2014).

18. See Madeline B. Deutsch & Jamie L. Feldman, *Updated Recommendations from the World Professional Association for Transgender Health Standards of Care*, 87 AM. FAM. PHYSICIAN 89 (2013). See also AM. MED. ASS’N HOUSE OF DELEGATES, *supra* note 15 (noting that “the World Professional Association for Transgender Health . . . is the leading international, interdisciplinary professional organization devoted to the understanding and treatment of gender identity disorders, and has established internationally accepted Standards of Care for providing medical treatment for people with GID”); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1170 (N.D. Cal. 2015) (“The World Professional Association for Transgender Health (‘WPATH’) has developed Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (‘Standards of Care’), which are recognized as authoritative standards of care by the American Medical Association, the American Psychiatric Association, and the American Psychological Association.”). Further, the United States government has in its regulatory guidance repeatedly recognized WPATH as a leader in setting standards for transgender healthcare. See *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. 31,376, 31,435 n.263 (May 18, 2016) (HHS Section 1557 regulation); *Discrimination on the Basis of Sex*, 81 Fed. Reg. 39,108, 39,136 n.166 (June 15, 2016) (Department of Labor regulation). The Centers for Medicare and Medicaid moreover relied extensively on WPATH’s research and testimony in concluding that Medicare’s prohibition on covering transition-related care was inconsistent with Medicare’s medical necessity standard, on the ground that “transsexual surgery is an effective treatment for persons with severe gender dysphoria.” NCD 140.3, *Transsexual Surgery*, DAB No. 2576 (U.S. Dep’t of Health & Human Servs. May 30, 2014), 2014 WL 2558402, at \*12–\*13, \*17 (“The new evidence indicates that the WPATH standards of care have attained widespread acceptance.”).

19. These preconditions include a period of social transition and cross-sex hormone therapy, and are designed to ensure that the individual has experience living in accord with his or her gender identity and remains committed to undergoing irreversible procedures. See, e.g., WPATH, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* 58–61 (2011), [https://s3.amazonaws.com/amo\\_hub\\_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20\(2\)\(1\).pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf) [<https://perma.cc/AJ95-27W7>].

mined by “generally accepted standards of medical practice.”<sup>20</sup> In the context of Medicaid, which imposes such a standard, courts determine whether a coverage limitation violates the medical necessity standard based on the totality of the evidence, including the views of individual physicians on their patients’ needs, published medical studies, and the determinations of recognized medical associations.<sup>21</sup> WPATH’s Standards of Care note that numerous independent studies “have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes” for patients’ mental health, including declines in depression, anxiety, and related measures of psychopathology.<sup>22</sup>

While some procedures or treatments sought by transgender individuals have commonly been denied by insurers as “cosmet-

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20. AM. MED. ASS’N, *Statement of the American Medical Association to the Institute of Medicine’s Committee on Determination of Essential Health Benefits* (Jan. 14, 2011), <http://www.nationalacademies.org/hmd/~media/8D03963CAEB24450947C1AEC0CAECD85.ashx> [<https://perma.cc/LR3E-AFWK>]. See also Linda A. Bergthold, *Medical Necessity: Do We Need It?*, 14 HEALTH AFFAIRS 180, 181–82 (1995) (noting that the definition of “medical necessity” incorporates the medical community’s view of medically appropriate treatment for particular diagnoses along with an individual physician’s judgment). In the context of Medicaid coverage determinations, courts have held that “both the state and [a private] physician have roles in determining what medical measures are necessary” to correct or ameliorate a medical problem, so long as any limitations placed by the state are reasonable. *Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1252 (11th Cir. 2011); *Lankford v. Sherman*, 451 F.3d 496, 511 (8th Cir. 2006) (noting that “a state’s failure to provide Medicaid coverage for non-experimental, medically-necessary services within a covered Medicaid category is both per se unreasonable and inconsistent with the stated goals of Medicaid.”). The Eighth Circuit has held 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.” *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989).

21. *Cruz v. Zucker*, 195 F. Supp. 3d 554, 573 (S.D.N.Y. 2016) (noting that “testimony of individual physicians as well as any other evidence of prevailing medical knowledge is relevant to a court’s determination of medical necessity”). See also *Norsworthy*, 87 F. Supp. 3d at 1186–87 (determining whether sexual reassignment surgery was medically necessary under the WPATH standards, the views of the individual’s treating physicians, and the testimony of expert physicians not involved with the individual’s treatment).

22. WPATH, *supra* note 19, at 55. See also Yolanda Smith et al., *Sex Reassignment: Outcomes and Predictors of Treatment for Adolescent and Adult Transsexuals*, 35 PSYCH. MED. 89, 93, 94 (2005); Steven Weyers et al., *Long-Term Assessment of the Physical, Mental, and Sexual Health Among Transsexual Women*, 6 J. SEXUAL MED. 752 (2009); Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE 1 (2011); Bastian Amend et al., *Surgical Reconstruction for Male-to-Female Sex Reassignment*, 64 EUR. UROLOGY 141 (2013); Ladislav Jarolim et al., *Gender Reassignment Surgery in Male-to-Female Transsexualism: A Retrospective 3-Month Follow-Up Study with Anatomical Remarks*, 6 J. SEXUAL MED. 1635 (2009); Luk Gijs & Anne Brewaeys, *Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges*, 18 ANN. REV. SEX RES. 178 (2007).

ic,”<sup>23</sup> these procedures are increasingly understood as medically necessary treatment for the alleviation of many patients’ gender dysphoria. These procedures include breast augmentation or reduction; facial modification; hair removal; and other interventions designed to bring physical appearance into alignment with a transgender individual’s gender identity.<sup>24</sup> Although these procedures do affect outward appearance and are in that sense “cosmetic,” that does not preclude them from being “medically necessary.” As WPATH explains, “medical procedures attendant to sex reassignment are not ‘cosmetic’ or ‘elective’ or for the mere convenience of the patient. These reconstruction procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition.”<sup>25</sup> The American Medical Association has likewise found that sex reassignment procedures are not cosmetic and can be medically necessary.<sup>26</sup> This judgment is reinforced by medical studies demonstrating an improved quality of life from such treatments. WPATH notes that:

[a]lthough it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty

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23. See, e.g., AETNA, *Gender Reassignment Surgery*, [http://www.aetna.com/cpb/medical/data/600\\_699/0615.html](http://www.aetna.com/cpb/medical/data/600_699/0615.html) [<https://perma.cc/4SDJ-9RJR>] (“Note: Blepharoplasty, body contouring (liposuction of the waist), breast enlargement procedures such as augmentation mammoplasty and implants, face-lifting, facial bone reduction, feminization of torso, hair removal, lip enhancement, reduction thyroid chondroplasty, rhinoplasty, skin resurfacing (dermabrasion, chemical peel), and voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords), which have been used in feminization, are considered cosmetic. Similarly, chin implants, lip reduction, masculinization of torso, and nose implants, which have been used to assist masculinization, are considered cosmetic.”). See also Kari E. Hong, *Categorical Exclusions*, 11 COLUM. J. GENDER & L. 88, 99–100 (2002) (describing how a private insurance company “defended its refusal to pay for [sexual reassignment surgery] on the basis that it was cosmetic in nature.”).

24. WPATH, *supra* note 19, at 9–10.

25. WPATH, *WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.* 3 (2008), <http://www.tgender.net/taw/WPATHMedNecofSRS.pdf> [<https://perma.cc/3MDJ-Z778>].

26. See AM. MED. ASS’N HOUSE OF DELEGATES, *supra* note 15 (“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. . . . 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.”).

can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.<sup>27</sup>

As the medical literature reflects, transgender people do not seek the procedures commonly deemed “cosmetic” due to their “personal preference,” but rather to change sex characteristics from one sex to another as treatment for their gender dysphoria.<sup>28</sup> For example, studies have shown that facial feminization for transgender women “is a key element in the treatment of gender dysphoria and that it can be more important from the patient’s psychological point of view” for an individual’s gender transition than genital reassignment.<sup>29</sup> Studies have likewise found that such procedures lead to improvements in psychological well-being, social relationships, and employment status.<sup>30</sup>

Transgender individuals with untreated or only partially-treated gender dysphoria also face much greater risk of suicide or self-harm than the general population. Surveys have found that transgender individuals attempt suicide at rates far higher than average, with estimates ranging from 12% to over 40%, compared to 1.6% for the general population.<sup>31</sup> Likewise, transgender individuals are disproportionately likely to engage in self-harm, with studies finding that more than one-third of transgender people have engaged in self-injurious behavior.<sup>32</sup> Studies that have

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27. WPATH, *supra* note 19, at 58.

28. *Id.*; Liza Khan, *Transgender Health at the Crossroads: Legal Norms, Insurance Markets, and the Threat of Healthcare Reform*, 11 YALE J. HEALTH POL’Y L. & ETHICS 375, 397 (2011) (citation omitted).

29. Luis Capitán et al., *Facial Feminization Surgery: The Forehead. Surgical Techniques and Analysis of Results*, 134 PLASTIC & RECONSTRUCTIVE SURGERY 609, 613 (2014).

30. *Supra* note 22. See also Tiffany A. Ainsworth & Jeffrey H. Spiegel, *Quality of Life of Individuals with and without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 QUALITY LIFE RES. 1019, 1022–24 (2010) (finding that the mental health-related quality of life for transsexual women who had feminizing facial reconstruction is significantly higher than for transsexual women who have not had such procedures).

31. Ann P. Haas et al., *Suicide Attempts Among Transgender and Gender Non-Conforming Adults*, AM. FOUND. FOR SUICIDE PREVENTION & THE WILLIAMS INST. 2 (2014), <http://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf> [<https://perma.cc/MM2F-DRYF>]; Collier M. Cole et al., *Comorbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses*, 26 ARCHIVES SEXUAL BEHAV. 13, 19 (1997); Jaime M. Grant et al., *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, NAT’L CTR. FOR TRANSGENDER EQUAL. & NAT’L GAY & LESBIAN TASK FORCE 2 (2011), [http://www.thetaskforce.org/static\\_html/downloads/reports/reports/ntds\\_full.pdf](http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf) [<https://perma.cc/47F3-CUUR>].

32. Claire M. Peterson et al., *Suicidality, Self-Harm, and Body Dissatisfaction in Transgender Adolescents and Emerging Adults with Gender Dysphoria*, 46 SUICIDE & LIFE



monitored individuals before and after they undergo medical treatment for gender transition have found that treatment corresponds with improvements in mental health and a decrease in the rate of suicide.<sup>33</sup> Although some might contend that a propensity to engage in self-harm due to mental distress should not be part of the analysis as to whether a particular treatment is “medically necessary,” that position has become untenable now that federal law mandates parity in coverage of mental health treatment on the same basis as other health problems.<sup>34</sup>

Moreover, the discrimination that transgender individuals face is inversely related to their ability to access transition-related medical care. As the National Transgender Discrimination Survey notes, transgender individuals who are able to “pass” in accordance with their gender identity, and thus are not visibly transgender, face lower levels of discrimination than those without that ability.<sup>35</sup> For example, individuals who are noticeably transgender have faced violence in places of public accommodations at almost twice the rate of those who can pass.<sup>36</sup> Researchers of “minority stress” have likewise found that the more discrimination that individuals face or expect to face, the more likely they are to develop a psychological disorder such as generalized anxiety, major depression, post-traumatic stress disorder, and substance abuse.<sup>37</sup> Studies have shown that transgender indi-

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THREATENING BEHAV. 1, 1 (2016); Walter O. Bockting, *Vulnerability and Resilience Among Gender-Nonconforming Children and Adolescents: Mental Health Professionals Have a Key Role to Play*, 55 J. AM. ACAD. CHILD & ADOLESCENT PSYCH. 441, 442 (2016).

