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Fixing Medicaid to "Fix Society": Extending Medicaid Coverage of Gender-Affirming Healthcare to Transgender Youth

Henry Parr

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**FIXING MEDICAID TO “FIX SOCIETY”:
EXTENDING MEDICAID COVERAGE OF
GENDER-AFFIRMING HEALTHCARE TO
TRANSGENDER YOUTH**

*Henry Parr**

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INTRODUCTION

In the early hours of December 28, 2014, a seventeen-year-old transgender girl named Leelah Alcorn left her home in Kings Mills, Ohio, and walked three miles to Interstate 71.¹ Before leaving, Alcorn had set up her Tumblr² account to automatically upload a post entitled “Suicide Note.”³ At 2:20 AM, Alcorn walked onto the six-lane highway and stepped in front of a tractor-trailer.⁴ A few hours later, the post appeared on Alcorn’s Tumblr page: “If you are reading this, it means that I have committed suicide and obviously failed to delete this post from my queue.”⁵

1. Tracy Connor, *‘Fix Society’: Transgender Teen Leelah Alcorn Posted Plea Before Suicide*, NBC NEWS (Dec. 31, 2014, 4:44 PM), <http://www.nbcnews.com/news/us-news/fix-society-transgender-teen-leelah-alcorn-posted-plea-suicide-n277666> [https://perma.cc/JXM2-Z829]; Hayley MacMillen, *Trans Teen Leaves Tumblr Suicide Note Before Her Death*, REFINERY29 (Apr. 29, 2015, 6:50 PM), <http://www.refinery29.com/2014/12/80149/leelah-alcorn-trans-teenager-suicide-letter> [https://perma.cc/WV67-YH5D]; Gillian Moheny, *Leelah Alcorn: Transgender Teen’s Reported Suicide Note Makes Dramatic Appeal*, ABC NEWS (Dec. 31, 2014, 1:00 AM), <http://abcnews.go.com/US/leelah-alcorn-transgender-teens-reported-suicide-note-makes/story?id=27912326> [https://perma.cc/6ZUP-ADU7].

2. Tumblr is a social media platform where individuals can post public blog posts. See TUMBLR, <http://www.tumblr.com> [https://perma.cc/9DGP-656J].

3. MacMillen, *supra* note 1.

4. *Id.*

5. Fallon Fox, *Leelah Alcorn’s Suicide: Conversion Therapy Is Child Abuse*, TIME (Jan. 8, 2015), <http://time.com/3655718/leelah-alcorn-suicide-transgender-therapy> [https://perma.cc/P8DE-595P] (linking to the actual note at <https://web.archive.org/web/20150102043958/http://lazerprincess.tumblr.com> [https://perma.cc/X7K9-3GF7]).

In her post, Alcorn explained why she chose to take her life.⁶ She described the feelings of gender nonconformity she had experienced since she was four, and the joy she felt when she found an explanation for these feelings.⁷ “When I was 14,” Alcorn wrote, “I learned what transgender meant and cried of happiness. After 10 years of confusion I finally understood who I was.”⁸ In her post, Alcorn also explained how her parents did not accept her identity, and the toll this took on her.⁹ Alcorn’s letter stated, “[w]hen I was 16 I realized that my parents would never come around, and that I would have to wait until I was 18 to start any sort of transitioning treatment, which absolutely broke my heart. The longer you wait, the harder it is to transition. I felt hopeless, that I was just going to look like a man in drag for the rest of my life.”¹⁰ Alcorn ended her post by stating: “My death needs to mean something. My death needs to be counted in the number of transgender people who commit suicide this year. I want someone to look at that number and say ‘that’s fucked up’ and fix it. Fix society. Please.”¹¹

Alcorn’s death drew widespread attention from media outlets and advocacy groups. Commentators wrote that Alcorn’s letter shed light on the painful experience that many transgender youth face.¹² Reports of the incident cited the disproportionately high rate of suicide attempts among transgender youth.¹³ Prominent transgender writers and actors, such as Laverne Cox, described their own suicide

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. See, e.g., Jennifer Finney Boylan, *How to Save Your Life: A Response to Leelah Alcorn’s Suicide Note*, N.Y. TIMES, Jan. 6, 2015, at A23; Zack Ford, *Leelah Alcorn and the Quiet Genocide of Transgender People*, THINK PROGRESS (Dec. 31, 2014, 1:33 PM), <http://thinkprogress.org/lgbt/2014/12/31/3607382/leelah-alcorn-transgender-genocide> [<https://perma.cc/37P9-VVW6>]; Kat Haché, *What Leelah Alcorn’s Death Means to Me As a Transgender Woman and Advocate*, BUSTLE (Dec. 31, 2014), <http://www.bustle.com/articles/56324-what-leelah-alcorns-death-means-to-me-as-a-transgender-woman-and-advocate>; Emma Margolin, *Leelah Alcorn’s Suicide Note Pointed Out Societal Problems*, MSNBC (Jan. 3, 2015, 4:01 PM), <http://www.msnbc.com/msnbc/leelah-alcorns-suicide-note-pointed-out-societal-problems> [<https://perma.cc/7FWZ-ZZ5H>].

13. Arnold H. Grossman & Anthony R. D’Augelli, *Transgender Youth and Life-Threatening Behaviors*, 35 SUICIDE & LIFE THREATENING BEHAV. 527, 532 (2007) (finding that forty-five percent of participants had seriously considered committing suicide, and twenty-six percent had engaged in life-threatening behavior such as suicide attempts).

attempts to bring more attention to the issue.¹⁴ With this publicity, Alcorn's death became a part of a larger conversation about transgender rights and gender-affirming policies.¹⁵ Some commentators argued that improved access to the gender-affirming healthcare that Alcorn sought could reduce the suicide attempt rate among transgender youth and ultimately save lives.¹⁶

Health organizations such as the American Psychiatric Association (APA),¹⁷ the World Health Organization,¹⁸ the American Medical Association (AMA),¹⁹ the Endocrine Society,²⁰ the American

14. Beth Sherouse, *Laverne Cox on Leelah Alcorn and Transgender Youth on The View*, HUM. RTS. CAMPAIGN BLOG (Jan. 9, 2105), <http://www.hrc.org/blog/entry/laverne-cox-on-leelah-alcorn-and-transgender-youth-on-the-view> [<https://perma.cc/6LJ7-SRSH>].

15. In the wake of Alcorn's death, advocates petitioned Congress to ban "conversion therapy"—psychotherapy aimed at changing an individual's gender identity or sexual orientation—which Alcorn's parents forced her to attend. See Mitch Kellaway, *Petition for 'Leelah's Law' Banning Conversion Therapy Heads to White House*, ADVOCATE (Jan. 30, 2015, 3:21 PM), <http://www.advocate.com/politics/transgender/2015/01/30/petition-leelahs-law-banning-conversion-therapy-heads-white-house> [<https://perma.cc/C6EH-U7JU>]. A congresswoman drafted a Concurrent Resolution that "encourages each state to protect minors from efforts that promote or promise to change sexual orientation, gender identity, or gender expression, based on the premise that being lesbian, gay, bisexual, transgender, or gender nonconforming is a mental illness or developmental disorder that can or should be cured." H.R. Con. Res. 36, 114th Cong. (2015). Alcorn's death has also brought more light to the violence that transwomen are subjected to as commentators noted the disproportionate media attention that Alcorn's death received when compared to the growing trend of murders of transgender women of color. Eunbyul Lee, *Who Gets To Be Human in Death?: Leelah Alcorn and Trans Legacies*, BLACK GIRL DANGEROUS (Jan. 6, 2015), <http://www.blackgirldangerous.org/2015/01/gets-human-death-leelah-alcorn-trans-legacies> [<https://perma.cc/GNW9-MGVF>] (noting that while transgender people of color face disproportionately high murder and violence rates compared to white transgender people, media coverage is racially fragmented: "While everyone is quick to circulate petitions online in Leelah's name and be distinguished as allies for the trans community, why do they continue to turn a blind eye to the lives and deaths of trans women of color? . . . When we fail to illuminate the dimmed narratives of trans people of color while advocating for justice exclusively for white trans people, we further notions of white supremacy.").

16. Margolin, *supra* note 12. See *infra* Part I, for a discussion of gender-affirming healthcare.

17. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451–59 (5th ed. 2013) [hereinafter DSM-V].

18. *International Classification of Diseases and Related Health Problems*, WORLD HEALTH ORG. (2015), <http://apps.who.int/classifications/icd10/browse/2015/en#/F60-F69> [<https://perma.cc/FCN9-XENV>] (classifying transsexualism and gender identity disorder of childhood in adult mental and behavioral disorders).

19. AM. MED. ASS'N, HOUSE OF DELEGATES RESOLUTION 122: REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS 1 (2008) [hereinafter

Academy of Family Physicians,²¹ the American College of Obstetricians and Gynecologists, and the American Psychological Association have recognized a form of anxiety, termed gender dysphoria (GD), that results from a discrepancy between an individual's sex identity assigned at birth and their gender identity.²² Mental health experts note that GD can exist during childhood and adolescence and that gender-affirming healthcare can alleviate GD.²³ Indeed, mental health organizations, such as AMA, have noted the seriousness of GD and the medical necessity of gender-affirming healthcare for certain individuals.²⁴ Without access to gender-affirming healthcare, individuals experiencing GD may develop "clinically significant psychological distress, dysfunction, debilitating depression, and . . . suicidality."²⁵ Thus, gender-affirming healthcare may be necessary for at least some adolescents. Given the experience of transgender youth like Leelah Alcorn, it is imperative for policy makers to consider adolescent access to medically necessary gender-affirming healthcare.

The psychological effects of GD raise important concerns for policymakers considering whether adolescents should have access to medically necessary gender-affirming healthcare. In particular, municipal governments and urban policymakers have an interest in considering the costs and benefits of providing access to gender-

AMA RESOLUTION 122] (finding that "[a]n 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 [GD]").

20. WYLIE C. HEMBREE ET AL., ENDOCRINE SOC'Y, ENDOCRINE TREATMENT OF TRANSSEXUAL PERSONS: AN ENDOCRINE SOCIETY CLINICAL PRACTICE GUIDELINE 7 (2009),

<https://www.endocrine.org/~media/endosociety/Files/Publications/Clinical%20Practice%20Guidelines/Endocrine-Treatment-of-Transsexual-Persons.pdf>

[<https://perma.cc/JJ7V-P7RE>] (providing a definition for "Gender Identity Disorder" that tracks the definition in the DSM-IV).

21. AM. ACAD. OF FAMILY PHYSICIANS, RESOLUTION NO. 1004 (May 3, 2012), http://www.aafp.org/dam/AAFP/documents/about_us/special_constituencies/2012RCAR_Advocacy.pdf [<https://perma.cc/E93B-JPV3>].

22. M. Dru Levasseur, *Gender Identity Defines Sex: Updating the Law to Reflect Modern Medical Science Is Key to Transgender Rights*, 39 VT. L. REV. 943, 953–54 (2015).

23. DSM-V, *supra* note 17, at 451–59; WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 8 (7th ed. 2012) [hereinafter WPATH].

24. AMA RESOLUTION 122, *supra* note 19.

25. *Id.*

affirming healthcare to transgender individuals and youth.²⁶ Urban areas possess a high density of transgender individuals, including transgender youth, since the geographic distribution of transgender and gender non-conforming individuals roughly mirrors that of the overall U.S. population.²⁷ In addition, studies suggest that the transgender population may be disproportionately eligible for Medicaid due to the disparities in income and unemployment that are likely the result of transphobia.²⁸ As a result, the urban transgender population consists of many individuals who are eligible for Medicaid and other services. Transgender youth may be particularly vulnerable and in need of medical services in urban areas, as reports on runaway homeless youth populations suggest that transgender youth are disproportionately represented in the homeless population.²⁹ These youth typically move to urban areas where identity-based homeless services organizations that are best prepared to serve transgender youth are based.³⁰ Municipal governments and urban policymakers therefore have a particular interest in trans youth³¹ access to gender-affirming healthcare.

Despite the medical community's recognition that gender-affirming healthcare is medically necessary for certain transgender youth, many are unable to gain access to it. Some, like Alcorn, are deterred from transitioning by their parents or families, while others find that they

26. JAMIE M. GRANT ET AL., NAT'L CTR. FOR TRANSGENDER EQUALITY, *INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY* 10 (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf [<https://perma.cc/XAP8-XCGD>].

27. *Id.*

28. Levasseur, *supra* note 22, at 949–51. “Transphobia” may be defined to mean negative attitudes directed towards trans people because of their transgender identity. Talia Mae Bettcher, *Transphobia*, 1 *TSQ: TRANSGENDER STUD. Q.* 249, 249 (2014).

29. NICHOLAS RAY, NAT'L GAY & LESBIAN TASK FORCE POLICY INST., *LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH: AN EPIDEMIC OF HOMELESSNESS* 4 (2006), http://www.thetaskforce.org/static_html/downloads/HomelessYouth.pdf [<https://perma.cc/8F2R-GLU3>]; *see also* NICO SIFRA QUINTANA ET AL., CTR. FOR AM. PROGRESS, *ON THE STREETS: THE FEDERAL RESPONSE TO GAY AND TRANSGENDER HOMELESS YOUTH* 1 (June 2010), <https://cdn.americanprogress.org/wp-content/uploads/issues/2010/06/pdf/lgbtyouthhomelessness.pdf> [<https://perma.cc/C9E2-D3B4>].

30. QUINTANA ET AL., *supra* note 29, at 17.

31. “Trans youth” is a common shorthand for transgender youth. *See generally* Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 *N.Y.U. REV. L. & SOC. CHANGE* 361 (2007).

cannot afford the costly treatments and appointments.³² While many private insurers have begun to cover gender-affirming healthcare,³³ the majority of state Medicaid programs do not.³⁴ Thus, in recent years, trans-rights activists have advocated for greater access to gender-affirming healthcare. New York, California, Vermont, Oregon, Massachusetts, and Washington D.C. have lifted the bans in their Medicaid programs for coverage of gender-affirming healthcare, but several of these states restrict coverage on the basis of age, requiring individuals to wait until they are eighteen to receive treatment.³⁵

Given the importance of gender-affirming healthcare for transgender youth, this Note considers whether age-based restrictions on Medicaid coverage of this healthcare are necessary and good policy. Part I of this Note provides context for the policy and law regarding gender-affirming healthcare and discusses the terms and rhetorical framing that mental health experts, trans-rights advocates, and legislators use to describe gender-affirming healthcare. In addition, it outlines the empirical research that supports the commonly held view of the mental health field that gender-affirming healthcare may be a medical necessity for transgender individuals. Lastly, it outlines the three approaches that states have taken to cover or exclude gender-affirming healthcare from Medicaid.

Part II examines the New York Medicaid program, which restricts coverage of gender-affirming healthcare on the basis of age. This Part also identifies the ways in which an age-based exclusion for Medicaid coverage of medically necessary treatment may conflict

32. MARY ANN HORTON, OUT & EQUAL WORKPLACE SUMMIT, THE COST OF TRANSGENDER HEALTH BENEFITS 4 (2008), <http://www.tgender.net/taw/thb/THBCost-OE2008.pdf> [<https://perma.cc/S8TJ-ZJ4Z>] (noting that the overall cost of medically necessary surgeries by United States transsexuals was \$19.3 million in 2001); Samantha Leal, *I Can't Afford to Transition: The Unseen Costs of Being Transgender in 2015*, MARIE CLAIRE (July 21, 2015), <http://www.marieclaire.com/culture/news/a15164/transgender-operation-procedure-costs/> [<https://perma.cc/CAZ8-FVXC>].

33. *Finding Insurance for Transgender-Related Healthcare*, HUM. RTS. CAMPAIGN (Aug. 1, 2015), <http://www.hrc.org/resources/entry/finding-insurance-for-transgender-related-healthcare> [<https://perma.cc/3ZP3-VJL5>].

34. Jennifer L. Casazza, *Sex Reassignment Surgery: Required for Transgendered Prisoners but Forbidden for Medicaid, Medicare, and CHAMPUS Beneficiaries*, 20 WM. & MARY J. WOMEN & L. 625, 642–45 (2014).

35. See George Liam Steptoe, *Gender-Affirming Coverage for Transgender People Under Proposed Medicaid Reform*, NY CITY LENS (Feb. 5, 2015), <http://nycitylens.com/2015/02/how-cuomos-medicare-medicoid-reforms-can-help-the-transgender-community/> [<https://perma.cc/HU3S-RG4Y>]; see also N.Y. COMP. CODES R. & REGS. tit. 18, §§ 505.2(1)(1)-(1)(2) (2016).

with the doctrine of informed consent, thereby potentially giving rise to litigation under the Affordable Care Act and enforcement actions by the Department of Health and Human Services.

Finally, Part III of this Note asserts that amending Medicaid programs to cover gender-affirming healthcare for transgender youth on a case-by-case basis would avoid the issues that an age-based exclusion presents. This Part argues that a case-by-case approach would align with the doctrine of informed consent and its exceptions, avoid litigation by providing medically necessary coverage in a non-discriminatory manner, and prevent the negative outcomes that beset too many transgender youth.

I. MEDICAID COVERAGE OF GENDER-AFFIRMING HEALTHCARE

As trans-rights advocates have pushed discussion of gender beyond a binary formulation, the rhetorical framing of gender and gender-affirming healthcare has become increasingly central. This Part provides background on gender-affirming healthcare and the language and terms that this Note will use to describe gender-affirming healthcare and the treatment of GD. In addition, this Part details the widely held medical consensus regarding transgender-related healthcare and the approaches health professionals have found that can alleviate the distress caused by GD. Last, this Part describes the extent to which states have extended Medicaid coverage for gender-affirming healthcare and will describe the age-based restrictions in New York's Medicaid regulation.

A. Definitions and Terms Used to Discuss Gender-Affirming Healthcare

Language that categorizes and defines people on the basis of sex and gender both frames society's outlook on sex and is subject to society's cultural values.³⁶ Such language runs the risk of instilling or reinforcing systems of sexual inequality and normativity.³⁷ For instance, a binary understanding of sex and gender that categorizes all individuals as either male or female on the basis of criteria founded

36. See GENNY BEEMYN & SUSAN RANKIN, *THE LIVES OF TRANSGENDER PEOPLE* 16 (2011).

37. See *id.* at 17; see also Mary Alice Adams, *Traversing the Transcapes: A Brief Historical Etymology of Trans* Terminology*, in *TRANSGENDER COMMUNICATION STUDIES: HISTORIES, TRENDS, AND TRAJECTORIES* 173, 179–81 (2015) (noting that language works to frame narratives about transgender identity “in a manner that privileges hegemonic cisnormativity”).

on ideas of “maleness” and “femaleness” works to marginalize individuals who do not meet these criteria.³⁸ Advocates of transgender rights have thus pushed for changes in terminology to counter this marginalization.³⁹ In particular, trans-rights activists and queer linguists have used language as a means of challenging a binary understanding of gender and the view of gender nonconformity as a mental illness or disorder.⁴⁰ In this manner, language may be viewed as not merely descriptive, but political, and some scholars argue that all language that categorizes or classifies transgender people, by its nature, is not neutral.⁴¹ The terms used to classify medical treatments that are medically necessary for many transgender individuals are similarly not neutral and risk pathologizing gender-nonconformity.⁴²

The notion of sex is central to any discussion involving the recognition of transgender rights under the law. A common misconception of sex is that it is assigned at birth as either male or female on the basis of external genitalia.⁴³ Genitalia, however, is not

38. Anne Fausto-Sterling, *The Five Sexes, Revisited*, 40 SCIENCES 18, 23 (2000) (arguing that “one can find levels of masculinity and femininity in almost every possible permutation” and that “[t]he medical and scientific communities have yet to adopt a language that is capable of describing such diversity Hence legal protection for people whose cultural and physical genitals do not match is needed during the current transition to a more gender-diverse world.”).

39. Adams, *supra* note 37, at 179 (arguing for the development of more gender terms as a means of conferring existence and that the “absence of a gender label that fits may feel like symbolic annihilation”).

40. WPATH, *supra* note 23, at 5 (noting that “[a] disorder is a description of something with which a person might struggle, not a description of the person or the person’s identity”).

41. BEEMYN & RANKIN, *supra* note 36, at 16–17 (citing J. WOOD, *GENDERED LIVES: COMMUNICATION, GENDER AND CULTURE* (2d ed. 1997)).

42. *Id.* at 16–17. While acknowledging the political implications of rhetorical framing, this Note addresses state regulations that bar access to gender-affirming healthcare on the basis of particular nomenclature and classifications. The terms used in this Note are not intended to marginalize, impose cultural norms, or pathologize gender nonconforming identities. However, in order to clearly address the statutes, it will be necessary to use the terms of these regulations and even adopt their framing of gender dysphoria in a manner which may appear to pathologize the experience of gender non-conforming and transgender individuals. For example, discussing “treatment” of GD as a medical need may work to pathologize the transgender experience or suggest that gender nonconformity requires medical attention.

