

## NOTES

# ADVOCATING A BROADER UNDERSTANDING OF THE NECESSITY OF SEX-REASSIGNMENT SURGERY UNDER MEDICAID

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*Even as the law has become an instrument for combating sex discrimination, it has continued to impose a rigid, binary sex-classification system where fundamental legal rights and protections depend on one being labeled “male” or “female.” In this Note, Jerry Dasti examines how this binary system of sexual identification has created a vicious Catch-22 for the small yet significant population of transgender people whose chosen sex and gender diverge from their sex at birth. While the law’s conception of gender identity is inconsistent and ad hoc, one theme emerges: Courts will not recognize a transgender person’s chosen sex or gender without successful completion of sex-reassignment surgery. Because the costs of the procedure, including pre- and postoperative treatment, are prohibitively high, many transsexual individuals are forced to seek coverage through Medicaid. Medicaid, however, only covers those procedures deemed “medically necessary,” which, for transsexuals, means they must first be diagnosed with a gender identity disorder that can only be cured by sex-reassignment surgery. Therefore, in order to establish a legal identity, transsexuals have to pathologize their social identity, which explains the backlash from many transgender groups against the coverage of sex-reassignment surgery under Medicaid. The law’s sex-classification system not only creates tension for the person seeking surgery but also puts the interests of individual transsexuals at odds with the interests of the transgender community as a whole. This Note argues for a broader conception of medical necessity—one that recognizes the legal and social necessity of the surgery to transsexuals’ full participation in society but does not simultaneously stigmatize gender variance as a “disease” that must be “cured.”*

Despite the progress made by women’s rights advocates over the last four decades, a person’s designation as either “male” or “female” still carries important consequences concerning the enjoyment of many fundamental legal rights. Most people are comfortable in their sex of birth and the gender traditionally associated with that sex.<sup>1</sup>

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<sup>1</sup> Generally, and for the purposes of this Note, the term “sex” is used to indicate one’s anatomical configuration of sexual organs and genitalia, while “gender” means the social

Transgender<sup>2</sup> people, however, constitute a significant minority of the population whose members find their "birth sex" to be in conflict with the gender with which they identify.

Estimates vary greatly, but some researchers believe that about one in 50,000 people identifies as transgender,<sup>3</sup> and transgender iden-

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construction of behaviors and rules guiding how each sex should act. See Katherine M. Franke, *The Central Mistake of Sex Discrimination Law: The Disaggregation of Sex from Gender*, 144 U. Pa. L. Rev. 1, 1-2 (1995). "Biological sex" will be used as a convenient shorthand for an individual's sex at birth; "chosen gender" will be used to indicate a self-identified gender not generally associated with one's biological sex; "chosen sex" will be used to mean a transsexual person's sex after reassignment surgery.

<sup>2</sup> "Transgender" is a broad term, which can be used to describe people exhibiting all degrees of gender nonconformity, including crossdressers (people who derive emotional and sexual satisfaction from dressing in clothing traditionally worn by the opposite sex), gays and lesbians (people who have emotional and sexual desires for people of the same sex), and transsexuals (those who identify as, and wish to live full-time as, their nonbiological sex). The term "transgender" because of its broadness and lack of focus on surgical sex reassignment, has largely replaced the use of "transsexual" within the transgender community. See Franke, *supra* note 1, at 32-33 n.130 (explaining author's preference for "transgendered" over "transsexual" because latter term implies acceptance of cultural tendency to use genitals as proxy for gender identity); Darren Rosenblum, "Trapped" in Sing Sing: Transgendered Prisoners Caught in the Gender Binarism, 6 Mich. J. Gender & L. 499, 500 n.1 (noting that term "transgender" has largely replaced "transsexual" in transgender community because "transgender" does not emphasize sex-reassignment surgery).

For the sake of clarity and consistency, this Note will use the term "transsexual" to indicate those transgender people who wish to live full-time as their chosen (that is, nonbiological) gender and whose goal is completion of sex-reassignment surgery; it will use the term "transgender" to refer to those gender-variant individuals for whom surgical reassignment is not, or is not necessarily, a personal goal. The term "transgender" can (and does) encompass transsexuals; the term "transsexual" does not necessarily encompass all transgender people.

The terms "transgender (or transsexual) woman" and "male-to-female transsexual" refer to a biological male who has a female gender identity; the terms "transgender (or transsexual) man" and "female-to-male transsexual" refer to a biological female who has a male gender identity. This Note will use pronouns that acknowledge a transgender person's gender identity, as opposed to his or her sex of birth; "she" will refer to a transgender woman, and "he" will refer to a transgender man. Cf., e.g., *Schwenk v. Hartford*, 204 F.3d 1187, 1192 n.1 (9th Cir. 2000) (explaining that court would use pronouns consistent with transgender litigant's self-identification); *Meriwether v. Faulkner*, 821 F.2d 408, 409 n.1 (7th Cir. 1987) (same); *Smith v. Rasmussen*, 57 F. Supp. 2d 736, 740 n.2 (N.D. Iowa 1999) (same), rev'd on other grounds, 249 F.3d 755 (8th Cir. 2001); Taylor Flynn, *Transforming the Debate: Why We Need to Include Transgender Rights in the Struggles for Sex and Sexual Orientation Equality*, 101 Colum. L. Rev. 392, 399-400 n.37 (2001) (explaining current healthcare professional standard advising use of pronouns that reflect subject's chosen gender). The terms "postoperative" and "preoperative" refer to a transsexual person's completion or noncompletion of sex-reassignment surgery.

<sup>3</sup> Hazel Glenn Beh, *Sex, Sexual Pleasure, and Reproduction: Health Insurers Don't Want You to Do Those Nasty Things*, 13 Wis. Women's L.J. 119, 150 (1998). It should be noted that due to the often ambiguous and fluid way in which gender-variant people identify themselves, this figure likely is both under- and overinclusive. Specifying an empirically sound figure for the number of transgender people in the population is difficult, if not impossible, and this Note will make no attempt to do so.

tities have been found in many cultures throughout history.<sup>4</sup> For these people, attempting to access rights and protections as their chosen gender or sex can be difficult, time consuming, and often humiliating. Because transgender people often challenge the binary sex-classification system employed by society and the law for most of recorded history,<sup>5</sup> their most basic desires, such as dressing in a manner consistent with their self-identified gender, traditionally have been subject to regulation and sanction.<sup>6</sup> Legislatures generally have been unwilling

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<sup>4</sup> See generally Leslie Feinberg, *Transgender Warriors: Making History from Joan of Arc to RuPaul* (1997); Richard Green, *Mythological, Historical, and Cross-Cultural Aspects of Transsexualism*, in *Transsexualism and Sex Reassignment* 13 (Richard Green & John Money eds., 1969). There is much written about transgender, or “two-spirit” people, in American Indian cultures. See Katrina C. Rose, *The Transsexual and the Damage Done: The Fourth Court of Appeals Opens PanDOMA’s Box by Closing the Door on Transsexuals’ Right to Marry*, 9 *Law & Sexuality* 1, 21-24 (1999-2000). Transgenderism was part of the heresy of Joan of Arc. See Comment, *Transsexualism, Sex-Reassignment Surgery, and the Law*, 56 Cornell L. Rev. 963, 964 (1971) [hereinafter *Transsexualism and the Law*]. The Bible contains at least one warning against gender variance: “The woman shall not wear that which pertaineth unto a man, neither shall a man put on a woman’s garment: for all that do so are an abomination unto the Lord thy God.” Deuteronomy 22:5 (King James).

“Genital reassignment” medical procedures, which provide some index of the existence a transgender population, have been practiced for quite a long time. The first modern instance of a genital reassignment surgery is reported to have been performed in Germany in the 1920s or 1930s. Rose, *supra*, at 19 (stating that first genital surgeries believed to have been performed in Germany in 1920s); *Transsexualism and the Law*, *supra*, at 986 (asserting that first such surgery known was performed in 1931 in Germany).

<sup>5</sup> See Leslie Pearlman, *Transsexualism as Metaphor: The Collision of Sex and Gender*, 43 Buff. L. Rev. 835, 845 (1995); Richard F. Storrow, *Naming the Grotesque Body in the “Nascent Jurisprudence of Transsexualism,”* 4 Mich. J. Gender & L. 275, 279 (1997) (“Without exclusion on some level from participation in society, transsexuals would threaten a subversion of the categories upon which the law of sexual identity rests.”).

<sup>6</sup> At one time, many anticrossdressing statutes were enforced in the United States, but many of these have been held inapplicable to preoperative transsexuals preparing for sex-reassignment surgery. See *Doe v. McConn*, 489 F. Supp. 76, 79-80 (S.D. Tex. 1980) (holding anticrossdressing statute in Houston invalid as applied to transsexuals preparing for sex-reassignment surgery); *City of Chicago v. Wilson*, 389 N.E.2d 522, 524-25 (Ill. 1978) (same with regard to similar Chicago statute); Note, *Patriarchy Is Such a Drag: The Strategic Possibilities of a Postmodern Account of Gender*, 108 Harv. L. Rev. 1973, 1993 (1995) [hereinafter *Patriarchy*] (noting that anticrossdressing statutes have been held inapplicable to transsexuals preparing for surgery).

ing to extend any protection or privilege to transgender people,<sup>7</sup> and courts rarely extend protections to transgender people as a class.<sup>8</sup>

Many transgender people are able to construct lives and communities that accommodate the discord between their anatomical or birth sex and their gender identity. Others, however, choose either to live (or be identified) as their birth sex, in irreconcilable conflict with their gender identity, or to go through sex-reassignment surgery and accompanying hormonal and psychological therapy in an attempt to gain social, and often legal, recognition as their reassigned sex.<sup>9</sup>

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<sup>7</sup> Minnesota, in 1993, became the first state to bar employment discrimination against transgender people by making statutory protections based on sexual orientation inclusive of nonconforming gender expression. Minn. Stat. §§ 363.01(41a), 363.03 (2001) (defining sexual orientation as inclusive of gender variance for purposes of antidiscrimination laws); see also *Goins v. West Group*, 619 N.W.2d 424, 428-29 (Minn. Ct. App. 2000) (holding that statute protects employees from being treated inconsistently with their self-image and therefore applies whether or not transgender claimant has undergone sex-reassignment surgery), rev'd on other grounds, 635 N.W.2d 717 (Minn. 2001) (ruling, without addressing broader interpretive issues, that employer's policy of designating restrooms by sex did not constitute discrimination); *Rose*, *supra* note 4, at 39 (identifying Minnesota as only state that prohibits employment discrimination based on gender variance). But generally, when dealing with state or local discrimination statutes that include protections for sexual orientation, courts usually distinguish homosexuality from transgenderism, denying protection under the statutes to transgender people. See, e.g., *Maffei v. Kolaeton Indus., Inc.*, 626 N.Y.S.2d 391, 393 (Sup. Ct. 1995) (finding transsexuals ineligible for protection under New York City provision barring discrimination based on "sexual orientation"); *Storror*, *supra* note 5, at 312-13. The Americans with Disabilities Act explicitly excludes transgender people from protection. 42 U.S.C. § 12211(b) (2001) ("Under this chapter, the term 'disability' shall not include . . . transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders . . . ."); see also Susan Etta Keller, *Crisis of Authority: Medical Rhetoric and Transsexual Identity*, 11 Yale J.L. & Feminism 51, 64 (1999). A New Jersey court has held that transsexuals are entitled to protection under the state's antidiscrimination law prohibiting discrimination based on both sex and disability, but not sexual orientation. *Enriquez v. W. Jersey Health Sys.*, 777 A.2d 365, 371-73, 377 (N.J. Super. Ct. App. Div. 2001). Many municipalities bar discrimination based on gender identity and presentation. See *Paisley Currah & Shannon Minter, Transgender Equality: A Handbook for Activists and Policy-makers* (2000), available at <http://www.ngltf.org/downloads/transeq.pdf>; *Chicago Passes Gender Rights Ordinance*, Nov. 7, 2002, at [http://www.advocate.com/new\\_news.asp?ID=6893&sd=11/07/02](http://www.advocate.com/new_news.asp?ID=6893&sd=11/07/02).

<sup>8</sup> Courts generally have interpreted Title VII protections to exclude transgender people. E.g., *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081, 1084 (7th Cir. 1984); *Sommers v. Budget Mktg., Inc.*, 667 F.2d 748, 750 (8th Cir. 1982); *Holloway v. Arthur Andersen & Co.*, 566 F.2d 659, 663 (9th Cir. 1977); see also *Storror*, *supra* note 5, at 311-12 (critiquing courts' findings that Title VII prohibitions on sex discrimination do not outlaw discrimination based on transsexualism). But cf. *Schwenk v. Hartford*, 204 F.3d 1187, 1201-02 (9th Cir. 2000) (allowing claim by transsexual under Gender Motivated Violence Act, which "parallels" Title VII protection); *Brown v. Zavaras*, 63 F.3d 967, 971 (10th Cir. 1995) (suggesting that new medical information may warrant reevaluating lack of suspect-class status for transgender persons).

<sup>9</sup> See Note, *Transsexuals in Limbo: The Search for a Legal Definition of Sex*, 31 Md. L. Rev. 236, 254 (1971) ("If [the transsexual] chooses to live within the sex to which he was born he has, in effect, condemned himself to a perpetual masquerade. If he decides to seek

Sex-reassignment surgery is a necessary (though often not sufficient) condition for legal recognition of a transsexual's chosen identity. In truth, even sex-reassignment surgery may not bring a transsexual person's legal identity in line with his or her gender identity because there is very little judge-created or statutory law explaining exactly how one goes about changing his or her sex designation. Courts inconsistently have recognized the chosen sex of individual transgender people, but such recognition is highly dependent on the particular judge hearing the case, the jurisdiction, and the legal context in which the question is raised.<sup>10</sup> The law, in short, is very thin, heterogeneous, and *ad hoc*. But one consistent theme clearly emerges: Courts generally will not recognize a transgender person's chosen sex or gender without successful completion of sex-reassignment surgery.<sup>11</sup>

The full cost of sex-reassignment surgery—including the psychoanalytic treatment required to obtain a recommendation for surgery and life-long hormone treatments—is, for many, a prohibitively high expense, often exceeding \$100,000.<sup>12</sup> This cost has led some transsexuals, starting in the late 1960s and 1970s, to seek coverage of the procedure under Medicaid.<sup>13</sup> While courts were initially hesitant,<sup>14</sup> in the late 1970s and early 1980s some began to find sex-reassignment surgery medically necessary to treat for gender identity disorder<sup>15</sup> and ruled in favor of transsexual plaintiffs seeking coverage of the procedure under state Medicaid statutes.<sup>16</sup> However, this has created backlash from many commentators who object to the characterization of sex-reassignment surgery as “medically necessary.” These critics argue that because the binary sex-gender system employed by legal authorities is factually incorrect, the notion of “treating” transsexuals erroneously pathologizes nonconforming gender identities.<sup>17</sup>

The transgender community thus finds itself caught in a dilemma. On one hand, the law makes certain basic rights and protections contingent upon completed sex-reassignment surgery. On the other hand,

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medical reassignment, he subjects himself to the scorn and curiosity of society and the limbo of no legal sex identity.”).