33. Daphna Stroumsa, *The State of Transgender Health Care: Policy, Law, and Medical Frameworks*, 104 AM. J. PUB. HEALTH 31, 33 (2014); Mohammad Hassan Murad et al, *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 CLINICAL ENDOCRINOLOGY 214, 216, 229; see also Ainsworth & Spiegel, *supra* note 30, at 1024.

34. See 29 U.S.C. § 1185a (2012) (entitled “[p]arity in mental health and substance use disorder benefits”); 42 C.F.R. § 438.910(b) (2016) (requiring that a Medicaid managed care program “must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees.”).

35. Grant et al., *supra* note 31, at 27, 93, 126, 128.

36. *Id.* at 128.

37. Peggy A. Thoits, *Stress and Health: Major Findings and Policy Implications*, 51 J. HEALTH & SOC. BEHAV. S41, S42 (2010). See also Laura Baams, Arnold H. Grossman, & Stephen T. Russell, *Minority Stress and Mechanisms of Risk for Depression and Suicidal Ideation Among Lesbian, Gay, and Bisexual Youth*, 51 DEVELOPMENTAL PSYCH. 688, 693–94 (2015); Luis A. Parra et al., *Minority Stress Predicts Depression in Lesbian, Gay, and Bisexual Emerging Adults via Elevated Diurnal Control*, 4 EMERGING ADULTHOOD 365

viduals face disproportionately high rates of depression and anxiety, which increases with the amount of discrimination they experience (such as verbal harassment).<sup>38</sup> Transgender individuals who can “pass” in accordance with their gender identity are less likely to face actual discrimination or to “expect rejection,” and thus less likely to experience the deleterious health effects of discrimination.<sup>39</sup> Transgender individuals whose appearance does not conform to their gender identity also experience notably higher rates of discrimination by healthcare providers and in receiving medical care.<sup>40</sup> Around one in five transgender people report that they have been denied healthcare by a provider due to their gender identity, and more than one-quarter of transgender people have postponed medical care because of discrimination.<sup>41</sup> The discrimination faced by transgender individuals, as well as these structural barriers to healthcare, can and should be included in the analysis when considering whether treatments to alleviate gender dysphoria are medically necessary, as these social factors affect quality of life, mental health, and access to medical care for ailments unrelated to gender transition.

### III. CATEGORICAL EXCLUSIONS & ACCESS TO HEALTH INSURANCE COVERAGE

Despite their need for healthcare, transgender people face considerable barriers to obtaining care through health insurance coverage. Both private and public health insurers frequently include so-called “categorical exclusions” in their policies, which state that any healthcare related to gender transition is excluded

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(2016); David M. Frost, Keren Levahot & Ilan H. Meyer, *Minority Stress and Physical Health among Sexual Minority Individuals*, 38 J. BEHAV. MED. 1, 7 (2015) (finding that “the deleterious effect of prejudice events on physical health is robust, and can persist above and beyond the impact of general life stress”).

38. Walter O. Bockting et al., *Stigma, Mental Health, and Resilience in an Online Sample of the US Transgender Population*, 103 AM. J. PUB. HEALTH 943, 943–46–47 (2013).

39. Brian A. Rood et al., *Expecting Rejection: Understanding the Minority Stress Experiences of Transgender and Gender-Nonconforming Individuals*, 1 TRANSGENDER HEALTH 151, 157–58 (2016).

40. Grant et al., *supra* note 31, at 73.

41. Stroumsa, *supra* note 33, at 32. *See also id.* at 33 (noting that, in addition to outright refusals of care, transgender people often face “lack of respect and acceptance of chosen gender by health care staff, privacy and safety, cultural appropriateness and understanding, and adequate knowledge of some of their specific medical needs.”).

from coverage.<sup>42</sup> Currently, at least eighteen states contain categorical exclusions in their Medicaid programs,<sup>43</sup> while only a

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42. Hong, *supra* note 23, at 96–97; *infra* note 43.

43. ALASKA ADMIN. CODE tit. 7, § 110.405(d)(5) (2017) (providing that Alaska’s Medicaid program will not make payment for “transsexual surgical procedures or secondary consequences”); ARIZ. ADMIN. CODE § R9-22-205(B)(4)(a) (2017) (Arizona’s Medicaid program will not pay for “gender reassignment surgeries”); HAW. CODE R. § 17-1737-84(22)(A) (2017) (Hawaii’s Medicaid program will not pay for “cosmetic surgery procedures” including “[s]ex transformation treatments, procedures, hormones, or other medication for the establishment or maintenance of gender reassignment except that medication may be allowed if the sex of the individual has been changed by court order”); IDAHO ADMIN. CODE r. 18.01.73.021(19) (2017) (Idaho’s Medicaid program will not pay for “[s]ex change operations and treatment in connection with transsexualism”); ILL. ADMIN. CODE tit. 89, § 140.6(j) (2017) (Illinois has removed its categorical exclusion, while still indicating that it will not pay for “[m]edical or surgical transsexual treatment, for dates of service prior to April 1, 2015”); STATE OF IND., *Healthy Indiana Plan Member Handbook* 14, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-HIP/in-healthy-indiana-plan-mdwise-handbook.pdf> [<https://perma.cc/VF9P-QAYM>] (Indiana’s Medicaid program does not cover “transsexual surgery”); IOWA ADMIN. CODE r. 441-78.1(4)(b), (d)(2), (15) (2017) (Iowa’s Medicaid program will not make payment for “[p]rocedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders”; “[c]osmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need”; or “[s]ex reassignment”); 10-144 ME. R. CODE § 90.07(C)(8) (2017) (Maine’s Medicaid program will not make payment for “[t]ranssexual procedures”); MICH. DEPT OF CMTY. HEALTH, *Medicaid Provider Manual, Pharmacy* 12 (Jan. 1, 2017), <http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf> [<https://perma.cc/7LFX-PX9H>] (Michigan’s Medicaid program will not make payment for “[d]rugs used to treat gender identity conditions, such as hormone replacement”); MINN. STAT. § 256B.0625 (2017) (providing that under Minnesota’s Medicaid program “[s]ex reassignment surgery is not covered”); 471 NEB. ADMIN. CODE §§ 10-004.01(31), 18-003.01(30) (2017) (Nebraska’s Medicaid program will not make payment for “[s]ex change procedures”); N.H. CODE ADMIN. R. ANN. HE-W 531.06(g) (2017) (New Hampshire’s Medicaid program will not make payment for “[s]ex change operations”); NEV. DEPT OF HEALTH & HUMAN SERVS., *Medicaid Serv. Manual* 603.10(3)(k), (Oct. 1, 2015), [http://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Resources/AdminSupport/Manuals/MSM/C600/MSM\\_600\\_16\\_07\\_15.pdf](http://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Resources/AdminSupport/Manuals/MSM/C600/MSM_600_16_07_15.pdf) [<https://perma.cc/9Y6R-VCZ3>] (Nevada’s Medicaid program will not cover “[t]ranssexual surgery, also known as sex reassignment surgery or intersex surgery and all ancillary services including the use of pharmaceuticals”); 55 PA. CODE §§ 1121.54(10), 1126.54(a)(7), 1141.59(11), 1163.59(a)(1) (2017) (providing that Pennsylvania’s Medicaid program will not make payment for “[d]rugs prescribed in conjunction with sex reassignment procedures” or “[p]rocedures and medical care performed in connection with sex reassignment,” which “includes but is not limited to hormone therapy, penile construction, revision of labia, vaginoplasty, vaginal dilation, vaginal reconstruction, penectomy, orchiectomy, mamoplasty, mastectomy, hysterectomy, and release of vaginal adhesions”); TENN. COMP. R. & REGS. §§ 1200-13-13-10(3)(b)(72), (86), 1200-13-14-10(3)(b)(72) (2017) (Tennessee’s Medicaid program will not make payment for “[s]ex change or transformation surgery” or “[t]ranssexual surgery”); TEX. MEDICAID PROVIDERS MANUAL § 1.8 (2012), [http://www.tmhp.com/HTMLmanuals/TMPPM/2012/Vol1\\_01\\_Provider\\_Enrollment.03.61.html](http://www.tmhp.com/HTMLmanuals/TMPPM/2012/Vol1_01_Provider_Enrollment.03.61.html) [<https://perma.cc/4VU5-3466>] (providing that Texas’s Medicaid program will not make payment for “[s]ex change operations”); W. VA. DEPT OF HEALTH & HUMAN RES., *West Virginia Medicaid Provider Manual* § 161 (Jan. 2005), *available at* [http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/bms\\_manuals\\_Chapter\\_100.pdf](http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/bms_manuals_Chapter_100.pdf) [<https://perma.cc/N3TL-YNKW>] (West Virginia’s Medicaid

handful of states expressly provide some level of coverage for gender transition in their Medicaid programs.<sup>44</sup> Categorical exclusions in Medicaid, a joint federal-state program for the indigent,<sup>45</sup> are particularly significant given the socioeconomic disadvantage that transgender individuals face. Transgender people are four times as likely to have an annual household income below \$10,000 than the general population, even though on average they have higher levels of education.<sup>46</sup> Transgender people are thus disproportionately likely to be eligible for Medicaid. The U.S. Department of Health and Human Services, in its rule prohibiting discrimination on the basis of gender identity described below, states that although traditionally Medicaid programs and other insurers “have justified these blanket exclusions by categorizing all transition-related treatment as cosmetic or experi-

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program prohibits coverage for “[t]ranssexual surgery” “regardless of medical necessity.”); WIS. ADM. CODE HEALTH & FAMILY SERVS. § 107.03(23)–(24) (2017) (Wisconsin’s Medicaid program will not make payment for “[d]rugs, including hormone therapy, associated with transsexual surgery or medically unnecessary alteration of sexual anatomy or characteristics” or “[t]ranssexual surgery.” One supposes that Wisconsin’s reference to “medically unnecessary alterations” is meant to suggest that all such procedures for gender transition are medically unnecessary, but it might leave open the argument that in some circumstances such procedures are medically necessary to alleviate gender dysphoria.).