43. Levasseur, *supra* note 22, at 982–83 (citing Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 ARIZ. L. REV. 265, 278–79 (1999)) (arguing that separating tangible sex characteristics for psychological sex characteristics “reflects a fundamental misunderstanding of sex. The etiology of sex reveals that it is a multi-faceted determination.”).

the sole factor determining one's sex.⁴⁴ Medical experts define sex on the basis of at least eight attributes, including an individual's internal morphologic sex, external genitalia, gonadal sex, chromosomal sex, phenotypic sex (secondary sex characteristics), hormonal sex, assigned sex, and gender identity.⁴⁵ The problematic formulation of sex on the basis of genitalia, or other physical characteristics, alone is seen in the experience of intersex individuals.⁴⁶ Roughly 1.7% of the world's population does not conform to chromosomal, gonadal, hormonal, or genital standards for either assigned sex.⁴⁷ Such individuals are often subjected to medical interventions, including surgery while they are still infants, so as to make their genitals more easily reflect male or female genitalia.⁴⁸ Given the uncertainty of whether such "corrective" procedures are necessary, and the reality that gender identity may not "match" the sex assigned through surgery, scholars argue that these interventions are merely justifications for classifying people as one sex or the other.⁴⁹ Psychologists have thus begun to understand sexual identity as

44. *Id.* ("Sex determinations have not always been based on 'genital shorthand.'").

45. JULIE GREENBERG, INTERSEXUALITY AND THE LAW: WHY SEX MATTERS 11 (2012) (citing Melanie Blackless et al., *How Sexually Dimorphic Are We? Review and Synthesis*, 12 AM. J. HUM. BIOLOGY 151, 161 (2000)); see also WPATH, *supra* note 23, at 97 (defining the term "sex").

46. Ilana Gelfman, *Because of Intersex: Intersexuality, Title VII, and the Reality of Discrimination "Because of... [Perceived] Sex"*, 34 N.Y.U. REV. L. & SOC. CHANGE 55, 62 (2010) ("[T]he intersex body fits the definition of neither a male nor a female body—and that it defies the gender binary so commonly assumed by individuals and the law.").

47. BEEMYN & RANKIN, *supra* note 36, at 18; see also PEGGY T. COHEN-KETTENIS & FRIEDMAN PFÄFFLIN, TRANSGENDERISM AND INTERSEXUALITY IN CHILDHOOD AND ADOLESCENCE 24, 41 (2003) ("[E]stimates of intersexuality climb to include nearly two percent of the population.").

48. The practice of "corrective" surgeries for intersex infants is common. See Noa Ben-Asher, *The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties*, 29 HARV. J.L. & GENDER 51, 60–61 (2006) (citing Am. Acad. of Pediatrics, *Evaluation of the Newborn with Developmental Anomalies of the External Genitalia*, 106 PEDIATRICS 138, 139 (2000)); see also BEEMYN & RANKIN, *supra* note 36, at 18. Pediatric guidelines advise for the injection of testosterone or the removal of testes where the child is born with a penis less than two centimeters. *Id.* Similarly, medical standards do not allow clitorises larger than 0.9 centimeters at birth. *Id.*; see also Chineyere Ezie, *Deconstructing the Body: Transgender and Intersex Identities and Sex Discrimination – The Need for Strict Scrutiny*, 20 COLUM. J. GENDER & L. 141, 146–47 (2011) (discussing the standards that determine a "normal" clitoris or "adequate" penis that need not be operated on in order to "ensure that intersex patients end up [as] functioning heterosexuals").

49. See, e.g., BEEMYN & RANKIN, *supra* note 36, at 18–19.

consisting of a greater number of factors, any of which may be determinative.⁵⁰

Gender identity, in contrast, is not assigned, but is rather a person's own intrinsic sense of being male, female, or an alternative gender.⁵¹ For most individuals, gender identity is sufficiently close to their assigned sex so as to be consistent with their gender expression.⁵² The term "cisgender" is used to describe people whose gender identity is aligned with their sex assignment at birth.⁵³ However, the gender identity of some individuals differs from the normative expectations of their assigned sex.⁵⁴ Centering gender identity on the individual's own sense of self allows for a more nuanced and accurate understanding of gender and properly acknowledges that gender-nonconforming individuals may cross-identify with either gender or may not conform to a binary understanding of gender at all.⁵⁵

GD, formerly known as gender identity disorder,⁵⁶ is understood by the medical community as mental distress caused by a discrepancy

50. *Id.* at 17.

51. Individuals may identify outside the binary of male and female and, instead, identify with an alternative gender identity or identities. Given the emphasis on defining one's own gender identity, the labels for gender nonconforming identities are not comprehensive, may overlap, and likely work to confound and confuse notions of a gender binary. Some labels include agender, genderqueer, bigender, trigender, neutrois, genderfluid, trans, transmasculine, transfeminine, bear, butch, femme, boi, demiboy, demigirl, genderfree, and androgyne. WPATH, *supra* note 23, at 96; Adams, *supra* note 37, at 179–81; Vanessa Vitiello Urquhart, *What the Heck is Genderqueer?*, SLATE (Mar. 24, 2015, 10:00 AM), http://www.slate.com/blogs/outward/2015/03/24/genderqueer_what_does_it_mean_and_where_does_it_come_from.html [https://perma.cc/2JS6-JQZA]; *Some Genderqueer Identities*, GENDER QUEERIES: FOR ALL YOUR GENDERQUEER AND NON-BINARY NEEDS, <http://genderqueeries.tumblr.com/identities> [https://perma.cc/8XZT-MBV8].

52. Shuvo Ghosh, *Gender Identity*, MEDSCAPE (Mar. 16, 2016), <http://emedicine.medscape.com/article/917990-overview> [https://perma.cc/HA5V-55P4]; see WPATH, *supra* note 23, at 97.

53. Cisgender is a useful term as it challenges cisnormativity, or the cultural notion that it is "normal" for one's gender identity to align with one's sex assignment at birth. The term is derived from the Latin root *cis*, meaning "on the same side as." B. Aultman, *Cisgender*, 1 TSQ: TRANSGENDER STUD. Q. 61, 61 (2014), <http://tsq.dukejournals.org/content/1/1-2/61.full.pdf+html?sid=0a257206-1e7b-4d01-baf6-16ebfb5e3d6b>; see also Julia Serano, Keynote lecture presented at the 8th Annual Philadelphia Trans-Health Conference: Psychology, Sexualization and Trans-Invalidations (Jun. 12, 2009), <http://www.juliaserano.com/av/Serano-TransInvalidations.pdf> [https://perma.cc/D5Y3-YF64].

54. WPATH, *supra* note 23, at 97.

55. BEEMYN & RANKIN, *supra* note 36, at 20.

56. The APA renamed Gender Identity Disorder as Gender Dysphoria in 2013 as part of its release of the DSM-V. *Gender Dysphoria Fact Sheet*, AM. PSYCHIATRIC ASS'N (2013)

between a person's gender identity and that person's assigned sex.⁵⁷ GD is listed in the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM-V),⁵⁸ which is the standard classification system for mental disorders that mental health professionals in the United States use.⁵⁹ GD has been the subject of mental health studies for more than thirty years.⁶⁰ Studies have found that GD can be alleviated with individual treatment, which may or may not include physical interventions such as hormone therapy or surgeries.⁶¹ Indeed, the APA and AMA have acknowledged that gender-affirming healthcare may be necessary to alleviate GD.⁶² It is important to note, however, that not all individuals who are gender-nonconforming experience GD, nor will all individuals who experience GD require physical interventions.⁶³ Further, health professionals have made clear that GD is to be distinguished from gender nonconformity.⁶⁴ Gender nonconformity, as an identity, is not to be understood as a mental disorder, while GD, which entails a feeling of distress or anxiety, may be understood as clinically

<http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf> [<https://perma.cc/M4GM-97HR>]. The APA made this decision because it sought to reclassify gender identity disorder with a term that would protect transgender individuals' "access to care and [would not] be used against them in social, occupational, or legal areas." *Id.* Additionally, the APA noted that "replacing 'disorder' with 'dysphoria' in the diagnostic label is not only more appropriate and consistent with familiar clinical sexology terminology, it also removes the connotation that the patient is 'disordered.'" *Id.* It is also worth noting that the APA considered removing the condition from the DSM-V but was concerned that doing so would jeopardize access to care. *Id.*

57. WPATH, *supra* note 23, at 96 (defining the term "gender dysphoria").

58. DSM-V, *supra* note 17, at 451–59.

59. *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, AM. PSYCHIATRIC ASS'N, <http://www.psychiatry.org/practice/dsm> [<https://perma.cc/9VNC-YN6C>].

60. See Ciaran Judge et al., *Gender Dysphoria—Prevalence and Co-Morbidities in an Irish Adult Population*, 5 *FRONTIERS IN ENDOCRINOLOGY* 1, 3 (2014).

61. WPATH, *supra* note 23, at 5.

62. AMA RESOLUTION 122, *supra* note 19 (finding that treatment for GD is medically necessary); Gunter Heylens et al., *Effects of Different Steps in Gender Reassignment Therapy on Psychopathology: A Prospective Study of Persons with a Gender Identity Disorder*, 11 *J. MED.* 119, 123–24 (2014) (finding that sex-affirming surgery lowered the overall level of psychoneurotic distress in individuals displaying signs of GD, to levels that of the general population).

63. Heylens et al., *supra* note 62, at 124.

64. *Id.*

significant distress that warrants mental health treatment.⁶⁵ The APA has recognized that children and adolescents may experience GD.⁶⁶

The phrase gender-affirming healthcare refers to all psychological and medical procedures or treatments necessary to treat GD, including hormone therapy and gender-affirming surgery. While gender-affirming healthcare is also often referred to as transition-related healthcare, or gender transition healthcare, the use of gender-affirming healthcare may be most in line with the goal of GD treatment: to affirm an individual's gender identity.⁶⁷ Gender-affirming surgery, also termed gender reassignment surgery or sex reassignment surgery, refers to surgical interventions that are intended to treat GD by modifying primary and/or secondary sex characteristics.⁶⁸

The term "transgender" is an umbrella term that includes all individuals who cross or transcend culturally prescribed gender norms.⁶⁹ The gender identity of transgender people differs in varying degrees from the sex they were assigned at birth, and consequently, the extent that transgender individuals may desire to acquire the physical characteristics of another sex may vary as well.⁷⁰ However, requiring or desiring gender-affirming treatment is not determinative of being transgender. Given the broad framing of the term, transgender individuals may also not seek to acquire the physical

65. *Id.*; Eli Coleman et al., World, Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 INT'L J. TRANSGENDERISM 165, 168 (2011).

66. *See infra* Section I.B.

67. Levasseur, *supra* note 22, at 956–57; *see also* Brynn Tannenhill, *Myths About Gender Affirmation Surgery*, 102 POLARE 25, 27 (2015) <http://www.gendercentre.org.au/documents/polare/Polare-102.pdf> [<https://perma.cc/G6SE-XGAH>].

68. Surgical procedures may include breast or chest surgeries such as augmentation mammoplasty or subcutaneous mastectomy; genital surgeries such as penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty, hysterectomy/salpingo-oophorectomy, urethra reconstruction, possibly combined with a metoidioplasty or with a phalloplasty, vaginectomy, scrotoplasty, and implantation of erection and/or testicular prosthesis; facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, pectoral implants, and various procedures that facilitate a person being perceived as the gender with which they identify. WPATH, *supra* note 23, at 57.

69. *Id.* at 97.

70. *Id.*; Jack Drescher, *From Bisexuality to Intersexuality: Rethinking Gender Categories*, 43 CONTEMP. PSYCHOANALYSIS 204, 208 (2007).

characteristics of another sex, or might not experience GD.⁷¹ As the World Professional Association for Transgender Health (WPATH) standards note, “[o]nly *some* gender-nonconforming people experience gender dysphoria at *some* point in their lives.”⁷² Thus, the term transgender should be construed broadly to include individuals who seek access to gender-affirming healthcare and gender non-conforming individuals who do not.

B. Diagnosis and Treatment of Adolescent Gender Dysphoria

This section explores the medical community’s acceptance of GD as a clinical condition that requires treatment and the development of appropriate health protocols to treat it. In addition to recognizing the occurrence of GD among adults, the medical community also recognizes that children and adolescents may experience GD. Indeed, health professionals and psychologists who have studied GD have developed diagnostic criteria for adolescent GD and have outlined the best methods and practices for treatment.

1. *Diagnosis of Adolescent Gender Dysphoria*

The DSM-V classifies GD as “the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.”⁷³ The DSM-V has two separate diagnostic criteria for gender dysphoria in children⁷⁴ and gender dysphoria in

71. Adams, *supra* note 37, at 179 (noting that using a desire for gender affirming surgery as a determinative factor for identifying an individual as transgender ignores that individual’s dignity).

72. WPATH, *supra* note 23, at 5 (emphasis added).

73. DSM-V, *supra* note 17, at 451.

74. *Id.* at 452. For children, the DSM-V requires six of the following manifestations:

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of

adolescents and adults.⁷⁵ Under both criteria, diagnosis is based upon manifestations of (1) incongruence between an individual's gender expression and their sex assigned at birth, and "(2) clinically significant distress or impairment in social, school, or other important areas of functioning."⁷⁶ For adolescents and adults, the DSM-V requires that the incongruence be manifested by at least two of the following:⁷⁷

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).⁷⁸

rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.

7. A strong dislike for one's sexual anatomy.

8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

Id.

75. *Id.* at 452-53.

76. *Id.*

77. *Id.* at 452.

78. *Id.* Critics of the DSM-V's definition have argued that the criteria emphasize an expectation for individuals to conform with gender and heterosexual norms that harkens back to an era in which homosexuality was pathologized. It is worth noting that the APA first added the diagnostic criteria for GD to the DSM-V in the same year that homosexuality was removed. Some scholars argue that these changes were based on the then-emerging gay and lesbian rights movement, which made inclusion

Mental health experts have also recognized treatment protocols and standards for diagnosing and treating GD.⁷⁹ One such source of protocols and standards is WPATH, an international association of multidisciplinary professionals with a mission towards producing evidence-based education, advocacy, and policy surrounding transgender health.⁸⁰ The association was founded by Harry Benjamin, whose seminal work, *The Transsexual Phenomenon*, brought wide attention to transgender identities and the notion that individuals should live according to their preferred gender.⁸¹ Benjamin eventually founded WPATH and oversaw the development of the WPATH Standards of Care, a treatment protocol that provides guidance to health professionals to assist transgender and gender-nonconforming individuals.⁸² The Standards of Care, now in its seventh edition, are used by professionals in the field of transgender health, have been accepted by the AMA,⁸³ and have been acknowledged by federal courts as being generally accepted in the medical field.⁸⁴

of homosexuality in the DSM-V unacceptable, but it did not disturb the association of gender-variant behavior with homosexuality. Mental health professionals have since sought to acknowledge the role that varying cultural attitudes towards gender play in defining gender identities while still understanding the occurrence of GD amongst adolescents. See Shield, *supra* note 31, at 387–88; Ian Wilson et al., *The Validity of the Diagnosis of Gender Identity Disorder (Child and Adolescent Criteria)*, 7 CLINICAL CHILD PSYCHOL. & PSYCHIATRY 335, 339 (2002).

79. WPATH, *supra* note 23, at 1–2 (noting the purpose of the Standards of Care is to offer “standards for promoting optimal care and guiding the treatment of people experiencing gender dysphoria” and that it is based upon “the best available science and expert professional consensus”).

80. *Id.*

81. Wilson et al., *supra* note 78, at 337–38.

82. WPATH, *supra* note 23, at 2.

83. AMA RESOLUTION 122, *supra* note 19, at 1 (“The [WPATH] is the leading international interdisciplinary professional organization devoted to the understanding and treatment of gender identity disorders, and [it] has established internationally accepted Standards of Care for providing medical treatment for people with [GD].”).

84. See, e.g., NCD 140.3, Transsexual Surgery, Docket No. 2576, at 20–23 (Dep’t of Health & Human Serv. May 30, 2014) [hereinafter *H.H.S. Medicare Decision*] (citing *De’Lonta v. Johnson*, 708 F.3d 520, 522–23 (4th Cir. 2013) (noting that the SOC “are the generally accepted protocols for the treatment of [GD]”), <http://www.hhs.gov/dab/decisions/dabdecisions/dab2576.pdf> [<https://perma.cc/B6JX-TQF5>] and *Glenn v. Brumby*, 724 F. Supp. 2d 1284, 1289 n.4 (N.D. Ga. 2010) (noting that “there is sufficient evidence that statements of WPATH are accepted in the medical community”).

2. Occurrence of Gender Dysphoria Among Children and Adolescents

It is generally accepted within the medical community that children may experience GD.⁸⁵ Eminent psychologist Lawrence Kohlberg suggests that children develop an understanding of their gender identity between the ages of five and seven when they realize that they will not be able to change their physiological characteristics.⁸⁶ More recent studies show that the average age at which transgender participants “felt different from others” was seven and a half years old.⁸⁷ Other studies indicate that individuals become aware of their “gender difference” at any age before fourteen.⁸⁸ Collectively, these studies suggest that most transgender individuals are aware of their gender nonconformity during adolescence.⁸⁹

While the medical community recognizes that children may experience GD, most professionals suggest that treatment is better suited for adolescents.⁹⁰ Both the DSM-V and the WPATH standards note that children as young as two years old may show indications of GD,⁹¹ but that persistence of GD into adolescence and adulthood is

85. *Id.* at 10; *see also* DSM-V, *supra* note 17, at 452 (providing diagnostic criteria for GD in children).

86. BEEMYN & RANKIN, *supra* note 36, at 42 (citing Lawrence Kohlberg, *A Cognitive Developmental Analysis of Children's Sex Role Concepts and Attitudes*, in *THE DEVELOPMENT OF SEX DIFFERENCES* 88–173 (E.E. Maccoby ed., 1966)).

87. Arnold H. Grossman et al., *Parents' Reactions to Transgender Youths' Gender Nonconforming Expression and Identity*, 18 J. GAY & LESBIAN SOC. SERVS. 3, 5 (2005) (finding that fifty-five FTM and MTF transgender youths felt “different from others” at a mean age of 7.5).

88. BEEMYN & RANKIN, *supra* note 36, at 42 (discussing one study in which respondents stated that their earliest memories of being transgender were from their earliest memories to age fourteen, with a median age of five years old).

89. *Id.* at 43 (finding one study where ninety-seven percent of the 3747 respondents indicated that they “recognized themselves as being different from others or their assigned gender by the end of the[ir] teenage years”).

90. AMA RESOLUTION 122, *supra* note 19; *see* WPATH, *supra* note 23, at 12 (noting that “in most children, gender dysphoria will disappear before, or early in, puberty”); *see also* Bernadette Wren, *Early Physical Intervention for Young People with Atypical Gender Identity Development*, 5 CLINICAL CHILD PSYCHOL. & PSYCHIATRY 220, 222–23 (2000) (noting that “research and clinical descriptions” make clear that adolescents experiencing GD invariably seek gender affirming surgery later in life, while children who experience GD do so at lower levels or not at all).

91. WPATH, *supra* note 23, at 12; DSM-V, *supra* note 17, at 455. While the diagnostic criteria has been criticized for focusing too heavily on the child's gender expression as opposed to their own intrinsic sense of gender identity, such criticisms do not question the phenomenology of gender dysphoria within children.

not inevitable.⁹² The WPATH standards note, however, that some children experiencing feelings of GD will find that these “feelings will intensify and the body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop.”⁹³ While it is uncertain whether a particular child with GD will continue to experience GD as he or she transitions into adolescence, research indicates that an adolescent who experiences GD is likely to continue experiencing feelings of gender dysphoria into adulthood.⁹⁴ In fact, one study found that all of its participants who were diagnosed with adolescent GD and given puberty-suppressing hormones⁹⁵ continued with gender-affirming treatment as they transitioned into adulthood, which is strong evidence that their feelings of GD did not disappear as they aged.⁹⁶

3. *Treatment of Gender Dysphoria Among Adolescents*

The WPATH Standards of Care outline proper treatment for GD that could include psychological interventions, social interventions, and physical interventions.⁹⁷ This “triadic therapy” approach has been embraced by psychologists.⁹⁸ Psychological interventions consist of psychotherapy that is focused on reducing the distress related to GD.⁹⁹ Social interventions consist of the individual taking on the cultural role of the desired gender identity so that they may appreciate the familial, interpersonal, and legal consequences of

92. DSM-V, *supra* note 17, at 455 (stating that persistence in natal males has ranged from 2.2% to 30% and 12% to 50% in natal females).

93. WPATH, *supra* note 23, at 12.

94. *Id.*; Annelou L.C. de Vries et al., *Puberty Suppression in Adolescents with Gender Identity Disorder: A Prospective Follow-Up Study*, 8 J. SEXUAL MED. 2276, 2281 (2010).