<sup>10</sup> See *infra* Part I.B.

<sup>11</sup> See *infra* notes 33-34, 40 and accompanying text.

<sup>12</sup> See *infra* note 127 and accompanying text.

<sup>13</sup> See *infra* Part II.B.

<sup>14</sup> See *infra* note 88 and accompanying text.

<sup>15</sup> Various terms are used to describe the medical and psychological condition of being transgendered, including “gender dysphoria” and “gender identity disorder.” This Note uses the term “gender identity disorder” to indicate the medical diagnosis of transgender identities.

<sup>16</sup> See *infra* Part II.B.

<sup>17</sup> See *infra* notes 107-11 and accompanying text.

to be covered by Medicaid, transsexuals must show that the surgery is a “medical necessity,” and to receive that finding they must label themselves as having a disorder. In order to establish a legal identity, transsexuals have to pathologize their social identity. The dilemma not only creates tension for the person seeking surgery; it also puts the interests of individual transsexuals potentially at odds with the interests of the transgender community as a whole.

This dilemma is an artificial one, produced by rigid conceptions of sex and gender. This Note addresses the issue of “medical necessity” as an example of how society and the legal system attempt to subvert gender nonconformity and enforce an ultimately inaccurate binary sex-gender classification scheme. One way out of the dilemma is to recognize people according to their chosen gender rather than anatomical configuration, allowing individuals to unite their legal and social identities without putting them at the mercy of doctors, bureaucrats, and courts.

But, until that day, this Note argues for a broader definition of “medical necessity,” one that takes into account the legal and social—as well as the strictly medical—ramifications of sex-reassignment surgery. A broader definition would enable transsexuals to seek coverage without labeling themselves as having a disorder. It thus would address concerns about pathologizing identity while accounting for the fact that completed sex-reassignment surgery is often necessary to access certain legal rights and integrate fully into society.

Part I of this Note will examine the process of legal sex designation and the primary importance the law currently places on genital structures when evaluating challenges to legal sex designation. Part II will explore the medicalization of transsexual identities, the employment of this medical model in advocating for Medicaid coverage of sex-reassignment surgery, and the resulting backlash against the designation of sex-reassignment surgery as “medically necessary.” Part III will explain why the criticisms of the “medically necessary” requirement are unlikely to significantly affect the legal reasoning on decisions to cover sex-reassignment surgery under Medicaid. It then will suggest ways in which these valid criticisms can be reconciled with the requirement of surgical modification for legal acknowledgement of one’s chosen gender.

This Note concludes with the recommendation that both commentators and governmental actors more fully appreciate the bind in which our legal system has placed transsexual people, and it urges that there be a broader account of the necessity of sex-reassignment surgery in determining its coverage under Medicaid.

## I

### THE LEGAL PROCESS AND RAMIFICATIONS OF SEX DESIGNATION

With one's sex designation comes a host of legal ramifications, including marriage rights,<sup>18</sup> benefits under private insurance policies, social security benefits, rights under probate law,<sup>19</sup> placement in sex-segregated prisons,<sup>20</sup> military service obligations,<sup>21</sup> participation in sporting events,<sup>22</sup> liability under certain criminal statutes,<sup>23</sup> and eligibility for protection under antidiscrimination statutes and the Constitution.<sup>24</sup> The ability to fit into the binary sex classification employed by our legal system also has significant social consequences, affecting one's ability to maintain employment, obtain medical care, and use gender-appropriate bathrooms.<sup>25</sup>

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<sup>18</sup> See infra Part I.B.2.

<sup>19</sup> If the validity of a transsexual's marriage is successfully challenged on the grounds that she or he is not anatomically her or his chosen gender, then the person is ineligible for benefits and rights as a widow or widower. See infra Part I.B.2.

<sup>20</sup> See infra notes 57-65 and accompanying text.

<sup>21</sup> Whether a transsexual is considered a male or female for military purposes may be irrelevant with regard to the transsexual himself or herself because the military generally discharges transsexuals. See, e.g., *Leyland v. Orr*, 828 F.2d 584 (9th Cir. 1987) (upholding discharge of transsexual from Air Force Reserves on grounds that completed sex-reassignment surgery necessarily renders one physically unfit). But the military's designation of one's transsexual spouse may have significant consequences. See *Von Hoffburg v. Alexander*, 615 F.2d 633, 634-35 (5th Cir. 1980) (dismissing on procedural grounds plaintiff's challenge to her discharge from Army for homosexuality based on her marriage to preoperative transsexual man). Interestingly, the Department of Veteran's Affairs has decided that when a veteran goes through sex-reassignment surgery and marries someone of his or her birth sex, that spouse is entitled to veterans' benefits for vocational rehabilitation. See Benefit Determination Involving Validity of Marriage of Transsexual Veterans, 55 Fed. Reg. 26,810 (June 29, 1990).

<sup>22</sup> See *Richards v. U.S. Tennis Ass'n*, 400 N.Y.S.2d 267, 272-73 (Sup. Ct. 1977) (holding that postoperative transsexual woman cannot be barred from women's tennis tournament based simply on her male chromosomal pattern).

<sup>23</sup> Most sex-based criminal statutes in the United States either have been repealed or are unenforced, but some criminal laws maintain a sex distinction. See, e.g., *Michael M. v. Superior Court*, 450 U.S. 464 (1981) (upholding constitutionality of statutory rape law defining prohibited sexual contact as intercourse with female less than eighteen years old). Foreign jurisdictions also place importance on a criminal defendant's sex designation. See, e.g., *R. v. Harris and McGuiness* (1988) 17 N.S.W.L.R. 158 (Crim. App. Austrl.) (determining that under Australian law, statute prohibiting indecency by "male person" was inapplicable to postoperative transsexual woman, but was applicable to preoperative transsexual woman); *Regina v. Tan*, [1983] 1 Q.B. 1053 (C.A.) (holding postoperative transsexual woman in U.K. properly charged under statute prohibiting male from living off prostitution earnings of females because transsexual woman was man under law).

<sup>24</sup> See supra note 8.

<sup>25</sup> See, e.g., *Shannon Minter, Representing Transsexual Clients: An Overview of Selected Legal Issues* (2000), <http://www.transgenderlaw.org.translaw/html> (giving overview of limited measures protecting transgender people from employment discrimination); *Southern Comfort* (HBO 2001) (documenting life of Robert Eads, female-to-male

Before enjoying the basic legal benefits provided to those who were born into a particular sex, transgender people often must convince a court that they should be identified as their chosen gender. The process of sex designation is therefore vital to a realization of those benefits.

#### A. *The Process of Sex Designation*

The legal designation of sex usually occurs moments after birth and the law gives it presumptive weight throughout an individual's life.<sup>26</sup> This designation, recorded on a birth certificate (usually made by an attending medical professional), is made almost exclusively by an examination of external genitalia.<sup>27</sup> For the large majority of people, this external evidence of biological sex leads to an appropriate and correct determination. For some, however, it does not. For example, birth defects could result in a mistaken sex determination at

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transsexual who was unable to find doctor willing to treat his ovarian cancer). Many commentators recognize that these legal determinations have important effects on a transsexual's place in, and recognition by, society. See, e.g., Storrow, *supra* note 5, at 293 (arguing that in many legal determinations, "the transsexual's place in societal institutions, interacting with other people and forming a part of the social fabric, is at issue").

<sup>26</sup> Paisley Currah, Defending Genders: Sex and Gender Non-Conformity in the Civil Rights Strategies of Sexual Minorities, 48 Hastings L.J. 1363, 1363-64 (1997). The law's reliance on the sex determination made at birth is likely the result of a number of factors, including unfamiliarity with the concept of gender variance, the lack of clearly defined standards for evaluating a person's legal sex, and other, less legal concerns. Cf. *Littleton v. Prange*, 9 S.W.3d 223, 224 (Tex. App. 1999) ("The deeper philosophical (and now legal) question is: can a physician change the gender of a person with a scalpel, drugs and counseling, or is a person's gender immutably fixed by our Creator at birth?"), cert. denied, 121 S. Ct. 174 (2000); Julie A. Greenberg, When Is a Man a Man, and When Is a Woman a Woman?, 52 Fla. L. Rev. 745, 746 (2000) (criticizing court in *Littleton* for relying on "religious rhetoric" instead of examining developments in other disciplines, analyzing policy concerns of sex determination, and looking at cases in other jurisdictions). A detailed examination of the process of initial sex designation is beyond the scope of this Note; this discussion will deal primarily with the legal means of changing one's initial designation. For an argument in favor of revoking the state's power to determine one's sex, see generally Currah, *supra*.

<sup>27</sup> See Suzanne Kessler & Wendy McKenna, Gender: An Ethno-Methodological Approach 119 (1978) ("[G]enitals are not merely a clarifying sign of gender; they are its essential sign."); Franke, *supra* note 1, at 1-2; Jamison Green, Introduction to Currah & Minter, *supra* note 7, at 1, 2.

Medical professionals often evaluate a broader range of factors when determining an individual's gender, as opposed to biological sex. These include: (1) chromosomes; (2) gonads; (3) sex hormone pattern; (4) internal sex organs; (5) genitalia; (6) secondary sex characteristics, such as body hair and breast development; (7) sex of rearing (the gender in which one is raised); and (8) assumed sex role, or psychological sex. See *Transsexualism and the Law*, *supra* note 4, at 965. The weight given to each of these characteristics varies. With intersexed children, for example (i.e., those whose genitalia, sexual organs, and chromosomal pattern are mutually incongruent), the determination of sex and gender is often made by finding the sex with which the majority of factors are in alignment. See *id.* at 966. For a discussion of intersexed infants, see *infra* notes 29-30 and accompanying text.

birth.<sup>28</sup> Intersexed<sup>29</sup> infants may have external genitalia that contain evidence of both sexes or may possess internal reproductive organs that are not in alignment with either their chromosomal composition or their external reproductive organs. Often, these infants are subject to “sex-correction surgery” very early in life in an attempt to place them in conformity with the binary sex-classification system employed by legal authorities.<sup>30</sup> Usually, however, a transgender individual’s

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<sup>28</sup> Cf. *Transsexualism and the Law*, supra note 4, at 26-27 & nn.130-32 (telling stories of children born with ambiguous genitals who “are subjected to numerous surgeries to reinforce” arbitrary gender designations made by physicians).

<sup>29</sup> The term “intersexed” describes a condition in which a person has a combination of both male and female internal sexual organs, genitalia, and/or hormones. Researchers on the subject of intersexuality, most notably Dr. Anne Fausto-Sterling, often prefer the term to the more commonly known term “hermaphrodite” because true hermaphrodites, those with one testis and one ovary, in fact comprise only a subset of intersexed individuals. Anne Fausto-Sterling, *The Five Sexes: Why Male and Female Are Not Enough*, Sciences, Mar.-Apr. 1993, at 20. Intersexed infants may display one of three traits: (1) one testis and one ovary (identified above with the true hermaphrodites); (2) testes and some evidence of female genitalia; or (3) ovaries and some evidence of male genitalia (excluding testes). Ruth Colker, *Bi: Race, Sexual Orientation, Gender, and Disability*, 56 Ohio St. L.J. 1, 43 n.147 (1995). Some estimates place the frequency of intersexed infants at about four percent of all births. See Fausto-Sterling, *supra*.

Beyond visible evidence of intersexuality, some infants have one or two extra sex chromosomes; some have variations that can be traced to unusual hormonal influences in the womb or an inability to process sex hormones. Chromosomal disorders can include Klinefelter Syndrome, in which a mostly typical male has two or more X chromosomes (in addition to a Y) and may develop female secondary sex characteristics at puberty, and Turner Syndrome, in which a mostly typical female has an XO chromosomal pattern instead of the normal XX and lacks clearly defined gonadal structures. See Julie A. Greenberg, *Defining Male and Female: Intersexuality and the Collision Between Law and Biology*, 41 Ariz. L. Rev. 265, 283-84 (1997). Hormonal disorders can include Androgen Insensitivity Syndrome, in which a chromosomal male lacks the ability to process androgens, the male hormones, and as a result develops female genitalia but no internal female reproductive organs. *Id.* at 286.

<sup>30</sup> Some commentators find ample fodder for criticism in the medical community’s treatment of intersexed people. Intersexed people are largely an “invisible” minority because most sex-correction surgery takes place very early in life. See Colker, *supra* note 29, at 43 (“By engaging the [intersexed infant] in surgery at birth, we assign that person to one pole of the bipolar spectrum, rather than allowing the person to live as a transgender person.”).

The decision to correct surgically a sexually ambiguous infant is made before the individual being altered has the ability to give his or her informed consent. Dr. Anne Fausto-Sterling has suggested that sex-correction surgery should be postponed until the onset of puberty so that the intersexed child will be a more active participant in his or her sex assignment. See generally Anne Fausto-Sterling, *Sexing the Body: Gender Politics and the Construction of Sexuality* (2000). The choice of sex is often made based on what will be the easiest surgical procedure, rather than an informed decision as to which sex will be more congruous with the child’s physical, hormonal, and psychological composition—over ninety percent of infants with ambiguous genitalia are designated female. Rose, *supra* note 4, at 132 (referring to Johns Hopkins specialist who reportedly said, “You can make a hole, but you can’t build a pole”). Genital size plays a crucial role in determining the sex of a surgically corrected intersexed infant—if a genital structure that resembles a penis is not

sexual organs are initially in complete conformity with one sex or the other. It is not until the transgender person begins to express evidence of gender identification, often in childhood or adolescence,<sup>31</sup> that it becomes apparent that his or her biological sex is incongruent with his or her psychological gender. For these people, the ability to gain legal recognition of their chosen sex and/or gender can vary greatly according to the analysis employed by the legal authority—often a court—making that determination.<sup>32</sup>

An examination of judicial decisions reveals a wide range of standards applied by different courts. While successful completion of sex-reassignment surgery is not dispositive, it is a prerequisite to a transsexual's claim for recognition as her or his chosen sex and gender. Preoperative transsexuals are precluded from obtaining legal status as their chosen gender and are sometimes precluded from a legal name change as well.<sup>33</sup> It could be said that one reason for this “geni-

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large enough, it will be deemed a clitoris and the infant will be surgically altered to have female genitalia. See Pearlman, *supra* note 5, at 849. The effectiveness of these procedures is being called into doubt in patient follow-ups. See John Colapinto, *As Nature Made Him* (2000) (recounting story of boy whose penis was severed in botched circumcision and who was thereafter raised as girl and given genital surgery and hormone treatments, but who self-identified as male at age fourteen, having struggled against his imposed femininity from the start); *Study: Gender Identity Decided in Womb*, Chi. Trib., May 13, 2000, at 5 (reporting study following up on male babies born without penises and reassigned as females; nearly all patients self-identified as male by puberty in conflict with sex of rearing).

At least one commentator views sex-correction surgery on intersexed infants as another example of society's “punitive treatment” of transgender individuals. Colker, *supra* note 29, at 41 (noting society's desire to “correct” genitalia of transgender people).

<sup>31</sup> Cf. Harry Benjamin Int'l Gender Identity Disorder Ass'n, Standards of Care of Gender Identity Disorders 20-21 (6th version 2001), <http://www.hbigda.org/socv6.pdf> [hereinafter Benjamin Standards] (describing existence and symptoms of “gender identity conflicts” in children and adolescents).