44. CAL. DEP’T OF HEALTH & HUMAN SERVS., *Ensuring Access to Transgender Servs., All Plan Letter No. 13-011* (Sept. 25, 2013), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-011.pdf> [https://perma.cc/PLR8-FQ5W]; D.C. DEP’T OF HEALTH CARE FIN., *Non-discrimination in the District’s State Medicaid Program Based on Gender Identity or Expression* (Feb. 27, 2014), <https://dhcf.dc.gov/publication/MedicaidPolicy-GenderIdentity> [https://perma.cc/DP5G-A2DX]; MD DEP’T OF HEALTH & HUMAN HYGIENE, *Gender Transition: Covered Services, Coverage Criteria, Limitations and Exclusions* (Mar. 10, 2016), [https://mmcp.health.maryland.gov/MCOupdates/Documents/pt\\_37\\_16.pdf](https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_37_16.pdf) [https://perma.cc/GXE9-QHPJ] (but note that Maryland excludes thirty-one procedures commonly (though not explicitly here) deemed cosmetic, *id.* at 3); MASSHEALTH, *Guidelines for Medical Necessity Determination for Gender Reassignment Surgery* (Jan. 2015), <http://www.mass.gov/eohhs/docs/masshealth/guidelines/mg-genderreassignment.pdf> [https://perma.cc/NC79-MFHV]; N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l); DEP’T OF VERMONT HEALTH ACCESS, *Gender Reassignment Surgery* (Nov. 16, 2016), <http://dvha.vermont.gov/for-providers/gender-reassignment-surgery-w-icd-10-coded-111616.pdf> [https://perma.cc/LW66-R98B] (authorizing hormonal therapy and genital and chest surgery for treatment of gender dysphoria, but prohibiting payment for twenty-three procedures as “cosmetic”).

45. See 42 U.S.C. §§ 1396a, 1396c (2012).

46. CTR. FOR AM. PROGRESS & MOVEMENT ADVANCEMENT PROJECT, *Paying an Unfair Price: The Financial Penalty for Being Transgender in America* 3 (Feb. 2015), <http://www.lgbtmap.org/file/paying-an-unfair-price-transgender.pdf> [https://perma.cc/AC7Y-5BR8].

mental . . . such across-the-board categorization is now recognized as outdated and not based on current standards of care.”<sup>47</sup>

This Part considers the argument that these restrictions in state Medicaid policies are unlawful, first under the nondiscrimination mandate of the Affordable Care Act and then based on more general federal Medicaid law. It concludes that although Section 1557 of the Affordable Care Act and its implementing regulations clearly invalidate categorical exclusions and require that care be provided on a non-discriminatory basis, they do not necessarily mandate that all medically necessary care for gender transition be provided. Federal Medicaid law, however, does provide a clear path to argue that medically necessary treatment for gender dysphoria must be covered. Thus, whether or not Section 1557 or its implementing regulations are ultimately repealed or enjoined, this argument will survive.

#### A. SECTION 1557 OF THE AFFORDABLE CARE ACT

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of sex in health programs or activities that receive federal financing, in particular by incorporating Title IX’s prohibition on sex discrimination.<sup>48</sup> Following a notice-and-comment rulemaking process, the U.S. Department of Health and Human Services (HHS) issued its final regulations under Section 1557 on May 13, 2016. Among other things, this rule provides that a “covered entity” — which includes “all of the operations of

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47. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,429 (May 18, 2016) (citing Liza Khan, *Transgender Health at the Crossroads*, 11 YALE J. HEALTH POL’Y L. & ETHICS 375, 393 (2011)).

48. 42 U.S.C. § 18116(a), Pub. L. No. 111–148, title I, § 1557, 124 Stat. 260 (2010) (incorporating by reference the prohibition on sex discrimination of Title IX, 20 U.S.C. § 1681 (2012)). In particular, the statute states that: “Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.” Thus, as discussed below, the validity of the Section 1557 regulations turns in significant part on the proper interpretation of Title IX’s ban on sex discrimination. *Infra* notes 68–71 and accompanying text.

a State Medicaid program<sup>49</sup> — may not “[h]ave or implement a categorical coverage exclusion or limitation for all health services related to gender transition.”<sup>50</sup> Nor may a covered entity like a State Medicaid program “deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender person.”<sup>51</sup> HHS explained in its guidance that for denials of insurance coverage not based on a categorical exclusion, covered entities “will be expected to provide a neutral, nondiscriminatory reason for the denial or limitation that is not a pretext for discrimination.”<sup>52</sup> As the statute makes clear<sup>53</sup> and the regulatory guidance<sup>54</sup> and courts<sup>55</sup> have recognized, Section 1557 and its imple-

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49. 45 C.F.R. § 92.4 (2016). This technically takes two steps to make clear: A “covered entity” is defined as “[a]n entity that operates a health program or activity, any part of which receives Federal financial assistance.” A “health program or activity” in turn includes “all of the operations of a State Medicaid program.”

50. 45 C.F.R. § 92.207(b)(4) (2016).

51. 45 C.F.R. § 92.207(b)(5) (2016).

52. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,433 (May 18, 2016).

53. The statutory text of Section 1557 makes clear the existence of a private cause of action, as it provides that “[t]he enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.” *Supra* note 48. Courts have long recognized that Title IX authorizes a private cause of action. *Cannon v. Univ. of Chicago*, 441 U.S. 677 (1979).

54. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,472 (May 18, 2016).

55. *Cruz v. Zucker*, 195 F. Supp. 3d 554, 579–81 (S.D.N.Y. 2016) (interpreting Section 1557 as authorizing a private cause of action for its implementing regulations); *Esparza v. Univ. Med. Ctr. Mgmt. Corp.*, No. 17-4803, 2017 WL 3868955, at \*4 (E.D. La. Sept. 5, 2017) (“[T]he Court agrees with its sister courts and concludes that § 1557 is enforceable via an implied private right of action.”); *Callum v. CVS Health Corp.*, 137 F. Supp. 3d 817, 847–48 (D.S.C. 2015) (“The Court finds Congress intended to create a private right and private remedy for violations of Section 1557 by expressly incorporating the enforcement provisions of the four federal civil rights statutes. . . . In short, the Court concludes Section 1557 creates a private cause of action.”); *Rumble v. Fairview Health Servs.*, No. 14-cv-2037, 2015 WL 1197415, at \*7 n.3 (D. Minn. Mar. 16, 2015) (“Because Section 1557 states that the enforcement mechanisms available under these four statutes apply to violations of Section 1557, Section 1557 necessarily also permits private causes of action.”); *Se. Pennsylvania Transp. Auth. v. Gilead Sciences*, 102 F. Supp. 3d 688, 697–98 (E.D. Pa. 2015) (concluding that Section 1557’s cross-references to other civil rights statutes “manifest Congressional intent to create a private right” of action); *but see Baker v. Aetna Life Ins. Co.*, 228 F. Supp. 3d 764, 768–69 (N.D. Tex. 2017) (finding that “§ 1557 does not provide a cause of action for discrimination based on gender identity,” at least in part because Section 1557’s implementing regulations had yet to go into effect at the time of the facts in plaintiff’s complaint).

menting regulations authorize a private cause of action, and thus courts have begun to entertain challenges that, under Section 1557, categorical exclusions are unlawful.<sup>56</sup>

However, this method of challenging categorical exclusions or coverage denials may be unlikely to last. Upon a lawsuit by eight states and healthcare providers challenging the Section 1557 regulations, the U.S. District Court for the Northern District of Texas in *Franciscan Alliance v. Burwell* has preliminarily enjoined the relevant Section 1557 regulations from taking effect.<sup>57</sup> In particular, the court rejected the regulations based on its view that Title IX — incorporated by reference in Section 1557’s statutory text as the hook for banning sex discrimination<sup>58</sup> — did not encompass protections on the basis of gender identity.<sup>59</sup> The court reasoned that “[w]hen Title IX was enacted in 1972, the term ‘sex’ was commonly understood to refer to the biological differences between males and females.”<sup>60</sup> The court moreover concluded that the Department of Health and Human Services’ regulation was not entitled to *Chevron* deference, on the ground that “[t]he challenged Rule undoubtedly implicates significant policy questions — namely, the scope and meaning of sex discrimination prohibited by Title IX and incorporated by Section 1557. If Congress wished to assign that decision to HHS, it surely would have done so expressly.”<sup>61</sup>

The *Franciscan Alliance* court then entered a nationwide preliminary injunction enjoining enforcement of the gender identity regulations by HHS.<sup>62</sup> Whatever the merits of nationwide injunc-

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56. See *Cruz*, 195 F. Supp. 3d at 580–81 (explaining that New York’s categorical exclusion in Medicaid violated Section 1557 and its implementing regulations); *Tovar v. Essentia Health*, 857 F.3d 771, 777–79 (8th Cir. 2017) (holding that a parent receiving health insurance through her employer had standing to bring Section 1557 claim challenging the plan’s categorical exclusion on behalf of her transgender son); *Prescott v. Rady Children’s Hosp.-San Diego*, No. 16-cv-02408, 2017 WL 4310756, at \*3–\*4 (S.D. Cal. Sept. 27, 2017) (holding that Section 1557 prohibited insurer’s categorical exclusion as unlawful sex discrimination, without relying on the HHS regulations); *Robinson v. Dignity Health*, No. 4:16-cv-03035, 2016 WL 7102832 (N.D. Cal. Dec. 16, 2016) (staying plaintiff’s Section 1557 suit challenging employer’s categorical exclusion in light of Supreme Court’s consideration of *Gloucester Cty. School Bd. v. G.G.*), *voluntarily dismissed*, Dkt. 80 (Apr. 28, 2017); *Rumble v. Fairview Health Servs.*, No. 14-cv-2037, 2017 WL 401940 (D. Minn. Jan. 30, 2017) (same), *voluntarily dismissed*, Dkt. 257 (June 28, 2017).

57. *Franciscan Alliance v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016).

58. *Supra* note 48.

59. *Franciscan Alliance*, 227 F. Supp. 3d at 687–89.

60. *Id.* at 688.

61. *Id.* at 687 (citing *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015)).

62. *Id.* at 695.

tions,<sup>63</sup> it is unclear whether any party will have the ability to appeal the injunction or defend the regulations as the litigation moves forward, as the Trump Administration has thus far not been willing to do so.<sup>64</sup> The Department of Justice has allowed the deadline to appeal the preliminary injunction to pass and obtained an extension to answer the plaintiffs' complaint.<sup>65</sup> The American Civil Liberties Union has sought to intervene, hoping to stay the preliminary injunction pending appeal; however, the District Court has denied its motion to intervene as of right without ruling on whether it can intervene by permission, and the Fifth Circuit has declined to take jurisdiction of the ACLU's appeal until the District Court has rendered a final decision on intervention.<sup>66</sup> Consequently, the preliminary injunction is currently insulated from review, and HHS has indicated that it is considering a new notice-and-comment rulemaking to modify or repeal the Section 1557 regulations.<sup>67</sup>

On the other hand, because courts reviewing the legality of Section 1557's regulations are necessarily analyzing whether Title IX's ban on sex discrimination encompassed or could reasonably be interpreted to encompass gender identity discrimination, the resolution of that question in the context of Title IX would also resolve the same issue here.<sup>68</sup> Although the Supreme Court in March 2017 vacated and remanded the case that might have

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63. For a criticism of nationwide injunctions, see Samuel L. Bray, *Multiple Chancellors: Reforming the National Injunction*, forthcoming HARV. L. REV. (last revised Feb. 9, 2017), at 3–4 & 9 n.38, [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2864175](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2864175) [<https://perma.cc/KM26-39B9>].