95. Puberty-suppressing hormones delay the onset of puberty, giving children and adolescents who experience gender dysphoria some time to further discover their gender identity. Kristian Foden-Vencil, *Puberty Suppression Now a Choice for Teens On Medicaid in Oregon*, NPR (Apr. 3, 2015), <http://www.npr.org/sections/health-shots/2015/04/05/397275700/puberty-suppression-now-choice-for-teens-on-medicaid-in-oregon>; see also Kristian Foden-Vencil, *The Medical Pros and Cons of Suppressing Puberty in Transgender Teens*, OR. PUB. RADIO (Mar. 25, 2015), <http://www.opb.org/news/article/the-medical-pros-and-cons-of-suppressing-puberty-in-transgender-teens> [https://perma.cc/R3E4-8T5E] [hereinafter Foden-Vencil, *Medical Pros and Cons*]. The hormones have been prescribed and approved for precocious puberty, but are now covered under Oregon’s state Medicaid program for treatment of GD. *Id.*

96. Foden-Vencil, *Medical Pros and Cons*, *supra* note 95.

97. WPATH, *supra* note 23, at 15.

98. COHEN-KETTENIS & PFÄFFLIN, *supra* note 47, at 132.

99. WPATH, *supra* note 23, at 15.

gender transition.¹⁰⁰ Examples of social interventions might include wearing clothes or a hairstyle that reflects the adolescent's gender identity or using a name and pronouns that are congruent with the adolescent's gender identity.¹⁰¹ Physical interventions, which the WPATH suggests should be pursued only after an individual has engaged in the psychological and social interventions,¹⁰² consist of estrogen or testosterone suppressants, as well as surgical procedures.¹⁰³ The WPATH approach relies on the individual to determine his or her own gender identity, rather than framing treatment within a gender binary.¹⁰⁴

C. Medicaid Coverage of Gender-Affirming Healthcare

Medicaid is a joint federal and state program that helps individuals with low income or low resources pay for health services and medical treatments.¹⁰⁵ Although states receive federal funding for Medicaid, states' governments establish and define the scope of their Medicaid programs.¹⁰⁶ Because gender-affirming healthcare is costly, individuals seeking to transition often cannot afford to pay for treatment on their own,¹⁰⁷ and only a few state Medicaid programs provide coverage for gender-affirming healthcare.¹⁰⁸ States that do not expressly cover gender-affirming treatments either expressly deny Medicaid coverage of gender-affirming healthcare or deny coverage

100. *Id.* at 17; COHEN-KETTENIS & PFÄFFLIN, *supra* note 47, at 141.

101. WPATH, *supra* note 23, at 16.

102. WPATH's Standards of Care have been criticized for this as it places the mental health practitioners in a determinative role that requires greater financial resources, and some view the WPATH standards as also placing psychology professionals as "gatekeepers" to medically necessary care. Sebastian, *Transgender People, Transitioning, and Those Darn Standards of Care*, AUTOSTRADDLE (Oct. 5, 2011, 10:12 AM), <http://www.autostraddle.com/transgender-people-and-those-darn-standards-of-care-113430> [<https://perma.cc/HDD8-2ZAN>] (discussing the 6th edition of the WPATH standards).

103. WPATH, *supra* note 23, at 18.

104. *Id.* at 9.

105. *Medicaid*, MEDICARE.GOV, <http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html> [<https://perma.cc/9H4F-PHPZ>].

106. Nicole M. True, *Removing the Constraints to Coverage of Gender-Confirming Healthcare by State Medicaid Programs*, 97 IOWA L. REV. 1329, 1343–44 (2012).

107. Casazza, *supra* note 34, at 649–50; *see also* HORTON, *supra* note 32, at 4.

108. Casazza, *supra* note 34, at 642; *see also* Levasseur, *supra* note 22, at 957 (citing *Trans Aging: We're Still Here!*, LAMBDA LEGAL (2016), http://www.lambdalegal.org/sites/default/files/2016_trans-aging-fs-v6-single-withbleed.pdf [<https://perma.cc/J67G-QFYF>] (noting that "most private and public insurance companies are still behind the times").

on the grounds that it is not “medically necessary.”¹⁰⁹ Some states that do extend coverage, such as New York and Vermont, restrict it on the basis of age.¹¹⁰

1. *Federal and Private Insurance Coverage of Gender-Affirming Healthcare*

Due to the high costs of gender-affirming healthcare, most individuals who seek to transition can only do so if the treatment is covered by private insurers or Medicaid.¹¹¹ A 2001 study found that the average cost for male-to-female gender-affirming surgery and hormones was close to \$20,000 over the course of three years.¹¹² That same study found that the average cost of female-to-male gender-affirming surgery and hormones was \$16,512 over a three-year period.¹¹³ More recent reports vary, with some suggesting that the cumulative costs could be between \$40,000 and \$100,000.¹¹⁴ Gender-affirming healthcare is thus likely to be cost-prohibitive if covered by an individual alone.

109. Casazza, *supra* note 34, at 642 (noting that many states “specifically prohibit the use of funds for sex reassignment surgery,” and that federal courts have denied coverage of medically necessary sex reassignment surgery (SRS) “in instances when states fail to address whether SRS is covered or not”); see *Rush v. Johnson*, 565 F. Supp. 856, 868 (N.D. Ga., 1983) (finding Georgia reasonably determined that “transsexual surgery” is experimental); see also *Smith v. Rasmussen*, 249 F.3d 755, 760 (8th Cir., 2001) (finding that Iowa’s exclusion of “sex reassignment surgery” from Medicaid coverage was not arbitrary and capricious).

110. See N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2 (2016) (denying coverage for hormone therapy and gender affirming surgery for individuals under the age of eighteen and denying coverage for gender affirming surgery that results in sterilization for individuals under the age of twenty-one); *Gender Reassignment Surgery*, DEP’T OF VT. HEALTH ACCESS MED. POL’Y (Dep’t of Vt. Health Access, Williston, Vt.), July 14, 2015, <http://dvha.vermont.gov/for-providers/1gender-reassignment-surgery071415.pdf> [<https://perma.cc/4BYD-JPNU>] (denying coverage for any gender-affirming healthcare to individuals under the age of twenty-one).

111. Casazza, *supra* note 34, at 649–50.

112. HORTON, *supra* note 32.

113. *Id.*

114. *Transaction Costs*, TRANSSEXUAL ROAD MAP, <http://www.tsroadmap.com/reality/finance/fintrncost.html> [<https://perma.cc/2XPP-BENH>]. Additionally, it appears that genital surgery alone could cost around \$20,000. *Female to Male Price List*, PHILA. CTR. FOR TRANSGENDER SURGERY, <http://www.thetransgendercenter.com/index.php/femaletomale1/ftm-price-list.html> [<https://perma.cc/XEW5-Y33J>]; *Male to Female Price List*, PHILA. CTR. FOR TRANSGENDER SURGERY, <http://www.thetransgendercenter.com/index.php/mtf-price-list.html> [<https://perma.cc/P25Q-27MR>]; see Amanda Kennedy, *Because We Say So: The Unfortunate Denial of Rights to Transgender Minors Regarding Transition*, 19 HASTINGS WOMEN’S L.J. 281, 284 (2008) (citing a Transgender Law Center report which finds that surgery may cost up to \$100,000).

These costs present significant challenges to a large proportion of the transgender population, as many individuals cannot afford gender-affirming healthcare. One reason for this is that transgender individuals are disproportionately subjected to employment discrimination and wage discrimination.¹¹⁵ In a 2011 study of transgender individuals, fifteen percent of respondents reported making \$10,000 or less per year, a percentage nearly four times that of the general population.¹¹⁶ Transgender youth, in particular, are also less likely to have the means to meet the costs of gender-affirming healthcare, as they typically are dependent on a parent for access to healthcare coverage and because transgender youth are overrepresented among runaway and homeless youth.¹¹⁷

In recent years, more employers have implemented health benefit plans that cover some form of gender-affirming healthcare.¹¹⁸ State and municipal legislatures have created incentives for insurance companies and businesses to cover gender-affirming healthcare.¹¹⁹ In New York, for instance, the Department of Financial Services issued a circular in 2014 clarifying that a denial of gender-affirming treatments, where that treatment is otherwise covered, would be a

115. MOVEMENT ADVANCEMENT PROJECT, FAMILY EQUALITY COUNCIL & CTR. FOR AM. PROGRESS, ALL CHILDREN MATTER: HOW LEGAL AND SOCIAL INEQUALITIES HURT LGBT FAMILIES 9 (2011), <http://action.familyequality.org/site/DocServer/AllChildrenMatterFullFinal10212011.pdf?docID=2401> [<https://perma.cc/S7QW-38RY>] (citing JAIME M. GRANT ET AL., NAT'L CTR. FOR TRANSGENDER EQUAL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 2 (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf [<https://perma.cc/XAP8-XCGD>]).

116. *Id.* at 9.

117. ANDREW CRAY ET AL., CTR. FOR AM. PROGRESS, SEEKING SHELTER: THE EXPERIENCES AND UNMET NEEDS OF LGBT HOMELESS YOUTH 4, 8 (2013); LANCE FREEMAN & DARRICK HAMILTON, EMPIRE STATE COAL. OF YOUTH & FAMILY SERVS., A COUNT OF HOMELESS YOUTH IN NEW YORK CITY (2008).

118. HUMAN RIGHTS CAMPAIGN FOUND., CORPORATE EQUALITY INDEX: INCLUSIVE HEALTH CARE COVERAGE AND THE CORPORATE EQUALITY INDEX 3 (2012) (finding a five-fold increase in the number of major U.S. employers affording transgender-inclusive health care coverage, from forty-nine in 2009 to more than two hundred in 2012).

119. *See* Insurance Circular Letter No. 7 from the New York State Dep't of Fin. Servs., to All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, and Health Maintenance Organizations ("HMOs") (collectively, "insurers") (Dec. 11, 2014), http://www.dfs.ny.gov/insurance/circltr/2014/cl2014_07.pdf [<https://perma.cc/D85Y-32G5>] (citing N.Y. COMP. CODES R. & REGS. tit. 11, § 52.16(c) (2016)) (clarifying that a denial of medically necessary GD coverage would violate state law); Phila. City Council 130224 (Pa. 2013) (providing tax credits to employers who expand health benefits to cover transgender related healthcare).

violation of state regulations prohibiting companies from limiting coverage on the basis of illness, treatment, or medical condition.¹²⁰ Market forces may also have motivated insurers to cover gender-affirming healthcare, as more employers are seeking this coverage.¹²¹

Despite evidence of the medical necessity of gender-affirming healthcare for adults and adolescents with GD, government subsidized health insurance varies in its coverage.¹²² Medicare, which provides coverage for individuals over the age of sixty-five and is administered solely by the federal government's Department of Health and Human Services (HHS), covers gender-affirming surgery for eligible Medicare recipients.¹²³ By contrast, Tricare, the federal government's healthcare program for members of the military and Department of Defense, expressly excludes coverage for all gender-affirming healthcare.¹²⁴ Medicaid coverage of gender-affirming healthcare varies by state, as each state determines the scope of its Medicaid program.¹²⁵ Unlike Medicare and Tricare, Medicaid is

120. Insurance Circular Letter No. 7 from the New York State Dep't of Fin. Servs., *supra* note 119 (citing (tit. 11, § 52.16(c)).

121. TRANSGENDER LAW CTR., TRANSGENDER HEALTH BENEFITS: NEGOTIATING FOR INCLUSIVE COVERAGE 14 (2014), <http://transgenderlawcenter.org/wp-content/uploads/2014/01/Health-Insurance-Exclusions-Guide-2-WEB.pdf> [<https://perma.cc/X4YB-W2BB>] (advising that employees show employers how their competitors may be gaining an advantage by offering trans-inclusive healthcare plans).

122. DSM-V, *supra* note 17, at 454; *see also H.H.S. Medicare Decision*, *supra* note 84. In its decision to extend Medicare coverage to gender-affirming healthcare, the Department of Health and Human Services found that there is "a consensus among researchers and mainstream medical organizations that transsexual surgery is an effective, safe, and medically necessary treatment for [gender dysphoria]." *H.H.S. Medicare Decision*, *supra* note 84. The decision also cited new evidence which asserted that "gender affirming surgeries . . . are the standard of care and are not experimental." *Id.*

123. *See H.H.S. Medicare Decision*, *supra* note 84, at 1 ("The Board has determined that the National Coverage Determination (NCD) denying Medicare coverage of all transsexual surgery as a treatment for transsexualism is not valid under the 'reasonableness standard' the Board applies.").

124. 32 C.F.R. § 199.4 (2015) ("All services and supplies directly or indirectly related to transsexualism or such other conditions as gender dysphoria are excluded under [Civilian Health and Medical Program of the Uniform Services] [(CHAMPUS)]."). Note, it is odd that the federal government finds that gender affirming surgery and hormone treatments are medically necessary when one is sixty-five or older, but not when one is young and has served or is serving in the military.

125. Casazza, *supra* note 34, at 642; *Transgender Health Care*, HEALTHCARE.GOV, <https://www.healthcare.gov/transgender-health-care/> [<https://perma.cc/6ZZP-7E2V>] ("Many health plans are still using exclusions such as 'services related to sex change' or 'sex reassignment surgery' to deny coverage to transgender people for certain health care services. Coverage varies by state.").

administered jointly by the federal government and states.¹²⁶ States determine the coverage of their Medicaid programs, but only receive federal funding if they meet federal regulations.¹²⁷ Thus, states have taken three different approaches to include or exclude gender-affirming healthcare from Medicaid coverage.

2. *Three Approaches to Medicaid Coverage of Gender-Affirming Healthcare*

In regulating the coverage of their Medicaid plans, states fall into one of three distinct groups. First, a minority of states have promulgated regulations that expressly exclude Medicaid coverage of gender-affirming healthcare or gender-affirming surgery.¹²⁸ The language of these statutes varies in breadth: some arguably only limit the exclusion to gender-affirming surgical procedures,¹²⁹ while others use broader language that clearly excludes all forms of gender-affirming healthcare.¹³⁰ Second, a majority of states do not have regulations that expressly deny coverage for gender-affirming healthcare or gender-affirmation surgery, but nonetheless, they have a practice of not extending coverage on the grounds that the treatments are not “medically necessary.”¹³¹ These states have prevailed in federal court against challenges seeking coverage, as the

126. “Medicaid offers the States a bargain: Congress provides federal funds in exchange for the States’ agreement to spend them in accordance with congressionally imposed conditions.” *Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1382 (2015).

127. 42 U.S.C. § 1396b (2015).

128. *See, e.g.*, MINN. STAT. ANN. § 256B.0625 (West 2016); MO. CODE REGS. ANN. tit. 22, §10-2.060 (2010); 471 NEB. ADMIN. CODE § 18-003.01 (2010); 55 PA. CODE § 1163.59 (2016).

129. *See, e.g.*, IOWA ADMIN. CODE r. 441-78.1(249A) (2016) (prohibiting coverage of “[c]osmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are . . . [p]rocedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.”); MINN. STAT. ANN. § 256B.0625 (West 2016) (“Sex reassignment surgery is not covered.”); 471 NEB. ADMIN. CODE § 18-003.01 (2010) (“[Nebraska Medical Assistance Program] [(J)NMAP]) does not cover . . . sex change procedures); 55 PA. CODE § 1163.59 (2016) (excluding coverage of all “[t]ranssexual surgical procedures for gender change or reassignment”).

130. MO. CODE REGS. ANN. tit. 22, §10-2.060 (2010) (excluding “[g]ender reassignment services and associated expenses of transformation operations, regardless of any diagnosis of gender role disorientation or psychosexual orientation or any treatment or studies related to gender reassignment; also, hormonal support for gender reassignment”).

131. *See Casazza, supra* note 34, at 642; *see, e.g.*, IOWA ADMIN. CODE r. 441-78.1(249A) (2016); MINN. STAT. ANN. § 256B.0625 (West 2016); 55 PA. CODE § 1163.59 (2016).

Supreme Court has given states broad discretion in determining what constitutes a medical necessity.¹³² Third, a growing minority of states is adopting regulations that expressly extend Medicaid coverage for gender-affirming healthcare.¹³³ Among these states is New York, which repealed its blanket exclusion of gender-affirming healthcare in 2014.¹³⁴ While each state may have particular requirements for individuals to meet in order to be eligible for coverage, the New York regulation contains a few provisions that distinguish it from other states.

3. *New York's Medicaid Coverage of Gender-Affirming Healthcare*

Before 2014, New York statutorily excluded all gender-affirming healthcare from Medicaid coverage.¹³⁵ Section 505.2 of title 18 of the New York Codes, Rules and Regulations (NYCRR) sets forth the physicians' services the New York State Medicaid program covers.¹³⁶ When section 505.2 was promulgated in 1998, it denied coverage for all care, services, drugs, or supplies rendered for the purpose of gender reassignment or any care, services, drugs, or supplies intended to promote such treatment.¹³⁷ In December 2014, however, the New York State Department of Health proposed an amendment to the regulation that would authorize Medicaid coverage for gender-affirming healthcare.¹³⁸ The amendment was the result of a twelve-year campaign¹³⁹ by transgender-rights advocates that included the

132. *Beal v. Doe*, 432 U.S. 438, 444 (1977).

133. N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2 (2016); *see also Gender Reassignment Surgery*, *supra* note 110; HEALTH EVIDENCE REV. COMM'N AUG. 14, 2014 MEETING MINUTES, at 7 (Or. 2014), <http://www.oregon.gov/oha/herc/CommitteeMeetingMaterials/HERC%20Minutes%208-14-2014.pdf> [<https://perma.cc/T3NJ-M2KH>].

134. tit. 18, § 505.2(1).

135. Transgender Related Care and Services, 2014 N.Y. Reg. 2 (Dec. 17, 2014) (codified at tit. 18, § 505.2(1)) ("Section 505.2(1) of 18 NYCRR, related to Medicaid payment for physicians' services, currently prohibits payment for any care, services, drugs, or supplies rendered in connection with GRS.").

136. tit. 18, § 505.2(1).

137. Transgender Related Care and Services, 2014 N.Y. Reg. 2; *see* N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(1).

138. Transgender Related Care and Services, 2014 N.Y. Reg. 2.

139. In 2008, New York Legal Assistance Group, Orrick Herrington & Sutcliffe, and the Sylvia Rivera Project filed a § 1983 claim on behalf of Teri Casillas, a transgender woman from the Bronx, that challenged New York's Medicaid program on the grounds that it violated the 14th Amendment. *Casillas v. Daines*, 580 F. Supp. 2d 235 (S.D.N.Y. 2008); *see* 42 U.S.C. § 1983 (2015). Following the court's decision to uphold the regulation, the Sylvia Rivera Project lobbied the Governor's office and

filing of *Cruz v. Zucker*, a class action suit brought by the Sylvia Rivera Project, the Legal Aid Society, and Wilkie Farr & Gallagher LLP against the Department of Health.¹⁴⁰ In *Cruz*, the two named plaintiffs—transgender Medicaid recipients who were residents of New York City—argued that the state’s Medicaid program violated three requirements of the federal Medicaid Act, the New York State Constitution, and the Affordable Care Act.¹⁴¹ The claim was brought against the Commissioner of the New York State Department of Health, Howard Zucker, and was settled with one of the named plaintiffs shortly before the Department of Health announced it would amend section 505.2 of the State’s Medicaid regulation.¹⁴² The express purpose of the amended version of section 505.2 was “to authorize Medicaid coverage for transgender related care and services,” and indeed, the amendment explicitly extended coverage for medically necessary hormone therapy and gender-affirming surgery for the treatment of gender dysphoria.¹⁴³

4. *New York’s Age-Based Limitations of Medicaid Coverage for Gender-Affirming Care*

While advocates lauded the proposed amendments to section 505.2, organizations like the Transgender Legal Defense and Education Fund (TLDEF) also noted that it fell short.¹⁴⁴ During the notice and comment period, advocates criticized section 505.2’s age-

began media campaigning in conjunction with GLAAD. *End Healthcare Discrimination for Transgender People*, GLAAD, <http://www.glaad.org/healthcare> [<https://perma.cc/48QH-33UH>]. In June of 2014, the Sylvia Rivera Project worked with the Legal Aid Society of New York and Wilkie, Farr & Gallagher to file *Cruz v. Zucker*. Elana Redfield, *Medicaid Programs Will Now Cover Transgender Healthcare Following SLRP’s Twelve-Year Campaign*, SYLVIA RIVERA L. PROJECT (Dec. 17, 2014), <http://srlp.org/medicaid-programs-will-now-cover-transgender-healthcare-following-srlps-twelve-year-campaign> [<https://perma.cc/989S-B7W4>].

140. Complaint at 1, *Cruz v. Zucker*, 116 F. Supp. 3d 334 (S.D.N.Y. 2015) (No. 14 CV 4456), 2014 WL 2872300); *see also* Redfield, *supra* note 139.