<sup>32</sup> Some commentators argue that the determination of sex is an improper exercise of authority by the judiciary. See Currah, *supra* note 26, at 1363-64 (advocating end of judicial power to enforce any particular definition of sex); *Transsexualism and the Law*, *supra* note 4, at 972 (“Ultimately it is not for the law to decide the sex of an individual. The law must accept medical decisions in this area and give them the legal effect that is in the best interests of the individual and society.”). One commentator has argued that, even if the law is the proper means for determining sex, courts give weight to inappropriate factors such as the sex determination made at birth. See *Transsexuals in Limbo*, *supra* note 9, at 241 (arguing that, because law is primarily concerned with regulating human interaction, only “detectable” factors—such as, for postoperative transsexuals, gender presentation and surgically reassigned genitals—should be used in making determination of sex).

<sup>33</sup> See Rose, *supra* note 4, at 30-31. Fraud is usually a consideration when transgender people apply for a legal name change, though the authorities citing this concern rarely elaborate as to the manner or type of fraud that is feared. See *In re Eck*, 584 A.2d 859, 860-61 (N.J. Super. Ct. App. Div. 1991) (listing fraud as main concern courts should have when evaluating name-change applications); *In re Rivera*, 627 N.Y.S.2d 241, 244 (Civ. Ct. 1995) (granting preoperative transsexual's request for name change as long as she did not use it as evidence that she had successfully completed sex-reassignment surgery); *In re*

tal bias" in the law is the fact that the law embodies the common, and inaccurate, notion that there are two types of persons: one with male genitalia and corresponding male gender, the other with female genitalia and corresponding female gender. No other combination is socially permitted. But what makes the law favor one's genitalia over chosen gender when determining a person's legal sex? Some courts and commentators have invoked fears of fraud.<sup>34</sup> Most likely, however, legal authorities simply find it inconceivable that a "normal" person could have a nonconforming gender identity, and they feel that the legal system should not allow itself to be used as a means of validating what society regards as a mental defect or disorder.<sup>35</sup>

The fact that a person's genitalia often determine his or her legal sex is belied in the case of the postoperative transsexual. Where a person has, in fact, altered her genitalia to conform with her chosen gender,<sup>36</sup> courts have had to struggle to find a coherent basis for denying legal recognition of her reassigned sex. The next Section will examine three of the most common contexts in which challenges to legal sex determinations of postoperative transsexuals arise: birth certificate amendment, marriage, and placement in prison populations.

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Anonymous, 587 N.Y.S.2d 548, 548 (Civ. Ct. 1992) (noting court's responsibility to weigh possibility of fraud in granting name change applications); In re Anonymous, 293 N.Y.S.2d 834, 838 (Civ. Ct. 1968) (finding that concerns of fraud are not realized when name change is sought by postoperative, as opposed to preoperative, transsexual); In re Harris, 707 A.2d 225, 228 (Pa. Super. Ct. 1997) (evaluating petitioner's commitment to living full-time as woman before granting name change); In re Dickinson, 4 Pa. D. & C.3d 678, 679-70 (1978) (granting transsexual's request to change name and sex designation on birth certificate "where [she] has acquired an emotional, psychological and *physiological* change from one sex to another" (emphasis added)); In re Dowdrick, 4 Pa. D & C.3d 681, 684-85 (1978) (denying preoperative transsexual's petition for name change, in part, because it would not comport with "fairness" to public), criticized by In re McIntyre, 715 A.2d 400, 402 (Pa. 1998) (calling it "an arbitrary determination" to refuse to grant name change until after operation, and overruling trial court, which relied on decisions like *Dowdrick*).

<sup>34</sup> See Transsexualism and the Law, *supra* note 4, at 970-71 (noting that requirement of sex-reassignment surgery for change of transsexual's legal status "protects the public against possible fraud"); see also Rose, *supra* note 4, at 31 (examining transsexuals' name change requests); Storrow, *supra* note 5, at 327-28 (detailing courts' concerns with fraud committed on public in name-change hearings). As is the case in name-change hearings, the manner of "fraud" feared by courts hearing claims to amend birth certificates is never clearly specified.

<sup>35</sup> Cf. Greenberg, *supra* note 26, at 764.

<sup>36</sup> Leslie Pearlman writes that there are two steps for legal "gender construction": (1) The medical community constructs the transsexual's chosen sex; and (2) the legal community responds by directing and restricting the ways in which the transsexual can live as a person of the reassigned sex. Pearlman, *supra* note 5, at 851.

## B. Overturning the Legal Weight of Biological Sex

### 1. Birth Certificate Amendment

The ability to amend a birth certificate affects many sex-based legal rights, as the birth certificate is one of the most persuasive pieces of evidence in sex determinations. A number of states allow amendments to birth certificates; such amendments most commonly are used to correct straightforward mistakes in the original document. Many jurisdictions have allowed postoperative transsexuals to amend their birth certificates to reflect their chosen sex,<sup>37</sup> but only after completion of sex-reassignment surgery.<sup>38</sup> Only one state, Tennessee, has said specifically that birth certificate amendments are not available to transsexuals seeking to change their sex designations.<sup>39</sup> Claims for birth certificate amendment often are brought by postoperative transsexuals whose anatomical sex no longer conforms with their birth sex and are usually premised on the notion that the birth certificate is inaccurate.

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<sup>37</sup> A number of states and territories allow postoperative transsexuals either to amend their birth certificates or to be issued new ones, including Alabama, Ala. Code § 22-9A-19(d) (2001); Arizona, Ariz. Rev. Stat. Ann. § 36-326(A)(4) (West 2001); Arkansas, Ark. Code Ann. § 10475 (Michie 2002); California, Cal. Health & Safety Code § 103425 (West 2002); Colorado, Colo. Rev. Stat. Ann. § 25-2-115(4) (West 2002); the District of Columbia, D.C. Code Ann. § 7-217(d) (2001); Georgia, Ga. Code Ann. § 31-10-23(e) (2001); Guam, 10 Guam Code Ann. § 3222 (2002); Hawaii, Haw. Rev. Stat. § 338-17.7(a)(4)(B) (2001); Illinois, 410 Ill. Comp. Stat. Ann. § 535/17 (West 2002); Iowa, Iowa Code Ann. § 144.23(3) (West 2002); Louisiana, La. Rev. Stat. Ann. § 40:62(A) (West 2002); Maryland, Md. Code Ann., Health-Gen. I § 4-214(b)(5) (2002); Massachusetts, Mass. Gen. Laws Ann. ch. 46, § 13(e) (West 2002); Michigan, Mich. Comp. Laws Ann. § 333.2831(c) (West 2002); Mississippi, Miss. Code Ann. § 41-57-21 (2001); Missouri, Mo. Ann. Stat. § 193.215(9) (West 2002); Nebraska, Neb. Rev. Stat. § 71-604.01 (2001); New Jersey, N.J. Stat. Ann. § 26:8-40.12 (West 2002); New Mexico, N.M. Stat. Ann. § 24-14-25(D) (Michie 2002); North Carolina, N.C. Gen. Stat. § 130A-118(b)(4) (2002); Oregon, Or. Rev. Stat. § 432.235(4) (2001); Utah, Utah Code Ann. § 26-2-11 (2002); Virginia, Va. Code Ann. § 32.1-269(E) (Michie 2002); and Wisconsin, Wis. Stat. Ann. § 69.15(1)(a) (West 2002).

Amendment of one's birth certificate, however, does not necessarily carry with it full legal recognition of one's new sex. See Greenberg, *supra* note 26, at 758-59 (noting that courts simply may ignore sex designation on official documents when deciding whether individual can marry under self-identified sex).

<sup>38</sup> See sources cited *supra* note 37; see also Human Rights Campaign Found., Legal Center: Gender Identity: Transsexuals and Births Certificates, at <http://www.hrc.org/familynet/chapter.asp?article=541>. There is an effort by some transgender activists to eliminate the surgical requirement for birth certificate amendment. See Storrow, *supra* note 5, at 331 n.294 (reporting that Phyllis Randolph Frye, Executive Director of International Conference on Transgender Law and Employment Policy, "pioneered the procedure" of changing gender markers on birth certificates prior to sex-reassignment surgery).

<sup>39</sup> See Tenn. Code Ann. § 68-3-203(d) (2001).

## 2. Marriage

The validity of a marriage can affect many subsequent rights, including the right to insurance benefits and the standing to sue in certain situations.<sup>40</sup> Occasionally, courts are asked to rule on whether a marriage is valid under the law, but challenges to transsexuals' marriages have been rare. In those instances when courts have upheld the validity of a transsexual's marriage in her chosen gender, the transsexual's postoperative status is usually an explicit reason for doing so.

An English case, *Corbett v. Corbett*,<sup>41</sup> decided in 1970, appears to be the first reported decision in Anglo-American jurisprudence to assess the validity of a marriage involving a postoperative transsexual. To a large degree this case has framed the debate in American courts.<sup>42</sup> In *Corbett*, the court voided the marriage, despite the fact that the wife, a male-to-female transsexual, had undergone full sex-reassignment surgery. The court gave two reasons for this decision. First, it maintained that a person cannot, through surgery, change his or her "true sex."<sup>43</sup> And second, the court explained that sex with an "artificial vagina" could not be considered traditional vaginal sex, and as such, the transsexual spouse had not—and was unable to—consummate the marriage.<sup>44</sup>

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<sup>40</sup> Often, the right to insurance benefits and the standing to sue for certain tort claims, such as wrongful death, are reserved for the surviving legal spouse of a decedent. See, e.g., *Littleton v. Prange*, 9 S.W.3d 223 (Tex. App. 1999) (dismissing wrongful death suit because transsexual female widow was not legal "wife" of decedent).

<sup>41</sup> [1976] 2 W.L.R. 1306. The validity of the marriage in *Corbett* was being challenged by both parties. The non-transsexual spouse brought this action having spent fewer than fourteen days with the transsexual spouse during the nearly four years that had elapsed since their marriage ceremony. *Id.* at 1313-15.

<sup>42</sup> See, e.g., *M.T. v. J.T.*, 355 A.2d 204, 208 (N.J. Super. Ct. App. Div. 1976) (introducing analysis of validity of postoperative transsexual's marriage with fairly detailed discussion of *Corbett*).

<sup>43</sup> See *Corbett*, 2 W.L.R. at 1323 (claiming, based on testimony from medical witnesses, that operation "cannot affect . . . [the] true sex" of respondent).

<sup>44</sup> *Corbett*, 2 W.L.R. at 1326.

The ability to consummate a marriage is often judged as a condition of validity, but the same requirement is not imposed on others who wish to marry, such as elderly couples, who may be unable to consummate their marriages. See *Transsexualism and the Law*, supra note 4, at 1004 n.270. Nor do courts rest the validity of marriage on the ability to procreate because this would deny marriage to sterile people. See *id.* at 1006.

Resting the validity of a transsexual's marriage on the ability to consummate places transsexual men in jeopardy with regard to marriage validity because even the most advanced phalloplasty techniques are usually unable to create a penis that can sustain an erection well enough to engage in vaginal penetration. See *Storrow*, supra note 5, at 291 (noting many postoperative female-to-male transsexuals cannot achieve erection suitable for vaginal penetration). But see *Vecchione v. Vecchione*, L.A. Daily J., Nov. 26, 1997, at 1 (Cal. Sup. Ct. Nov. 25, 1997) (refusing to treat woman's marriage to transsexual man as void in child-custody dispute because "California recognizes the postoperative gender of all transsexual persons").

The first American case to uphold the validity of a marriage involving a postoperative transsexual, *M.T. v. J.T.*,<sup>45</sup> explicitly rejected the *Corbett* analysis.<sup>46</sup> The *M.T.* court ruled that for the purposes of marriage, the plaintiff was legally a female and that the marriage was therefore valid.<sup>47</sup> Following common law tradition, the *M.T.* court focused, as the *Corbett* line of cases had done, on one's ability to consummate the marriage. But the *M.T.* court came down on the other side of the factual issue: Because the plaintiff was able to consummate the marriage as a woman,<sup>48</sup> her marriage was therefore legally valid. Like other cases, its ruling was limited to postoperative transsexuals.<sup>49</sup>

However, in a 1999 case called *Littleton v. Prange*, a Texas court moved away from the focus on consummation, arguing instead that one's "sex" was fixed at birth.<sup>50</sup> Invalidating the marriage of a postoperative transsexual, the majority decided that sex determination was a matter of law, not fact, implicitly acknowledging that sex is ultimately a legal construction.<sup>51</sup> It voided the plaintiff's marriage on the basis that she was legally a man and therefore could not be legally married

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<sup>45</sup> 355 A.2d 204 (N.J. Super. Ct. App. Div. 1976). The court cites two earlier cases that ruled on the validity of marriages involving transsexuals, *Anonymous v. Anonymous*, 67 Misc. 2d 982 (N.Y. Sup. Ct. 1971), and *B. v. B.*, 78 Misc. 2d 112 (N.Y. Sup. Ct. 1974). Both of these marriages were found invalid. In *Anonymous*, the transsexual spouse did not undergo sex-reassignment surgery until after the marriage took place, and the couple apparently had never consummated the marriage. *Anonymous*, 67 Misc. 2d at 984. *B. v. B.* involved the marriage of a transsexual man who apparently was unable to consummate the marriage. *B. v. B.*, 78 Misc. 2d. at 117-18.

<sup>46</sup> *M.T.*, 355 A.2d at 208. The *M.T.* court said that the *Corbett* court had improperly disaggregated sex and gender, resulting in a finding that the transsexual spouse's gender was female, while her sex, though surgically reassigned, was permanently male. The *M.T.* court said that when anatomical sex and gender are in "disharmony," as in the case of preoperative transsexuals, it is proper to consider the transsexual as belonging to her biological sex. But where the transsexual has been surgically reassigned so her sex and gender are congruous, the law should recognize her chosen sex. *Id.* at 209.

<sup>47</sup> *Id.* at 211.

<sup>48</sup> *Id.* at 205-07, 210-11.

<sup>49</sup> *Id.* at 207. Interestingly, the *M.T.* court, unlike other courts determining the validity of marriages involving transsexual spouses, did not discuss whether the transsexual spouse's birth certificate had been amended. See *Rose*, *supra* note 4, at 80 n.444.

<sup>50</sup> *Littleton v. Prange*, 9 S.W.3d 223, 230-31 (Tex. App. 1999) (framing legal question as: "[C]an a physician change the gender of a person with a scalpel, drugs and counseling, or is a person's gender immutably fixed by our Creator at birth?"). The court granted summary judgment to the defendant doctor in a wrongful death action because the plaintiff, a postoperative transsexual woman, was legally a man. Therefore, her marriage to the decedent was declared void, and she no longer had standing to sue. See *id.* at 225, 231.