64. See Chris Johnson, *DOJ lets stand court order against transgender health care*, WASH. BLADE (March 2, 2017, 12:03 AM), <https://www.washingtonblade.com/2017/03/02/doj-lets-court-order-stand-trans-health-care/> [<https://perma.cc/CD27-F93X>].

65. *Id.*

66. *Franciscan Alliance v. Cochran*, No. 17-10135, slip op. at 2–3 (5th Cir. June 30, 2017); see also *id.* at 4–5 (Costa, J., specially concurring) (urging the District Court to decide the motion to intervene, as “those seeking intervention deserve to be heard on whether they have a right to be heard.”). The District Court subsequently indicated that it will defer a decision on intervention until after the federal defendants have filed an answer. *Franciscan Alliance v. Price*, No. 7:16-cv-00108, 2017 WL 3616652, at \*2 n.7 (N.D. Tex. July 10, 2017).

67. *Franciscan Alliance v. Price*, 2017 WL 3616652, at \*5.

68. As noted above, Section 1557 incorporates Title IX in its statutory framework, and thus if the Supreme Court ultimately rules that Title IX encompasses discrimination on the basis of gender identity, that would also seem to apply to Section 1557 and the Department of Health and Human Services' implementing regulations. See *supra* note 48 and accompanying text.



decided this issue on statutory grounds,<sup>69</sup> the Seventh Circuit has since held that transgender students can state a claim under Title IX when denied access to the restroom corresponding to their gender identity, on the ground that such treatment constitutes unlawful sex stereotyping.<sup>70</sup> The school district in the Seventh Circuit case has filed for certiorari, and if the Supreme Court rules that Title IX outlaws gender identity discrimination, that would abrogate the basis for the district court's injunction in *Franciscan Alliance*.<sup>71</sup> A federal district court, citing the Seventh Circuit's decision, has likewise held that Section 1557 prohibits categorical exclusions regardless of the validity of the Section 1557 regulations, as an unlawful form of sex discrimination.<sup>72</sup> Moreover, the preliminary injunction in *Franciscan Alliance* is not binding in private litigation by plaintiffs seeking to apply

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69. G.G. *ex rel.* Grimm v. Gloucester Cty. Sch. Bd., 822 F.3d 709 (4th Cir. 2016), *certiorari granted*, 137 S. Ct. 369 (2016), *judgment vacated and remanded* 137 S. Ct. 1239 (U.S. Mar. 6, 2017).

70. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ., 858 F.3d 1034, 1048–50 (7th Cir. 2017) (affirming a preliminary injunction ordering school to allow transgender student to use the bathroom in accord with his gender identity, based on his likelihood of success under Title IX and the Equal Protection Clause), *petition for cert. filed*, No. 17-301 (U.S. Aug. 25, 2017).

71. Notably, this would have been resolved had the Supreme Court decided the question of whether Title IX encompassed discrimination on the basis of gender identity in the case of G.G. *ex rel.* Grimm v. Gloucester Cty. Sch. Bd., 822 F.3d 709 (4th Cir. 2016), *certiorari granted*, 137 S. Ct. 369 (2016), *judgment vacated and remanded* 137 S. Ct. 1239 (U.S. Mar. 6, 2017). The Supreme Court was expected to decide whether Title IX's prohibition on sex discrimination encompasses discrimination on the basis of gender identity, but remanded to the Fourth Circuit for an initial determination of whether Title IX prohibited gender identity discrimination absent the administrative guidance revoked by the Trump Administration. See Adam Liptak, *Justices Step Out of the Debate in a Transgender Rights Case*, N.Y. TIMES (Mar. 7, 2017), <https://www.nytimes.com/2017/03/06/us/politics/supreme-court-transgender-rights-case.html> [<https://perma.cc/FA87-9MS8>]. As noted above, the Seventh Circuit has since held that transgender students can state a claim for relief under Title IX. *Supra* note 70. Other cases are percolating and may be decided by the Courts of Appeals as well. See Bd. of Educ. of Highland Local Sch. Dist. v. U.S. Dep't of Educ., 208 F. Supp. 3d 850 (S.D. Ohio 2016) (granting preliminary injunction ordering school to allow transgender student to use the bathroom in accord with her gender identity based on Title IX), *appeal docketed*, No. 16-4107 (6th Cir.) The Sixth Circuit denied a stay pending appeal in a published decision, reasoning that the Circuit had already recognized that discrimination on the basis of "gender nonconformity" was unlawful sex discrimination and thus that the school district had not demonstrated a likelihood of success on appeal. Dodds v. U.S. Dep't of Educ., 845 F.3d 217, 221 (6th Cir. 2016) (citing Smith v. City of Salem, 378 F.3d 556 (6th Cir. 2004)). Thus, it seems likely that this issue of Title IX's application to transgender students will be considered by the Supreme Court soon, particularly since the defendants in Whitaker have filed a petition for certiorari. *Supra* note 70.

72. Prescott v. Rady Children's Hosp.-San Diego, No. 16-cv-02408, 2017 WL 4310756, at \*3–\*4 (S.D. Cal. Sept. 27, 2017).

Section 1557 through its private cause of action, as the injunction — though nationwide in scope — only prohibits enforcement by the Department of Health and Human Services.<sup>73</sup> Whatever the ultimate resolution in *Franciscan Alliance*, the preliminary injunction is already reverberating among the states: for example, Wisconsin has announced that it is reinstating its categorical exclusion for its state employees, which it had previously removed based on the Section 1557 regulations.<sup>74</sup>

Even if Section 1557's implementing regulations were to survive, it is not clear whether they would suffice as a basis to attack state Medicaid restrictions on medically necessary care for gender transition that did not rise to the level of categorical exclusions. As one example, Hawaii's Medicaid program contains a categorical exclusion<sup>75</sup> while also prohibiting payment for "cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons," or breast-reconstructive or reduction surgeries "except following medically indicated mastectomies" for

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73. *Franciscan Alliance v. Burwell*, 227 F. Supp. 3d 660, 696 (N.D. Tex. 2016) (enjoining the Department of Health and Human Services "from enforcing the Rule's prohibition against discrimination on the basis of gender identity"). See also *Prescott*, 2017 WL 4310756, at \*3-\*4, \*9 (applying Section 1557 to hold an insurer's categorical exclusion unlawful without reference to the HHS regulations, and explaining that the preliminary injunction in *Franciscan Alliance* therefore did not affect its analysis). The existence of a private cause of action to enforce Section 1557 thus makes this nationwide injunction unlike other such injunctions prohibiting the federal government from enforcing policies that only it can enforce, such as in the immigration context. See *Bray*, *supra* note 63, at 2 (citing *Texas v. United States*, 809 F.3d 134, 187–88 (5th Cir. 2015) (affirming a nationwide injunction against the Obama Administration's Deferred Action for Parents of Americans and Lawful Permanent Residents), *aff'd by an equally divided Court*, 136 S. Ct. 2271 (2016); *Washington v. Trump*, 847 F.3d 1151, 1166–67 (9th Cir. 2017) (declining to modify a nationwide injunction against President Trump's immigration Executive Order)). In granting a stay of proceedings on a Section 1557 claim, one court has suggested that the private cause of action for the gender identity regulations might not be operative given the national injunction in *Franciscan Alliance*, as "when a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated — not that their application to the individual petitioners is proscribed." *Rumble v. Fairview Health Servs.*, No. 14-CV-2037, 2017 WL 401940, at \*4 (D. Minn. Jan. 30, 2017) (quoting *Nat'l Mining Ass'n v. U.S. Army Corps of Eng'rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998)). That reasoning is true so far as it goes, but it does not mean that other courts would be precluded from making their own determinations regarding the validity of the Section 1557 regulations as applied to the private cause of action. The court in *Rumble*, moreover, ultimately relied on the fact that the G.G. case then-pending at the Supreme Court would resolve the matter of Section 1557's validity and thus warranted a stay of proceedings. *Id.*; see also *supra* note 68–71 and accompanying text.

74. WIS. DEPT OF EMP. TR. FUNDS, *Gender Reassignment Exclusion Reinstated* (Feb. 2, 2017), [http://etf.wi.gov/news/ht\\_20170201.htm](http://etf.wi.gov/news/ht_20170201.htm) [<https://perma.cc/48SQ-9KAU>].

75. Haw. Admin. Rules (HAR) § 17-1737-84(22)(A). However, Hawaii does provide that "medication may be allowed if the sex of the individual has been changed by court order." *Id.*

certain forms of cancer.<sup>76</sup> Hawaii’s categorical exclusion would clearly be invalid under the Section 1557 rule, as it is a “categorical coverage exclusion or limitation for all health services related to gender transition” in prohibition of the HHS final rule; as the regulatory guidance puts it, such a categorical exclusion is under the rule “unlawful on its face.”<sup>77</sup> It might well be possible to argue that its prohibition on breast procedures except for those arising after cancer violated the rule’s prohibition on “deny[ing] or limit[ing] coverage . . . for specific health services related to gender transition if such denial . . . results in discrimination against a transgender person,” as the regulatory guidance states that the inquiry is “whether and to what extent coverage is available when the same service is not related to gender transition.”<sup>78</sup> But the implications for other transition-related care are less clear. The Section 1557 rule states that “[n]othing in this section is intended to determine, or restrict a covered entity from determining, whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.”<sup>79</sup> Thus, according to the guidance, “these provisions do not . . . affirmatively require covered entities to cover any particular procedure or treatment for transition-related care; nor do they preclude a covered entity from applying neutral standards that govern the circumstances in which it will offer coverage to all its enrollees in a nondiscriminatory manner.”<sup>80</sup> The Section 1557 rule thus provides that Medicaid programs may not have categorical exclusions, and also cannot discriminate when care was authorized in another context, but does not on its face require that Medicaid programs cover any particular procedure.

The difficulty with applying these provisions in tandem, when assuming the invalidity of categorical exclusions, is how to know whether a particular denial of care constitutes unlawful “discrimination” under the regulations, or instead is a permissible denial of coverage based on neutral principles. That inquiry is particularly challenging given the frequent lack of a comparator for the types of care that transgender people might seek to undergo for

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76. *Id.* at (22)(B)–(D).

77. 45 C.F.R. § 92.207(b)(4) (2016); Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376, 31,429 (May 18, 2016).

78. 45 C.F.R. § 92.207(b)(5) (2016); Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,429.

79. 45 C.F.R. § 92.207(d) (2016).

80. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,429.

their transition. Namely, when a medical procedure would be denied as cosmetic or medically unnecessary in all other cases, but is in fact medically necessary to treat gender dysphoria, does a denial in the latter instance constitute discrimination under the rule?<sup>81</sup> The answer is likely no. HHS suggests that the appropriate inquiry under the nondiscrimination rule is whether “a covered entity utilized, in a nondiscriminatory manner, a neutral rule or principle when deciding to . . . take the challenged action or whether the reason for its coverage decision is a pretext for discrimination.”<sup>82</sup> But at a more granular level, it could be challenging to determine whether a Medicaid program’s denial of care to a transgender individual seeking to transition was in fact violating the rule. Absent a facially discriminatory policy, that inquiry would seem to require a case-by-case assessment of whether the denied treatment was medically necessary for treating gender dysphoria and was also authorized for another purpose.<sup>83</sup>

Yet as the next section explains, federal Medicaid law has been interpreted to require that medical treatment be authorized if it is considered “medically necessary.”<sup>84</sup> That creates a tenable argument that a state Medicaid program’s denial of coverage for transition-related treatment that is medically necessary is in fact

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81. This problem of needing a comparator to prove discrimination even when the complained-of injury may be distinct to a particular group or individual is not unique to this context. See Suzanne B. Goldberg, *Discrimination by Comparison*, 120 YALE L.J. 728, 753–59 (describing how, in the context of employment discrimination, the focus on comparators can stymie an employee’s discrimination claim due to the lack of sufficiently comparable coworkers, a small sample size of employees, or uniquely situated employees).

82. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,433.

83. For instance, some cisgender individuals have rhinoplasties when medically necessary following a broken nose, or perhaps might be placed on gender-confirming hormones when related to a medical deficiency, but these are often excluded for transgender people for alleviation of gender dysphoria. See, e.g., UNITED HEALTHCARE, *Rhinoplasty and Other Nasal Surgeries Guideline Number: CDG.019.08*, UNITED HEALTHCARE COMMERCIAL COVERAGE DETERMINATION GUIDELINE 2 (effective July 1, 2017), [https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/RhinoSepto\\_CD.pdf](https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/RhinoSepto_CD.pdf) [<https://perma.cc/LZ6M-BTBZ>] (stating that “rhinoplasty . . . is considered reconstructive and medically necessary when all of the following criteria are present”); MAYO CLINIC STAFF, *Menopause: Hormone Therapy: Is It Right for You?*, MAYO CLINIC (Apr. 14, 2015), <http://www.mayoclinic.org/diseases-conditions/menopause/in-depth/hormone-therapy/art-20046372> [<https://perma.cc/URZ6-7YC5>] (noting that women are sometimes prescribed estrogen as “hormone replacement therapy” in order to mitigate symptoms of menopause). It would thus be possible to argue that transgender individuals who likewise require those treatments as medically necessary treatment for gender dysphoria must have access to such procedures in conformance with the rule’s nondiscrimination mandate.

84. *Infra* notes 97–100 and accompanying text.

“discrimination” in violation of the Section 1557 rule, because it fails to provide healthcare for gender dysphoria on the same basis as other medical treatment. The rule’s guidance appears to contemplate this possibility. On the one hand, HHS’s response to comments on the scope of the rule rejects the notion that the rule requires a covered entity “to provide coverage for all medically necessary health services related to gender transition regardless of the scope of their coverage for other conditions.”<sup>85</sup> Yet at the same time, “the rule does require that a covered entity apply the same neutral, nondiscriminatory criteria that it uses for other conditions when the coverage determination is related to gender transition.”<sup>86</sup> HHS also makes clear that “if a covered entity covers certain types of elective procedures that are beyond those strictly identified as medically necessary or appropriate, it must apply the same standards to its coverage of comparable procedures related to gender transition.”<sup>87</sup> In conjunction, this reasoning suggests that at whatever level of abstraction the state’s Medicaid program authorizes medical treatment, it must treat gender dysphoria in the same manner. One way to reconcile this language, therefore, is that although the HHS rule does not *in itself* mandate that all medically necessary treatment for gender dysphoria be covered, to the extent that a medical necessity standard is otherwise enshrined in Medicaid law, Section 1557 requires that medically necessary care for gender transition also be covered.

In summary, the implementing rule of Section 1557 unequivocally prohibits categorical exclusions of transition-related healthcare by state Medicaid programs. The regulation also allows transgender individuals to contend that a denial of a particular treatment for gender dysphoria is unlawfully discriminatory, which may or may not be possible to show given the information available about when such treatment is authorized in other contexts. Moreover, the rule and its guidance can also be used to argue that, although the rule purports not to mandate any particular treatment, it does require that Medicaid programs cover all medically necessary treatment for an individual’s gender dysphoria so long as other procedures are authorized according to that standard. Yet as also noted, the rule has been preliminarily

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85. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. at 31,435.

86. *Id.*

87. *Id.*

enjoined, and the Trump Administration has yet to show any willingness to defend it on appeal.<sup>88</sup> Thus, with or without the continued force of the Section 1557 regulations, it is necessary also to examine the arguments that can be made under more general federal Medicaid law.

#### B. FEDERAL MEDICAID LAW AS APPLIED TO TRANSITION-RELATED HEALTHCARE

The more general provisions of federal Medicaid law are thus likely to be a fruitful area for analysis going forward, and they provide ample grounds for arguing that categorical exclusions are unlawful and that medically necessary care for gender dysphoria must be provided.

In particular, federal Medicaid law encompasses two significant principles, sufficiency and comparability, that bind the states through their participation in Medicaid.<sup>89</sup> Under federal law, once a state's Medicaid program covers certain medical services, it must then ensure that the treatment it offers is "sufficient in amount, duration, and scope to reasonably achieve its purpose," namely by adequately treating those diagnoses it is covering through a given procedure.<sup>90</sup> Moreover, under the same federal regulation, "[t]he Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope" of such treatment "because of the diagnosis, type of illness, or condition."<sup>91</sup> Instead, a state Medicaid plan may "place appropriate limits on a service based on such criteria as medical necessity."<sup>92</sup> The comparability requirement under federal law, in turn, requires that medical assistance "made available to any individual" must not be "less in amount, duration, or scope than the medical assistance made available to any other such individual."<sup>93</sup> The U.S. Court of Appeals for the Second Circuit has held that "[t]he comparability provision of the Medicaid Act seeks to ensure that the categorically needy receive *maximum* access to benefits provided under a

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88. See *supra* note 64 and accompanying text.

89. See 42 U.S.C. § 1396a (2012).

90. 42 C.F.R. § 440.230(b) (2016).

91. 42 C.F.R. § 440.230(c) (2016).

92. 42 C.F.R. § 440.230(d) (2016).

93. 42 U.S.C. § 1396a(a)(10)(B)(i) (2012). See also 42 C.F.R. § 440.240(b) (2016) (requiring a state Medicaid plan to ensure that "the services available to any individual . . . are equal in amount, duration and scope" for all eligible beneficiaries).

state Medicaid plan.”<sup>94</sup> Accordingly, this comparability standard “prohibits discrimination among individuals with the same medical needs stemming from different medical conditions.”<sup>95</sup> It thus prohibits discrimination in available care on the basis of an individual’s diagnosis when that care is determined to be necessary to treat that diagnosis, so long as that treatment is authorized in another context.<sup>96</sup>

These regulations are distinct but related, for as courts have often held they ensure that the standard for determining whether procedures must be allowed under Medicaid is one of medical necessity. Although the statutory text of the federal Medicaid Act does not explicitly set a medical necessity standard, it has been interpreted by many lower courts to require one based on the statutory text and regulations. The Supreme Court has suggested that “serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage.”<sup>97</sup> Regulations related to the sufficiency principle, for example, declare that a state Medicaid plan may “place appropriate limits on a service based on such criteria as medical necessity.”<sup>98</sup> As the Eighth Circuit has noted, the federal regulation’s prohibition on arbitrary denials of treatment due to diagnosis, combined with its invocation of medical necessity as the appropriate standard, “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.”<sup>99</sup> Similarly, the Eleventh Circuit explained in 2013 that “[a]lthough nei-

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94. *Davis v. Shah*, 821 F.3d 231, 255 (2d Cir. 2016) (emphasis added).

95. *Id.* at 258.

96. In addition, the court explained that under this regulation, “a selective distribution of medical assistance offers an unequal ‘scope’ of benefits to individuals within the categorically needy class, violating the plain language” of the statute and regulation at issue. *Id.* at 256.

97. *Beal v. Doe*, 432 U.S. 438, 444 (1977). See also Nicole M. True, Note, *Removing the Constraints to Coverage of Gender-Confirming Healthcare by State Medicaid Programs*, 97 IOWA L. REV. 1329, 1342 (2011–2012).

98. 42 C.F.R. § 440.230(d) (2016).

99. *Weaver v. Reagen*, 886 F.2d 194, 198 (8th Cir. 1989) (citing *Beal v. Doe*, 432 U.S. at 444). But see *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980), finding that although a physician has the “primary responsibility” of determining which treatments are medically necessary, “the physician is required to operate within such reasonable limitations as the state may impose.” The issue then of course becomes whether a particular limitation is “reasonable.” The Second Circuit’s ruling that a state need not fund all medically necessary treatment was vacated by the Supreme Court and has not been reinstated. *DeSario v. Thomas*, 139 F.3d 80, 96 (2d Cir. 1998), *vacated and remanded sub nom.*, *Slekis v. Thomas*, 119 S. Ct. 864 (1999).

ther the Medicaid Act nor its implementing regulations explicitly define the standard of ‘medical necessity,’ it has become a judicially accepted component of the federal legislative scheme.”<sup>100</sup> States therefore must provide that the standard for determining whether medical care will be covered by their Medicaid programs is one of medical necessity,<sup>101</sup> and thus under the comparability provision the same should be true for treatment for gender dysphoria, as the regulation “prohibits discrimination among individuals with the same medical needs stemming from different medical conditions.”<sup>102</sup> In the context of the New York Medicaid litigation, discussed below, Judge Jed Rakoff ruled that a state cannot enact a “categorical ban on medically necessary treatment” consistent with federal Medicaid law.<sup>103</sup>

Courts have generally recognized that coverage of medically necessary treatments for gender dysphoria are required under the Medicaid Act, and those decisions which have not done so rely on assumptions about the efficacy of such care that predate the most recent research substantiating the case for its necessity. In *J.D. v. Lackner*<sup>104</sup> and *G.B. v. Lackner*,<sup>105</sup> for example, the California Court of Appeals ruled that gender reassignment surgery was medically necessary and “cannot be arbitrarily classified as cosmetic” for purposes of its Medicaid program.<sup>106</sup> The Supreme Court of Minnesota similarly held that a per se ban on “transsex-

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100. *Garrido v. Dudek*, 731 F.3d 1152, 1154 (11th Cir. 2013) (internal citation omitted).

101. *Id.* See also *Lankford v. Sherman*, 451 F.3d 496, 511 (8th Cir. 2006) (explaining that “a state’s failure to provide Medicaid coverage for non-experimental, medically-necessary services within a covered Medicaid category is both per se unreasonable and inconsistent with the stated goals of Medicaid”); *Hope Med. Group for Women v. Edwards*, 63 F.3d 418, 427 (5th Cir. 1995) (state Medicaid rule that bans medically necessary abortions is invalid); *Hern v. Beye*, 57 F.3d 906, 910–11 (10th Cir. 1995) (same); *Dexter v. Kirschner*, 984 F.2d 979, 983 (9th Cir. 1992) (explaining that, absent an enumerated statutory exception, states must provide “medically necessary” services as part of their Medicaid programs).