141. Complaint, *supra* note 140, at 2.

142. Stipulation & Order, *Cruz*, 116 F. Supp. 3d 334 (No. 14 CV 4456).

143. Transgender Related Care and Services, 2014 N.Y. Reg. 2.

144. TLDEF’s executive director stated: “While this new regulation will dramatically improve the lives of many transgender New Yorkers by ensuring that they receive the medically necessary care that they need, it does not address all of the medically necessary health care needs that transgender people have. And it continues to exclude transgender youth. We look forward to working with the administration in the coming weeks to remedy this.” Press Release, Transgender Legal Def. & Educ. Fund, New York State Acts to Remove Medicaid Ban on Transgender Health Care (Dec. 16, 2014), http://www.transgenderlegal.org/headline_show.php?id=554New [<https://perma.cc/29RJ-BBTE>].

based restriction of coverage, its referral requirements for certain procedures, and its exclusion of “cosmetic procedures.”¹⁴⁵ Despite this criticism, the state nonetheless kept these provisions in place.¹⁴⁶

New York’s procedure-based exclusion is similar to those in other states, such as Vermont, where procedures that are categorized as cosmetic are excluded from coverage.¹⁴⁷ These kinds of exclusions have been criticized for denying coverage that many medical and psychological experts could designate as medically necessary, including, for instance, breast augmentation or reduction procedures.¹⁴⁸ While New York’s Medicaid program covers the cost of breast reduction, it excludes coverage for breast augmentation.¹⁴⁹ All of these procedures may be merely cosmetic in other contexts; however, they are often identified as medically necessary for transgender individuals.¹⁵⁰ The WPATH further notes that in the context of gender-affirming surgeries, procedures that might typically have little therapeutic value to someone without GD—such as a rhinoplasty—may have a radical and permanent effect on the quality of life for someone experiencing GD.¹⁵¹

New York and other states adopt a list of requirements that transgender individuals seeking gender-affirming surgery must meet

145. Letter from Ethan Boehme Rice, Staff Att’y, Transgender Legal Def. & Educ. Fund, to Katherine Cerolao, Bureau of House Counsel, N.Y. Dep’t of Health (Feb. 2, 2015) [hereinafter TLDEF Comments], http://www.transgenderlegal.org/media/uploads/doc_608.pdf [https://perma.cc/8RDU-E5HD] (“Many of these procedures can be medically necessary for the treatment of gender dysphoria. The Proposed Rule should be clarified to ensure that coverage is available for all medically necessary care for the treatment of gender dysphoria.”).

146. Transgender Related Care and Services, 2015 N.Y. Reg. 13–15 (Feb. 24, 2015); See N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l) (2016).

147. *Gender Reassignment Surgery*, *supra* note 110 (excluding coverage of facial feminization surgery, jaw shortening/sculpting/facial bone reduction or other head or neck reconstruction, blepharoplasty, rhinoplasty, lip reduction/enhancement, face/forehead lift, chin/nose transplants, trachea shave/reduction thyroid chondroplasty, laryngoplasty, electrolysis, hair removal, liposuction, collagen injections, removal of redundant skin, hair transplantation, voice modification surgery.).

148. TLDEF Comments, *supra* note 145 (“Certain procedures that are designated ‘cosmetic’ interventions can have a profound beneficial effect in treating gender dysphoria and are medically necessary in such cases. For example, Subsection (4)(v)(b) excludes coverage for ‘breast augmentation.’ However, the [WPATH] Standards of Care include breast augmentation (implants, lipofilling) as medically necessary treatment for some patients with gender dysphoria.”).

149. Mastectomies or breast reduction surgery is absent from the list of excluded procedures. tit. 18, § 505.2(l).

150. WPATH, *supra* note 23, at 58.

151. *Id.* at 58.

to be reimbursed for gender-affirming surgery.¹⁵² Specifically, a patient must: (1) have referrals from two independent physicians, (2) have “a well-documented case of gender dysphoria,” (3) have taken hormones for a minimum of twelve months, (4) have lived in the congruent gender role for at least twelve months and received medically necessary health counseling during that time,¹⁵³ (5) have “no other . . . medical . . . conditions that would be a contraindication of gender-affirmation surgery”, and (6) have “the capacity to make a fully informed decision and to consent to the treatment.”¹⁵⁴ Thus, the regulation requires that an individual provide evidence that gender-affirming surgery is a medical necessity.

The most problematic requirement imposed by section 505.2 is its limitation of coverage for hormone therapy and gender-affirming surgery on the basis of age.¹⁵⁵ Section 505.2 limits coverage for gender-affirming surgery that results in sterilization to patients who are twenty-one or older.¹⁵⁶ Further, the regulation limits coverage for hormone therapy and gender-affirming surgery that does not result in sterilization to patients who are eighteen or older.¹⁵⁷ At least one other state, Vermont, has implemented a similar age restriction in their Medicaid program that excludes coverage for individuals under the age of twenty-one.¹⁵⁸ New York diverges from a number of states in this regard, as many states have extended Medicaid coverage without age-based restrictions.¹⁵⁹ In Oregon, for example, treatment

152. tit. 18, § 505.2(l).

153. This requirement bears similarities to the WPATH Standards of Care that recommend mental health professionals help clients and their families decide about the timing and extent to which adolescents express a gender role that is consistent with their gender identity. WPATH, *supra* note 23, at 21. For example, a mental health professional should help a client decide when they might wear clothing or a hairstyle that reflects their gender identity or when to adopt a name and pronouns that reflects their gender identity. *Id.*

154. tit. 18, § 505.2(a).

155. Transgender Related Care and Services, 2015 N.Y. Reg. 13–15 (Feb. 24, 2015) (“The majority of commenters objected to the proposed regulation restricting coverage to individuals 18 years of age or older. Specifically, commenters recommended that Medicaid cover pubertal suppressants and cross-sex hormone therapy for children and adolescents under the age of 18.”); *See* tit. 18, § 505.2(l).

156. tit. 18, § 505.2(l) (“Hormone therapy . . . may be covered for individuals 18 years of age or older. Gender reassignment surgery may be covered for an individual who is 18 years of age or older, or 21 years of age or older if the surgery will result in sterilization.”).

157. *Id.*

158. *Gender Reassignment Surgery*, *supra* note 110 (“The services will only be considered for individuals who are active Vermont Medicaid beneficiaries, age 21 or older.”).

159. OR. ADMIN. R. 410-141-0480 (2016).

for gender dysphoria—psychotherapy, hormone treatment, and gender-affirming surgery—is covered for all eligible patients, regardless of age.¹⁶⁰

As advocates have begun to disrupt the gender binary and traditional notions of gender identity, states have struggled to reconcile this development with their Medicaid programs. Gender-affirming healthcare seeks to address GD, the anxiety that results from a discrepancy between one's gender identity and assigned sex at birth.¹⁶¹ States differ in their Medicaid coverage of gender-affirming healthcare to the extent to which they recognize it as medically necessary.¹⁶² New York's Medicaid program recognizes the medical necessity of gender-affirming healthcare for adults, but does not do so for trans youth.¹⁶³ Putting aside whether this varied coverage reflects the state's reluctance to acknowledge trans youth and notions of gender nonconformity generally, the age-based restrictions in section 505.2 may be at odds with the public health, legal, and policy goals of the state.¹⁶⁴

II. CONFLICTS IN DOCTRINE AND LAW THAT MAY ARISE FROM MEDICAID AGE RESTRICTIONS ON GENDER-AFFIRMING HEALTHCARE

Age-based restrictions on Medicaid coverage for gender-affirming treatment find support and criticism from a number of sources. This Part discusses the areas of dispute that provide support and opposition to section 505.2 of New York's Medicaid program. Section II.A describes the debate within the medical community as to whether gender-affirming treatment is medically necessary for individuals under the age of eighteen and the difficulties that the medical community has faced in determining how to treat GD during adolescence. Section II.B describes how the doctrine of informed consent might support age-based restrictions on Medicaid coverage for gender-affirming treatment on the grounds that it presumes

160. Oregon's medical assistance program regulation provides coverage for treatments included on the prioritized list of services provided by the State's Health Evidence Review Commission (HERC). *See id.* In August 2014, HERC approved hormone treatment and sex reassignment surgery for the prioritized list of services without any age restrictions. OR. HEALTH AUTH., PRIORITIZED LIST: GUIDELINE FOR GENDER DYSPHORIA (2015), <http://www.oregon.gov/oha/herc/FactSheet/Gender-dysphoria.pdf> [https://perma.cc/236F-NN2R].

161. *See* discussion *supra* Section I.A.

162. *See* discussion *supra* Section I.C.

163. *Id.*

164. *See infra* Parts II, III.

adolescents do not have the capacity to make informed decisions about their health. In contrast, Section II.B also examines how the statutory definitions and exceptions to the doctrine of informed consent allow for minors to make informed health decisions and, therefore, undermine a bright-line age-restriction. Section II.C examines the different legal claims that may result from the age-based restrictions and whether they justify removing the age-based restriction on coverage.

A. The Medical Community's View as to the Medical Necessity of Gender-Affirming Treatment for Individuals Under the Age of Eighteen

Dispute amongst the medical community regarding the diagnosis of childhood GD may support the implementation of an age-based restriction on Medicaid coverage of gender-affirming treatment. While the DSM-V, WPATH, and APA recognize that it is possible for children to experience GD, research suggests that treating children under the age of twelve for GD may be unnecessary.¹⁶⁵ The WPATH Standards of Care note that some children may stop experiencing GD when they begin puberty and do not affirmatively recommend physical interventions for children.¹⁶⁶ The APA also notes that it is not possible to differentiate between children who will cease to experience GD from those in whom GD will persist into adolescence and adulthood.¹⁶⁷ Further complicating the treatment of GD during childhood is the lack of randomized controlled studies which might otherwise allow for a clear consensus to develop on the best methods of treating children who are experiencing GD.¹⁶⁸ Thus,

165. The DSM-V recognizes the occurrence of GD amongst children and adolescents and specifically provides diagnostic criteria for assessing GD in children. DSM-V, *supra* note 17, at 452. WPATH notes that “[c]hildren as young as two may show features that could indicate gender dysphoria.” WPATH, *supra* note 23, at 12; *see also* AM. PSYCHOLOGICAL ASS'N, REPORT OF THE APA TASK FORCE ON TREATMENT OF GENDER IDENTITY DISORDER (2011) [hereinafter REPORT OF THE APA TASK FORCE ON TREATMENT OF GENDER IDENTITY DISORDER].

166. WPATH, *supra* note 23, at 12; *see also* Peggy Cohen-Kettenis et al., *Sex Reassignment of Adolescent Transsexuals: A Follow Up Study*, 36 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 263, 263 (1997) (“Prospective studies have shown that children with gender identity disorder will not grow up to be transsexuals. In a few, however, the cross-gender feelings will remain. These individuals become adolescents who will attend gender identity clinics to obtain sex reassignment surgery (SRS).”).

167. *See* REPORT OF THE APA TASK FORCE ON TREATMENT OF GENDER IDENTITY DISORDER, *supra* note 165, at 4.

168. *Id.* The APA has identified two general approaches to treating GD during childhood: one which encourages a child to explore their expressed gender identity,

proponents of the age-based restriction may argue that there is little support for providing Medicaid coverage for gender-affirming treatment for individuals under the age of twelve.

Treating GD during adolescence also presents concerns that may support the implementation of an age-based restriction. Adolescents may have concurring mental health conditions that may make it more difficult for a mental health expert to assess them.¹⁶⁹ In addition, adolescents can become intensely focused on their immediate desires, which may make it difficult to assess whether they are cognitively and emotionally capable of making the decision to pursue gender-affirming treatment.¹⁷⁰ As a result of these concerns, some health professionals are also reluctant to treat adolescent GD on the grounds that it may motivate an adolescent to seek unnecessary treatment.¹⁷¹

Despite these concerns regarding the diagnosis and treatment of adolescent and childhood GD, the weight of support within the medical community supports gender-affirming treatment for adolescents who need it.¹⁷² The DSM-V has recognized the unique challenges in diagnosing childhood GD by adopting a separate

and another which encourages a child to adopt their assigned gender role and sex identity at birth. *Id.* at 17. The latter is based on a view that it may be less desirable for a child to adopt a non-conforming gender identity because of the social stigma that is often attached to transgender and gender non-conforming individuals. *Id.* There is, however, growing public support for the former method. *See generally* Kate Snow, *Congressman's Transgender Granddaughter Makes Him Proud*, MSNBC (Oct. 10, 2015, 8:17 PM), <http://www.msnbc.com/msnbc/congressman-mike-honda-transgender-granddaughter-makes-him-proud> [<https://perma.cc/PT5V-RRCN>].

169. *See* AM. PSYCHOLOGICAL ASS'N, GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH TRANSGENDER AND GENDER NONCONFORMING PEOPLE 17 (2015), <http://www.apa.org/practice/guidelines/transgender.pdf> [<https://perma.cc/CJC2-QTQP>] [hereinafter GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH TRANSGENDER AND GENDER NONCONFORMING PEOPLE] (“Complicating their clinical presentation, many gender-questioning adolescents also present with co-occurring psychological concerns, such as suicidal ideation, self-injurious behaviors, drug and alcohol use, and autism spectrum disorders.”).

170. *Id.*

171. Cohen-Kettenis et al., *supra* note 166, at 263 (“Professionals fear that experimenting with certain aspects of gender, such as gender role behavior, will lead adolescents to conclude that they have a gender identity problem and that they will as a result wrongly seek medical means of resolving their confusion.”).

172. *See* GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH TRANSGENDER AND GENDER NONCONFORMING PEOPLE, *supra* note 169, at 17 (noting “there is greater consensus that treatment approaches for adolescents affirm an adolescent’s gender identity”).

diagnostic criteria for childhood GD.¹⁷³ The DSM-V diagnostic criteria of adolescent GD, however, is the same as the criteria for adult GD.¹⁷⁴ In regard to treatment, the WPATH Standards of Care, which have been supported and accepted widely by mental health experts, includes separate treatment protocols for adolescent and childhood GD.¹⁷⁵ Thus, there is support from the DSM-V and WPATH Standards to suggest that the diagnosis and treatment of adolescent GD may bear fewer concerns than treatment of childhood GD.

The support for treating adolescent GD is based on studies that indicate that adolescents who experience GD throughout childhood are likely to experience those feelings into adulthood.¹⁷⁶ Thus, unlike children, most adolescents will continue to experience GD without intervention.¹⁷⁷ Additionally, adolescents beyond the age of twelve are more likely to have a firmer understanding of gender constancy,¹⁷⁸ and thus are more likely to experience persistent GD.¹⁷⁹ The growing consensus surrounding treatment of GD during adolescence is also reflected in empirical research that shows an increasing number of adolescents are seeking treatment for gender dysphoria and are living in their desired gender role upon entering high school.¹⁸⁰ Mental health experts thus note the need to address GD earlier and,

173. The DSM-V recognizes the occurrence of GD amongst children and adolescents and specifically provides diagnostic criteria for assessing GD in children. DSM-V, *supra* note 17, at 452.

174. *Id.*

175. The WPATH Standards of Care have been generally accepted by the medical community and assert the medical necessity of gender-affirming healthcare for adolescents. See *H.H.S. Medicare Decision*, *supra* note 84, at 22–23 (noting the acceptance of the WPATH Standards of Care); see also WPATH, *supra* note 23, at 10.

176. GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH TRANSGENDER AND GENDER NONCONFORMING PEOPLE, *supra* note 169, at 175.

177. de Vries et al., *supra* note 94, at 2276 (2011) (“Gender dysphoria will remit in most prepubertal children with [GD] but not in most gender dysphoric adolescents.”).

178. Gender constancy is a term used in the field of cognitive development that refers to a child’s cognitive understanding that gender is an invariant part of the self. Before developing the capacity for concrete operational thought, children often conflate gender identity with surface expressions of gender identity. Gender constancy is reached when the child has the capacity to self-label themselves as a particular gender with the understanding that engaging in certain activities (e.g. wearing boys’ clothes) will not change it. Kenneth Zucker et al., *A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder*, 59 J. HOMOSEXUALITY 369, 377 (2012).

179. *Id.*

180. *Id.*

specifically, the negative impact of delaying treatment until the individuals reach the age of eighteen or twenty-one.¹⁸¹

One method of treatment which may work to dispel the criticism of treating GD during adolescence is the use of puberty suppressants. The suppressants, which suspend the development of unwanted secondary sex characteristics, may be a viable option for adolescents who are experiencing GD.¹⁸² The Endocrine Society has also developed guidelines for the use of these suppressants that allow patients to decide, after several years of treatment, whether to pursue further gender-affirming treatment or to develop the secondary sex characteristics of their assigned sex at birth.¹⁸³ A 2010 follow-up study of seventy adolescents who began taking puberty suppressants between the ages of twelve and sixteen found that all participants continued to pursue gender-affirming treatment into adulthood and demonstrated a significant decrease in depression and emotional problems.¹⁸⁴ More recently in 2014, a follow-up study of adolescents who began taking puberty suppressants found that those adolescents were generally satisfied with the results and had greater psychological functioning as a result.¹⁸⁵ Thus, medical research may also support extending Medicaid coverage to gender-affirming treatments such as puberty suppressants to individuals under the age of eighteen.

181. de Vries et al., *supra* note 94, at 2277 (“However, as secondary sex characteristics develop before the age of 16, waiting for medical interventions is highly upsetting for most younger adolescents.”); *see also* Cohen-Kettenis et al., *supra* note 166, at 263 (“Despite the early onset of the disorder, in most countries it is common practice not to start the actual SRS procedure earlier than 18 or even 21 years of age.”); Yolanda L.S. Smith et al., *Adolescents with Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-Up Study*, 40 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 472, 472 (2001) (“Despite the early onset of gender identity disorder (GID) in many transsexuals, and in spite of the fact that transsexuals apply for sex reassignment surgery (SRS) at increasingly younger ages, it is common practice not to start the actual sex reassignment (SR) procedure before the age of 18 or 21 years.”).

182. *See* GUIDELINES FOR PSYCHOLOGICAL PRACTICE WITH TRANSGENDER AND GENDER NONCONFORMING PEOPLE, *supra* note 169, at 17; *see also* REPORT OF THE APA TASK FORCE ON TREATMENT OF GENDER IDENTITY DISORDER, *supra* note 165, at 6.

183. *See* REPORT OF THE APA TASK FORCE ON TREATMENT OF GENDER IDENTITY DISORDER, *supra* note 165, at 6.

184. de Vries et al., *supra* note 94, at 2276–77 (“Previous studies on the effectiveness of [gender affirming treatment], starting at with cross-sex hormone (CSH) treatment between the ages of 16 and 18, showed that the gender dysphoria had dissipated, 1 year or more after GR surgery and that psychological and social functioning of these young transsexuals was favorable.”).

185. *See generally* Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 PEDIATRICS 6, 11–12 (2014).

B. Age Restrictions on the Access to Gender-Affirming Healthcare May be Inconsistent with Principles of Informed Consent

Conflicting rationales for and against an age-based restriction on Medicaid coverage for gender-affirming treatment may also be based on the doctrine of informed consent. The doctrine of informed consent presumes that minors do not have the capacity to fully understand health decisions and, thus, cannot give informed consent to treatment.¹⁸⁶ The doctrine may provide support for the age-based restrictions in section 505.2 on the grounds that adolescents would not be able to provide consent to undergo gender-affirming treatment. On the other hand, statutory definitions and exceptions to the doctrine of informed consent may suggest that a bright-line age restriction to coverage is inappropriate.

1. *Support for the Age-Based Restriction as a Mechanism to Enforce the Doctrine of Informed Consent*

The doctrine of informed consent generally limits the kinds of decisions minors can make without parental consent on the grounds that children and adolescents do not have the capacity to make fully informed decisions.¹⁸⁷ The Supreme Court has consistently upheld the doctrine and distinguished adolescents from fully formed adults who have a greater capacity to make decisions.¹⁸⁸ In *Roper v. Simmons*, the Court held that the Eighth Amendment forbids the imposition of the death penalty on offenders who are under the age of eighteen at the time of the offense.¹⁸⁹ The Court reasoned that the death penalty is an unnecessary and inappropriate punishment for adolescent offenders because adolescents are more likely than adults to engage in reckless behavior and are not likely to consider the consequences of their actions.¹⁹⁰ Justice Kennedy noted that research confirms “a lack of maturity and an underdeveloped sense of responsibility are found in youth more often than in adults These qualities often result in impetuous and ill-considered actions

186. Shield, *supra* note 31, at 393 (citing *Schall v. Martin*, 467 U.S. 253, 265 (1984) (“Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae*.”)).

187. *Id.* at 393–94.

188. *See Roper v. Simmons*, 543 U.S. 551, 571–73 (2005); *Bellotti v. Baird*, 443 U.S. 622, 633, 635 & n.13 (1979).

189. *Roper*, 545 U.S. at 578.