<sup>51</sup> See *id.* ("We hold, as a matter of law, that [plaintiff] is a male."); see also *Rose*, *supra* note 4, at 75. According to the majority, absent explicit legislative action granting transsexuals legal status as their chosen sex, their legal sex was fixed at birth. *Greenberg*, *supra* note 26, at 754. The court noted that the plaintiff had legally amended her birth certificate, albeit after the initiation of the lawsuit, to reflect her surgically reassigned sex.

to another man.<sup>52</sup> The court did not identify any dispositive piece of evidence leading to its conclusion, but the evidence that the court found most persuasive was the fact that the plaintiff had male sex chromosomes.<sup>53</sup> (This factual finding itself could only be described as “judicial notice” because, in truth, the court simply presumed it to be true: No chromosomal evidence was ever entered into the record.<sup>54</sup>)

In many U.S. jurisdictions, the validity of a transsexual’s marriage has not yet been decided, and the Supreme Court in the past two years has twice declined to hear cases addressing the legality of marriage involving postoperative transsexuals.<sup>55</sup> Those jurisdictions that

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See Rose, *supra* note 4, at 73 (commenting on how chief justice characterized plaintiff’s amended birth certificate as not legally binding on courts).

A dissent by Justice Lopez said that sex determination was not a matter of law, and because conflicting evidence made it a triable issue of fact for the jury, summary judgment was inappropriate. *Littleton*, 9 S.W.3d at 233-34 (Lopez, J., dissenting).

<sup>52</sup> *Littleton*, 9 S.W.3d at 231 (“As a male, [plaintiff] cannot be married to another male.”).

The *Littleton* decision, because of its holding that a transsexual remains his or her biological sex regardless of surgical sex reassignment, implies that a preoperative or post-operative transsexual person would have no problem obtaining a marriage license for a same-sex marriage as their chosen gender (i.e., a transsexual man could be married to a biological man, and a transsexual woman could be married to a biological woman). This is not merely a hypothetical situation; same-sex marriages involving a transgender spouse have already happened in a number of jurisdictions. See Greenberg, *supra* note 29, at 268; Lesbians to Legally Marry Because One Is an Ex-Man, *The People*, June 11, 1995, at 2; Oregon Couple Adds Twist to Love Story, *Morning News Trib.* (Tacoma, Wash.), Dec. 14, 1996, at A3 (reporting that marriage plans between woman and preoperative transsexual woman—still legally male—“may result in the first openly homosexual couple legally married in Oregon”), 1996 WL 1474948; Afi-Odelia E. Scruggs, *Tying Legalities into Tangled Knot*, *Plain Dealer* (Cleveland), Oct. 7, 1996, at B1; Michael Vigh, *Transsexual Weds Woman in Legally Recognized Union*, *Salt Lake Trib.*, Feb. 5, 1999, at C1, LEXIS, Nexis Library, Salt Lake Tribune File.

The International Conference on Transgender Law and Employment Policy completed a study that indicates that more than forty percent of transgender people are lesbian, gay, or bisexual in their chosen gender. See Rosenblum, *supra* note 2, at 511 n.57. This has led one commentator to write that courts and legislatures must decide whether marriage between a transsexual woman and a biological man, or transsexual woman and a biological woman, would better further “the values that the law and society seek to promote.” Greenberg, *supra* note 26, at 764. The *Littleton* court contemplated this situation in discussing an unreported New Zealand case that held postoperative transsexuals should be allowed to marry as their reassigned sex, because the opposite result was less desirable. *Littleton*, 9 S.W.3d at 229 (citing Mary Coombs, *Sexual Dis-Orientation: Transgendered People and Same-Sex Marriage*, 8 UCLA Women’s L.J. 219, 250 & n.137 (1998), which cited New Zealand case as M. v. M. (unreported), 30 May 1991 (S. Ct. of N.Z.)).

<sup>53</sup> *Littleton*, 9 S.W.3d at 230.

<sup>54</sup> See Greenberg, *supra* note 26, at 746 n.4 (noting chromosomal evidence not entered into record in *Littleton*). It was undisputed that the plaintiff, Christie Littleton, could engage in sexual intercourse as a woman, and that her marriage with the decedent had been consummated. *Littleton*, 9 S.W.3d at 227.

<sup>55</sup> See *Gardiner v. Gardiner*, 123 S. Ct. 113 (2002) (denying certiorari where Kansas Supreme Court, in *In re Gardiner*, 42 P.3d 120, had declared void marriage of postopera-

have ruled on the issue are divided on the reasoning and outcome, but one message is clear: Completion of sex-reassignment surgery, while not a guarantee of success, has been a necessary precondition to any successful defense of the validity of a transsexual's marriage.<sup>56</sup>

### 3. Placement in Prison Populations

The successful completion of sex-reassignment surgery also has important implications for prison placement.<sup>57</sup> Prison authorities al-

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tive transsexual); *Littleton v. Prange*, 531 U.S. 872 (2000) (denying certiorari in appeal from Texas appeals court).

<sup>56</sup> This entire issue could be mooted, at least in certain jurisdictions, by successful challenges to marriage laws by gay and lesbian couples, because they would eliminate the requirement that legally married partners be of the opposite sex. See, e.g., *Baehr v. Lewin*, 852 P.2d 44 (Haw. 1993) (holding restriction of marriage to heterosexual couples violated Hawaii's constitution); *Baker v. State*, 744 A.2d 864 (Vt. 1999) (holding that inability of same-sex couples to enter into marriage, or equivalent union, violated Vermont's constitution); *Complaint, Lewis v. Harris*, No. L-423302 (N.J. Super. Ct. Ch. Div. filed June 26, 2002), [http://www.lambdalegal.org/binary-data/LAMBDA\\_PDF/pdf/135.pdf](http://www.lambdalegal.org/binary-data/LAMBDA_PDF/pdf/135.pdf) (seeking injunction requiring state to grant plaintiff same-sex couples full marriage rights accorded to opposite-sex couples). A full discussion of challenges to marriage laws by gays and lesbians, and their impact on transsexual marriage rights, is beyond the scope of this Note.

<sup>57</sup> Claims by transsexual prisoners for medical treatment, including requests for hormone therapy and sex-reassignment surgery, are beyond the scope of this Note since prisoner cases, instead of focusing on the finding of medical necessity (which most courts acknowledge either explicitly or implicitly), usually focus on the security of the prison environment. See, e.g., *Smith v. Rasmussen*, 57 F. Supp. 2d 736, 772 n.12 (N.D. Iowa 1999) (distinguishing issue of prisoner's entitlement to sex-reassignment surgery under Eighth Amendment from issue of plaintiff's entitlement to coverage of sex-reassignment surgery under Medicaid standards), rev'd on other grounds 249 F.3d 755 (8th. Cir. 2001); *Storrow*, supra note 5, at 303 (arguing that transsexual prisoners' rights cases focus on security of prison to exclusion of medical analysis, giving deference to prison officials). There is, however, a fairly substantial body of law examining those types of claims. See generally *Maggert v. Hanks*, 131 F.3d 670 (7th Cir. 1997) (holding that prisoner is not entitled under Eighth Amendment to curative treatment for undiagnosed gender dysphoria); *Brown v. Zavaras*, 63 F.3d 967 (10th Cir. 1995) (dismissing equal protection claim but suggesting prisoner may have Eighth Amendment right to some medical treatment); *White v. Farrier*, 849 F.2d 322 (8th Cir. 1988) (reversing summary judgment for transsexual prisoner because there were genuine issues of fact as to her diagnosis and as to liability of prison officials); *Meriwether v. Faulkner*, 821 F.2d 408 (7th Cir. 1987) (finding that untreated transsexual stated valid claim under Eighth Amendment for lack of treatment and for failure to protect from assault); *Supre v. Rickets*, 792 F.2d 958 (10th Cir. 1986) (refusing to award attorneys' fees to transsexual inmate who successfully obtained hormone therapy because her treatment was not judicially ordered and not required by law); *Smith*, 57 F. Supp. 2d 736 (holding that transsexual is entitled to Medicaid coverage of sex-reassignment surgery); *Farmer v. Hawk*, 991 F. Supp. 19 (D.D.C. 1998) (upholding Eighth Amendment and equal protection claims brought by transsexual prisoner for failure to continue estrogen treatment in accordance with prison policy); *Phillips v. Mich. Dep't of Corr.*, 731 F. Supp. 792 (W.D. Mich. 1990) (granting preliminary injunction to transsexual prisoner because prison officials failed to allow her to continue estrogen treatment with deliberate indifference to serious medical need); *Lamb v. Maschner*, 633 F. Supp. 351 (D. Kan. 1986) (holding that providing therapy to inmate instead of hormone treatment and transfer to female facility is not Eighth Amendment violation).

most always segregate inmates based on their anatomical sex.<sup>58</sup> Post-operative transsexuals, therefore, will be placed in prisons that correspond to their gender identities, whereas preoperative transsexuals (and transgender persons), generally will not, even if they have secondary sex characteristics (e.g., breasts) normally associated with their chosen sex and gender due to hormone intake. The Supreme Court has held that prisoners have no due process right to be assigned to a particular prison,<sup>59</sup> and the Seventh Circuit, in *Meriwether v. Faulkner*,<sup>60</sup> has stated in dicta that equal protection claims for wrongful sex classification by prison officials likely would fail.<sup>61</sup> An exami-

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Transgender prisoners often request either medical treatment, placement in a gender-appropriate prison population, or both, whether in a lawsuit or when dealing with prison authorities directly. See, e.g., *White*, 849 F.2d at 323 (describing prisoner's requests for "electrolysis, cosmetic surgery, hormone therapy, a sex change operation, female clothes and cosmetics, and a transfer to a women's prison"); *Lamb*, 633 F. Supp. at 352 ("Plaintiff . . . requests relief in the nature of a transfer to a women's facility, cosmetics, and female clothing; or in the alternative, pre-operative hormone treatment and a sex-change operation.").

<sup>58</sup> Rosenblum, *supra* note 2, at 522 n.108. Federal prison practice is to house preoperative transsexuals with inmates of the same biological sex, while housing postoperative transsexuals with inmates of their reassigned sex. *Farmer v. Brennan*, 511 U.S. 825, 829 (1994); Storror, *supra* note 5, at 303.

The only notable exception to be found in the case law, where prison authorities placed a preoperative transgender woman in a female prison facility, is *Crosby v. Reynolds*, 763 F. Supp. 666, 670 (D. Me. 1991) (holding that placement of plaintiff biological woman in cell with preoperative transgender woman was not violation of plaintiff's constitutional rights to privacy and procedural due process). The *Crosby* court indicated that authorities placed the preoperative transgender woman in a women's prison facility to avoid the likely physical and psychological injury she would suffer at a male facility. *Id.* at 667. The court did not hold that the transsexual defendant had a right to be placed in a female prison population, merely that the prison officials were not acting unreasonably when they did so. *Id.* at 669-70.

It is important to note that all of the cases surveyed here challenging the place of confinement are claims regarding transgender women. Transgender men file fewer claims for transfer because they usually face less harassment in women's prisons than transgender women face in men's prisons. Rosenblum, *supra* note 2, at 517 n.84.

<sup>59</sup> *Meachum v. Fano*, 427 U.S. 215, 224 (1976) (

The Constitution does not . . . guarantee that the convicted prisoner will be placed in any particular prison . . . . The initial decision to assign the convict to a particular institution is not subject to audit under the Due Process Clause, although the degree of confinement in one prison may be quite different from that in another.).

<sup>60</sup> 821 F.2d 408 (7th Cir. 1987).

<sup>61</sup> The Seventh Circuit wrote:

[A] prison administrative decision may give rise to an equal protection claim only if the plaintiff can establish that "state officials had purposefully and intentionally discriminated against him." While complaining that the defendants' decision to classify her as a male was arbitrary and irrational, plaintiff has not alleged any "design or intent to discriminate."

*Id.* at 415 n.7 (quoting *Shango v. Jurich*, 681 F.2d 1091, 1104 (7th Cir. 1982) (citations omitted)).

nation of cases where preoperative transsexual plaintiffs challenged their placements in prison populations according to their biological sex shows that, because of their preoperative status, their requests for transfer were not granted.

Courts have denied requests for transfer by preoperative transsexual prisoners, citing, among other reasons, concerns that such a transfer may violate the rights of other prisoners.<sup>62</sup> However, placement of transgender prisoners in gender-inappropriate prisons (meaning, for example, placement of a preoperative transsexual woman in a male prison) often results in administrative segregation,<sup>63</sup> leaving the transsexual prisoner with fewer opportunities and activities than other prisoners.<sup>64</sup>

While transgender prisoners occasionally may be placed in a prison population consistent with their gender identities,<sup>65</sup> given the formal and informal regulations that currently govern sex segregation in federal and state prisons,<sup>66</sup> such placement occurs only at the whim of corrections officials, if at all. Absent completion of sex-reassignment surgery, transsexual prisoners will be subject to the difficulties and dangers of placement in gender-inappropriate prisons.

It is unlikely that any transsexual would seek sex-reassignment surgery solely to access legal rights, but the extent to which our legal system relies on anatomy to categorize people illustrates the importance of access to the procedure. The cost of the surgery and accompanying procedures, however, can be prohibitively high and private health insurance, when available to transsexuals, generally does not cover the treatment.<sup>67</sup> These factors have led many transsexuals,

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<sup>62</sup> See *Lamb v. Maschner*, 633 F. Supp. 351, 353 (D. Kan. 1986) (holding that “[e]ven though a transfer [of transsexual woman to women’s prison] may relieve plaintiff’s anxieties, clearly a violation of the [other prisoners’] rights would be at issue”). But cf. *Crosby*, 763 F. Supp. at 670 (“Although it is clear that there is a constitutional right to privacy, I conclude that the contours of that right are not clear when it comes to the determination of where to house transsexuals.”).

<sup>63</sup> See *Meriwether*, 821 F.2d at 417 (“Because of plaintiff’s psychiatric and physical state, it may prove infeasible to fashion any kind of relief against the condition, namely, prolonged confinement in administrative segregation, she challenges.”).

<sup>64</sup> See, e.g., *id.* at 416 (observing that administrative segregation entails denial of “adequate recreation, living space, educational and occupational rehabilitation opportunities, and associational rights”).

<sup>65</sup> See generally *Crosby*, 763 F. Supp. 666 (describing decision to house preoperative transsexual who had male organs with female prison population); see also *supra* notes 57-58.

<sup>66</sup> See *supra* notes 57-62 and accompanying text.

<sup>67</sup> Even when transsexuals have access to private health insurance, insurers often categorically exclude sex-reassignment treatments from coverage. Kari E. Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 Colum. J. Gender & L. 88, 92 (2002). But cf. Rachel Gordon, *S.F. Set to Add*

starting in the 1970s, to seek coverage of the procedure under Medicaid.

## II

### MEDICAID COVERAGE OF SEX-REASSIGNMENT SURGERY

In 1965, Congress created the Medicaid system,<sup>68</sup> a broad medical insurance scheme of vital importance to lower-income Americans.<sup>69</sup> Medicaid is funded with both state and federal dollars but is administered by individual states.<sup>70</sup> Participation in the system is optional for states, but once a state decides to participate, it is obliged to follow federal statutory and regulatory requirements.<sup>71</sup> The Supreme Court has recognized, however, that beyond the statutory requirements and certain narrow federal regulations, the Medicaid statute "confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be 'reasonable' and 'consistent with the objectives' of the Act."<sup>72</sup> In particular, while states are required to extend Medicaid coverage to all procedures that are "medically necessary," the states themselves can determine which procedures meet that standard, and courts generally will defer to any rational definition of those terms.<sup>73</sup> Moreover, states

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Change Benefits, S.F. Chron., Feb. 16, 2001, at A1 (reporting decision by San Francisco city officials to cover sex-reassignment surgery under city employee health plan).

