Noah E. Lewis
Staff Attorney

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VIA EMAIL & FIRST CLASS MAIL

Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
Corning Tower, Room 2438
Empire State Plaza
Albany, NY 12237
regsqna@health.state.ny.us

Re: Amendment of Section 505.2 (Gender Reassignment)

Dear Ms. Ceroalo:

We submit these comments pursuant to the fifteen-year review of New York Medicaid's exclusion for gender dysphoria treatments under 18 NYCRR § 505.2(l) ("§ 505.2(l)"). This regulation excludes care for hormones, surgery, and mental health services in support of gender reassignment: "Payment is not available for care, services, drugs, or supplies rendered for the purpose of gender reassignment (also known as transsexual surgery) or any care, services, drugs, or supplies intended to promote such treatment." These treatments for gender dysphoria are also known as transgender care.

The sole purported justification the Department of Health ("DOH") offers for maintaining this total exclusion of gender dysphoria treatments is concern about the long-term safety and efficacy of these treatments.[1] However, at no point during the initial promulgation or during the prior 5- and 10-year reviews has DOH provided evidence to justify singling out

[1] 35 N.Y. Register 128, 134 (Jan. 2, 2013).

transgender care and subjecting it to a unique, wholesale exclusion.[2] As will be demonstrated below, § 505.2(l) is based solely upon animus toward transgender individuals.

Accordingly, § 505.2(l) is arbitrary and capricious, lacks a rational basis, and exceeds the authority of DOH. It is, among other things, also unlawful under the New York and federal Equal Protection clauses as well as the federal Supremacy Clause. DOH can seize this opportunity to eliminate this unlawful and harmful exclusion and thereby prevent the continued violation of the rights of transgender Medicaid recipients and the litigation that will otherwise surely result.

I. State and Federal Law Requires Coverage for Medically Necessary Transgender Care

Gender dysphoria is a medical condition for which care must be provided under state and federal Medicaid law. Medicaid covers medically necessary physician's services, hospital care, surgery and drugs.[3] Medically necessary services and supplies are those "necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap."[4] Treatments for gender dysphoria meet this definition. Gender dysphoria is a widely accepted serious medical condition with known dangers as well as well-established, safe and effective treatment protocols. But for the unlawful promulgation of § 505.2(l), transgender care would be covered.

DOH does not dispute that gender dysphoria is a serious medical condition with known health risks that meets this statutory definition. In the 15-year review notice, DOH simply states that it believes the treatments for this medical condition are not safe and effective.[5] During the initial promulgation of § 505.2(l), DOH also proffered the medically unsound position "that gender reassignment[] involve[d] the ablation of normal organs for which there is no medical necessity because of underlying disease or pathology in the organ."[6] The next subsections address the medical and legal consensus that gender dysphoria is a serious medical condition for which treatment is generally needed.

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[2] *See* 20 N.Y. Reg. 5 (Mar. 25, 1998); 25 N.Y. Reg. 100, 102 (Jan. 8, 2003); 30 N.Y. Reg. 135, 139 (Jan. 2, 2008).
[3] N.Y. Soc. Serv. Law § 365-a (2013).
[4] *Id.* at § 365-a(2).
[5] 35 N.Y. Register 128, 134 (Jan. 2, 2013).
[6] 12 N.Y. Reg. 5 (Mar. 25, 1998).

A. Global and national medical associations, insurance companies, and state and federal government agencies have all recognized gender dysphoria as a serious medical condition that requires treatment

Gender dysphoria,[7] "is a clinical term used to describe the symptoms of excessive pain, anguish, agitation, restlessness, and malaise" that transgender people often experience. It "describes the psychological discomfort experienced with the physiological body . . . as well as a presence of clinical [symptoms] associated with emotional difficulties."[8] Gender dysphoria is "[o]ften experienced as depression, anxiety, irritation, and/or agitation, [it] describes the sense that something is very wrong . . . ."[9] Gender dysphoria is "characterized by 'a strong and persistent cross-gender identification' and a 'persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex,' 'caus[ing] clinically significant distress or impairment in social, occupational, or other important areas of functioning.'"[10] Before treatment, individuals with gender dysphoria "live in a dissociated state of mind and body."[11] In these individuals, "[t]he mind is of one gender, and the body is of the other."[12]

Gender dysphoria has been recognized and treated in modern medicine since the early 1900's and was included as transsexualism in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition ("DSM-III") over 30 years ago.[13] Gender dysphoria is also a recognized

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[7] Although the precise definitions may vary slightly, generally the terms gender dysphoria, gender identity disorder ("GID"), and transsexualism all refer to the same medical condition and are used interchangeably in medical literature and in this letter.

[8] Arlene Istar Lev, TRANSGENDER EMERGENCE: THERAPEUTIC GUIDELINES FOR WORKING WITH GENDER-VARIANT PEOPLE AND THEIR FAMILIES 10 (2004).

[9] Randi Kaufman, *Introduction to Transgender Identity and Health*, in THE FENWAY GUIDE TO LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH 331, 337 (Harvey Makadon et al. eds., 2008).

[10] World Professional Association for Transgender Health ("WPATH"), *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7th Ed.) 96 (2011), *available at* http://www.wpath.org/documents/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf (quoting the Diagnostic and Statistical Manual of Mental Disorders (4th ed. text rev.) (2000) ("DSM-IV-TR") (Exhibit 1).

[11] David Seil, *The Diagnosis and Treatment of Transgendered Patients* in TRANSGENDER SUBJECTIVES: A CLINICIAN'S GUIDE 115 (eds. Ubaldo Leli & Jack Drescher) (2004) (describing the diagnosis and treatment of 271 transgender patients between 1979 and 2001).