102. *Davis v. Shah*, 821 F.3d 231, 258 (2d Cir. 2016).

103. *Cruz v. Zucker*, 195 F. Supp. 3d 554, 571 (S.D.N.Y. 2016). As Judge Rakoff noted, Medicaid regulations permit a state to place limits on medical expenditures based on “utilization control procedures.” *Id.* (citing 42 C.F.R. § 440.230(d) (2016)). However, that “limiting criteria must ultimately serve the broader aim of ‘assuring that individuals will receive necessary medical care.’” *Id.* (quoting *Alexander v. Choate*, 469 U.S. 287, 303 (1985)).

104. *J.D. v. Lackner*, 80 Cal.App.3d 90 (Cal. Ct. App. 1978).

105. *G.B. v. Lackner*, 80 Cal.App.3d 64 (Cal. Ct. App. 1978).

106. *Id.* at 71; see also *J.D.*, 80 Cal.App.3d at 95 (“We do not believe, by the wildest stretch of the imagination, that such surgery can reasonably and logically be characterized as cosmetic.”)



ual surgery” in the state’s Medicaid program was “arbitrary and unreasonable” given a finding that surgery was medically necessary for the plaintiff.<sup>107</sup> Likewise, the U.S. Court of Appeals for the Eighth Circuit, in *Pinneke v. Preisser*, ruled that Iowa’s denial of coverage for gender reassignment surgery constituted an “arbitrary denial of benefits based solely on the diagnosis, type of illness, or condition” in violation of the Medicaid Act’s comparability provision.<sup>108</sup> The court moreover held that a policy denying individual consideration of a treatment’s medical necessity “is not consistent with the objectives of the Medicaid statute.”<sup>109</sup> As the court explained, “[t]he decision of whether or not certain treatment or a particular type of surgery is ‘medically necessary’ rests with the individual recipient’s physician and not with a clerical personnel or government officials.”<sup>110</sup> A Massachusetts state court, in turn, has ruled that denying coverage of a transgender woman’s breast reconstructive surgery was “arbitrary and capricious” for failure to apply a medical necessity standard.<sup>111</sup> More recently, the U.S. Tax Court has ruled that because gender reassignment surgery was medically necessary for the plaintiff’s treatment and not cosmetic, she was entitled to deduct her expenses under the “medical care” deduction.<sup>112</sup> This determination

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107. *Doe v. Minnesota Dep’t of Public Welfare*, 257 N.W.2d 816, 821 (Minn. 1977). More generally, the court held that under the Medicaid Act an individual medical evaluation must be made for each patient “to determine whether the requested surgery is ‘medically necessary,’” finding that “[s]uch a requirement is consistent with applicable [f]ederal statutes concerning the funding of [Medicaid].” *Id.*

108. *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980).

109. *Id.*

110. *Id.* at 550.

111. *Berger v. Acting Com’r, Div. of Med. Assistance*, 2000 WL 576335, at \*3–\*4 (Mass. Sup. Ct. 2000).

112. *O’Donnabhain v. Com’r of Internal Revenue*, 134 T.C. 34, 56–57, 59, 65, 70–71, 74 (2010). The Tax Court, however, rejected a claim that her breast augmentation procedures were entitled to the deduction, on the ground that they did not “meaningfully promote the proper functioning” of her body. *Id.* at 73. This is not the proper inquiry in the Medicaid context in at least two respects. First, the “proper functioning” of a body part is not the only means by which to determine medical necessity, given the fact that gender dysphoria as a medical condition constitutes medically-cognizable distress regarding the disjuncture between an individual’s body and his or her gender identity. *See supra* notes 15, 17, & 31–32 and accompanying text. Second, as suggested above, to the extent it can be shown that there is any purpose for which a given procedure is approved, the Comparability Provision of federal Medicaid law requires that procedure be provided on an equal basis when medically necessary for the treatment of other diagnoses. *See supra* notes 93–96 and accompanying text. In the context of breast procedures, for example, some states expressly provide that breast augmentation can be authorized under certain conditions, and of course mastectomies are regularly provided for individuals with breast cancer. *See, e.g., STATE OF R.I. EXEC. OFFICE OF HEALTH & HUMAN SERVS., Medicaid Provider Manual:*

that treatments for gender dysphoria are medically necessary is not unique to the Medicaid context. In 2014, Medicare's Appeals Board removed its "National Coverage Determination," which had categorically excluded transition-related medical care, on the ground that it did not take into account modern research showing that such treatment was medically necessary.<sup>113</sup>

Court decisions denying coverage under Medicaid for treatments to gender dysphoria, by contrast, have either predated the modern medical literature demonstrating the efficacy of treatment in alleviating gender dysphoria or have not fully engaged with it. These courts, instead, have declared that transition-related medical coverage is experimental and/or cosmetic. For example, in *Rush v. Johnson*, a federal district court upheld Georgia's denial of payment for gender reassignment surgery, which the state justified on the ground that it was "experimental."<sup>114</sup> The court found that the state's determination was reasonable on two grounds: (1) a "growing concern" in the medical literature regarding the long-term efficacy of the surgery; and (2) that the Diagnostic and Statistical Manual "states that the long-term course of the treatment of transsexualism with surgical reassignment is unknown."<sup>115</sup> Likewise, in *Smith v. Rasmussen*, the U.S. Court of Appeals for the Eighth Circuit again considered Iowa's denial of payment for gender reassignment surgery.<sup>116</sup> The court ruled that its precedent in *Pinneke* ordering payment for such treatment was not outcome-determinative, because Iowa had by this time codified a regulation prohibiting payment for procedures related to gender identity disorder.<sup>117</sup> The court noted that Iowa's Department of Health had undergone a review of the medical literature and found a "lack of consensus" on the efficacy of surgery relative to other treatments like hormone therapy, while noting that "[t]he literature also revealed that the surgery can be appropriate and medically necessary for some people and

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*Prior Approval (PA) Criteria for Surgical Procedures*, <http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/Physician/PriorApprovalCriteriaforSurgicalProcedures.aspx> [<https://perma.cc/F39R-34RC>].

113. NCD 140.3, Transsexual Surgery, DAB No. 2576, 2014 WL 2558402 (U.S. Dep't of Health & Human Servs. May 30, 2014), available at <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf> [<https://perma.cc/JA3K-T46G>].

114. *Rush v. Johnson*, 565 F. Supp. 856, 858 (N.D. Ga. 1983).

115. *Id.* at 867.

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

117. *Id.* at 760.

that the procedure was not considered experimental.”<sup>118</sup> The court determined that it could not conclude that Iowa’s regulation was “unreasonable, arbitrary, or inconsistent with the [Medicaid] Act” and that the regulation thus “overcomes the presumption in favor of the determination of Smith’s treating psychiatrist.”<sup>119</sup>

Yet while states may as an initial matter set limits on Medicaid’s coverage based on their own assessment of a treatment’s medical necessity, courts have held that the reasonableness of this determination will be determined by whether that treatment is “generally accepted by the professional medical community as an effective and proven treatment.”<sup>120</sup> Whatever the merits of these denials of treatment at the time, their justifications have lost much of their persuasive power: as explained in Part II, there is now a considerably greater literature finding that medical interventions to treat gender dysphoria are effective.<sup>121</sup> Likewise, as noted above, all major medical associations now agree that medical procedures for gender dysphoria are efficacious for patients who satisfy criteria set by leading medical organizations.<sup>122</sup> Finally, because states must comply with the federal comparability and sufficiency provisions (which are enforceable through private causes of action)<sup>123</sup> they may not, as argued above, have a separate standard for receiving care related to gender transition than for care unrelated to gender dysphoria.

As a result, federal Medicaid law provides an independent basis for the argument that state Medicaid programs must provide medically necessary care to treat an individual’s gender dysphoria. That argument would be made easier by the clear invalidity of categorical exclusions based on the Affordable Care Act’s Section 1557 regulations, but the Section 1557 regulations are not strictly necessary for that goal.<sup>124</sup> Moreover, the federal Medicaid regulations are a necessary component of this argument, as they

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118. *Id.*

119. *Id.* at 761–62.

120. *Weaver v. Reagen*, 886 F.2d 194, 198 (8th Cir. 1989); *see also True*, *supra* note 97, at 1343.

121. *See supra* notes 22 & 29–32 and accompanying text.

122. *See supra* notes 14–15.

123. *See Davis v. Shah*, 821 F.3d 231, 255 n.12 (2d Cir. 2016) (holding that the comparability requirement is enforceable through a private cause of action); *Bontrager v. Indiana Family & Social Servs. Admin.*, 697 F.3d 604, 606–607 (7th Cir. 2012) (holding that the sufficiency requirement is enforceable through a private cause of action).

124. This does not mean that the Section 1557 regulations are irrelevant, as they apply to all “covered entities” receiving federal money, not just public insurers. *Supra* note 49.

make clear that state Medicaid programs must cover all medically necessary treatment for gender dysphoria. With or without the Section 1557 regulations, therefore, there is a good argument that states that fail to cover medically necessary care for gender dysphoria are in violation of federal law.

#### IV. THE *CRUZ V. ZUCKER* LITIGATION AND THE PATH AHEAD

New York's experience may be a bellwether for other states facing litigation based on this modern understanding, with its gradual evolution from having a categorical exclusion, then deeming particular care cosmetic, and eventually embracing a medical necessity standard. In *Cruz v. Zucker*, transgender plaintiffs brought a class-action suit challenging New York's categorical exclusion of transition-related care, relying on the comparability and sufficiency provisions of Medicaid law as well as the statutory provision of Section 1557.<sup>125</sup> New York then removed its categorical exclusion in March 2015, and authorized payment for sexual reassignment surgery under some conditions while prohibiting payment for specific procedures it deemed "cosmetic."<sup>126</sup> The irony was that these procedures needed to be enumerated only because they were frequently sought by transgender people as treatment for their gender dysphoria.

After the plaintiffs amended their complaint, the court granted their motion for summary judgment on the ground that this

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125. *Cruz v. Zucker*, 116 F. Supp. 3d 334, 338–39 (S.D.N.Y. 2015).

126. *Id.* See N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l)(4) (2015). This section formerly provided that under New York's Medicaid program:

Payment will not be made for the following services and procedures:

- (a) abdominoplasty, blepharoplasty, neck tightening, or removal of redundant skin;
- (b) breast augmentation;
- (c) breast, brow, face, or forehead lifts;
- (d) calf, cheek, chin, nose, or pectoral implants;
- (e) collagen injections;
- (f) drugs to promote hair growth or loss;
- (g) electrolysis, unless required for vaginoplasty;
- (h) facial bone reconstruction, reduction, or sculpturing, including jaw shortening and rhinoplasty;
- (i) hair transplantation;
- (j) lip reduction;
- (k) liposuction;
- (l) thyroid chondroplasty; and
- (m) voice therapy, voice lessons, or voice modification surgery.