<sup>68</sup> Pub. L. No. 89-97, 79 Stat. 343 (codified as amended at 42 U.S.C. § 1396 (2001)).

<sup>69</sup> Cf. Hong, *supra* note 67, at 88 ("Health insurance has an enormous impact on determining who receives medical care. If a policy does not cover a particular treatment, an individual in need of care either pays for the medical procedure from her own resources or foregoes treatment altogether.").

<sup>70</sup> See *Smith v. Rasmussen*, 57 F. Supp. 2d 736, 754 (N.D. Iowa 1999) (citing *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990)), rev'd on other grounds, 249 F.3d 755 (8th Cir. 2001)).

<sup>71</sup> *Id.* at 753-54 (citing *Harris v. McRae*, 448 U.S. 297, 301 (1980)); *Beh*, *supra* note 3, at 137. These regulations include the definition of two types of "needy" individuals for the purposes of the federal Medicaid statute. States are required to provide coverage for the "categorically needy," including the elderly, the disabled, children, and their adult caretakers. 42 U.S.C. § 1396a(a)(10)(A) (2001). Section 1396a(a)(10)(C) gives states the option of also providing coverage to "medically needy" individuals—i.e., those who lack the financial resources to obtain required medical care but who do not fit into one of the "categorically needy" groups. For descriptions of the two categories of needy individuals under the federal Medicaid statute, see *Beal v. Doe*, 432 U.S. 438, 440 n.1 (1977); *Smith*, 57 F. Supp. 2d at 754.

<sup>72</sup> *Beal*, 432 U.S. at 444 (quoting § 1396a(a)(17)).

<sup>73</sup> "Medical necessity" is not defined in the Medicaid statute or accompanying regulations. It is often based primarily on physician determinations regarding the necessity of a certain procedure and sometimes guided by state regulations for particularly common procedures. See, e.g., *Beal*, 432 U.S. at 442 n.3 (noting that, in Pennsylvania, whether abortions are "medically necessary" is "a determination that the physician is authorized to make on the basis of all relevant factors"); *Doe v. Bolton*, 410 U.S. 179, 192 (1973) ("Whether 'an abortion is necessary' is a professional judgment that . . . may be exercised

are free to cover any procedures that are not medically necessary, though states must refuse coverage to procedures that are "medically inappropriate."<sup>74</sup> The federal Medicaid statute does not provide for coverage of services that are designated as "optional," like home health care, private nursing services, and physical therapy, even though they may be medically beneficial.<sup>75</sup>

In choosing which procedures to cover, a state's discretion is limited in one important respect: It may not discriminate in coverage of procedures on the basis of the diagnoses or conditions they are designed to treat.<sup>76</sup> Thus, coverage of sex-reassignment surgery under Medicaid turns on each state's determination of whether or not the procedure is medically necessary to the plaintiff.<sup>77</sup>

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in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient."); *Rush v. Parham*, 440 F. Supp. 383, 389 (D. Ga. 1977) (emphasizing "pre-eminence" of attending physician's judgment and ordering state to pay for sex-reassignment surgery), rev'd, 625 F.2d 1150 (5th Cir. 1980) (finding state can reasonably exclude experimental surgery).

The federal Medicaid statute requires states to cover medically necessary procedures in five categories: (1) inpatient hospital treatment; (2) outpatient hospital treatment; (3) laboratory work and x-ray services; (4) skilled nursing services, periodic screening and diagnosis, and family planning services; and (5) physician's services. § 1396a(a)(13)(B) (2001). The federal Medicaid statute does not provide for coverage of services that are designated as "optional," like home health care, private nursing services, and physical therapy, even though they may be medically necessary.

<sup>74</sup> Beh, *supra* note 3, at 137. The Fifth Circuit, following guidelines issued by Medicare, adopted the following means of determining whether a procedure should be deemed "experimental":

In making such a decision [whether to provide payment for a particular service], a basic consideration is whether the service has come to be generally accepted by the professional medical community as an effective and proven treatment for the condition for which it is being used. If it is, Medicare may make payment. On the other hand, if the service or treatment is not yet generally accepted, is rarely used, novel or relatively unknown, then authoritative evidence must be obtained that it is safe and effective before Medicaid may make payment.

*Rush*, 625 F.2d at 1156 n.11 (quoting Enclosure 2, Intermediary Letters Nos. 77-4 & 77-5, [Mar. 1976-Feb. 1977 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 28,152 (January 1977)).

<sup>75</sup> § 1396d(a)(6)-(17).

<sup>76</sup> See 42 C.F.R. § 440.230(c) (2002) ("[A state] may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition."). Many states, however, do have flat statutory bans on coverage for procedures to treat gender identity disorder. See *infra* note 89. Some cases involving transsexuals claiming coverage for sex-reassignment surgery under Medicaid have resulted in the invalidation of such statutes. See *infra* Part II.B.

<sup>77</sup> Cf., e.g., *Beal*, 432 U.S. at 444-45 ("[I]t is hardly inconsistent with the objectives of the [Medicaid] Act for a State to refuse unnecessary—though perhaps desirable—medical services.").

### A. Medical Justifications for Sex-Reassignment Surgery

Though different courts have varied widely in their rulings on the subject, litigants have been moderately successful in convincing courts that sex-reassignment surgery is the most promising treatment for gender identity disorder and is therefore “medically necessary.”<sup>78</sup> This is due primarily to the weight courts have given to medical opinions. The explanation of transgender identities in medical and diagnostic terms is common throughout the case law, even in cases that do not deal specifically with sex-reassignment surgery or sex designation.<sup>79</sup> Often, it is the transgender party who inserts the medical analysis into the record since a medical explanation is seen as giving legitimacy to a transgender identity.<sup>80</sup>

This quest for legitimacy explains why the transgender community traditionally has embraced the medical model of transgender identities.<sup>81</sup> In the 1970s, for example, even as gays and lesbians were lobbying to have homosexuality excluded from the list of disorders recognized by the American Psychiatric Association (APA), transsex-

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<sup>78</sup> Storrow, *supra* note 5, at 281. The mere fact that a court acknowledges the procedure as medically necessary does not guarantee that it will rule in favor of Medicaid coverage—for example, a court could still conclude that a medically necessary procedure is experimental—but it is an important component of a successful argument for coverage.

<sup>79</sup> See, e.g., *J.L.S. v. D.K.S.*, 943 S.W.2d 766 (Mo. Ct. App. 1997) (detailing transsexual parent’s medical history and condition in context of custody case); *Daly v. Daly*, 715 P.2d 56 (Nev. 1986) (same); *Maffei v. Kolaeton Indus., Inc.*, 626 N.Y.S.2d 391, 393 (Sup. Ct. 1995) (giving medical definitions of transsexualism in employment discrimination case); *In re Rivera*, 627 N.Y.S.2d 241, 244 (Civ. Ct. 1995) (describing, at name-change hearing, petitioner’s treatment by physicians); *In re Harris*, 707 A.2d 225, 225-26 (Pa. Super. Ct. 1997) (detailing petitioner’s medical history in name-change hearing); *In re Dickinson*, 4 Pa. D. & C.3d 678, 679 (1978) (same); *Keller*, *supra* note 7, at 59-60 (discussing judiciary’s embrace of medical rhetoric in cases dealing with transsexualism).

<sup>80</sup> See *Keller*, *supra* note 7, at 62 (“[T]he judicial use of medical rhetoric is often a response to the manner in which transsexual litigants frame their claims.”); *Storrow*, *supra* note 5, at 280 (highlighting pervasiveness of medical evidence in judicial opinions involving transsexuals). One commentator has noted that the medical authority cited by transsexual litigants also has the effect of making transsexuals seem less “threatening” to the legal system’s binary sex-classification system than, for example, gays and lesbians. See *Patriarchy*, *supra* note 6, at 1990 (“[B]ecause the public face of transsexuality (illness) reasserts the stability of masculinity and femininity, the transsexual may receive better treatment at the hands of the law than do gays and lesbians.”).

<sup>81</sup> One commentator suggests that this embrace of medical authority for legal purposes is not limited to transgender people but is in fact evident in many cases involving plaintiffs for whom the presence of a certain condition is a relevant piece of their claim: “[M]any patients also understand the potential legal utility of a medical diagnosis, which is only partially counterbalanced by concerns about their future insurability and even social stigma.” Lars Noah, *Pigeonholing Illness: Medical Diagnosis as a Legal Construct*, 50 Hastings L.J. 241, 289 (1999).

ual activists were lobbying to have “gender identity disorder” included in the very same list.<sup>82</sup>

Starting in the 1950s and 1960s, researchers began publishing their findings and analyses regarding transgender identities.<sup>83</sup> Medical authorities started promoting sex reassignment—entailing psychotherapy, hormone treatment, and surgical reconfiguring of genitalia<sup>84</sup>—as the only successful treatment for gender identity disorder. They also

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<sup>82</sup> Keller, *supra* note 7, at 52. The first year that the American Psychiatric Association (APA) recognized “transsexualism” as a distinct diagnosis—1980—was the same year that homosexuality was deleted from the APA Diagnostic and Statistical Manual (DSM). *Id.*

The most recent edition of the APA’s Diagnostic and Statistical Manual of Mental Disorders removes “transsexualism” as a distinct diagnosis in favor of “gender identity disorder,” a broader category. Am. Psychiatric Ass’n, Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) [hereinafter DSM-IV]. This was, in part, to acknowledge that not all transgender individuals suffer emotional confusion and distress. Beh, *supra* note 3, at 124 n.24. The DSM-IV does, however, retain the diagnosis of Gender Identity Disorder of Childhood (GIDC), which pathologizes, among other things, boys who enjoy playing with Barbie dolls and girls who identify with “powerful male figures, such as Batman or Superman.” DSM-IV, *supra*, at 533, 538; see also Flynn, *supra* note 2, at 410 n.101. Interestingly, few children diagnosed with GIDC grow up to be transsexual; many grow up to be gay or lesbian. *Id.*

At least one commentator has suggested that one benefit of diagnostic procedures for gender identity disorder is that it provides a screening function for those seeking surgery. Rose, *supra* note 4, at 25-26.

<sup>83</sup> Prominent early researchers include Dr. Harry Benjamin and Dr. John Money. Benjamin is largely credited with being the first medical researcher to describe the syndrome that became known as gender identity disorder or transsexualism. *Smith v. Rasmussen*, 57 F. Supp. 2d 736, 742 (N.D. Iowa 1999), rev’d on other grounds, 249 F.3d 755 (8th Cir. 2001); cf. Benjamin Standards, *supra* note 31. Money established the Gender Identity Clinic at Johns Hopkins University in the 1960s to study and treat gender identity disorder. See generally *Transsexualism and Sex Reassignment*, *supra* note 4.

Beyond his work with adult transsexuals, much of Dr. Money’s research involved the surgical “sex correction” of infants born intersexed or with malformed genitals. See generally John Money, *Sex Reassignment as Related to Hermaphroditism and Transsexualism*, in *Transsexualism and Sex Reassignment*, *supra* note 4, at 91. This procedure is still practiced today, but is increasingly subject to harsh criticism. See, e.g., Colapinto, *supra* note 30 (recounting life of biological male, former patient of Dr. Money and subject of numerous medical papers by him, who underwent male-to-female sex-reassignment surgery at age two after botched circumcision, and who renounced his reassigned sex as teenager and adopted male gender identification); Bruce C. Steele, *Scary Movie*, Advocate, Nov. 6, 2001, at 57 (reviewing Nova documentary on Colapinto, who is now married adult male and still angered by decision of parents, at urging of Dr. Money, to surgically remove his penis).

<sup>84</sup> Sex-reassignment surgery entails a number of individual surgical procedures, not all of which are appropriate for every patient. For female-to-male transsexuals, available surgical procedures include breast removal, hysterectomy, vaginectomy, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. Benjamin Standards, *supra* note 31, at 20-21. For male-to-female transsexuals, available procedures include breast augmentation, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. *Id.*

developed demanding criteria to evaluate people who came seeking treatment.<sup>85</sup>

Gradually, during the late 1960s and 1970s, the work of those researching transgender persons began to receive more notice in the medical and legal communities. The conclusion of much of this research—that sex-reassignment surgery was the best, or only, treatment for gender identity disorder<sup>86</sup>—persuaded many courts confronting the issue that it was medically necessary,<sup>87</sup> and this greatly affected the adjudication of Medicaid claims.

### *B. Successful Arguments for Medicaid Coverage*

Two New York cases in the mid-1970s held that the transsexual plaintiffs who sought coverage of sex-reassignment surgery under Medicaid had failed to prove the medical necessity of the treatment.<sup>88</sup> Around the same time, courts in other states were beginning to adopt the idea that sex-reassignment surgery was the only accepted and successful treatment for transgender adults, leading to several decisions that overturned what the courts deemed arbitrary or unreasonable denials of coverage. Coverage in these cases usually was denied for one

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<sup>85</sup> The Benjamin Standards require the following before a patient will be allowed to undergo reassignment surgery: (1) recommendations in writing from two behavioral scientists; (2) successful experience living as a person of the chosen gender for at least a year; and (3) legal, social, psychological, sexual, and (exogenous) endocrine success during cross-living. Beh., *supra* note 3, at 152 (citing Benjamin Standards, *supra* note 31). Presurgery screening procedures are meant to ensure that (1) the patient is truly a transsexual; (2) surgery is the only beneficial treatment available; (3) the patient is giving informed consent; (4) the patient is aware of the limitations and possible complications of surgery; and (5) surgery is almost certain to improve the patient's condition, both physically and emotionally. *Transsexualism and the Law*, *supra* note 4, at 974.

<sup>86</sup> See Storrow, *supra* note 5, at 281 (noting ease with which commentators and some courts have found sex-reassignment surgery medically necessary).

<sup>87</sup> See Storrow, *supra* note 5, at 281 (noting ease with which commentators and some courts have found sex-reassignment surgery medically necessary).

<sup>88</sup> In *Denise R. v. Lavine*, 347 N.E.2d 893 (N.Y. 1976), the New York Court of Appeals held that denial of coverage by the Commissioner of Social Services was not arbitrary, even though the Commission had not performed an independent medical evaluation to refute the evidence proffered by plaintiff's physicians that sex-reassignment surgery and hormone treatment were necessary to treat her gender identity disorder. *Id.* at 895. The court reviewed evidence of the plaintiff's history of treatment, including hormone therapy, and it ruled against the plaintiff, in part because one of her treating psychiatrists had reported that she showed no "disturbance in thinking" or suicidal ideation. *Id.*

*Vickers v. Toia*, 411 N.Y.S.2d 598 (App. Div. 1978), upheld the dismissal of the plaintiff's petition for Medicaid coverage of sex-reassignment surgery because of an incomplete showing of medical necessity. *Id.* at 599. The court dismissed the petition without prejudice, leaving the plaintiff the option of refiling a claim. *Id.* The court seemed to indicate, however, that a future showing of medical necessity could be made by showing that the plaintiff, who had already started hormone therapy and completed breast augmentation surgery, would suffer psychological trauma from being left sexually ambiguous. *Id.*

of three reasons: The state had a flat statutory or regulatory ban on coverage of sex-reassignment procedures under Medicaid; the state Medicaid administration had deemed sex-reassignment surgery a “cosmetic” procedure and therefore excluded it from coverage under the federal Medicaid statute; or the state Medicaid administration had characterized the procedure as “experimental.”