190. *Id.* at 569–72.

and decisions.”¹⁹¹ Kennedy thus reasoned that the law should treat youth differently than adults because of a discrepancy in decision-making capability.¹⁹²

The Court has similarly considered the limited decision-making capabilities of adolescents in the context of health decisions.¹⁹³ In *Bellotti v. Baird*, the Court heard a challenge to a Massachusetts statute that required minors to obtain parental consent or authorization from a court before undergoing abortions.¹⁹⁴ While the Court acknowledged the constitutional right of a pregnant minor to choose to terminate her pregnancy, it ultimately held that the vulnerability of children, their inability to make important decisions, and the state’s interest in protecting the parental role in child rearing justified limiting the scope of a child’s constitutional rights.¹⁹⁵ Writing for the majority, Justice Powell concluded that because “immature minors often lack the ability to make fully informed choices that take into account both the immediate and long-range consequences,”¹⁹⁶ states may validly “limit the freedom of children to choose for themselves in the making of important, affirmative choices with potentially serious consequences.”¹⁹⁷ The Court thus balanced the doctrine of informed consent with an adolescent’s right to choose to terminate a pregnancy by upholding the Massachusetts requirement for parental consent on the condition that the state also allows adolescents to bypass the requirement when a court finds that the minor is mature enough to make a fully informed decision and that the decision is in her best interests.¹⁹⁸

The Court’s decisions in *Bellotti* and *Roper* may provide support for the age-based restriction in section 505.2. The reasoning in *Roper* adopted the view of adolescents as being susceptible to reckless

191. *Id.* at 569.

192. Shield, *supra* note 31, at 405.

193. *See, e.g., Bellotti*, 443 U.S. at 639 (hearing a challenge regarding a state statute which required that adolescents receive parental consent prior to obtaining an abortion).

194. *Id.* at 625 (ruling on the constitutionality of Mass. Gen. Laws Ann., ch. 112, § 12S (West Supp. 1979), which provided in relevant part: “If the mother is less than eighteen years of age and has not married, the consent of both the mother and her parents [to an abortion to be performed on the mother] is required. If one or both of the mother’s parents refuse such consent, consent may be obtained by order of a judge of the superior court for good cause shown, after such hearing as he deems necessary.”)

195. *Bellotti*, 443 U.S. at 633.

196. *Id.* at 640.

197. *Id.* at 635.

198. *Id.* at 643–44.

decisions that are not made with due consideration.¹⁹⁹ Likewise, the Court in *Bellotti* held that states are justified in protecting adolescents from poor decisions, even if that health decision is constitutionally protected.²⁰⁰ Thus, the age-based restriction on Medicaid coverage may work to protect adolescents from deciding they need gender-affirming treatment when they are less likely to fully consider the consequences of this decision.

2. *Age-Based Restrictions May Conflict with Exceptions to the Doctrine of Informed Consent*

While the doctrine of informed consent may support age-based restrictions on gender-affirming treatment, the statutory definitions of informed consent suggest that a blanket age-restriction is inappropriate. Although most states set the age of informed consent at eighteen, statutory definitions also generally focus on the capacity of the individual to make decisions about his or her health.²⁰¹ For instance, in New York, informed consent “means that the patient has to demonstrate the intellect to understand what is being proposed, to realize and assess the risks and benefits, and to voluntarily consent to or refuse the proposed major medical treatment.”²⁰² On this basis, some states, such as Oregon, have set the age of consent below the age of eighteen, which authorizes adolescents to give informed consent when they are fifteen.²⁰³ Thus, the age-based restriction of section 505.2 may conflict with the doctrine of informed consent as it focuses solely on the age of the individual and not his or her actual ability to make informed decisions.

199. *Roper*, 545 U.S. at 569; Alicia Ouellette, *Body Modification and Adolescent Decision Making: Proceed with Caution*, 15 J. HEALTH CARE L. & POL’Y 129, 138–39 (2012) (discussing the *Roper* decision and its application to parental consent to body modification).

200. Shield, *supra* note 31, at 394.

201. N.Y. COMP. CODES R. & REGS. tit. 14, § 710.1 (2016).

202. *Id.*

203. OR. REV. STAT. § 109.640(2) (2013) (“A minor 15 years of age or older may give consent to, without the consent of a parent or guardian of the minor to . . . [h]ospital care, medical or surgical diagnosis or treatment by a physician licensed by the Oregon Medical Board.”); *see also* 23 R.I. GEN. LAWS § 23-4.6-1 (2012) (“Any person of the age of sixteen or over or married may consent to routine emergency medical or surgical care.”); ALA. CODE § 22-8-4 (2010) (“Any minor who is 14 years of age or older, or has graduated from high school, or is married, or having been married is divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself, and the consent of no other person shall be necessary.”).

Research shows that by the time they reach sixteen, adolescents have the same cognitive capacity as adults to make decisions about medical treatment.²⁰⁴ Adolescents who are sixteen have essentially the same cognitive abilities as adults to process and understand information and to appreciate the nature of a given situation.²⁰⁵ The risk-taking behavior and “impetuous and ill-considered actions” of adolescents that the Court noted in *Roper* is generally not attributed to limited cognitive development but rather to emotionally charged or high-pressure situations that require adolescents to control impulses.²⁰⁶ Most scholars agree that health decisions are devoid of the same stressors that compromise adolescent decision-making in other contexts.²⁰⁷ To this point, three studies examining the decision making process of adolescents who are deciding whether to undergo an abortion found that adolescents conceptualized and considered treatment in the same manner as adults.²⁰⁸

Most states have also carved out exceptions in their informed consent statutes, recognizing that certain adolescents may be able to provide informed consent despite being minors.²⁰⁹ These exceptions may be divided into two categories: statutes that permit minors to give informed consent when they hold a certain status and statutes

204. Oullette, *supra* note 199, at 144 (“Consistently research on the development of adolescent decision making, judgment, and brain development supports the capacity of adolescents in medical decision making, when the criteria for measuring decisional capacity in adults are applied.”); *see also* Vivian E. Hamilton, *Immature Citizens and the State*, 2010 B.Y.U. L. REV. 1055, 1109 (2010).

205. Hamilton, *supra* note 204, at 1109; *see also* Andrew Newman, *Adolescent Consent to Routine Medical and Surgical Treatment*, 22 J. LEGAL MED. 501, 528 (2001) (“There seems to be agreement that somewhere around the age of 15 of 16, persons acquire sufficient decisional capacity to make reasoned decisions.”).

206. Newman, *supra* note 205, at 528.

207. Ouellette, *supra* note 199, at 146 (“Most scholars argue that the deficiencies (impulsiveness, excessive risk-taking, susceptibility to peer pressure) are not relevant in the healthcare context to the same degree they are in the juvenile justice context.”).

208. Shield, *supra* note 31, at 403 (citing Bruce Ambuel, *Developmental Trends in Adolescents’ Psychological and Legal Competence to Consent to Abortion*, 16 L. & HUM. BEHAV. 129 (1992); Catherine C. Lewis, *A Comparison of Minors’ and Adults’ Pregnancy Decisions*, 50 AM. J. ORTHOPSYCHIATRY 446 (1980)) (finding that “adolescents could conceptualize and reason about treatment possibilities as capably as adults.”).

209. Newman, *supra* note 205, at 504 (“There are exceptions to the standard rule that, until one reaches majority, one cannot lawfully make a final decision as to medical treatment. Two exceptions that are generally recognized are the emergency exception and ‘the emancipated minor’ exception.”).

that allow minors to give informed consent when they are seeking a particular kind of procedure.²¹⁰

The status-based exceptions allow a minor to give informed consent when they are emancipated, married, have children, are in the military, or are deemed to be a “mature minor” by a court.²¹¹ For instance, New York provides that minors who are married or have given birth may give consent for their own health and the health of their children.²¹² The mature minor exception requires a court to assess whether a minor’s decision-making capacity is that of an adult.²¹³

Courts have recognized the validity of a mature minor adjudication in the context of a right to refuse treatment.²¹⁴ In *In re E.G.*, the Supreme Court of Illinois held that a seventeen-year-old girl with leukemia, who would not consent to a medically necessary blood transfusion because she was a Jehovah’s Witness, had a right to refuse such treatment.²¹⁵ The court noted that while the age of consent was eighteen in Illinois, a minor is entitled to exercise a right to refuse treatment if there is clear and convincing evidence she is “mature enough to exercise the judgment of an adult.”²¹⁶ The court also noted that the state’s status and procedure-based exceptions to informed

210. Shield, *supra* note 31, at 398.

211. N.Y. PUB. HEALTH LAW § 2504(1),(2) (McKinney 2012); Shield, *supra* note 31, at 419 (citing other states: GA. CODE ANN. § 31-9-2(a)(3) (2006); MD. CODE ANN., HEALTH-GEN. § 20-102 (West 2016); COLO. REV. STAT. ANN. § 13-22-103 (West 2016); S.C. CODE ANN. § 63-5-330 (2015); 35 PA. STAT. AND CONS. STAT. ANN. § 10101 (West 2015)).

212. *See* Shield, *supra* note 31, at 419.

213. *Id.* at 399; *Bellotti v. Baird*, 443 U.S. 622, 644 (1979) (“We therefore conclude that if the State decides to require a pregnant minor to obtain one or both parents’ consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained.”).

214. Martin T. Harvey, *Adolescent Competency and the Refusal of Medical Treatment*, 13 HEALTH MATRIX 297, 301–08 (2003) (explaining a minor may be granted informed consent if she can “prove competency by evidencing her capacity to provide a thorough understanding of the consequences of her proposed decision to terminate treatment along with well articulated reasons as to why her decision ought to be respected”); *see In re E.G.*, 549 N.E.2d 322, 327–28 (Ill. Sup. Ct. 1989); *In re Rena*, 46 Mass. App. Ct. 335, 337–38 (1999) (finding lower court erred in not making a determination as to a seventeen-year-old girl’s maturity); *but see, In re Long Island Jewish Medical Center*, 17 Misc.2d 724, 730 (Sup. Ct. of Westchester 1990) (“While this Court believes there is much merit to the ‘mature minor’ doctrine, I find that [petitioner] is not a mature minor.”).

215. *In re E.G.*, 549 N.E.2d at 323–25.

216. *Id.* at 328.

consent indicate that the legislature did not intend for a bright line age-based barrier to informed consent.²¹⁷

The procedure-based exceptions allow minors to give informed consent for certain procedures.²¹⁸ Following the Supreme Court's ruling in *Carey v. International Population Services*,²¹⁹ a number of states permit minors to give informed consent to obtain contraceptives or abortions without parental consent.²²⁰ New York also allows minors to give informed consent for procedures that are not constitutionally protected, such as prenatal care, substance abuse treatment, and certain outpatient mental health services.²²¹

Thus, statutory definitions and exceptions to the doctrine of informed consent may provide support for removing the age-based restrictions in section 505.2. Definitions of informed consent generally focus on the decision-making capacity of individuals.²²² Despite being more prone to emotionally charged situations, adolescents have been shown to have the same decision-making capacity as adults and may exercise the same or similar judgment as adults when making healthcare related decisions.²²³ Furthermore, states appear to have recognized that, in some health contexts, adolescents have the capacity to give informed consent.²²⁴ Although the doctrine of informed consent presumes minors are incapable of making informed decisions, the definitions and exceptions to the doctrine also suggest that adolescents may have the capacity to make

217. *Id.* at 325–26 (citing the state's status-based exception and procedure-based exceptions and finding that the "two acts, when read together in a complementary fashion, indicate that the legislature did not intend that there be an absolute 18-year-old age barrier prohibiting minors from consenting to medical treatment.").

218. *See* Shield, *supra* note 31, at 399.

219. *Carey v. Population Serv. Int'l*, 431 U.S. 678, 695–96 (1977).

220. Shield, *supra* note 31, at 399 (explaining the Supreme Court's holding in *Carey v. Population Services International*, which indicated that states cannot ban minors from obtaining contraception, and that states have extended this ruling to allow minors to access contraceptives without parental consent); *see, e.g.*, CAL. FAM. CODE § 6925 (West 1996) (allowing minors to consent to an abortion without parental consent).

221. *See* N.Y. PUB. HEALTH § 2504 (McKinney 2012) (allowing pregnant minors to consent prenatal care); N.Y. MENTAL HYG. LAW § 22.11(c) (McKinney 2016) (allowing minors to consent to substance abuse treatment); *see also* N.Y. MENTAL HYG. LAW § 33.21 (McKinney 2016) (providing for medical practitioners to provide outpatient mental health treatment to minors where the minor voluntarily seeks services, and their parents are unavailable or have refused to consent to the health treatment which the practitioner determines is medically necessary).

222. N.Y. COMP. CODES R. & REGS. tit. 14, § 710.1 (2016).

223. Newman, *supra* note 205, at 528; Ouellette, *supra* note 199, at 146.

224. Shield, *supra* note 31, at 398.

informed health decisions such as undergoing gender-affirming treatment.

C. Age Restrictions May Give Rise to Legal Claims

As noted above, the medical community's current view of treating GD and the doctrine of informed consent provides rationales that support and oppose the age-based restrictions for Medicaid coverage of gender-affirming treatment.²²⁵ Additionally, there may be conflicting views as to whether age-based restrictions on Medicaid coverage for gender-affirming treatment will give rise to valid legal claims or the withholding of federal Medicaid funds, which would justify removing the restrictions. State programs, such as New York's, that deny coverage of gender-affirming treatment on the basis of age may be susceptible to legal claims brought by individuals under the Patient Protection and Affordable Care Act (ACA), which prohibits programs from discriminating on the basis of gender identity.²²⁶ Likewise, states that restrict Medicaid coverage of gender-affirming treatment on the basis of age may be subject to HHS enforcement actions on the grounds that such restrictions violate 42 U.S.C. §§ 1396 et seq., otherwise known as the Medicaid Act.²²⁷

1. Age-Based Restrictions Could Give Rise to Claims Under the Affordable Care Act

A Medicaid regulation that imposes age restrictions on hormone therapy and gender affirming surgery could give rise to legal claims brought under the Affordable Care Act. Since its passage in 2010, the ACA has been described as the biggest overhaul of the U.S. healthcare system since the authorization of Medicaid and Medicare in 1965.²²⁸ The Act implemented a number of reforms that were intended to improve the quality of and access to healthcare, while

225. See discussion *supra* Sections II.A, II.B.

226. See 42 U.S.C. § 18116 (2012).

227. See 42 U.S.C. § 1396(c) (2012).

228. 70C AM. JUR. 2D *Social Security and Medicare* § 1905 (2016), (“The contemplated changes to the U.S. healthcare system, resulting from the Act, have been described as being ‘on a scale not seen since the enactment of Medicare in 1965.’”); James Vicini et al., *Top Court Upholds Healthcare Law in Obama Triumph*, REUTERS (Jun. 28, 2012), <http://www.reuters.com/article/us-usa-healthcare-court-idUSBRE85R06420120628> [<https://perma.cc/ZAP7-EBVL>] (“The healthcare law, known formally as the Patient Protection and Affordable Care Act, is the biggest overhaul of the \$2.6 trillion healthcare system in about 50 years.”).

also lowering the costs of healthcare.²²⁹ Pursuant to its goal of increasing access to affordable healthcare, the ACA prohibits insurance providers and state Medicaid programs from discriminating on the basis of race, sex, age, or disability.²³⁰

It is unclear whether challenges to the age-based restrictions in section 505.2 would succeed. First, while HHS has implied that disparate coverage for transgender individuals amounts to sex discrimination,²³¹ federal courts have yet to recognize transgender identity as a protected status.²³²

The ACA's prohibition on sex discrimination draws its authority from Title IX of the Education Amendments of 1972.²³³ Title IX prohibits programs that receive federal financial assistance from denying benefits on the basis of sex.²³⁴ Although the ACA does not explicitly prohibit discrimination on the basis of gender identity, the Director of the HHS Office for Civil Rights, the body that enforces the anti-discrimination provisions of the ACA, issued a letter to trans-rights advocates clarifying HHS's view that the ACA anti-discrimination provision extends to discrimination on the basis of

229. See generally *Key Features of the Affordable Care Act by Year*, U.S. DEP'T OF HEALTH & HUM. SERVS., <http://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca-by-year/index.html#> [<https://perma.cc/BG4T-8SW6>] (last updated Aug. 13, 2015).

230. See 42 U.S.C. § 18116 (2012).

231. See Letter from Leon Rodriguez, Dir. of Office for Civil Rights, Dep't of Health & Human Servs., to Maya Rupert, Fed. Policy Dir., Nat'l Ctr. for Lesbian Rights (July 12, 2012), <https://www.nachc.com/client/OCRLetterJuly2012.pdf> [<https://perma.cc/F3CB-8VYN>]; see also *Nondiscrimination in Health Programs and Activities*, 80 Fed. Reg. 54,172 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

232. *Johnston v. Univ. of Pittsburgh of Commonwealth Sys. of Higher Educ.*, 97 F. Supp. 3d 657, 674 (W.D. Pa. 2015).

233. 42 U.S.C. § 18116 (2012) ("Except as otherwise provided for in 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.").

234. 20 U.S.C. §1681(a) (2012) ("No person in the United States shall, on the basis of sex, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.").

gender identity and sex stereotypes.²³⁵ Moreover, HHS has also proposed using its rule to implement the anti-discrimination provision of the ACA, which defines sex stereotypes as including “expectations that gender can only be constructed within two distinct opposite and disconnected forms (masculinity and femininity), and that gender cannot be constructed outside of this gender construct (individuals who identify as neither, both, or a combination of male and female).”²³⁶ The proposed regulation contains provisions that specifically address discrimination against transgender individuals in health insurance and Medicaid coverage.²³⁷ Under these provisions, an explicit, categorical exclusion of coverage for all health services related to gender affirmation would be unlawful sex discrimination.²³⁸ Likewise, the proposed rule elaborates that limiting coverage or denying coverage of a specific claim on the basis of gender identity might also be prohibited under the ACA.²³⁹ Individuals might thus seek to bring claims against the state on these grounds.

Individual Medicaid recipients would also have a private cause of action to challenge a state’s Medicaid program under Title IX.²⁴⁰ The ACA expressly adopts the enforcement mechanisms of Title IX to prohibit a denial of benefits on the basis of sex,²⁴¹ and the United States Supreme Court has read an implied right of action into Title IX.²⁴² In *Cannon v. University of Chicago*, the Court held that while it is better for Congress to specify when a statute provides a right of action, its failure to do so is not dispositive.²⁴³ Examining Title IX, the Court used a four-factor test to find that the statute was intended to include a private right of action.²⁴⁴ Additionally, the Court noted that

235. See Letter from Leon Rodriguez, *supra* note 231.

236. Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. at 54,172.

237. *Id.* at 69 (“Paragraphs (b)(3) through (5) of the proposed rule specifically address discrimination faced by transgender individuals in accessing coverage of health services.”).

238. *Id.* at 72–73 (“Based on these principles, an explicit, categorical (or automatic) exclusion of coverage for all health services related to gender transition is unlawful on its face under paragraph (b)(4); in singling out the entire category of services and treatments for gender-affirming care, such an exclusion systematically denies services and treatments for transgender individuals and is prohibited discrimination on the basis of sex.”).

239. *Id.* at 73.

240. 42 U.S.C. § 18116(a) (2016).

241. *Id.*

242. *Franklin v. Gwinnett Cty. Pub. Sch.*, 503 U.S. 60, 65 (1992); *Cannon v. Univ. of Chi.*, 441 U.S. 677, 709 (1979).

243. *Cannon*, 441 U.S. at 717.

244. *Id.* at 688. Citing its decision in *Cort v. Ash*, 422 U.S. 66, 78 (1975), the Court held that a court must first review the following four factors before deciding whether

Title IX was modeled on Title VI of the Civil Rights Act,²⁴⁵ which was intended to offer victims of discrimination a private cause of action.²⁴⁶ Litigants would thus have standing to bring a claim under Title IX, through 42 U.S.C. § 1983 to challenge age-based restrictions in section 505.2. However, the likelihood of success of these claims may be uncertain given courts' interpretation of Title IX as it applies to discrimination on the basis of gender identity.

Although HHS has made clear its view that discrimination on the basis of transgender identity is unlawful under Title IX, courts have not recognized transgender identity as a protected status under Title IX.²⁴⁷ For instance, in *Johnston v. University of Pittsburgh*, the Western District of Pennsylvania held that a university receiving federal funds did not violate Title IX by prohibiting a transgender male student from using sex-segregated locker rooms and bathrooms.²⁴⁸ In order to determine whether the language of Title IX could be construed as prohibiting discrimination on the basis of gender identity, the court referred to Title VII claims of employment discrimination.²⁴⁹ Circuit Courts have generally held that Title VII does not prohibit employment discrimination on the basis of gender identity, but rather only prohibits employers from discriminating on the basis of a traditional binary formulation of sex.²⁵⁰ Thus, while it

a federal statute provides a private of action: "1) whether the statute was enacted for the benefit of a special class of which the plaintiff is a member, (2) whether there is any indication of legislative intent to create a private remedy, (3) whether implication of such a remedy is consistent with the underlying purposes of the legislative scheme, and (4) whether implying a federal remedy is inappropriate because the subject matter involves an area basically of concern to the States." *Id.* at 689–709.

245. *See* 42 U.S.C. § 2000(d) (2012).

246. *Cannon*, 441 U.S. at 703 ("We have no doubt that Congress intended to create Title IX remedies comparable to those available under Title VI and that it understood Title VI as authorizing an implied private cause of action for victims of the prohibited discrimination.").

247. *See Johnston v. Univ. of Pittsburgh of Commonwealth Sys. of Higher Educ.*, 97 F. Supp. 3d 657, 674 (W.D. Pa. 2015); Letter from Leon Rodriguez, *supra* note 231.