(5) For purposes of this subdivision, cosmetic surgery, services, and procedures refers to anything solely directed at improving an individual's appearance.

ban on payment for “cosmetic” procedures was unlawful as a categorical exclusion in violation of the Section 1557 regulations and the comparability provision of the federal Medicaid Act.<sup>127</sup> New York then revised its regulation again, now indicating that procedures would be prohibited as “cosmetic” if “performed solely for the purpose of improving an individual’s appearance.”<sup>128</sup> It then denoted a series of specific medical services commonly employed for gender transition that “will be presumed to be cosmetic and will not be covered, unless justification of medical necessity is provided and prior approval is received.”<sup>129</sup> In response to comments that this presumption set an unlawfully discriminatory standard for transgender healthcare, the Department of Health said that it would “consider whether the presumption language should be eliminated or modified in a subsequent rulemaking, in order to dispel any misconception that the Department is setting a stricter standard for coverage” of gender transition.<sup>130</sup>

In evident response to concern about further litigation, the Department of Health in October 2016 overhauled its regulation yet again, removing the so-called “cosmetic presumption” and instituting a policy that all transgender healthcare will be covered if medically necessary.<sup>131</sup> The Department said in a new rulemaking that although it “does not agree” with comments arguing that the cosmetic presumption was unlawfully discriminatory, it was “proposing changes to the regulation in order to be sensitive to their concerns and to try to avoid any misconceptions about Medicaid’s policy.”<sup>132</sup> In addition to listing those procedures that would be covered by Medicaid “without the need . . . for prior approval,”<sup>133</sup> the Department of Health indicated that procedures it previously considered cosmetic would be covered if medically necessary to treat an individual’s gender dysphoria, including proce-

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127. Cruz v. Zucker, 195 F. Supp. 3d 554, 576–77, 579–81 (S.D.N.Y. 2016).

128. N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l) (2016) (effective Aug. 31, 2016).

129. *Id.*

130. N.Y. DEP’T OF HEALTH, *Notice of Adoption, Transgender Related Care and Services* (Aug. 31, 2016), <http://docs.dos.ny.gov/info/register/2016/aug31/pdf/rulemaking.pdf> [<https://perma.cc/LB5Q-N5XU>].

131. N.Y. DEP’T OF HEALTH, *Proposed Rule Making, Transgender Related Care and Services* (Oct. 5, 2016), <http://docs.dos.ny.gov/info/register/2016/oct5/pdf/rulemaking.pdf> [<https://perma.cc/PV9Q-3SRC>].

132. N.Y. DEP’T OF HEALTH, *Notice of Adoption, Transgender Related Care and Services* (Dec. 7, 2016), <https://docs.dos.ny.gov/info/register/2016/dec7/pdf/rulemaking.pdf> [<https://perma.cc/JT2A-76E6>].

133. N.Y. DEP’T OF HEALTH, *supra* note 131.

dures “for the purpose of changing an individual’s appearance to more closely conform secondary sex characteristics to those of the patient’s identified gender.”<sup>134</sup> However, the regulation “would continue to provide that Medicaid coverage is not available for surgeries, services, and procedures that are purely cosmetic, i.e., that enhance an individual’s appearance but are not medically necessary to treat the individual’s underlying gender dysphoria.”<sup>135</sup> Thus, New York has now made clear that medical treatment will be approved if medically necessary for the alleviation of an individual’s gender dysphoria, without a presumptive judgment that any particular care shall not be covered. That is a signal development in state Medicaid policy.

This iterative process may well be a model for litigation moving forward: although New York ultimately kept one step ahead of the litigation, its progression from categorical exclusion to a medical necessity standard for treating gender dysphoria was without question prompted by litigation.<sup>136</sup> The question that will arise shortly is how other states, perhaps less inclined to spend resources on treating gender dysphoria, will respond. Given that disinclination, courts will more likely be making these determinations going forward without the participation of the political branches.

## V. COUNTERARGUMENTS TO COVERING TRANSGENDER HEALTHCARE

The arguments against covering transition-related medical care take many forms. Some commentators dispute that all or some medical care for gender transition is in fact medically nec-

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134. *Id.*

135. *Id.*; see also Jesse McKinley, *State May Extend Medicaid to Cover Treatments for Transgender Youth*, N.Y. TIMES (Oct. 6, 2016), <http://www.nytimes.com/2016/10/06/nyregion/new-york-moves-to-allow-medicare-to-cover-hormone-therapy-for-transgender-youth.html> (discussing the notice of proposed rulemaking).

136. *Cruz v. Zucker*, 218 F. Supp. 3d 246, 248 (S.D.N.Y. 2016) (court granted summary judgment for the plaintiffs on their motion for reconsideration with respect to New York State’s limits on age-appropriate treatment for gender dysphoria. The court refused to stay entry of judgment on the basis of the state’s notice of proposed rulemaking, noting that: “Having failed to accord plaintiffs their full federal rights for most of the two-and-a-half years since this litigation was commenced, the defendant waited until just eight days before the scheduled trial of the remaining claims to promulgate a proposed regulation that may eventually implement those rights.”)

essary.<sup>137</sup> That argument is placed to the side here, as it is discussed above in Part II. The two counter-arguments that are considered here are (1) that transition-related care is too expensive and (2) that it should be left to the states to determine whether such care should be covered, based on principles of federalism.

### A. COST

Opponents of comprehensive insurance coverage for transgender healthcare frequently cite its cost, implicitly or explicitly arguing that the cost of care is too high for an insurer reasonably to cover.<sup>138</sup> The estimates quoted both by opponents and the press are often on the higher end of available estimates, for instance over \$100,000 for a complete surgical transition,<sup>139</sup> while in fact the average cost of transition-related care has been estimated at around \$30,000 per person.<sup>140</sup> It is of course undeniable

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137. See, e.g., Dale O’Leary & Peter Sprigg, *Understanding and Responding to the Transgender Movement*, FAM. RES. COUNCIL (June 2015), <http://www.frc.org/transgender> [<https://perma.cc/38C6-9LZR>] (“Government should not pay for gender reassignment (hormone treatments and surgery). Such treatments — involving, as they do, the amputation of healthy body parts — are, arguably, a violation of medical ethics. These are elective procedures rather than necessary health care—just like any other form of cosmetic or plastic surgery.”).

138. For example, Peter Sprigg of the Family Research Council has stated that “We would oppose sex change operations all together [sic]. . . . But as a public policy issue, we would feel particularly strongly that taxpayers shouldn’t be asked to pay for it.” Anna Gorman, *With Coverage Through Obamacare, Transgender Woman Opts for Surgery*, KAISER HEALTH NEWS (Aug. 25, 2014), <http://khn.org/news/with-coverage-through-obamacare-transgender-woman-opts-for-surgery/> [<https://perma.cc/KC3E-5TPB>]. Courts, however, have held that “cost considerations alone do not grant participating states a license to shirk their statutory duties under the Medicaid Act.” *Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1259 (11th Cir. 2011); *AMISUB (PSL), Inc. v. Colorado Dep’t of Soc. Servs.*, 879 F.2d 789, 800–01 (10th Cir. 1989) (noting that “budgetary constraints alone can never be sufficient” to deny reimbursement for care provided to Medicaid recipients).

139. E.g., Alyssa Jackson, *The High Cost of Being Transgender*, CNN (July 31, 2015, 11:40 AM), <http://www.cnn.com/2015/07/31/health/transgender-costs-irpt/> [<https://perma.cc/G3T7-SVPG>].

140. Aaron Belkin, *Caring for Our Transgender Troops — The Negligible Cost of Transition-Related Care*, 373 NEW ENG. J. MED. 1089, 1091 (2015). In the context of the military paying for transition-related treatment for transgender service members (approved by Defense Secretary Ashton Carter), this estimate suggested that care would cost about \$5.6 million annually, a “negligible” amount given the military’s \$47.8 billion annual budget for healthcare. *Id.* at 1090. The RAND Corporation, in turn, estimated that the cost of extending transition-related healthcare to servicemembers would cost \$2.4 million, an increase in healthcare spending of 0.038%. Agnes Gereben Schaefer et al., *Assessing the Implications of Allowing Transgender Personnel to Serve Openly*, RAND CORP. 33 (2016), [https://www.rand.org/pubs/research\\_reports/RR1530.html](https://www.rand.org/pubs/research_reports/RR1530.html) [<https://perma.cc/8KTH-H4FQ>].

that covering transition-related treatments would lead to higher expenditures than not doing so. Moreover, the cost of such coverage may soon become a more acute budgetary and political issue. Many congressional Republicans have proposed transforming Medicaid into a block-grant program, such that states would have a fixed amount of money to cover Medicaid recipients' care and thus that any increased costs could crowd out other care.<sup>141</sup> However, as noted above, not every transgender person seeks a medical transition, and not every individual wishes to undergo the full panoply of medical treatments.<sup>142</sup>

A recent study, moreover, has found that covering transition-related medical is cost-effective for insurers, given reduced costs from a decline in other medical expenses related to gender dysphoria, including those arising from mental health problems, substance abuse, and higher rates of HIV.<sup>143</sup> More specifically, these researchers estimated that although over a five-year time span that transition-related medical treatment costs an average of \$21,326, the failure to provide medical coverage costs an average of \$10,712 per person over the same period. Thus, the net cost

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141. See Robert Pear, *Trump's Health Plan Would Convert Medicaid to Block Grants, Aide Says*, N.Y. TIMES, (Jan. 22, 2017), <https://www.nytimes.com/2017/01/22/us/politics/donald-trump-health-plan-medicaid.html> [<https://perma.cc/8KTH-H4FQ>]; see also Sarah Kliff, *Cassidy-Graham: the Obamacare Repeal Plan McCain is Supporting, Explained*, VOX, (Sept. 6, 2017, 4:00 PM), <https://www.vox.com/policy-and-politics/2017/9/6/16263316/cassidy-graham-mccain-obamacare-repeal> [<https://perma.cc/KUQ4-6UZP>]. This contrasts with the current system in which the federal government contributes the majority of funding for states' Medicaid spending (generally varying from 50% to 75% outside the context of the Medicaid expansion, and totaling at least 90% for those added to Medicaid as a result of the Medicaid expansion of the Affordable Care Act). KAISER COMM'N ON MEDICAID AND THE UNINSURED, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)*, KAISER FAM. FOUND. (Sept. 2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf> [<https://perma.cc/HNS5-MGDS>] (noting that the federal contribution for a state's Medicaid spending ranges from "a floor of 50 percent to a high of 74 percent," except that for the population newly eligible for Medicaid by the Affordable Care Act, at least 90% of Medicaid spending will be covered by the federal government, with the percentage the federal government will contribute set by 42 U.S.C. § 1396d(y)(1) (2012)).

142. See *supra* notes 6–13 and accompanying text; see also Dean Spade, *Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview With Advocates*, 8 SEATTLE J. SOC. JUST., 497, 498 (2010) (detailing "several reasons why" many transgender people do not seek to undergo surgical procedures).