Many states have statutory or regulatory bans on Medicaid coverage of sex-reassignment surgery.<sup>89</sup> Courts that overturn denials of coverage made pursuant to such bans usually find the bans to be inconsistent with the federal Medicaid regulations,<sup>90</sup> which prohibit denials of benefits based solely on the “diagnosis, type of illness, or condition.”<sup>91</sup> Thus, for example, the Eighth Circuit, in *Pinneke v. Preisser*,<sup>92</sup> found that Iowa’s statutory ban on the procedure removed treatment decisions from claimants’ physicians and rested them instead with government personnel.<sup>93</sup> Vital to decisions overturning

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<sup>89</sup> E.g., Alaska Admin. Code tit. 7, § 43.385 (1997); Ariz. Admin. Code R9-27-203 (1997); Ill. Admin. Code tit. 89, § 140.6(l) (1998); Mass. Regs. Code tit. 130, §§ 410.405, 405.418, 415.408, 423.415, 433.404, 433.440 (1998); N.Y. Comp. Codes R. & Regs. tit. 18, § 505.2 (1998); Ohio Admin. Code § 5101.3-13-05 (1998); Or. Admin. R. 410-120-1200 (1996); 55 Pa. Code § 1163.59 (1998); Wis. Admin. Code § 107.03 (1997).

Attempts to lift these statutory and regulatory bans can be met with spirited debate and outcry among those opposed to coverage. See, e.g., Alice Barnes, Editorial, Sex Change Not Always What It’s Cut Out to Be, *Oregonian* (Portland), Apr. 17, 1998, at D11 (arguing that Oregon health plan should not pay for sex-reassignment surgeries); Brad Cain, Oregon Considers Taxpayer-Financed Sex-Change Surgery, *Columbian*, Apr. 20, 1998, at B7; Elaine Lerner, Editorial, Let Medical Professionals Decide Whether to Cover Sex Changes, *Oregonian* (Portland), May 30, 1998, at D11 (arguing question of coverage of sex-reassignment surgeries should be decided by medical and psychological professionals, not general public); Patrick O’Neill, Oregon Will Study Sex-Change Policy, *Oregonian* (Portland), Apr. 18, 1998, at A1 (reporting on subcommittee hearings about funding of sex-reassignment operations).

Often, statutory bans are justified on the grounds that sex-reassignment surgery is an “experimental” procedure and therefore cannot be considered “medically necessary.” E.g., *Rush v. Parham*, 625 F.2d 1150, 1156 & n.11 (5th Cir. 1980).

<sup>90</sup> See *Pinneke v. Preisser*, 623 F.2d 546, 547, 549-50 (8th Cir. 1980) (holding statutory ban unreasonable, in part, because it took treatment decisions away from doctors in conflict with federal Medicaid statute); *Doe v. State Dep’t of Pub. Welfare*, 257 N.W.2d 816, 819-20 (Minn. 1977) (holding advisory rule impermissibly discriminated against a type of illness, treatment, or diagnosis). In *Doe*, the court found that sex-reassignment surgery was the only surgical treatment categorically excluded from coverage, even with a doctor’s recommendation. *Doe*, 257 N.W.2d at 819-20.

<sup>91</sup> 42 C.F.R. § 440.230(c) (2002); see also *Doe*, 257 N.W.2d at 820 (quoting language of 1976 version of same regulation, 45 C.F.R. § 249.10(a)(5)(i) (1976), mis-cited in case as 45 CFR § 249.10(5)(i)).

<sup>92</sup> 623 F.3d 546 (8th Cir. 1980).

<sup>93</sup> Id. at 550 (“The decision of whether or not certain treatment or a particular type of surgery is ‘medically necessary’ rests with the individual recipient’s physician and not with clerical personnel or government officials.”). The court also found fault with the lack of formal procedures involved in the rulemaking. Id. at 549 (finding state engaged in no formal rulemaking proceedings or hearings before excluding coverage of treatment). But

statutory bans is an acceptance of the “medical necessity” of sex-reassignment surgery as the only available, successful treatment for transgender adults.<sup>94</sup> While states cannot effect bans on necessary treatments on the basis of diagnosis discrimination, any nonnecessary procedure can be barred from coverage by states as they choose.<sup>95</sup>

Another reason for denial of coverage is when a state’s health officials classify sex-reassignment surgery as “cosmetic surgery,” which by definition is not medically necessary (as opposed to plastic surgery, which may help or correct disabilities or injuries). In a pair of companion cases decided in 1978, the California Court of Appeal considered two instances in which the director of the California Department of Health invoked this “cosmetic” designation as a basis for denying coverage.<sup>96</sup> Here, the court flatly rejected the argument that sex-reassignment surgery was merely cosmetic and not medically necessary, due at least in part to the majority’s insistence that alteration of one’s genitals is significantly different from, for example, alteration of one’s nose.<sup>97</sup>

Courts also generally have required state Medicaid administrations to provide meaningful justifications for their rulings that sex-reassignment surgery is an “experimental procedure.” The Fifth Circuit,

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see *Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001) (upholding new Iowa ban on coverage of sex-reassignment surgery).

<sup>94</sup> See *Doe*, 257 N.W.2d at 819 (“By the time an individual reaches adulthood, the problem of gender role disorientation and the transsexual condition resulting therefrom are so severe that the only successful treatment known to medical science is sex conversion surgery.”).

<sup>95</sup> See *supra* notes 72-74 and accompanying text.

<sup>96</sup> *J.D. v. Lackner*, 145 Cal. Rptr. 570, 572 (Ct. App. 1978); *G.B. v. Lackner*, 145 Cal. Rptr. 555, 556 (Ct. App. 1978). Although the court notes that a 1974 bulletin issued by Medi-Cal explicitly said that medical treatment related to sex reassignment, including surgery, hormone therapy, and psychiatric care, was not eligible for coverage, *G.B.*, 145 Cal. Rptr. at 556, the state apparently did not rely on this bulletin when it gave its denial of coverage. *J.D.*, 145 Cal. Rptr. at 572 (stating Department of Health’s denial of coverage was based on ground that proposed surgery was cosmetic); *G.B.*, 145 Cal. Rptr. at 556 (same).

<sup>97</sup> See *G.B.*, 145 Cal. Rptr. at 558 (“Surely, castration and penectomy cannot be considered surgical procedures to alter the texture and configuration of the skin and the skin’s relationship with contiguous structures of the body. Male genitals have to be considered more than just skin, one would think.” (citing definition of cosmetic surgery adopted by California Department of Health)).

The dissent argued that sex-reassignment surgery can be classified as cosmetic surgery because it changes a patient’s body parts to fit “the patient’s misperception of himself.” *Id.* at 562 (Scott, J., dissenting). Judge Scott disputed the majority’s implicit acceptance of sex-reassignment surgery as a medically necessary procedure. *Id.* at 566 (“The fact that no technique has yet been found which will relieve the depression associated with transsexualism, except transsexual surgery, does not compel the conclusion that such surgery is medically necessary.”). Based on these factors, the dissent felt that the state Medi-Cal director acted within his discretion in denying funding for a transsexual surgery. *Id.* at 570.

in *Rush v. Parham*, did not rule in favor of the transsexual claimant, but it did hold that states denying coverage had the burden of showing the denial was "reasonable."<sup>98</sup> States, the court held, have freedom to tailor Medicaid to their own particular requirements,<sup>99</sup> as long as they do not interfere unduly with a physician's determination of medical necessity.<sup>100</sup>

In New Jersey, a state administrative law judge found that the phalloplasty sought by a transsexual was not experimental, contrary to the assertion of the state's Department of Human Services.<sup>101</sup> The administrative law judge distinguished between a medical procedure that is in its "refining" stage, when changes in technique and in the sorts of patients deemed eligible for treatment are changing, and a procedure that is truly experimental, meaning that its "safety and efficiency are unknown."<sup>102</sup>

The apparent ease with which some courts dismiss states' characterizations of sex-reassignment surgery as "experimental" is encouraging to those who believe that Medicaid coverage is a desirable goal and that "medical necessity" is a reasonable requirement for obtaining it.<sup>103</sup> However, many commentators and scholars have suggested that success in these cases may be a Pyrrhic victory for transsexuals, relying as it does on the pathologization of nonconforming gender identities.<sup>104</sup>

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<sup>98</sup> *Rush v. Parham*, 625 F.2d 1150, 1152 (5th Cir. 1980) (reversing summary judgment for plaintiff and remanding to allow State to show either that sex-reassignment surgery is actually experimental or that it is not appropriate for plaintiff).

<sup>99</sup> *Id.* at 1155.

<sup>100</sup> *Id.* at 1156 ("This [holding] does not remove from the private physician the primary responsibility of determining what treatment should be made available to his patients."). The court said the legislative history of the federal Medicaid statute indicated a desire by Congress that physicians be a "key figure" in determining the conferral of Medicaid benefits. *Id.* at 1157.

<sup>101</sup> M.K. v. Div. of Med. Assistance & Health Servs., 92 N.J. Admin. 2d 38 (DMA) (May 7, 1992), 1992 WL 280789.

<sup>102</sup> *Id.*

<sup>103</sup> There is evidence that previously sympathetic courts are becoming more willing to enforce flat bans on coverage of sex-reassignment surgery. The Eighth Circuit, which before had found Iowa's flat ban on sex-reassignment surgery in conflict with Medicaid requirements, last year upheld a newly promulgated ban on the procedure. Compare *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980) ("We find that a state plan absolutely excluding the only available treatment known at this stage of the art for a particular condition must be considered an arbitrary denial of benefits . . . ."), with *Smith v. Rasmussen*, 249 F.3d 755, 761 (8th Cir. 2001) ("In light of the evidence before the Department questioning the efficacy of and the necessity for sex-reassignment surgery, given other treatment options, we cannot conclude as a substantive matter that the Department's regulation is unreasonable, arbitrary, or inconsistent with the Act . . . .").

<sup>104</sup> See *infra* notes 107-09 and accompanying text.

### C. The Backlash Against Medical Necessity

As courts have become more willing to rule in favor of transsexual plaintiffs on their Medicaid claims, a backlash has emerged against the idea that sex-reassignment surgery is a “medically necessary” treatment for transsexuals. Some have questioned a legal rationale that, in their view, only serves to reinforce an artificial, binary conception of gender and sex that has long been imposed by social, governmental, and legal authorities on those with nontraditional gender identities.<sup>105</sup> At the same time, medical and scientific researchers and theorists began to critique the methods that had been used to demonstrate that sex reassignment was a necessary treatment for transsexual people and the criteria that had been established to identify good candidates for the procedure.<sup>106</sup>

#### 1. Criticism of the Assumptions Made in a Medical Necessity Argument

One objection to the classification of sex-reassignment surgery as medically necessary is the implication that transgender identities are disorders requiring treatment.<sup>107</sup> Commentators have noted the vigor with which society, and the legal institutions that serve it, have protected a two-sex legal scheme.<sup>108</sup>

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<sup>105</sup> See *infra* notes 109-11 and accompanying text.

<sup>106</sup> See *infra* notes 112-19 and accompanying text.

<sup>107</sup> See Keller, *supra* note 7, at 58-59 (cautioning that medicalization of transsexualism, while increasing access to public and private insurance benefits, also has disempowering effect); cf. Noah, *supra* note 81, at 244-45 (noting that definitions of “disease” assume shared understanding of what is “healthy” or “normal”). But see Hong, *supra* note 67, at 106 (“[T]he medicalization of the transsexual identity may actually be the means by which transsexuality is no longer stigmatized. . . . [T]he classification of gender dysphoria . . . protects transsexuals from discrimination.”).

<sup>108</sup> E.g., Storror, *supra* note 5, at 278-79. This scheme is seen as necessary to the maintenance of a socio-legal system that favors heterosexuality. Patriarchy, *supra* note 6, at 1976 (“The heterosexual matrix depends on a rigid distinction between the categories of masculinity and femininity.”). Any recognition of the acceptability of deviance, whether by gay, lesbian, or transgender people, threatens the stability that gender-appropriate behavior gives to the traditional two-sex scheme. *Id.* at 1987. Transgender people, many of whom often seek to “pass” as much as possible in their chosen gender, even if not seeking full reassignment treatment, are often seen as merely conforming to society’s traditional definitions of gender roles. See Storror, *supra* note 5, at 298 (describing how transsexuals are bringing themselves into alignment with society’s gender criteria (citing Judith Shapiro, *Transsexualism: Reflections on the Persistence of Gender and the Mutability of Sex*, in *Body Guards: The Cultural Politics of Gender Ambiguity* 248, 260 (Julia Epstein & Kristina Straub eds., 1991))).

This desire for conformity with many traditional sex-gender roles is one reason for what some commentators see as the more accommodating posture courts take toward transsexual litigants, as opposed to gay and lesbian ones. See Patriarchy, *supra* note 6, at 1992 (“[T]he transsexual’s concern with correcting her gender transgression reverses the

Some argue that a legal regime that permits and even encourages surgical sex reassignment merely serves to enforce this inaccurate bimodal system of sex classification, in which the "male" physiology and "male" gender identity are essentially always paired in a single person, as are the "female" biology and "female" gender identity—so that the distinct conceptions of sex and gender are collapsed into two basic human types.<sup>109</sup> Even the criteria for evaluating eligibility for sex-reassignment surgery (such as a requirement that those seeking male-to-female surgery already have a "feminine appearance") and the factors used to evaluate success (such as an ability to "pass" in normal social interactions<sup>110</sup> or the development of heterosexual relationships as a member of one's reassigned sex<sup>111</sup>) are cited as evidence that the medical professionals practicing sex-reassignment surgery are explicitly seeking to enforce gender stereotypes.<sup>112</sup>

## 2. *Criticism of the Diagnostic Process*

Just as medical diagnoses play a part in shaping the law, so too can the law shape medical diagnoses. Legal rulings often affect the diagnosis, acceptance, and treatment of newly classified diseases and syndromes. This process of "feedback" from the legal system can, of course, be abused by both patients and doctors.<sup>113</sup> On the one hand, there is the misplaced desire by some doctors for the creation of new

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image of the open homosexual. Unlike the homosexual, whose juxtaposition of masculinity and femininity is purposeful and public, the transsexual wants to pass.").

<sup>109</sup> See, e.g., Bernice L. Hausman, *Changing Sex: Transsexualism, Technology, and the Idea of Gender* 196 (1995) (discussing ways to "truly destabilize bipolar gender schema"); Dwight D. Billings & Thomas Urban, *The Socio-Medical Construction of Transsexualism: An Interpretation and Critique*, 29 Soc. Probs. 266, 278 (1982) (stating that sex-reassignment surgery has "indirectly tamed and transformed a wildcat strike at the gender factory"); Pearlman, *supra* note 5, at 842-43 ("[A] binary construction of gender fails to recognize gender identity as a relative construction."); cf. Patriarchy, *supra* note 6, at 1973-74 (noting that feminist perspective, ostensibly critiquing traditional bipolar gender framework, may paradoxically help enforce it, as feminists seek to identify common trait uniting all women in effort to identify "women" as feminism's coherent political constituency).