248. *Johnston*, 97 F. Supp. 3d at 661.

249. *Id.* at 674.

250. *Id.* at 675 (citing *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081, 1085 (7th Cir. 1984), which held: "The words of Title VII do not outlaw discrimination against a person who has a sexual identity disorder, i.e., a person born with a male body who believes himself to be female, or a person born with a female body who believes herself to be male; a prohibition against discrimination based on an individual's sex is not synonymous with a prohibition against discrimination on an individual's sexual identity disorder or discontent with the sex into which they were born."); *see also Etsitty v. Utah Transit Auth.*, 502 F.3d 1215 (10th Cir. 2007) ("In light of the traditional binary conception of sex, transsexuals may not claim protection under Title VII from discrimination based solely on their status as a transsexual.").

may be illegal to discriminate against a woman or a man because of their sex assigned at birth, it is not unlawful to discriminate against a transgender woman because of her transgender identity.²⁵¹ Following this reading of Title VII, the court in *Johnston* held that neither Title VII nor Title IX would provide a basis for a discrimination claim on the basis of transgender status without Congressional adoption of a broader definition of “sex.”²⁵²

In order to avoid the plain language of Title VII or Title IX, transgender litigants might argue that a denial of coverage was based on their failure to meet sex stereotypes.²⁵³ In *Price Waterhouse v. Hopkins*,²⁵⁴ the Supreme Court held that an employer violated Title VII when it denied a female employee a promotion on the grounds that she did not meet stereotypes associated with women.²⁵⁵ Transgender litigants might find support with this theory as the Department of Education has released letters of clarification, informing school districts that it will apply the prohibition on sex-stereotyping of Title VII to Title IX.²⁵⁶ Courts have also construed Title IX as prohibiting discrimination on the basis of non-conformity with gender stereotypes.²⁵⁷ However, it is not evident that litigants would prevail under a sex-stereotyping theory, as the court in *Johnston* held that the

251. *Ulane*, 742 F. 2d at 1085; *cf.* *Schroer v. Billington*, 577 F. Supp. 2d 293, 305 (D.D.C. 2008).

252. *Johnston*, 97 F. Supp. 3d at 676–77.

253. *Id.* at 679–80.

254. *Price Waterhouse v. Hopkins*, 490 U.S. 228, 258 (1989).

255. *Id.* at 250 (“[A]n employer who acts on the basis of a belief that a woman cannot be aggressive, or that she must not be, has acted on the basis of gender.”).

256. U.S. DEP’T OF EDUC., OFF. FOR CIVIL RIGHTS, QUESTIONS AND ANSWERS ON TITLE IX AND SEXUAL VIOLENCE 5 (2014) (“Title IX’s sex discrimination prohibition extends to claims of discrimination based on gender identity or failure to conform to stereotypical notions of masculinity or femininity and OCR accepts such complaints for investigation.”) <http://www2.ed.gov/about/offices/list/ocr/docs/qa-201404-title-ix.pdf> [<https://perma.cc/MR3D-7FXD>]; Letter from Russlynn Ali, Assistant Sec’y for Civil Rights, U.S. Dep’t of Educ., to Colleague (Oct. 26, 2010), <http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010.html> [<https://perma.cc/NM6G-CFHN>] (explaining to school officials across the country that Title IX’s prohibition on sex discrimination prohibits harassment of lesbian, gay, bisexual, or transgender students based on gender nonconformity)..

257. Letter from Russlynn Ali, *supra* note 256; *see Wolfe v. Fayetteville, Ark. Sch. Dist.*, 648 F. 3d 860, 867 (8th Cir. 2011) (upholding the district court’s jury instructions that a Title IX claim must show that harassment in school was motivated by the plaintiff’s “gender or his failure to conform to stereotypical male characteristics”); *Pratt v. Indian River Cent. Sch. Dist.*, 803 F. Supp. 2d 135, 151 & n.9 (N.D.N.Y. 2011) (noting that the Supreme Court looked to its interpretation of Title VII when considering sex discrimination under Title IX in *Davis v. Monroe County Board of Education*, 526 U.S. 629, 631 (1999), and *Franklin v. Gwinnett County Public Schools*, 503 U.S. 60, 74 (1992)).

University did not discriminate on the basis of sex stereotypes.²⁵⁸ The court reasoned that instead of requiring that the student dress or act a certain way consistent with a gender role, the University distinguished the plaintiff from others on the basis of his sex assigned at birth.²⁵⁹ Thus, it may be difficult for litigants to pursue a sex-stereotyping theory where the Medicaid program is not classifying or distinguishing individuals on the basis of their conduct.

In addition to facing challenges as to whether Title IX would prohibit the age-based restriction of Medicaid coverage, litigants would also have to show that the restriction did in fact discriminate on the basis of sex.²⁶⁰ Litigants might be able to argue that the age restrictions are discriminatory as they deny transgender youth medically necessary treatments that are otherwise offered to cisgender youth.²⁶¹ Claimants could offer evidence of the surgeries such as “complete mastectomy, mammoplasty, plastic operation on breasts, reconstructive surgery of the genitalia, amputation of the penis, plastic operation on penis, orchiectomy, scrotoplasty, urethroplasty, construction of artificial vagina with or without graft, vulvectomy, episioplasty, salpingo-ooporectomy, and hysterectomy,” are all listed on the state’s schedule for reimbursement and could thus be available to cisgender minors who require these procedures for conditions other than GD.²⁶² In addition, claimants could offer evidence that puberty suppressors could be covered for cisgender youth but not for transgender youth as the FDA has approved use of certain hormones for the treatment of early onset puberty, diagnosed as “precocious puberty.”²⁶³ For instance, New York’s Medicaid

258. *Johnston*, 97 F. Supp. 3d at 681.

259. *Id.*

260. *See* 20 U.S.C. § 1681 (2012).

261. Memorandum of Law in Support of Plaintiffs’ Motion for Preliminary Injunction and Class Certification at 3, *Cruz v. Zucker*, No. 14 CV 4456 (S.D.N.Y. July 3, 2014).

262. *Id.* at 23–24 (citing N.Y. COMP. CODES R. & REGS. tit. 18, § 533.5 (2016)).

263. *See, e.g.*, U.S. FOOD & DRUG ADMIN., HIGHLIGHTS OF PRESCRIBING INFORMATION: SUPPRELIN LA, http://www.accessdata.fda.gov/drugsatfda_docs/label/2013/022058s011bl.pdf [https://perma.cc/CM4U-BS7E] (“SUPPRELIN LA (histrelin acetate) subcutaneous implant is indicated for the treatment of children with central precocious puberty (CPP).”); Regan Morris, *Transgender 13-Year-Old Zoey Having Therapy*, BBC (Jan. 12, 2015), <http://www.bbc.com/news/world-us-canada-30783983> [https://perma.cc/XNB3-MTVY] (“The puberty suppressors Zoey and others take are reversible and FDA-approved because they have been used for decades in children going through premature puberty.”).

program currently covers prescriptions for the drug Lupron Depot,²⁶⁴ which has been approved by the FDA to treat precocious puberty.²⁶⁵ Showing this disparity in coverage could support a claim under the ACA that the state is impermissibly limiting coverage on the basis of transgender identity.

On the other hand, it is also unclear as to whether such evidence would be sufficient, even if a court considers the view of HHS. While *Zucker* proved to be successful and consisted of claims under the Medicaid Act and Title IX, a case brought by transgender youth would face a number of new obstacles. First, it may be difficult to obtain evidence that Medicaid provides coverage for hormones for cisgender adolescents or coverage for genital surgery.²⁶⁶ The state has also asserted that the age restriction was put in place because the FDA has not approved puberty suppressants or hormones to treat GD for individuals under the age of eighteen.²⁶⁷ In at least one other state, however, Medicaid would cover puberty suppressants because the FDA has approved the use of such drugs to treat precocious puberty.²⁶⁸ The conflicting views of the HHS and the courts as to whether Title IX would prohibit discrimination on the basis of transgender identity provide support and opposition to the assertion that the age-based restriction is vulnerable to legal challenges. Further, it is also unclear whether or not there would be factual or legal support for a discrimination claim under the ACA and, consequently, whether the age-based-restriction on Medicaid coverage leaves the state vulnerable to legal challenges brought by individuals.

264. N.Y. STATE DEP'T OF HEALTH, MEDICAID LIST OF REIMBURSABLE DRUGS 273 (2016), <https://www.emedny.org/info/fullform.pdf> [<https://perma.cc/N88G-DNEK>].

265. *See generally* U.S. FOOD & DRUG ADMIN., LUPRON DEPOT (LEOPROLIDE ACETATE FOR DEPOT SUSPENSION) PRESCRIBING INFORMATION (2013) http://www.accessdata.fda.gov/drugsatfda_docs/label/2013/019732s040,020517s0351bl.pdf [<https://perma.cc/66Q5-3PZX>].

266. A 2013 report on a pilot program for Medicaid of precocious puberty noted that there were fewer than 300 patients who sought puberty suppressors for precocious puberty. FLA. AGENCY FOR HEALTHCARE ADMIN., FLORIDA MEDICAID SPECIALTY PHARMACY PILOT PROGRAM FOR CENTRAL PRECOCIOUS PUBERTY IMPLEMENTATION AND STATUS 3 (2013), https://ahca.myflorida.com/Medicaid/recent_presentations/PPP_Report_Final.pdf [<https://perma.cc/N7KA-6J5T>].

267. N.Y. DEP'T OF HEALTH, TRANSGENDER RELATED CARE AND SERVICES 13-14, (2015) http://health.ny.gov/regulations/recently_adopted/docs/2015-03-11_transgender_related_care_and_services.pdf [<https://perma.cc/RL3M-DMYS>].

268. Morris, *supra* note 263.

2. *Age Restrictions May Be Vulnerable to Challenges Under the Reasonable Standards Requirement of the Medicaid Act*

In addition to claims brought by individuals, New York's age-based restriction on Medicaid coverage of gender-affirming healthcare may also face enforcement actions by HHS for violating Title XIX of the Social Security Act (the Medicaid Act). While individuals do not have a private right of action under the Medicaid Act, the Secretary of HHS is authorized to withhold Medicaid funds from a state that violates the Medicaid Act.²⁶⁹ The Medicaid Act requires states to implement Medicaid programs with "reasonable standards"²⁷⁰ that must aim to provide medical services "sufficient in amount, duration, and scope to reasonably achieve its purpose."²⁷¹ In addition, states may not arbitrarily deny or reduce treatment solely because of the type of illness.²⁷² Because there is some support from the medical community that gender affirming treatment is medically necessary for adolescents, the Secretary could find that the age-based restriction is unreasonable.²⁷³ In this circumstance, New York could risk the withdrawal of Medicaid funding by the Secretary of HHS.

a. *The Medicaid Act Conditions Federal Funding of State Medicaid Programs on Certain Requirements*

Medicaid regulations that limit coverage of gender-affirming healthcare on the basis of age might be viewed as failing to comply with the requirements of the Medicaid Act.²⁷⁴ The objective of the Medicaid Act was to enable states to provide medical assistance to those who could not afford it.²⁷⁵ In order to meet this objective, the Medicaid Act authorizes the federal government to disburse funds to states with Medicaid programs that provide medical assistance and treatment to individuals who meet income and categorical eligibility requirements.²⁷⁶

269. 42 U.S.C. § 1396(c) (2012).

270. *See* Lankford v. Sherman, 451 F.3d 496, 506 (8th Cir. 2006) ("While a state has considerable discretion to fashion medical assistance under its Medicaid plan, this discretion is constrained by the reasonable-standards requirement.").

271. 42 C.F.R. § 440.230 (2012).

272. *Id.*

273. 42 U.S.C. § 1396a(a)(17) (2012).

274. 42 U.S.C. §§ 1396 et seq (2012).

275. *Schweiker v. Hogan*, 457 U.S. 569, 571–72 (1982).

276. 42 U.S.C. § 1396b (2012).

The Supreme Court views the Medicaid Act as a contract between the states and the federal government.²⁷⁷ States thus must comply with federal Medicaid statutes and regulations in order to receive federal Medicaid funds.²⁷⁸ Under § 1396(c) of the Medicaid Act, the Secretary of HHS is authorized to withhold all or a portion of a state's Medicaid funds when a state "breaches" the contract by failing to comply with the requirements of the Act.²⁷⁹ In *Armstrong v. Exceptional Child Center*, the Court held that Congress intended § 1396(c) to be the exclusive remedy for a state's failure to comply with the Act.²⁸⁰ Under this framework, the Court held that the Medicaid Act does not provide an implied right of action and, therefore, may not be enforced by private claims.²⁸¹ As such, states will not face private litigation under the Medicaid Act, but could still face enforcement action from the Secretary of HHS.

b. Programs That Restrict Coverage of Gender-Affirming Healthcare May Be Interpreted as Unreasonable

Section 1396(a) of the Medicaid Act requires that all state Medicaid programs provide coverage for seven broad categories of medical assistance: inpatient hospital, outpatient hospital, laboratory and x-ray, nursing facility, physician, nurse-midwife, and nurse-practitioner services.²⁸² States may also provide coverage for optional services, such as prescription drugs;²⁸³ however, they must comply with federal regulations if they choose to do so.²⁸⁴ While the Medicaid Act broadly requires that these services be provided, states have the authority to decide the type and range of services covered and the eligibility of individuals.²⁸⁵ In determining the scope of coverage, states must use "reasonable standards . . . for determining eligibility

277. *Armstrong v. Exceptional Child Ctr. Inc.*, 135 S. Ct. 1378, 1387 (2015) (citing *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, (1981)).

278. 42 U.S.C. §§ 1396, 1396a, 1396c (2012).

279. 42 U.S.C. § 1396c (2012).

280. *Armstrong*, 135 S. Ct. at 1385.

281. *Id.*

282. 42 U.S.C. § 1396(a)(10)(A); *Lankford v. Sherman*, 451 F.3d 496, 504 (8th Cir. 2006) ("To receive federal approval the Medicaid act mandates that a plan include only seven enumerated medical services."); *see also* 42 U.S.C. § 1396d(a)(1) (2012).

283. 42 U.S.C. § 1396d(a)(11)–(12).

284. *Lankford*, 451 F.3d at 504.

285. 42 C.F.R. § 430.0 (2012) ("Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.").

for and the extent of medical assistance.”²⁸⁶ These standards must be “based on such criteria as medical necessity or on utilization control procedures”²⁸⁷ and may not deny or reduce coverage of a medical treatment “to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.”²⁸⁸ Further, federal Medicaid regulations require that each service that is covered under a state’s plan “must be sufficient in amount, duration, and scope to reasonably achieve its purpose.”²⁸⁹ A state plan that chooses to cover a service, therefore cannot arbitrarily exclude coverage for certain items or treatments within that service.²⁹⁰

There is support for viewing the age-based restriction of section 505.2 as an unreasonable standard and, therefore, not in compliance with the Medicaid Act. In *Lankford v. Sherman*, for instance, the Eighth Circuit held that a plan that excludes a non-experimental and medically necessary treatment from a covered service is per se unreasonable.²⁹¹ Additionally, in *Beal v. Doe*, the Supreme Court noted in dicta that a Medicaid program seriously conflicts with the objectives of the Medicaid Act if it does not cover medically necessary treatment.²⁹² Given that HHS has already acknowledged the medical necessity of gender-affirming healthcare for Medicare recipients,²⁹³ it may similarly view exclusion of these services from coverage as unreasonable.

Section 505.2 may also be construed as unreasonable should the Secretary find that it is discriminatory. The Medicaid Act requires that “the medical assistance made available to any individual . . . shall not be less in amount, duration, or scope than the medical assistance

286. 42 U.S.C. § 1396a(a)(17); *Beal v. Doe*, 432 U.S. 438, 441 (1977) (“Although [the Medicaid Act] does not require States to provide funding for all medical treatment falling within the [seven] general categories, it does require that state Medicaid plans establish “reasonable standards . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [the Act].”).

287. 42 C.F.R. § 440.230(d) (2012).

288. *Id.* § 440.230(c).

289. *Id.* § 440.230(b).

290. *Lankford*, 541 F.3d at 511.

291. *Id.* (“[F]ailure 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.”).

292. *Beal v. Doe*, 432 U.S. 438, 444–45 (1977) (discussing the validity of a Medicaid program that did not cover abortion, the Court noted, “[a]lthough serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary though perhaps desirable medical services”).

293. *H.H.S. Medicare Decision*, *supra* note 84, at 20.

made available to any other such individual” who is covered by that state’s Medicaid program.²⁹⁴ In addition, a state “may not arbitrarily reduce the amount, duration, or scope of a required service . . . solely because of the diagnosis, type of illness, or condition.”²⁹⁵ Should the Secretary view the age-based restrictions as limiting coverage on the basis of a condition, it may find that section 505.2 violates the Medicaid Act. However, similar to a Title IX claim, the Secretary would have to find evidence that certain treatments are covered for cisgender youth, but not for transgender youth when intended to treat GD. There may be little evidence to suggest that cisgender youth have greater access to puberty suppressors or other procedures that might also be gender-affirming treatments.

The Secretary could also find that the age restrictions are unreasonable, as they contradict the Medicaid Act’s requirement that state plans provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The Medicaid Act mandates all states to provide EPSDT for Medicaid eligible children under the age of twenty-one.²⁹⁶ EPSDT consists of regular screenings and treatment of “mental illnesses and conditions discovered by screening services, whether or not such services are covered under the State plan.”²⁹⁷ As such, EPSDT requires states to provide screening and treatment for Medicaid-eligible children.²⁹⁸ An adolescent could therefore be diagnosed with GD under EPSDT and require treatment but ultimately be denied treatment because of the age-based restrictions of section 505. However, at least one court has found that EPSDT services are still subject to, and may be denied on, the basis of the state’s determination that such treatment is not medically necessary.²⁹⁹

The state may therefore be vulnerable to enforcement action by the HHS on the basis that the age-based restriction is unreasonable and violates the Medicaid Act. While there is some support to suggest that the HHS could proceed with such an action, the Secretary may also be unable to do so without greater evidence of the medical necessity of gender-affirming treatments for adolescents and evidence that the age-based restriction discriminates on the basis of transgender identity.

294. 42 U.S.C. § 1396a(a)(10)(B); 42 C.F.R. § 440.240(a).

295. 42 C.F.R. § 440.230(c); *Lankford*, 541 F.3d at 506.

296. 42 U.S.C. § 1396d(r).

297. *Id.* § 1396d(r)(5).

298. *Id.* § 1396d(r); *D.U. v. Rhoades*, No. 13-CV-1457, 2015 WL 224932, at *1 (E.D. Wis. Jan. 15, 2015) (finding that daycare was not medically necessary).

299. *Rhoades*, 2015 WL 224932, at *1.

III. PROPOSAL FOR MEDICAID REGULATIONS THAT EXTEND COVERAGE TO TRANSGENDER YOUTH

Given the myriad of issues that arise from Medicaid regulations that exclude coverage of gender-affirming healthcare on the basis of age, states should consider viable alternatives. One alternative to the age-based restriction is to replace the bright-line age limit with a case-by-case assessment of the individual recipient that is aligned with the WPATH Standards of Care.³⁰⁰ This Part explains how replacing the restrictions would ensure that the state's Medicaid program covers medically necessary treatment, resolve any conflicts that the Medicaid program might have with the doctrine of informed consent, and avoid the risk of litigation that the state might face under the current age-based restriction. Further, this Part discusses the likely policy outcomes and costs that justify removing the age-based restriction.

A. Necessary Provisions for a Trans-Inclusive Medicaid Program to Meet Medical and Legal Standards

States would avoid the issues that age restrictions present by amending or enacting regulations that are aligned with the WPATH Standard of Care. In so doing, states would provide for a more flexible approach that is based on the individual recipient's need for treatment.³⁰¹ Additionally, removing the blanket age restriction would allow states to comply with principles of informed consent and recognize the exceptions to informed consent.³⁰² States would further find that aligning Medicaid regulations with the WPATH Standard of Care would provide safeguards against inadequate treatment and erroneous diagnoses of GD.

1. *States Should Align Regulations with WPATH Standards*

States should amend their Medicaid regulations so as to align them with the WPATH Standards of Care. By doing so, states would avoid possible HHS litigation and regulation.³⁰³ Aligning regulations to the WPATH Standards of Care would also avoid conflicts with the medical consensus on gender identity because it would determine coverage on an individualized basis, provide sufficient safeguards so as to ensure that individuals receive care they need, provide standards to determine whether health professionals are eligible to treat

300. *See generally* WPATH, *supra* note 23.

301. *See* discussion *supra* Section II.A.

302. *See* discussion *supra* Section II.B.