143. William V. Padula, Shiona Heru, & Jonathan D. Campbell, *Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis*, 31 J. GEN. INTERNAL MED. 394, 395, 398–400 (2016). See also Julie Beck, *Covering Transgender Care is Good Economics for Insurance Companies*, THE ATLANTIC (Dec. 1, 2015), <https://www.theatlantic.com/health/archive/2015/12/covering-transgender-health-care-is-good-economics-for-insurance-companies/417804/> [<https://perma.cc/V8DL-7CEF>] (describing the research findings).



of providing coverage is about \$10,500 per person over a five year period.<sup>144</sup> The researchers find that this increase in marginal cost is justified by standard measures of cost per quality-adjusted life year, and that in the long-run a society will break-even on this investment.<sup>145</sup> The researchers also determined that there were broader social benefits to covering care for gender-transition, including that transgender individuals were less likely to lose their jobs following a medical transition (likely due to a decline in discrimination), leading to higher incomes and thus a broader tax base.<sup>146</sup> It might still be objected that broader access to insurance coverage for gender dysphoria (including more robust coverage for a broader range of treatments that alleviate gender dysphoria) could increase costs such that these estimates would become inapt. This study, however, devised its model based on coverage for hormone therapy as well as the most expensive forms of surgery (including genital surgery), and also treatment often deemed cosmetic like breast augmentation or reduction, and nonetheless came to the conclusion that such treatment was cost-effective.<sup>147</sup> These discrete procedures address a host of problems related to gender dysphoria in one swoop, and thus are less likely to result in long-term costs arising from the treatment of the various ills attendant to gender dysphoria.<sup>148</sup>

## B. FEDERALISM

Medicaid, as a federal-state partnership, has undoubtedly developed with federalism concerns at the forefront, and thus some might argue that it should be up to the states to decide whether to provide transition-related treatment designed to alleviate gen-

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144. *Id.* at 399. The study notes that health insurers regularly cover treatments in other contexts that are costlier on a quality-adjusted life year basis. For example, the Orphan Drug Act of 1983 affords those who suffer from cystic fibrosis access to pharmaceuticals even though its quality-adjusted life year cost is far higher than treatment for gender dysphoria (as the cost of one such pharmaceutical for cystic fibrosis approximates \$300,000 per year). *Id.*

145. *Id.* at 398, 400.

146. *Id.* at 397–98.

147. *Id.* at 397.

148. See Smith et al., *supra* note 22, at 94 (noting that transgender individuals undergoing sexual reassignment surgery “had fewer psychological problems,” including a decline in gender dysphoria, anxiety, depression, sleeping problems, somatization, and psychopathology generally).

der dysphoria. Each state has a choice whether to participate in Medicaid (though since 1982 all states have done so).<sup>149</sup> Although state Medicaid programs must cover the “categorically needy” (including those households meeting a state’s eligibility for welfare benefits), it is up to the states whether to cover those who are merely “medically needy” (including some who otherwise would not meet the requisite age or income thresholds).<sup>150</sup> Most recently, states have had the option whether to expand Medicaid as part of the Affordable Care Act to individuals making up to 133% of the federal poverty line, and around 40% of the states have chosen not to do so.<sup>151</sup> The states themselves administer their Medicaid programs, while receiving a majority of the money for their programs from the federal government.<sup>152</sup> Medicaid has thus been described as one of the paradigmatic examples of “co-operative federalism.”<sup>153</sup>

Yet with all that said, federal regulation of Medicaid has already placed certain requirements on state programs outside the context of gender transition. As a general matter, the Medicaid Act is structured so that states have some flexibility as to the persons *eligible* for coverage under the program, but states have always been required to cover certain services for those who are insured.<sup>154</sup> The federal sufficiency and comparability provisions

149. Charles N. Oberg & Cynthia Longseth Polich, *Medicaid: Entering the Third Decade*, 7 HEALTH AFFAIRS 83, 85 (1988) (noting that Arizona became the final state to participate in the Medicaid program in 1982, and that by 1970 all states but two had done so).

150. 42 U.S.C. § 1396a(a)(10)(A)(i) (2012) sets forth those who must be covered as categorically needy, and 42 U.S.C. § 1396a(a)(10)(A)(ii) (2012) sets forth the groups that may optionally be covered by a state as medically needy. As of December 2012, 34 states cover at least some of the population of those eligible for Medicaid under the medically needy classifications. KAISER COMM’N ON MEDICAID AND THE UNINSURED, *The Medicaid Medically Needy Program: Spending and Enrollment Update*, KAISER FAM. FOUND. (Dec. 2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/4096.pdf> [<https://perma.cc/L394-U5Y3>].

151. Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519, 581–88 (2012). Nineteen states have chosen not to expand Medicaid. See KAISER FAM. FOUND., *Status of State Action on the Medicaid Expansion Decision* (Jan. 1, 2017), <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> [<https://perma.cc/6AMM-9QXD>].

152. See KAISER COMM’N ON MEDICAID AND THE UNINSURED, *Medicaid Financing*, *supra* note 141.

153. Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists’ Gamble*, 81 FORDHAM L. REV. 1749, 1750 (2013).

154. See 42 U.S.C. § 1396u-7(b)(2)(A) (2012) (requiring coverage of services such as “[i]npatient and outpatient hospital services”; “[p]hysicians’ surgical and medical services”; “[l]aboratory and x-ray services”; “[c]overage of prescription drugs”; “[m]ental health services”; “[w]ell-baby and well-child care, including age-appropriate immunizations”; and “[o]ther appropriate preventive services, as designated by the Secretary”). See

are generally applicable, and they apply both to the categorically needy as well as to the medically needy categories of Medicaid beneficiaries.<sup>155</sup> The Section 1557 regulations do go further and target state policies that discriminate against coverage for gender transition, and in that sense do undermine federalism. But they do so with express reference to and incorporation of federal statutes designed to promote civil rights, for which there is a long history of not allowing states' rights to reign supreme.<sup>156</sup> As Judge Rakoff put it in *Cruz v. Zucker*, in the context of the comparability requirement rather than Section 1557, “[d]efendant’s appeal to federalism likewise falls flat, for we are dealing here with a federal right. As the Second Circuit has stated, 42 U.S.C. § 1983 assigns federal courts a ‘paramount’ role in protecting federal rights.”<sup>157</sup>

Nonetheless, there are certain federalism-promoting elements of this regime. For example, states can always seek to justify their restrictions on transition-related care in litigation or administrative proceedings by arguing that they are merited by the medical literature. States may also argue that the comparability provision of Medicaid should not mandate coverage since certain transition-related treatments are not covered in other contexts (particularly if they can show that their general policy is not to cover those procedures even when determined to be medically necessary). States can also seek waivers of certain federal Medicaid policies from HHS (through so-called Section 1115 or 1332 demonstration waivers), though at least as of November 2014 HHS provided that the comparability requirement could not be waived.<sup>158</sup> The Trump Administration may perhaps be inclined to experiment with such waivers, though they may not have binding effect in litigation by private parties, as the comparability and

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also U.S. DEP’T OF HEALTH & HUMAN SERVS., *Letter to State Medicaid Directors Re: Minimum Essential Coverage* 7 (Nov. 7, 2014), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf> [<https://perma.cc/V5S8-9RQ3>] (describing HHS’s determination of “whether the coverage afforded to medically needy individuals is comprehensive” and thus in compliance with federal regulatory requirements).

155. *Davis v. Shah*, 821 F.3d 231, 255 (2d Cir. 2016) (citing 42 C.F.R. § 440.240(a) & 42 C.F.R. § 440.240(b), and noting in addition that these requirements “apply equally to mandatory and optional medical services.”).

156. See, e.g., 42 U.S.C. § 1983 (2012); 42 U.S.C. § 2000d (2012); 20 U.S.C. § 1681 (2012).

157. *Cruz v. Zucker*, 218 F. Supp. 3d 246, 248 (S.D.N.Y. 2016) (citation omitted).

158. U.S. DEP’T OF HEALTH & HUMAN SERVS., *Letter to State Medicaid Directors*, *supra* note 154, at 8–9.

sufficiency provisions are both enforceable through private causes of action, as is Section 1557.<sup>159</sup> As a prudential matter, it would not be surprising if courts were to accord states more deference in making coverage decisions if Medicaid were transformed into a block grant program, as that would force states to balance the number of people eligible against the types of care covered in a more direct manner.<sup>160</sup> Based on the law as written, however, federalism is not an adequate basis for upholding an exclusion of medically necessary care for gender dysphoria.

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The arguments against requiring the states to provide medically necessary care for gender transition do have some force: mandating such care would increase expenses in the short-term, and would undercut values of federalism. But in both instances, requiring coverage for gender transition has those effects to a substantially lesser extent than opponents contend, and in essentially the same manner as has always been the case for federal regulation of the benefits provided by Medicaid. While these arguments are likely to be emphasized by those opposed to covering transition-related healthcare, under current law neither suffices as a basis for denying care determined to be medically necessary for individuals with gender dysphoria.

## VI. CONCLUSION

Transgender individuals often have a critical need for medical treatment that mitigates their gender dysphoria. This Note argues not only that categorical exclusions of transition-related care in state Medicaid programs are unlawful, but also that limitations on that care based on considerations other than medical necessity are unlawful as well. That conclusion is bolstered by Section 1557 of the Affordable Care Act and its implementing regulations, but the argument is equally valid under the comparability and sufficiency regulations of the federal Medicaid Act —

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159. Molly E. Reynolds & Elizabeth Mann, *In Wake of AHCA Failure, Will Trump Turn to States to Revise ACA?*, BROOKINGS INST. (Mar. 28, 2017), <https://www.brookings.edu/blog/fixgov/2017/03/28/will-trump-turn-to-states-to-revise-aca/> [<https://perma.cc/QB6U-M9XW>]. On the private causes of action, see *supra* notes 55 & 123.

160. See *supra* note 141.

and thus would survive repeal or enjoinder of the Section 1557 regulations. This Note has also argued for a broader conception of medical necessity than some states or courts have been willing to accept: namely, that it should encompass the decline in mental health and quality of life faced by individuals unable to present their appearance in conformance with their gender identity. Numerous studies now demonstrate that care addressing these concerns can be medically necessary and effective. Accepting this argument would not mean that all care would be covered; rather, it would leave the determination to a medical provider's individualized finding of medical necessity, along with any reasonable limitations a state was able to justify. This care is less costly on a relative basis than many opponents of comprehensive insurance coverage fear. Although this argument concededly undermines federalism, it does so in the same way that the federal Medicaid regulations operate in general: by placing limits on the states' discretion to determine the substance of Medicaid benefits, which are accepted by the states through their participation in Medicaid.

Ultimately, this is an argument about human flourishing, and the role that medical care and law can play in furthering it. Let the last word go to a transgender individual: "I have . . . had several bouts with depression and anxiety disorders and once ended up in the emergency room for depression. I still bounce in and out of depression due to not being able to get the appropriate surgical procedures."<sup>161</sup> And another: "When I started living full time in my real gender, I blossomed into an outgoing, loving, giving person."<sup>162</sup>

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161. Grant, *supra* note 31, at 79.

162. *Id.* at 81.