The strongest empirical evidence arises in the context of the medical community's treatment of sexually ambiguous infants. See *supra* notes 29-30 and accompanying text.

<sup>110</sup> See, e.g., Shapiro, *supra* note 108, at 254 ("Physical attractiveness seems to have provided the major basis for an optimistic prognosis in male to female sex change."); see also Benjamin Standards, *supra* note 31, at 20 (citing success in passing for previous year as requirement for candidates seeking surgery).

<sup>111</sup> Keller, *supra* note 7, at 55.

<sup>112</sup> See, e.g., Shapiro, *supra* note 108, at 254 ("The gender conservatism of transsexuals is encouraged and reinforced by the medical establishment on which they are dependent for therapy.").

<sup>113</sup> Patient groups often form primarily to demand that their condition be classified as a disorder requiring medical, legal, and social recognition. Shapiro, *supra* note 108, at 291. The diagnostic process may, as a result, be marked by mere acquiescence to patient demand by the medical establishment. *Id.* at 242-43. Desire for both professional gain, *id.* at

diagnostic categories. On the other, there is the need for transsexual people to fit themselves neatly into some diagnostic category to get the treatment they seek.<sup>114</sup> The common bias created by these two motives might give one reason to doubt the accuracy (and existence) of many diagnoses and the appropriateness (or necessity) of the treatment given.<sup>115</sup>

At its 1993 annual conference, the APA concluded that “well-adjusted” transgender people should not automatically be diagnosed as having a medical disorder.<sup>116</sup> While this new classification certainly pleased those who maintained that transgender identities, *per se*, are not “disorders” requiring treatment,<sup>117</sup> another criticism of the diagnostic process remained. Some commentators believe that the existence of a diagnostic model of gender identity disorder, and the accompanying discourse on symptoms and criteria required for treatment, have created an incentive for patients seeking treatment to tailor their identities and “symptoms” to match the model.<sup>118</sup> Conversely, the fact that sex reassignment is seen as the only “viable treatment” for gender identity disorder often discourages the broader medical community from seeking to distinguish various forms of trans-

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289-90, and presumably pecuniary gain as well, can taint the process of diagnosis by doctors.

<sup>114</sup> There is evidence that some transgender people who approach medical authorities for treatment and surgery incorporate the distinguishing characteristics of published case studies into their own self-reported life stories. See Keller, *supra* note 7, at 54. Psychoanalysts and other mental health professionals rely on subjective patient complaints without a good method of authentication. See *Jaffee v. Redmond*, 518 U.S. 1, 10-11 (1996) (noting subjective nature of information gained in psychiatrist-patient relationships); *People v. Bledsoe*, 681 P.2d 291, 300 (Cal. 1984) (observing that verification of factual information is often not part of therapist’s job). Because most transsexuals seeking sex-reassignment surgery must be recommended for surgery by psychotherapists or similar medical professionals, see *Benjamin Standards*, *supra* note 31, at 6-8, it seems possible that fabricated life histories could become the basis for the desired treatment.

<sup>115</sup> For a discussion of the “social construction” of illness, see generally Robert A. Aronowitz, *Making Sense of Illness: Science, Society, and Disease* (1998); see also Noah, *supra* note 81, at 243 (“As with language and other systems of classification, disease categories are context-dependent and subject to manipulation.”).

One commentator sees a more sinister side effect of inaccurate diagnoses of gender identity disorder, where it is used to erase the threat of gender nonconformity: “Although official existence of GID [Gender Identity Disorder] lends credence to an assertion that transsexualism is not a form of sexual fraud, a downside exists: a diagnosis can be made against a person’s will, giving medical and psychological practitioners license to attempt to ‘cure’ the person.” Rose, *supra* note 4, at 24.

<sup>116</sup> Colker, *supra* note 29, at 46 n.161. This evaluation was reflected in the DSM-IV, which removed “Transsexualism” as a diagnosis and replaced it with “Gender Identity Disorder.” See *supra* note 82.

<sup>117</sup> See *supra* note 107 and accompanying text.

<sup>118</sup> See Keller, *supra* note 7, at 53 (discussing how disease “identities” are created by treatments and criteria for qualification).

gender identities from one another.<sup>119</sup> As a result, transgender and transsexual people tend to be lumped together in one category for which sex-reassignment surgery is considered the medically necessary treatment.<sup>120</sup>

Even doctors are divided over the validity of sex-reassignment surgery as a treatment for gender identity disorder. As a result, medical opinions in the very same case can vary widely, and courts hearing Medicaid cases often are called upon to weigh conflicting medical testimony.<sup>121</sup> Unfortunately, courts are not well-equipped to make such determinations.<sup>122</sup> Rather, the courts often link the realization of benefits too closely to a litigant's neat fit into a diagnostic model.<sup>123</sup>

Whether one agrees with these critics or not, they call into question, and potentially undermine, one of the current bases on which courts sometimes have justified Medicaid coverage of sex-reassignment surgery.<sup>124</sup> The fact remains, however, that the cost of sex-reas-

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<sup>119</sup> Cf. John I. Balla, *The Diagnostic Process: A Model for Clinical Teachers* 95 (1985) ("[I]ncreased precision for its own sake is of no benefit in any scientific endeavor. . . . In the days when tuberculosis and carcinoma of the lung were untreatable, a vague diagnosis of chest disease may have been satisfactory.").

<sup>120</sup> See Keller, *supra* note 7, at 56 & n.32 (describing relationship between transgender people and medical establishment) (citing Dave King, *The Transvestite and the Transsexual: Public Categories and Private Identities* (1993)).

Some researchers claim that sex-reassignment surgery is not as successful as some medical researchers claim because of flawed methodology in performing follow-up evaluations. See *id.* at 53 (stating that "sex-reassignment surgery has generally not been as successful as reported because the reports were disingenuously based on flawed follow up studies" (citing Billings & Urban, *supra* note 109, at 272-73)).

<sup>121</sup> See, e.g., *Oiler v. Winn-Dixie, Inc.*, No. 00-3114, 2002 U.S. Dist. LEXIS 17417, at \*5 nn.11-12 (E.D. La. Sept. 16, 2002) (involving dispute between experts over whether petitioner in antidiscrimination action should be diagnosed as having "transvestic fetishism" or gender identity disorder).

<sup>122</sup> See *Davidson v. Aetna Life & Cas. Ins. Co.*, 420 N.Y.S.2d 450, 453 (Sup. Ct. 1979) ("For this court to suggest alternative remedies or treatment for [sex-reassignment surgery] would interfere with the professional judgment of medical experts, and would be beyond the scope of this court's expertise or jurisdiction."); *Transsexualism and the Law*, *supra* note 4, at 968 (doubting qualification of courts in weighing "complex, confusing, and possibly contradictory medical data.").

<sup>123</sup> See Keller, *supra* note 7, at 59 (noting courts' embrace of medical model). This has led one commentator to call for courts to reevaluate their reliance on medical diagnostic processes in judicial proceedings. See *Noah*, *supra* note 81, at 243.

<sup>124</sup> It is important to note that at least some commentators who have advocated for an elimination or reevaluation of the medicalization of transsexual identities indicate that they are not advocating a complete elimination of the diagnosis of gender identity disorder because of the detrimental effect this would have on access to treatment options. See Shannon Minter & Phyllis Randolph Frye, *GID and the Transgender Movement: A Joint Statement by ICTLEP and the National Center for Lesbian Rights (NCLR)*, 5 Int'l Conf. on Transgender L. & Emp. Pol'y, at A1-2 (1996), <http://www.transgenderlegal.com/gid1.htm> ("WE DO NOT ADVOCATE an immediate, blanket elimination of [gender identity disorder] in a vacuum, without an alternative means of ensuring continued access to and reimbursement for hormones and surgeries.").

sgement surgery is prohibitively high, placing it out of the reach of many transsexuals, who often find it difficult to maintain steady employment due both to discrimination<sup>125</sup> and to the lack of protection by nondiscrimination laws.<sup>126</sup>

### III

#### ADVOCATING A BROADER CONCEPTION OF THE “NECESSITY” OF SEX-REASSIGNMENT SURGERY

While sex-reassignment surgery is almost always a prerequisite to a legal recognition of one's chosen sex and gender, the high cost of this treatment makes it inaccessible to many lower- and middle-class

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<sup>125</sup> See, e.g., *Sommers v. Budget Mktg., Inc.*, 667 F.2d 748, 748-49 (8th Cir. 1982) (describing how other employees threatened to quit if transsexual woman employee were allowed to use women's bathroom); *Kirkpatrick v. Seligman & Latz, Inc.*, 636 F.2d 1047, 1048 (5th Cir. 1981) (stating that transsexual woman was fired when she started wearing female clothes to work during transition); *Holloway v. Arthur Andersen & Co.*, 566 F.2d 659, 661 (9th Cir. 1977) (same); *Oiler*, 2002 U.S. Dist. LEXIS 17417 (rejecting antidiscrimination claim where plaintiff was terminated for crossdressing outside of work); *Underwood v. Archer Mgmt. Servs., Inc.*, 857 F. Supp. 96, 97 (D.D.C. 1994) (involving transitioning transsexual who was fired based on “personal appearance”); *Maffei v. Kolaeton Indus., Inc.*, 626 N.Y.S.2d 391, 392 (Sup. Ct. 1995) (concerning president of company who insulted and humiliated transitioning transsexual, stripping him of duties and ostracizing him from other employees); *Holt v. N.W. Pa. Training P'ship Consortium, Inc.*, 694 A.2d 1134, 1136 (Pa. 1997) (stating that transsexual was fired for violating employer dress code by dressing in unisex manner).

<sup>126</sup> See, e.g., *Sommers*, 667 F.2d at 750 (holding Title VII protections based on sex do not extend to transsexualism); *Kirkpatrick*, 636 F.2d at 1050-51 (finding no discrimination when firing transsexual woman employee for wearing female clothing); *Holloway*, 566 F.2d at 664 (holding Title VII protections do not extend to employee fired for beginning transition); *Oiler*, 2002 U.S. Dist. LEXIS 17417 (denying Title VII protection against sexual-orientation or gender-identity discrimination); *Dobre v. Nat'l R.R. Passenger Corp. (AMTRAK)*, 850 F. Supp. 284, 287-88 (E.D. Pa. 1993) (ruling that neither Title VII nor Pennsylvania Human Rights Act prohibit discrimination against transsexuals). But see, e.g., *Underwood*, 857 F. Supp. at 98 (ruling transsexual stated claim by alleging she was fired based on “personal appearance”); *Enriquez v. W. Jersey Health Sys.*, 777 A.2d 365, 371-73, 377 (N.J. Super. Ct. App. Div. 2001) (allowing transsexual's suit for gender discrimination under New Jersey antidiscrimination law); *Maffei*, 626 N.Y.S.2d at 396 (finding discrimination against transsexual actionable based on creation of hostile work environment); Transsexuals Can Sue Under Disability Laws, Advocate, Oct. 18, 2001 (reporting two Massachusetts Commission Against Discrimination decisions, *Jette v. Honey Farms* and *Millet v. Tutco*, which allowed transsexuals to sue under state laws prohibiting discrimination based on disability and sex), at [http://www.advocate.com/new\\_newsarchive.asp?ID=1042&sd=10/18/01](http://www.advocate.com/new_newsarchive.asp?ID=1042&sd=10/18/01).

The inability to maintain steady employment causes many transgender people to seek employment in illegal and dangerous trades, such as drug dealing and sex work. See, e.g., Kai Wright, To Be Poor and Transgender, Progressive, Oct. 2001, at 21 (noting large-scale unemployment in transgender community and describing one transgender woman's life as sex worker).

transsexuals.<sup>127</sup> Access to public funds for coverage of the procedure, therefore, is vital for many transsexuals to attain full legal recognition and rights in their chosen sex.

This Part will suggest that both courts and commentators would benefit from considering the practical necessity of sex-reassignment surgery in the attainment of legal rights. It will argue that the way in which "medical necessity" has been defined when granting Medicaid coverage of sex-reassignment surgery is too narrow and should be broadened to account for the fact that the procedure is critical to alleviating burdens on transsexuals imposed by a rigid socio-legal sex-classification scheme. Broadening the construction of "medical necessity" would help transsexuals obtain legal rights and integrate into society, and it would answer most of the current critiques by reducing the stigma of labeling gender variance a "disease" that must be "cured."<sup>128</sup> This Part will conclude by arguing that a legal system that imposes anatomical requirements on the attainment of certain legal rights, as ours clearly does, should do one of two things. In particular, when determining the necessity of sex-reassignment surgery, courts should recognize the fact that a person's physiognomy may be the only available gateway to certain important legal rights. This might result in a finding that sex-reassignment surgery is "necessary" for some people simply because they need it to bring their legal status in line with their self-image and chosen role in society, not because it is the cure to some disease that afflicts them. Absent this sort of dramatic redefinition of "necessity," our legal system might instead reevaluate the validity of conditioning important legal rights on certain—some would say arbitrary—anatomical requirements.

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<sup>127</sup> Beh, *supra* note 3, at 157 (citing *Maggert v. Hanks*, 131 F.3d 670, 672 (7th Cir. 1997)). The cost of surgery alone is approximately \$37,000 for male-to-female transsexuals, and approximately \$77,000 for female-to-male transsexuals. Gordon, *supra* note 67. This cost is due to the expense of hormones and the multiple surgeries that full sex reassignment requires, as well as the relative dearth of qualified doctors and willing hospitals. This dearth has led to some clinics attaining unwanted notoriety. See Sue Anne Pressley, Colorado Town Becomes World's "Sex Change Capital," *The Oregonian* (Portland), May 17, 1998, at A22, 1998 WL 4206664.

<sup>128</sup> It is important to state explicitly that this Note does not take the position that all people who self-identify as transgender/transsexual do, or should, pursue surgical sex reassignment; nor does it advocate the pursuit of such treatment solely for the purpose of obtaining legal recognition as one's chosen sex and gender. This Note merely recognizes that surgical reassignment is nearly always a prerequisite to both obtaining legal recognition as one's chosen sex and gender, and accessing legal rights that follow such recognition. For those transsexuals who desire surgical sex reassignment, these legal consequences serve to illustrate that the procedure has important implications beyond its effectiveness as a medical treatment.

### A. *The Legal Ramifications of Criticism of the “Medical Necessity” Rationale*

As a theoretical and academic matter, challenging the idea that sex-reassignment surgery is a “medically necessary” procedure is consistent with one of the goals of transgender activism: making society and the law reexamine the binary construction of sex and gender that those institutions have helped to enforce. As a practical matter, however, unseating the “medically necessary” determination could jeopardize the ability of those transsexual people who want, but cannot afford, sex-reassignment surgery to prevail in their claims for Medicaid coverage.