303. *See* discussion *supra* Section II.C.

transgender patients, and develop contemporaneously with research in the field.³⁰⁴ By aligning regulations with the WPATH Standards of Care, states would remove the age restrictions for Medicaid coverage of gender-affirming healthcare and also address the concerns of cost and efficacy on which the age restriction is predicated.³⁰⁵

a. Aligning Regulations with the WPATH Standards of Care Would Determine Coverage on an Individual Basis Rather Than a Fixed Age

By aligning their Medicaid statutes with the WPATH Standards of Care, states would determine Medicaid coverage for gender-affirming healthcare on a basis that is more consistent with the generally accepted view of the medical community. The Standards of Care provides guidelines for mental health practitioners working with gender-nonconforming youth, noting that health professionals should work with individuals to assess their desire and medical necessity for gender-affirming healthcare.³⁰⁶ This approach is preferable to determining eligibility for gender-affirming healthcare on the basis of a fixed-age limit, as psychology experts have argued that “psychological and somatic maturity varies largely interindividually.”³⁰⁷ Given the varying levels of maturity between individuals under the age of eighteen, experts have found that a determination of treatment based on a fixed age is arbitrary and less appropriate than a determination based on individual evaluation.³⁰⁸

Determining Medicaid coverage on an individual basis would further avoid the potential litigation described in Part II of this Note.³⁰⁹ Providing coverage on an individual basis would preclude challenges under the ACA.³¹⁰ Also, as noted earlier, challenges under the ACA would likely assert that state plans discriminate on the basis of gender identity by providing coverage for hormone therapy and gender-affirming surgical procedures for cisgender adolescents but not for transgender adolescents.³¹¹ Under the individualized approach of the Standards of Care, states would provide these same treatments on the permissible basis of medical necessity, allowing for some

304. See discussion *supra* Section II.A.

305. See discussion *supra* Section II.C.2.

306. See discussion *supra* Section II.A.

307. COHEN-KETTENIS & PFÄFFLIN, *supra* note 47, at 179.

308. See *id.*

309. See discussion *supra* Section II.C.

310. See discussion *supra* Section II.C.

311. See discussion *supra* Section II.C.1.

transgender adolescents to access treatment. Litigants would therefore be unlikely to assert that the individualized approach determines coverage on the impermissible basis of gender identity.

Adopting the WPATH Standards of Care would also avoid HHS enforcement actions. Under the Medicaid Act, the Secretary of HHS is authorized to withhold Medicaid funds when states violate the Medicaid Act.³¹² Under a WPATH-aligned regulation, the Secretary would not be authorized to withhold funds on the grounds that the state was failing to provide reasonable standards. Further, if states amended regulations to expressly align with the WPATH Standards of Care, they would ensure that the Medicaid regulations remained reasonable even as the field of transgender health developed. As an international organization, WPATH has issued new editions of the Standards of Care to remain consistent with developments in the field of transgender health. For instance, transgender advocates and health professionals have noted that the most recent edition of the Standards of Care made a number of significant modifications and improvements.³¹³

In addition to providing a medically sound basis for extending coverage to transgender youth, aligning regulations with the WPATH Standards of Care would provide quality control measures to ensure individuals receive proper healthcare and assessment. The WPATH Standards of Care set forth standards of competency for health professionals working with transgender youth that exceeds standards of competency observed in New York.³¹⁴ Under section 505.2, mental health professionals are authorized to refer patients for gender-affirming healthcare if they are qualified New York state-licensed professionals.³¹⁵ The WPATH provides a higher standard, requiring that health professionals have knowledge of gender-nonconformity

312. 42 U.S.C. § 1396c (2012).

313. Among the changes that advocates have noted in Volume 7 of the WPATH Standards of Care are: the recognition that gender nonconformity is not at disorder, that attempts to change a person's gender identity through therapy are ineffective, and discussion of a wider range of treatment options. Nat'l Ctr. for Transgender Equality, *The Top 10 Things Trans People Should Know About the New Standards of Care*, ADVANCING TRANSGENDER EQUALITY (Sept. 26, 2011, 5:33 PM), <https://transgenderequality.wordpress.com/2011/09/26/the-top-10-things-trans-people-should-know-about-the-new-standards-of-care> [<https://perma.cc/N3AL-X9C2>].

314. N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l) (2016); WPATH, *supra* note 23, at 22.

315. N.Y. COMP. CODES R. & REGS. tit. 18, § 505.2(l) (gender-affirming surgery will be covered where the Medicaid recipient has "letters from two qualified New York State licensed health professionals who have independently assessed the individual and are referring the individual for the surgery").

and assessment of gender dysphoria treatment and that they pursue continuing education of gender dysphoria assessment.³¹⁶ These requirements would provide stronger safeguards to ensure Medicaid recipients receive gender-affirming healthcare when it is necessary. Further, these safeguards would also encourage medical professionals to develop their cultural competency³¹⁷ when working with transgender youth, and prevent litigation under the ACA's provision prohibiting discrimination on the basis of gender identity.

2. *New York Should Align Its Regulation with the Exceptions for Informed Consent*

A state regulation that does not implement an age-based restriction on Medicaid coverage of gender-affirming healthcare would also avoid conflicting with the principles of the informed consent doctrine and its exceptions. As noted in Part II of this Note, a fixed-age restriction would conflict with the doctrine of informed consent and the exceptions to informed consent.³¹⁸ Age-based restrictions bar youth that have been deemed “mature minors” from accessing gender-affirming healthcare, despite the youth’s authorization to provide informed consent. States that remove age limits in their Medicaid regulations will allow these youth, who are deemed capable of giving informed consent, the ability to make their own health choices pursuant to their status-based exception. Further, removing the age-based restrictions would also be consistent with the procedure-based exceptions that many states have. As noted in Part II, states permit minors to provide informed consent to certain kinds of procedures that are medically necessary but, nonetheless, require parental consent, such as contraceptives, abortions, and mental health.³¹⁹ Gender-affirming healthcare could be considered comparable to these types of procedures in that they are medically necessary but are often denied as a result of parents’ refusal to consent. In New York, youth are permitted to consent to certain kinds of mental health treatments yet are statutorily prohibited from consenting to gender-affirming healthcare, which is intended to treat

316. *Id.*

317. *Id.* “Cultural competency refers to the ability to understand, communicate with, and effectively interact with diverse populations, and it can be measured by awareness, attitude, knowledge, skills, behaviors, policies, procedures, and organizational systems.” Willy Wilkinson, *Keywords*, 1 TSO: TRANSGENDER STUD. Q. 68 (2015).

318. *See* discussion *supra* Section II.B.

319. *See* discussion *supra* Section II.C.1.

the mental condition of gender dysphoria. By removing the age-based restriction, youth would be permitted to consent to gender-affirming healthcare, as they would be permitted to consent to other forms of mental health treatment.

While the removing the age restrictions would allow states to consistently recognize the exceptions to informed consent, it would not necessarily remove the requirement for informed consent. Research suggests that there may not be an entirely objective criterion for diagnosing GD, such as chromosomes or hormonal levels.³²⁰ Moreover, because an individual's gender identity is defined solely by his or her own intrinsic sense of gender, a regulation that did not require that the recipient be capable of understanding the consequences of undergoing gender-affirming procedures would contradict WPATH Standards, which also require the treating physician to abide by informed-consent law. States that amend their regulations to remove the age restrictions would therefore provide access for youth who need gender-affirming healthcare and who have the mental and emotional capacity to understand their decision to pursue treatment for GD.

B. Policy Justifications for Extending Medicaid Coverage of Gender-Affirming Healthcare

Removing the age-based restrictions to Medicaid coverage may also have a number of positive policy implications. Lifting the age-based restriction in section 505.2 would align New York's Medicaid coverage of gender-affirming treatment for youths with that of state agencies responsible for youths in custody. In addition, restricting access to gender-affirming surgery that results in sterilization may prevent transgender youth who are over eighteen from obtaining the benefits that conform with their gender identity.³²¹ Therefore, youth may be denied benefits because they sought medically necessary treatment. Most importantly, by denying transgender youth in New York access to gender-affirming care, the state requires them to endure mental distress and, in so doing, puts them at a greater risk of physical harm.

320. See COHEN-KETTENIS & PFÄFFLIN, *supra* note 47, at 265 (describing a two-phase, holistic test to diagnose GD).

321. Anne E. Silver, *An Offer You Can't Refuse: Coercing Consent to Surgery Through the Medicalization of Gender Identity*, 26 COLUM. J. GENDER & L. 488, 496–97 (2014) (discussing how many states follow a medical model of legal gender that “places legal significance on the treatments and surgery that a person has completed”).

1. *Replacing the Age-Based Restrictions Will Resolve the Disparity in Health Coverage That Youth May Receive When in Custody of the State*

Removing the age-based restriction of Medicaid coverage of gender-affirming treatment would avoid a negative policy outcome whereby youth find they have access to gender-affirming treatment while in the custody of the state but do not have access to those same treatments when they are covered by Medicaid. The Administration for Children's Services (ACS) is the agency responsible for supervising child welfare, foster care, and juvenile justice in New York City.³²² ACS is required by law to provide "necessary medical or surgical care . . . for any child needing such care and [to] pay for such care from public funds, if necessary."³²³ In *In re Brian L.*, the New York Appellate Division interpreted this statute to require ACS to pay for all necessary care, including that which is not covered by the state's Medicaid regulations.³²⁴ Following the decision in *Brian L.*, ACS released guidelines and procedures for requesting payment for Non-Medicaid Reimbursable Treatments (NMR), which were later amended to provide reimbursements of "gender-affirming healthcare associated with Gender Dysphoria," often referred to as "trans-related healthcare."³²⁵

Thus, under the NMR guidelines, children in ACS foster care or in the custody of New York State may be eligible for reimbursement for gender-affirming healthcare.³²⁶ In addition, the NMR guidelines also permit ACS to override the objection of parents or foster parents to

322. *About ACS*, ADMIN. FOR CHILDREN'S SERVS. (2016), <http://www1.nyc.gov/site/acs/about/about.page> [<https://perma.cc/CM8S-ESRS>].

323. N.Y. SOC. SERV. LAW § 398 (McKinney 2016).

324. *Brian L. v. Admin. for Child. Servs.*, 51 A.D.3d 488, 494 (2008) (emphasis added) ("The plain meaning of that sentence—and the one that gives it effect—is that ACS has a duty to provide necessary medical and surgical care to *all* of the children in its care and must, if necessary, pay for that care. The second sentence of that section, read in a manner that gives it effect and places it in harmony with the first, identifies the source from which certain medical expenditures must be paid; that sentence does not mean that children in ACS' care who are eligible for Medicaid are limited to the medical and surgical care covered by that program.").

325. ADMIN. FOR CHILD. SERVS., ACS INTERIM POLICY ON NON-MEDICAID REIMBURSABLE TREATMENTS AND SERVICES (Dec. 16, 2014), http://www1.nyc.gov/assets/acs/pdf/lgbtq/14_12_16_NMR_signed_interim_policy.pdf [<https://perma.cc/LJ9T-XQVF>] [hereinafter NMR POLICY]; Memorandum from Benita Miller, Deputy Comm'r of N.Y.C. Admin. for Child. Servs., on NMR Guidance for Trans-Related Healthcare to ACS and Provider Agency Staff (Jan. 29, 2013), <https://www.nycourts.gov/ip/judicialinstitute/transgender/220S.pdf> [<https://perma.cc/LRK6-QR75>].

326. NMR POLICY, *supra* note 325.

the child receiving gender-affirming healthcare.³²⁷ These guidelines may be a response to *In re D.F. v. Carrion*,³²⁸ where the New York Supreme Court found that ACS's denial of reimbursement for sex-reassignment surgery and hormone therapy was arbitrary and capricious.³²⁹ Similarly, youth who are in the custody of the State Office of Children and Family Services (OCFS) may have access to gender-affirming healthcare. In particular, OCFS's Division of Juvenile Justice, which operates facilities for juvenile offenders, has its own Lesbian, Gay, Bisexual, Transgender and Questioning Youth (LGBTQY) policy.³³⁰ This policy allows for youth to begin hormone therapy while they are in an OCFS facility if they meet the criteria for treatment in the WPATH Standards of Care.³³¹

By restricting Medicaid coverage of gender-affirming healthcare on the basis of age, the New York regulation may promote negative policy. Youth who are in the custody of ACS or OCFS may be less inclined to reunite with their families and communities if they risk losing hormone therapy as a result. Therefore, youth who are aware of the possibility of obtaining gender-affirming healthcare may also be inclined to either enter or remain in the custody of the state. Thus, removing the age-based restrictions of Medicaid coverage for gender-affirming treatment would achieve two positive outcomes. First, it would allow for greater uniformity between the healthcare that is covered under Medicaid and that provided by ACS and OCFS. Second, by creating greater uniformity of coverage, the state would avoid creating incentives for youth to remain in the custody of the state or to enter into the custody of the state, where they may be able to obtain gender-affirming healthcare.

2. *Removing Age-Based Restrictions Will Allow Individuals to Obtain Benefits Based on Their Legal Sex Without Delay*

Lifting age-based restrictions for Medicaid coverage would also allow individuals to obtain a legal-sex status that is congruent with their gender identity. Legal sex is an individual's sex identity as

327. *Id.* at 7.

328. *In re D.F. v. Carrion*, 43 Misc.3d 746 (N.Y. Sup. Ct. 2014).

329. *Id.* at 758.

330. N.Y. STATE OFFICE OF CHILDREN & FAMILY SERVS., POLICY & PROCEDURES MANUAL: LESBIAN, GAY, BISEXUAL AND QUESTIONING YOUTH (2008).

331. *Id.* ("OCFS will make a determination regarding the initiation of hormone therapy based on accepted standards of care (see WPATH standards of care for GID) and the youth's best interest. Appropriate consent must first be sought and obtained as required by law.").

recognized by the law and is typically defined as one's sex assignment at birth, based on biological genitalia.³³² Legal rights and benefits are bound to legal sex as it may determine an individual's marital rights, parental rights, placement in sex-segregated facilities such as prisons or homeless shelters, and the ability to access social services.³³³ Thus in order for transgender individuals to obtain benefits and rights that are congruent with their gender identity, they must first seek to obtain or amend their government identification so that it is congruent with their gender identity.³³⁴

Typically, requirements for changing gender markers on identification vary by state and form of identification. While the federal government has amended its requirements for passports, asking for "appropriate clinical treatment for gender transition to the new gender," states still typically require documentation of genital surgery in order to change the legal gender of a birth certificate.³³⁵ Though New York does not require genital surgery to change the gender marker on a birth certificate, an age-restriction that does impose this requirement would force transgender youth to live with an incongruent legal gender and deny them the rights and protections that a correct gender marker would confer. Without a congruent legal sex, trans youth risk being placed in schools, foster homes, and juvenile justice centers that are incongruent with their gender identity.³³⁶

Thus, removing the age-based restriction in states that condition legal sex on GD treatment would allow individuals to obtain a legal-gender status that is congruent with their gender identity. Doing so would result in youth obtaining gender-appropriate services, rights, and protections that they may not otherwise be afforded.

332. Silver, *supra* note 321, at 490.

333. *Id.* at 492–93; see SYLVIA RIVERA PROJECT, IT'S A WAR IN HERE: A REPORT ON THE TREATMENT OF TRANSGENDER AND INTERSEX PEOPLE IN NEW YORK STATE MEN'S PRISONS 17 (2007), <http://srp.org/files/warinhere.pdf> [<https://perma.cc/S6B7-WALY>]; Deborah Sontag, *Transgender Woman Cites Attacks and Abuse in Men's Prison*, N.Y. TIMES, Apr. 5, 2015, at A1.

334. Silver, *supra* note 321, at 493.

335. Dean Spade, *Documenting Gender*, 59 HASTING L.J. 731, 768 (2008); *Know Your Rights: Changing Birth Certificate Sex Designations: State-by-State Guidelines*, LAMDA LEGAL, <http://www.lambdalegal.org/know-your-rights/transgender/changing-birth-certificate-sex-designations> [<https://perma.cc/ND6G-SPM6>] (last updated Feb. 3, 2015).

336. See Silver, *supra* note 321, at 496.

3. *Mental Harm and Risk of Violence That Transgender Youth Face Without Treatment*

The most unfortunate result of the age-based restriction in section 505.2 is the psychological pain that it would force transgender youth to endure. Psychological authorities, including WPATH, the APA, and the AMA, as well as experts in the field, have recognized that adolescents under the age of eighteen may experience gender dysphoria.³³⁷ For some transgender adolescents, these feelings of distress may escalate to the point where youth experience “intense mental misery, isolation and despair if they are prevented from comprehensively living out their wish to belong to the other sex.”³³⁸ For these individuals, a regulation that prevents them from obtaining puberty suppressors or other gender-affirming treatment may, thus, force them to endure great psychological pain against the recommendation of their own mental health practitioners.

Evidence also suggests that delaying treatment of gender dysphoria may also allow comorbid mental conditions—distinct mental conditions that are co-occurring with GD—to persist.³³⁹ Adolescents and children experiencing gender dysphoria have shown elevated levels of emotional problems.³⁴⁰ In adolescents, the most common comorbid mental disorders are anxiety and depression.³⁴¹ A number of studies have found that transgender youth are at an elevated risk for suicidal ideation and attempts.³⁴² One study that focused on transgender youth, aged fifteen to twenty-one, found that forty-five percent of the participants had thought seriously about killing themselves, and half said that these thoughts were related to their transgender status.³⁴³ Another study that was not limited to

337. WPATH, *supra* note 23, at 12; DSM-V, *supra* note 17, at 452; AMA RESOLUTION 122, *supra* note 19; Wren, *supra* note 90, at 221.

338. Wren, *supra* note 90, at 221.

339. DSM-V, *supra* note 17, at 458, 459; SUICIDE PREVENTION RES. CTR., SUICIDE RISK AND PREVENTION FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER YOUTH (2008), http://www.sprc.org/sites/sprc.org/files/library/SPRC_LGBT_Youth.pdf [<https://perma.cc/3MAJ-LS7A>].

340. DSM-V, *supra* note 17, at 458.

341. *Id.* at 459.

342. SUICIDE PREVENTION RES. CTR., *supra* note 339; Jose M. Valderas, *Defining Comorbidity: Implications for Understanding Health and Health Services*, 7 ANNALS OF FAM. MED. 357, 358 (2009) (“Comorbidity is most often defined in relation to a specific index condition, as in the seminal definition of Feinstein: ‘Any distinct additional entity that has existed or may occur during the clinical course of a patient who has the index disease under study.’”).

343. *Id.* (citing A.H. Grossman & A.R. D’Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37 SUICIDE & LIFE-THREATENING BEHAV. 527–37 (2007)).

transgender youth found that rates of suicidal ideation were highest amongst participants aged thirteen to nineteen.³⁴⁴

Studies suggest that depression, anxiety, and suicidal ideation may not be caused by gender dysphoria alone but, rather, is the result of being targets of negative societal attitudes. Mental health professionals have found that an individual's minority status as transgender places him or her at risk of being prejudiced or discriminated against, which in turn may induce anxiety or depression.³⁴⁵ The negative attitudes that a transgender youth experiences can "become internalized, manifesting as negative self-concept, self-destructive behaviors, and low self-esteem."³⁴⁶ In a study conducted by the Virginia Transgender Health Initiative, transgender youth who had been the victimized at school were almost four times more likely to attempt suicide than those who had not.³⁴⁷

New York's Medicaid restriction on hormone therapy and gender affirming surgery will force transgender youth to endure psychological pain. There is little evidence to show that psychotherapy alone can alleviate feelings of gender dysphoria for individuals who meet the criteria for physical intervention.³⁴⁸ In contrast, the general conclusion drawn from studies measuring the success of hormone therapy and gender affirming surgery is that these treatments effectively resolve the gender dysphoria experienced by transgender individuals.³⁴⁹ As a result, a regulation that delays access to hormone therapy and gender affirming surgery will force some number of transgender youth to endure psychological pain.

Delaying access to gender-affirming care may also exacerbate any comorbid mental health issues that a transgender individual is experiencing. The anxiety and depression resulting from the adolescent process of consolidating and forming one's identity by evaluating it in relation to society may be exacerbated if that individual is unable to substantively acknowledge his or her identity.³⁵⁰ A transgender youth who is denied access to gender-

344. Peter Goldblum et al., *The Relationship Between Gender-Based Victimization and Suicide Attempts in Transgender People*, 43 PROF. PSYCHOL. 468, 470 (2002).

345. WPATH, *supra* note 23, at 4.

346. Goldblum et al., *supra* note 344, at 469.

347. *Id.* at 472.

348. COHEN-KETTENIS & PFÄFFLIN, *supra* note 47, at 141.

349. *Id.* at 148.

350. Wren, *supra* note 90, at 225 ("If identity is 'our changing knowledge of who we are and how we are placed as a person in relation to all those around us' (Shotter, 1998: 281) then the healthy adolescents need to find an 'evaluative space' that fits

affirming healthcare, and is unable to openly acknowledge a major dimension of his or her subjectivity, may continue to struggle with this identity forming process in a way that induces anxiety or depression.³⁵¹ In addition, the denial of early treatment may further expose an individual to minority status and victimization. Puberty suppressors, gender-affirming surgeries, or hormone treatments prior to the development of secondary sex characteristics will facilitate transgender youth to outwardly express their gender identity to others, in a manner that makes them less susceptible to victimization.³⁵² Further, a more inclusive regulation may help communities accept the existence of adolescent gender dysphoria, which in turn may reduce the negative societal attitudes concerning transgender youth.