The main objection lodged by commentators against the “medically necessary” designation is that it tends to reinforce an erroneous classification system acknowledging only two sexes.<sup>129</sup> If a court were to reject a claim that sex-reassignment surgery is medically necessary on the ground that it does not treat an actual disease, that court would have to accept (either explicitly or implicitly) the underlying premise of a multisex, multigender world. However, based on the judicial record with respect to the legal status of transgender people, it seems unlikely that a court would make such a radical departure from traditional legal norms.<sup>130</sup>

Another basis for attacking the assumption in the law is to criticize the process of diagnosing transsexuals.<sup>131</sup> This critique might prompt courts to scrutinize more carefully the diagnosis of gender identity disorder in cases of transsexuals seeking Medicaid coverage, but it likely would not prevent courts from finding the procedure medically necessary for particular plaintiffs. Indeed, even now, courts evaluating Medicaid claims are rarely content with an assertion by a plaintiff’s physicians that she or he simply “needs” surgical sex reassignment. Instead, judges often lace their opinions with details from the plaintiff’s life supporting the diagnosis,<sup>132</sup> and courts explicitly or implicitly validate or refute those medical findings in their rulings. The skepticism with which courts generally approach claims for coverage of the surgery, particularly in the face of a statutory ban, indicates

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<sup>129</sup> See *supra* Part II.C.1.

<sup>130</sup> See, e.g., *Littleton v. Prange*, 9 S.W.3d 223, 231 (Tex. App. 1999) (“[C]ourts are wise not to wander too far into the misty fields of sociological philosophy.”).

<sup>131</sup> See *supra* Part II.C.2.

<sup>132</sup> See, e.g., *Smith v. Rasmussen*, 57 F. Supp. 2d 736, 743-44 (N.D. Iowa 1999) (detailing transsexual plaintiff’s discomfort in puberty, bouts with depression, partial hysterectomy, and breast reduction surgery); *Doe v. Minn. Dep’t of Pub. Welfare*, 257 N.W.2d 816, 817 (Minn. 1977) (noting transsexual plaintiff’s history of crossdressing, hormone therapy, and psychiatric treatment).

that they are taking some care to ensure that the transsexual litigants' physicians are not making unsupported diagnoses.<sup>133</sup> Therefore, a viable strategy for transgender advocates may be to press courts to make more explicit statements that not all transgender persons are afflicted with gender identity disorder. The actual coverage determinations arrived at by courts would not necessarily change, but courts expressly would recognize any refusals of coverage as findings that the plaintiff is in no need of treatment at all. Conversely, findings that the surgery is medically necessary would explicitly put the plaintiff into a subclass of transsexual people, those with gender identity disorder, rather than operating under the assumption that all transgender people need to be "cured."

#### *B. A Broader Understanding of the "Necessity" of Sex-Reassignment Surgery*

There are limited instances where the federal government has mandated coverage of medical treatment that is arguably not medically necessary—most notably in the case of the Pregnancy Discrimination Act.<sup>134</sup> An independent legislative directive concerning sex-reassignment surgery could be very positive for transsexuals seeking

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<sup>133</sup> Criticism of the diagnostic process in general, or the diagnostic process for transsexual patients specifically, does not necessarily criticize the diagnosis itself—that of gender identity disorder severe enough to warrant treatment with sex-reassignment surgery. Rather, it takes issue with the fact that all patients who present as transgender are thought by some physicians to be good candidates for the surgery, and that the diagnostic model coerces otherwise inappropriate candidates into desiring it. See Rose *supra* note 4, at 24. Courts that adjudicate Medicaid claims are already acting based on skepticism of the diagnostic model. The ones that grant coverage of sex-reassignment surgeries are usually acting on the belief that the individual claimants before them fit precisely the profile for which such surgery is believed to be beneficial.

<sup>134</sup> Pub. L. No. 95-555, 92 Stat. 2076 (1978) (codified as amended at 42 U.S.C. § 2000e (2001)). Prior to the Act, many private insurers refused to cover the costs associated with pregnancy, on the theory that it was a "voluntary condition." Beh, *supra* note 3, at 160-61. While a federal statute mandating nondiscrimination against transgender people would help alleviate the threat that sex-reassignment surgery would not be covered under Medicaid, it is highly doubtful that Congress would take such action, given the difficulty of forming a majority coalition supporting the rights of transgender people. See *id.* at 154 n.234 ("[T]he pervasive discriminatory attitude makes judicial, piecemeal decision-making more advantageous.").

Many private insurers refuse to cover Viagra prescriptions because they are not medically necessary. *Id.* at 119-20. Insurers often view expression of transgender identity or the attempt to treat erectile dysfunction treatment as a "lifestyle choice." *See id.* at 146. Erectile dysfunction can result from a variety of both organic and psychological factors. *Id.* at 141. Similarly, much fault that can be found with diagnoses of gender identity disorder stems from researchers' disagreements over whether the cause of the condition is organic or psychological. See *Transsexuals in Limbo*, *supra* note 9, at 238. Unlike private insurers, many state Medicaid regimes do cover Viagra because Medicaid generally requires coverage of all FDA-approved drugs. Beh, *supra* note 3, at 145 nn.172-73 and accompanying

sex reassignment. In that situation, transsexuals would not have to invoke the language of illness any more than pregnant women are made to, and yet the law would still require its coverage. But it is unlikely that advocates of coverage for sex-reassignment surgery will enjoy much success pressing for legislative mandates, due in large measure to the general political weakness of the transgender community.<sup>135</sup>

The concept of medical necessity that governs Medicaid coverage decisions is arguably too narrow. The courts' analysis of "medical necessity" fails to include some treatments that significantly improve a patient's physical, emotional, and financial future. If treatments are not considered vital to the patient's immediate health, they usually are not considered medically necessary. One commentator has argued that this concept of medical necessity does not adequately address the social consequences of a transsexual's preoperative status, instead offering "social necessity" as a substitute benchmark.<sup>136</sup> A measure of social necessity in the evaluation of medical claims would shift focus

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text. However, this analogy again seems insufficient because of its reliance on federal regulatory commands.

Some state Medicaid regimes explicitly consider the benefit a procedure will have on a patient's earning potential when evaluating claims. See, e.g., *Doe*, 257 N.W.2d at 817 (noting that plaintiff's claim for coverage was denied, in part, because she "failed to prove that the requested surgery would allow [her] to become self-supporting"). In particular, cosmetic surgery is sometimes covered when the procedure will enhance a patient's ability to secure employment. For example, the California Administrative Code used to provide that authorization for coverage may be granted for cosmetic surgery, which by definition is not "medically necessary," if it corrects "disfiguring defects which substantially interfere with opportunities for employment." *G.B. v. Lackner*, 145 Cal. Rptr. 555, 558 (Ct. App. 1978) (citing Cal. Code Regs. tit. 22, § 51305, now amended to permit treatment for cosmetic purposes only for correction of serious disfigurement). The unavailability of sex-reassignment surgery can interfere significantly with the employment opportunities of transsexual people because of discrimination against preoperative transsexuals when their status is revealed and a lack of protection under employment antidiscrimination statutes. See *id.* at 68 (noting difficulty preoperative transsexuals have in obtaining employment); *Keller*, *supra* note 7, at 72-73 & n.140 (detailing discrimination in employment faced by preoperative and transitioning transsexual people); *supra* notes 7-8, 124-25.

<sup>135</sup> See *Beh*, *supra* note 3, at 154 n.234; *supra* note 7 (detailing lack of legislative protection for transgender people).

<sup>136</sup> *Keller*, *supra* note 7, at 71-72. *Keller* argues that transgender people suffer from a social disability, which has been enforced both directly and indirectly by the government and pervasive social attitudes. *Id.* at 73-74. She notes the lack of protected-class status for transgender people in both discrimination claims and hate crime protections as evidence that the government is complicit in their social disability. *Id.*

In addition to examining the legal disability placed on those who do not conform to traditional sex-gender roles, *Keller* cites the relative frequency of rapes and assaults of preoperative transsexuals, as well as their difficulty securing and maintaining employment, as evidence of social disability. *Id.* at 72-73. For an (admittedly incomplete) compilation of instances of violent crime against transgender people, see generally Nat'l Coalition of Anti-Violence Programs, Anti-Lesbian, Gay, Transgender and Bisexual Violence in 1999

from the value of the procedure to one's physical health to its value in allowing the patient to function and survive in our society.<sup>137</sup>

Similarly, as this Note has tried to demonstrate, arguments that sex-reassignment surgery is not "medically necessary" fail to acknowledge that the surgery, while perhaps not designed to heal an immediate health threat, is necessary for many transsexuals to access certain legal rights.<sup>138</sup> And, of course, whether one is given basic legal rights that are congruent with one's self-image and perceived role in the world can have a tremendous impact on one's emotional and mental health and integration into society. A broader conception of "necessity" would require courts (and administrative agencies) to recognize the beneficial effect these treatments have on patients' long-term health and social functioning. And this broader approach would take account of the fact that access to certain legal rights is contingent upon surgical genital reassignment. In a sense, if the law is going to drive a wedge between a person's self-image and the role that person is allowed to play in society, then the law should recognize sex-reassignment surgery as "necessary" to repair the fissure that the law itself has helped create.

Sex-reassignment surgery is necessary for transsexuals to be placed, for legal purposes, within our existing socio-legal system of binary sex classification as comfortably as possible.<sup>139</sup> While some

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(2000), <http://www.avp.org/>; Nat'l Coalition of Anti-Violence Programs, Anti-Lesbian, Gay, Transgender and Bisexual Violence in 2000 (2001), <http://www.avp.org/>.

<sup>137</sup> Keller, *supra* note 7, at 72 (

Whereas medical necessity considers the importance of a particular treatment to an individual's bodily or psychiatric well-being, a concept of social necessity might instead consider the importance of a treatment to an individual's ability to function and survive in society, given current biases and beliefs. . . . It is important, for instance, to take into account not only the severity of the distress experienced by individual transsexuals seeking treatment, but also the social consequences of not receiving treatment.).

<sup>138</sup> See *supra* Part I.B.

<sup>139</sup> Implicit in this assertion is an acceptance of the premise that one should be allowed to control one's self-identification and expression. Presumably, transsexuals would still fit into the two-sex system as their biological sex.

The acceptance of gender identity as both immutable and independent of anatomical sex similarly would support this proposition, but is not necessary. Immutability could be a necessary precondition if one were to insist that one's legal sex designation, once made (or amended), be unalterable. As this Note is, in part, arguing, the way in which our legal system classifies sex and gender is more rigid than it perhaps needs to be. One result of loosening the binary sex-classification scheme employed by legal authorities might be the ability to identify as one sex or gender for certain purposes, or at certain times in one's life, and to identify as the other sex or gender for other purposes or at other times. However, a discussion and determination regarding the immutability of gender identity, and an argument concerning the rigidity of one's legal sex determination, are beyond the scope of this Note.

commentators may question the accuracy of this system,<sup>140</sup> there is no denying that the system exists, and designation as one sex or the other carries important legal consequences,<sup>141</sup> which help create and fortify important social consequences. A broader understanding of necessity when adjudicating claims for Medicaid coverage of sex-reassignment surgery would force courts to contemplate the legal ramifications of sex designation, as well as the social consequences of remaining outside the two-sex system.<sup>142</sup> Since the legal system has forced transgender people to fit into an artificially binary sex-classification scheme,<sup>143</sup> requiring very expensive (and often dangerous) medical procedures for them to do so,<sup>144</sup> the legal system should respond in one of two ways: Either it can move away from an exclusive focus on genital configuration when entertaining challenges to sex designation; or it can acknowledge the legal and social components of the procedure's "necessity" and increase access to sex-reassignment treatments—at least in part through more liberal disbursement of Medicaid funds—without forcing transsexuals to pathologize something as basic as their very identification. Governmental authorities cannot have it both ways—that is, they cannot say that sex-reassignment surgery is only available for those suffering from a "gender identity disorder" while simultaneously requiring transgender people to undergo the surgery to enjoy basic, fundamental rights.

## CONCLUSION

Criticism of the legal reasoning and medical research that has led to the few victories in Medicaid claims for coverage of sex-reassignment surgery threatens to undermine the progress made by those who would like to undergo such surgery but lack the substantial resources needed to pay for it. A strong argument can be made that the socio-legal system, which has created an artificial binary sex-gender classifi-

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<sup>140</sup> See *supra* Part II.C.1.

<sup>141</sup> See *supra* Part I.B.

<sup>142</sup> See *supra* note 136.

<sup>143</sup> The incidence of intersexuality, see *supra* notes 29-30, is strong evidence that the strictly binary sex-classification scheme employed by socio-legal authorities is, at best, incomplete and underinclusive. While there is a difference between intersexuality and transsexuality, evidence that gender identity is perhaps not as mutable as Dr. John Money has asserted, see *supra* notes 30 and 83, indicates that for many people, transsexual identities are more than merely "alternative lifestyles."

<sup>144</sup> Cf. *Beal v. Doe*, 42 U.S. 438, 458-59 (1977) (Marshall, J., dissenting) (

The governmental benefits at issue . . . are . . . of absolutely vital importance in the lives of the recipients. . . . If funds for an abortion are unavailable, a poor woman may feel that she is forced to obtain an illegal abortion that poses a serious threat to her health and even her life. . . . All chance to control the direction of her own life will have been lost.).

cation scheme, also creates the need or, at the very least, the desire for sex reassignment, and that the legal system should therefore pay for the procedure.

Such arguments are unlikely to find support in the near future in a judicial system generally plagued by institutional inertia and often bound by statutes that are unsympathetic to the transgender person's plight. For people who wish to advocate for Medicaid coverage of the procedure, the best course of action may be to continue arguing on the basis of medical necessity, while attempting to educate courts more thoroughly on the many legal and social challenges that transgender people face and the primary importance of genital configuration in attaining legal rights. Ideally, this strategy would lead to one of two outcomes: a less medically based conception of "necessity" or a less strict reliance on anatomy when courts are faced with challenges to legal sex determination.

It would be best if our legal system were to shift away from a binary notion of sex and gender, at least acknowledging that a person's sex at birth is perhaps not the best evidence of sex for legal purposes.<sup>145</sup> And one certainly can hope for a future in which a transgender person can identify as neither fully male nor fully female, yet still be welcome as a full participant in society.<sup>146</sup> Until that day, however, the nearly fetishistic focus that the law places on genital structures undergirds a strong argument that access to sex-reassignment surgery is necessary in order to avoid shutting an entire class of citizens outside of the law.<sup>147</sup>

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<sup>145</sup> Cf. M.T. v. J.T., 355 A.2d 204, 207 (N.J. Super. Ct. App. Div. 1976) (affirming and quoting trial court in saying,

It is the opinion of the court that if the psychological choice of a person is medically sound, not a mere whim, and irreversible sex-reassignment surgery has been performed, society has no right to prohibit the transsexual from leading a normal life. Are we to look upon this person as an exhibit in a circus side show? What harm has said person done to society? The entire area of transsexualism is repugnant to the nature of many persons within our society. However, this should not govern the legal acceptance of a fact.).

<sup>146</sup> See Colker, *supra* note 29, at 4 ([W]e need to find ways to allow individuals to identify as . . . transgender . . . without fearing that moving off of one polar point on the traditional bipolar scheme will subject them to subordination . . . ).

<sup>147</sup> Cf. Romer v. Evans, 517 U.S. 620, 635 (1995) ("A State cannot . . . deem a class of persons a stranger to its laws.").