C. Cost Justifications for Extending Medicaid Coverage of Gender-Affirming Healthcare to Transgender Youth

A state regulation that extended Medicaid coverage of gender-affirming healthcare to individuals on a case-by-case basis might incur some additional costs by allowing greater access to gender affirming treatment. However, these costs would be justified because they would be only marginally greater than the cost of providing coverage with an age-based restriction. Further, an amended regulation would avoid other costs that the age restrictions would give rise to and would provide transgender youth with necessary medical care.

1. *Removing the Age Restriction Would Impose a Marginal Cost on States That Have Extended Medicaid Coverage for Gender-Affirming Healthcare*

States may be able to estimate the additional cost of removing the age restriction for gender-affirming coverage. New York has estimated the cost of extending coverage of gender-affirming healthcare to individuals above the age of eighteen as \$6,737,000.³⁵³ The estimate was based on the number of Medicaid recipients who receive mental health services with a diagnosis of gender dysphoria

with their most profound sense of self. They need to give substance to their sense of personal identity; it cannot be a purely inner and silent experience.”).

351. *Id.* (“If gender dysphoric children grow up without any acknowledgement of a major dimension of their subjectivity (if it is kept secret) or with responses that are incredulous, disgusted or dismissive, they will lack the necessary support to do identity work, to build up ‘identity capital.’”).

352. COHEN-KETTENIS & PFÄFFLIN, *supra* note 47, at 140.

353. N.Y. DEP’T OF HEALTH, *supra* NOTE 267.

and the number of those recipients who would seek hormone therapy only, partial gender affirming surgery, or full gender affirming surgery.³⁵⁴ States could conceivably make similar calculations to determine the cost of extending Medicaid coverage to transgender youth.

Given the basis of New York's calculation for the cost of extending Medicaid coverage to transgender recipients over the age of eighteen, it is unlikely that extending coverage to transgender youth would create additional costs beyond what is spent on covering adults. The WPATH standards also make clear that adolescents experiencing GD still may not be ready or need hormone therapy until they are older.³⁵⁵ Thus, lifting the restriction would not necessarily require the state to cover gender-affirming treatment for all adolescents who experience GD. In addition, studies suggest that adolescents who experience gender dysphoria most often continue to experience it into adulthood and eventually seek gender-affirming healthcare.³⁵⁶ Removing the restrictions would therefore not add any significant new cost but, rather, would address the needs of transgender Medicaid recipients earlier. While allowing youth to access gender-affirming healthcare would likely increase the cost to some extent, as there would be greater access to the treatment, this would likely be marginal.

2. *Removing the Age Restrictions Would Avoid Other Costs*

While removing the age restriction would be unlikely to increase the costs of extending coverage to individuals over the age of eighteen, increasing access to gender-affirming healthcare would likely avoid costs incurred by delaying treatment. Studies indicate that earlier treatment may be more effective at alleviating GD, as individuals have not fully developed the secondary sex characteristics that cause them distress.³⁵⁷ As a result, earlier treatment may prevent necessity for later, more expensive surgical procedures such as gender affirming surgery.³⁵⁸ Therefore, in states such as New York, removing the age restriction might avoid the cost of covering these procedures in some cases, which would be more expensive than early hormone therapy.³⁵⁹

354. *Id.*

355. WPATH, *supra* note 23, at 12.

356. COHEN-KETTENIS & PFÄFFLIN, *supra* note 47, at 146.

357. *Id.* at 140.

358. *Id.* at 144.

359. HORTON, *supra* note 32.

In addition to avoiding the cost of gender affirming surgery, providing access to gender-affirming healthcare for transgender youth would also avoid costs that are incurred to treat comorbid conditions of GD. By treating GD earlier, states would likely see savings related to mental health.³⁶⁰ Mental health experts have noted that the emotional and developmental arrest caused by GD is best treated earlier.³⁶¹ Therefore, removing the age restrictions might avoid the costs of mental health measures, such as mental health counseling, that might otherwise be incurred where individuals experience GD for a longer period of time. Additionally, removing the age restrictions on Medicaid coverage would avoid the costs associated with life-threatening behavior, such as suicides and suicide attempts.³⁶² Life-threatening behavior, such as suicide attempts, also present a significant cost to medical centers and local governments.³⁶³ Nationally, the economic costs for nonfatal injuries due to self-harm are estimated at \$3 billion a year for medical care.³⁶⁴ New York alone reported that treating suicide attempts cost the state around \$200 million in 2010.³⁶⁵ Given the statistics that show transgender youth having a higher occurrence of suicide attempts than the cisgender population, it is likely that a reduction in suicide attempts by transgender youth would produce a significant decrease in the state's costs associated with suicide and attempted suicides. Research indicates that hormone therapy and gender affirming surgery greatly improve outcomes for transgender youth and reduce the rate of clinical mental conditions.³⁶⁶ Therefore, removing the age restrictions

360. *Medicaid*, EMPIRE STATE PRIDE AGENDA FOUND., <http://www.prideagenda.org/advancing-justice/transgender-equality-justice/Medicaid> [https://perma.cc/WK4R-ND8K].

361. COHEN-KETTENIS & PFÄFFLIN, *supra* note 47, at 140.

362. *Suicide: Consequences*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/violenceprevention/suicide/consequences.html> [https://perma.cc/ZW2A-HCWA] (last updated Aug. 28, 2015); *see* RESEARCH AM., INVESTMENT IN RESEARCH SAVES LIVES AND MONEY: FACTS ABOUT: SUICIDE, <http://www.researchamerica.org/sites/default/files/uploads/factsheet21suicide.pdf> [https://perma.cc/H7G6-BRHL].

363. Stephanie Czernin et al., *Cost of Attempted Suicide: A Retrospective Study of Extent and Associated Factors*, 142 SWISS MED. WKLY. 13648 (July 23, 2012).

364. *Suicide*, ABUSE: AN ENCYCLOPEDIA OF CAUSES, CONSEQUENCES, AND TREATMENTS (Rosemarie Skaine ed., ABC-CLIO, LLC 2015), at 286.

365. N.Y. STATE OFFICE OF MENTAL HEALTH, DIV. OF QUALITY MGMT., GETTING TO THE GOAL: SUICIDE AS A NEVER EVENT IN NEW YORK STATE (2014), <https://www.omh.ny.gov/omhweb/dqm/bqi/suicideasaneverevent.pdf> [https://perma.cc/3CFQ-WDNG].

366. Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, 134 PEDIATRICS 1, 7 (Sept. 2014).

would likely avoid costs that would be incurred to treat attempted suicides.

While there are cost justifications for extending Medicaid coverage of gender-affirming healthcare to transgender youth, any cost incurred by a state may not be dispositive of extending coverage. The purpose of the Medicaid Act is to help Americans obtain medically necessary treatment that they cannot afford.³⁶⁷ A cost-benefits analysis cannot therefore be determinative of Medicaid coverage. Rather, the decision to extend Medicaid coverage to gender-affirming healthcare should turn on the recognition that it is medically necessary. Given that the medical community and federal government recognize that youth may need gender-affirming healthcare, state Medicaid programs should extend coverage of this treatment pursuant to the ultimate objectives of the Medicaid Act.

CONCLUSION

The past three years have seen enormous strides in strengthening and improving the rights of transgender people. So much so, that each of the past three years has been dubbed a “tipping point” for the trans-rights movement, or the year of transgender visibility.³⁶⁸ Once seen exclusively as comical or disturbing, transgender people and bodies are now more visible throughout mainstream media.³⁶⁹ A

367. *Beal v. Doe*, 432 U.S. 438, 444 (1977) (“Title XIX’s broadly stated primary objective to enable each State, as far as practicable, to furnish medical assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services.”).

368. Samantha Allen & Nico Lang, *11 Ways 2014 was the Biggest Year in Transgender History*, ROLLING STONE (Dec. 23, 2014), <http://www.rollingstone.com/culture/features/11-ways-2014-was-the-biggest-year-in-transgender-history-20141223> [https://perma.cc/T24A-S3WA]; Tracy Garza, *2012: An Amazing Year for Transgender Rights*, TRANSGENDER L. CTR., <http://transgenderlawcenter.org/archives/2773> [https://perma.cc/63P6-BZDX]; Brandon Griggs, *America’s Transgender Moment*, CNN (Apr. 25, 2015), <http://www.cnn.com/2015/04/23/living/transgender-moment-jenner-feat> [https://perma.cc/5RQA-QED6] (“It’s only April, but 2015 may be remembered as the year the term ‘transgender’ fully entered mainstream consciousness.”); Paris Lees, *2014, the Year of . . . Transgender Visibility*, VICE (Dec. 29, 2014), https://i.d.vice.com/en_gb/article/2014-the-year-of-transgender-visibility [https://perma.cc/EAM9-SR7H]; Parker Marie Malloy, *Year in Review: 10 Important Transgender Moments of 2013*, ADVOCATE (Jan. 4, 2014), <http://www.advocate.com/year-review/2014/01/04/year-review-10-important-transgender-moments-2013> [https://perma.cc/WFP2-A34H] (“concluding that 2013 was a true year of momentum”).

369. Calpernia Addams, *Transsexual Clichés and Stereotypes in Film, Television and Print Media*, CALPERNIA.COM (Aug. 31, 2009), <http://www.calpernia.com/2009/08/transsexual-cliches-and-stereotypes-in-media>

study by GLAAD found that from 2002–2012, transgender characters were disproportionately portrayed as villains, psychopathic killers, sex workers, or victims.³⁷⁰ In more recent years, critically acclaimed programs such as “Transparent” and “Orange is the New Black” have removed transgender characters from the fringes, portraying them instead as multidimensional individuals.³⁷¹ Transgender actors such as Laverne Cox have been inspiring examples of success among the trans community.³⁷² Transgender models such as Jazz Jennings and Andreja Pejic are finding success, earning spreads or contracts with notable magazines and companies.³⁷³ The process of transition has also become more visible, and perhaps socially acceptable, as pop culture icons such as Caitlyn Jenner openly discuss their process.³⁷⁴ President Obama also noted in his January 21, 2015 State of the Union Address the need to protect the rights of transgender individuals, the first time a United States President has acknowledged transgender identities in the nationally televised speech.³⁷⁵

[<https://perma.cc/G8RS-YA3K>]; Matt Kane, *Transgender Characters that Changed Film and Television #TransWK*, GLAAD (Nov. 12, 2013), <http://www.glaad.org/blog/transgender-characters-changed-film-and-television-transwk> [<https://perma.cc/3FS4-A94W>].

370. *Victims or Villains: Examining Ten Years of Transgender Images on Television*, GLAAD, <https://www.glaad.org/publications/victims-or-villains-examining-ten-years-transgender-images-television> [<https://perma.cc/5VKG-XMGR>].

371. EJ Dickson, “*She’s a Survivor*,” SALON (Jul. 25, 2013, 12:15 PM), http://www.salon.com/2013/07/25/laverne_cox_on_her_orange_is_the_new_black_character_shes_a_survivor [<https://perma.cc/BJX8-C8U5>]; Nico Lang, Op-ed, *Orange is the New Black Proves to Be the Model of Queer TV*, ADVOCATE (Jun. 30, 2014, 6:30 AM), <http://www.advocate.com/commentary/2014/06/30/op-ed-orange-new-black-proves-be-model-queer-tv> [<https://perma.cc/B5JL-C88X>]; Nora O’Donnell, *How Authentic Is ‘Transparent?’ A Transgender Activist on Jeffrey Tambor and Other Portrayals*, INDIEWIRE (Oct. 1, 2014, 10:28 AM), <http://www.indiewire.com/article/how-authentic-is-transparent-a-transgender-activist-on-jeffrey-tambor-and-other-portrayals-20141001> [<https://perma.cc/3ZKC-Q4GY>].

372. Lees, *supra* note 368.

373. Alice Gregory, *Has the Fashion Industry Reached a Transgender Turning Point?*, VOGUE (Apr. 21, 2015, 8:00 AM), <http://www.vogue.com/13253741/andreja-pejic-transgender-model> [<https://perma.cc/UBG6-CNWT>]; Emanuella Grinberg, *Why Transgender Teen Jazz Jennings Is Everywhere*, CNN (Mar. 19, 2015, 12:18 PM), <http://www.cnn.com/2015/03/16/living/feat-transgender-teen-jazz-jennings> [<https://perma.cc/R6MG-DDB5>].

374. Daniel E. Slotnik, *Bruce Jenner Says He’s Transitioning to a Woman*, N.Y. TIMES, Apr. 15, 2015, at B6.

375. President Obama stated: “As Americans, we respect human dignity . . . [t]hat’s why we defend free speech, and advocate for political prisoners, and condemn the prosecution of women, or religious minorities, or people who are lesbian, gay, bisexual or transgender.” President Barack Obama, Remarks by the President in State of the Union Address (Jan. 20, 2015) (transcript available at <https://www.whitehouse.gov/the-press-office/2015/01/20/remarks-president-state->

In addition to a shift in cultural norms, trans-rights advocates have succeeded in changing laws and policies that had previously denied transgender individuals' basic rights. Legal advocacy organizations, such as LAMDA, the Sylvia Rivera Project, the Legal Aid Society, and the New York Legal Assistance Group, have brought legal challenges to discriminatory practices and policies.³⁷⁶ Courts, in turn, have begun to recognize employment discrimination on the basis of gender identity as violating Title VII of the Civil Rights Act.³⁷⁷ Activists and allies have brought greater visibility to trans-rights issues by launching powerful direct action and social media campaigns aimed at challenging marginalizing policies, such as gendered public accommodations.³⁷⁸ These changes have come about rapidly, as the APA only reclassified GD so as to remove the label of "disorder" in 2012. Thus, the trans-rights movement has fundamentally altered public policy and opinions surrounding the rights and lives of transgender individuals.

Despite these advances, transgender individuals, and in particular transgender people of color, still find themselves subjected to discrimination, hate, and violence. In early 2015, advocacy organizations noted a disturbing trend of transphobic hate crimes.³⁷⁹

union-address-january-20-2015 [<https://perma.cc/8U7U-LA9S>]; Katy Steinmetz, *Why It's a Big Deal that Obama Said 'Transgender'*, TIME (Jan. 21, 2015), <http://time.com/3676881/state-of-the-union-2015-barack-obama-transgender> [<https://perma.cc/744S-HMUZ>] (noting that this was the first time a President mentioned transgender identity in the State of the Union address).

376. Amended Complaint, *Zollicoffer a/k/a Passion Star v. Livingston et al.*, No. 4:1-cv-03037 (S.D. Tex., Jan. 28, 2015) (initiating claim against Texas prisons for displaying "deliberate indifference to threats of sexual assault and violence" against plaintiff while in a male prison facility).

377. Mia Macy, EEOC DOC 0120120821, 2012 WL 1435995 at *4 (Apr. 20, 2012) ("To that end, the Commission hereby clarifies that claims of discrimination based on transgender status, also referred to as claims of discrimination based on gender identity, are cognizable under Title VII's sex discrimination prohibition, and may therefore be processed under Part 1614 of EEOC's federal sector EEO complaints process."); see also *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011) ("Accordingly, discrimination against a transgender individual because of her gender-nonconformity is sex discrimination, whether it's described as being on the basis of sex or gender."); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. 2008).

378. Mitch Kellway, *Trans Folks Respond to 'Bathroom Bills' With #WeJustNeedToPee Selfies*, ADVOCATE (Mar. 14, 2015), <http://www.advocate.com/politics/transgender/2015/03/14/trans-folks-respond-bathroom-bills-wejustneedtopee-selfies> [<https://perma.cc/Q5PD-6FT8>]; Claire-Renee Kohner, *Trans Man Behind #WeJustNeedToPee Isn't Selfie Centered*, ADVOCATE (Mar. 17, 2015), <http://www.advocate.com/politics/transgender/2015/03/17/trans-man-behind-wejustneedtopee-isnt-selfie-centered> [<https://perma.cc/FN4G-GW8Y>].

379. Parker Marie Molloy, *Trans Women of Color Deserve to Be Mourned as Much as Leelah Alcorn*, SLATE (Feb. 13, 2015, 3:17 PM),

Within the first three months of the year, Human Rights Campaign reported seven murders of transgender women, and all but one of the women killed were women of color.³⁸⁰ Such events suggest that society has not yet fully embraced transgender identities. Transgender youth still remain constant targets of harassment, abuse, and rejection, as is tragically evidenced by news reports of transgender youth who commit suicide.³⁸¹ These events continue well after Leelah Alcorn's words, "[f]ix society," captured the public's attention.³⁸²

Enacting state Medicaid programs that provide low-income transgender youth with coverage of gender-affirming healthcare would improve the lives of this group of transgender individuals by providing access to medically necessary healthcare and by leaving a lasting impact on the way society views transgender identity. The medical community has recognized that one's gender identity may not

http://www.slate.com/blogs/outward/2015/02/13/while_the_media_focuses_on_leelah_alcorn_murders_of_trans_women_of_color.html?wpsrc=sh_all_dt_tw_bot [https://perma.cc/S4FY-6FCT].

380. HUMAN RIGHTS CAMPAIGN, ADDRESSING ANTI-TRANSGENDER VIOLENCE 2 (2015), <http://hrc-assets.s3-website-us-east-1.amazonaws.com/files/assets/resources/HRC-AntiTransgenderViolence-0519.pdf> [https://perma.cc/3GNK-JAAR].

381. Hailey Branson-Potts, *Transgender Teen Who Spoke on YouTube of Bullying Takes Her Own Life*, L.A. TIMES (Apr. 9, 2015, 6:32 PM), <http://www.latimes.com/local/lanow/la-me-ln-transgender-teen-suicide-20150409-story.html> [https://perma.cc/6KFR-EZVC]; Kelli Busey, *TWOC Aubrey Mariko Shine Suicide from Golden Gate Bridge Caused Hardly a Ripple*, PLANET TRANSGENDER (Mar. 14, 2015), <http://planettransgender.com/twoc-aubrey-mariko-shine-suicide-from-the-golden-gate-bridge-caused-hardly-a-ripple> [https://perma.cc/56T4-XYTU]; Dominick Evans, *Her Name Was Melonie – Another Trans WOC Has Committed Suicide*, DOMINICKEVANS.COM (Feb. 26, 2015), <http://www.dominickevans.com/2015/02/her-name-was-melonie-another-trans-woc-has-committed-suicide> [https://perma.cc/WQ5N-ECVB]; Melissa Jeltsen, *Transgender Teen Who Was Crowned Homecoming King Dies*, HUFFINGTON POST (Mar. 25, 2015, 4:17 PM), http://www.huffingtonpost.com/2015/03/25/transgender-teen-who-was-n_6941780.html [https://perma.cc/4N8B-P3KF]; Mitch Kellaway, *Michigan Trans Teen Skater's Suicide Rocks Roller Derby Community*, ADVOCATE (Apr. 16, 2015, 4:45 PM), <http://www.advocate.com/politics/transgender/2015/04/16/michigan-trans-teen-skaters-suicide-rocks-roller-derby-community> [https://perma.cc/7JX8-MMA5]; Michael E. Miller, *'Killed Myself. Sorry.': Transgender Game Developer Jumps Off Bridge After Online Abuse*, WASH. POST (Apr. 28, 2015), <http://www.washingtonpost.com/news/morning-mix/wp/2015/04/28/killed-myself-sorry-transgender-game-developer-jumps-off-bridge-after-online-abuse> [https://perma.cc/62W3-HACX]; Web Staff, *NC Mother Believes Bullying Led to Transgender Teen's Suicide*, FOX8 NEWS (Feb. 28, 2015, 11:32 AM), <http://myfox8.com/2015/02/28/nc-mother-believes-bullying-led-to-transgender-teen-daughters-suicide> [https://perma.cc/P34C-VD56].

382. Connor, *supra* note 1.

correspond with one's assigned sex at birth, and that individuals, including youth, may experience clinically significant distress termed gender dysphoria. Despite the fact that medical experts agree that gender-affirming healthcare may be medically necessary for some transgender youth, some states, such as New York, do not extend Medicaid coverage for gender dysphoria for individuals under the age of eighteen. Age restrictions on Medicaid coverage give rise to possible violations of the Medicaid Act, legal claims under the Affordable Care Act, contradictions with principles of informed consent, and a myriad of negative outcomes. States could avoid these issues by aligning their programs with the WPATH Standards of Care, and doing so would avoid a number of costs and provide individuals with care that they need but cannot afford.

Providing transgender youth with access to affordable transition healthcare, however, would also create a lasting impact on society's view of transgender identity. States have already recognized the medical necessity of gender-affirming healthcare for adults, and in doing so have recognized that transitioning is a process that many individuals must go through in order to live happy and functional lives. By extending this coverage to transgender youth, states would recognize the existence of gender non-conforming youth. It would encourage private insurers to extend similar coverage, which in turn would motivate healthcare providers, employers, and schools to recognize gender non-conforming youth. In short, extending Medicaid coverage of gender-affirming healthcare to transgender youth would validate gender non-conforming identities. While the immediate impact of this validation may be seen in the healthcare that transgender youth receive, the ramifications would likely be seen on a much broader, social level.