[12] *Id.* For further discussion of the psychological symptoms of gender dysphoria, including the incongruence between the brain's internal body map and the physical body, see V.S. Ramachandran & Paul McGeoch, *Phantom Penises In Transsexuals: Evidence of an Innate Gender-Specific Body Image in the Brain*, 15 J. OF CONSCIOUSNESS STUDIES 8 (2008); V.S. Ramachandran, THE TELL-TALE BRAIN: A NEUROSCIENTIST'S QUEST FOR WHAT MAKES US HUMAN 259 (2010); V.S. Ramachandran and William Hirstein, *The Perception of Phantom Limbs. The D. O. Hebb lecture.* 121 BRAIN 1603 (1998); Vilayanur S. Ramachandran and David Brang, *Phantom touch*. 4 SCHOLARPEDIA 8244 (2009) *at* http://www.scholarpedia.org/article/Phantom_touch.

[13] *See* Friedemann Pfäfflin, *Mental Health Issues*, in PRINCIPLES OF TRANSGENDER MEDICINE AND SURGERY 169, 170-71, 173 (Randi Ettner et al. eds., 2007).

diagnosis under the International Classification of Diseases, Ninth Revision, Clinical Modification ("ICD-9-CM"), the classification of diseases and health-related problems maintained by the World Health Organization. In the ICD-9-CM, "trans-sexualism" has diagnosis code 302.5 and "gender identity disorder in adolescents or adults" is 302.85.[14]

Similarly, transsexualism is recognized under the International Classification of Diseases, Tenth Revision ("ICD-10"). Transsexualism is listed as "medical condition F.64.0," which is defined as a "desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex."[15]

According to the American Medical Association ("AMA"), the largest association of physicians and medical students in the United States, gender dysphoria "is a serious medical condition" that if left untreated "can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicide and death."[16] The American Psychiatric Association, the world's largest psychiatric organization and publisher of the Diagnostic and Statistical Manual, "[r]ecognizes that appropriately evaluated transgender and gender variant individuals can benefit greatly from medical and surgical gender transition treatments."[17] The National Association of Social Workers concurs, noting that transgender people can experience "a profound sense of mismatch of the physical body to their internal bodily experience. This body dysphoria (known as 'gender dysphoria') causes significant distress, negatively affects daily functioning and well-being, and requires medical services to realign the body with the self."[18]

Given gender dysphoria's well-recognized status as a serious medical condition, it is not surprising that several nationwide insurance companies currently recognize the medical necessity of treatment for gender dysphoria and provide benefits that will cover such care. For example, Empire Blue Cross and Blue Shield's Clinical UM Guideline on Gender Reassignment Surgery notes that "[g]ender reassignment surgery[] [is] considered medically necessary" when

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[14] International Classification of Diseases, 9th Revision, Clinical Modification, 6th edition, (October 1, 2011), *available at*, http://www.icd9data.com/2013/Volume1/290-319/300-316/302/302.5.htm (Ex. 2).
[15] World Health Organization, International Statistical Classification of Diseases and Related Health Problems, 10th Revision (2007) (emphasis added), *available at* http://apps.who.int/classifications/icd10/browse/2010/en#/F60-F69 (Ex. 3).
[16] American Medical Association ("AMA") House of Delegates' Resolution 122, *Removing Financial Barriers to Care for Transgender Patients*, ¶¶ 2-3 (2008) (Ex. 4).
[17] American Psychiatric Association, Position Statement on Access to Care for Transgender and Gender Variant Individuals (2012), *available at* http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/Position%20Statements/ps2012_TransgenderCare.pdf (Ex. 5).
[18] National Association of Social Workers, *Transgender and Gender Identity Issues*, in SOCIAL WORK SPEAKS: NATIONAL ASS'N OF SOCIAL WORKERS POLICY STATEMENTS 2009-2012 342 (8th Ed. 2009) (Ex. 6).

the diagnostic criteria listed in the guidelines are met.[19] Similarly, Aetna's policy notes, "Aetna considers sex reassignment surgery medically necessary when all of the following criteria are met."[20] Other insurers that have such medical policies in place include many other Blue Cross affiliates, Cigna, HealthNet, UnitedHealthcare, and several other regional insurers.[21]

In addition to insurance companies, many private employers with self-funded health benefit plans cover transgender care. The Human Rights Campaign's annual Corporate Equality Index surveys the Fortune 1000 list of the largest publicly traded companies along with American Lawyer magazine's top 200 revenue-grossing law firms (Am Law 200). In 2013, 287 companies (42%) explicitly covered transgender care.[22] Courts have also established that sex reassignment surgeries are medically necessary treatments for transsexualism and should be covered under employer-based insurance plans.[23] Universities are also increasingly eliminating exclusions for transgender care in student and employee health plans.[24]

Several areas of federal law have also recognized that gender dysphoria is a serious medical condition. For example, the Internal Revenue Service classifies gender dysphoria as a "disease" and transgender treatments are tax-deductible as non-cosmetic medical procedures.[25] The U.S. State Department also effectively recognized gender dysphoria as a medical condition when it revised its requirements for updating the sex designation on

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[19] EMPIRE BLUE CROSS AND BLUE SHIELD ASSOCIATION, CLINICAL UM GUIDELINE: GENDER REASSIGNMENT SURGERY (2012), *available at* http://www.empireblue.com/medicalpolicies/guidelines/gl_pw_a051166.htm.
[20] AETNA, CLINICAL POLICY BULLETIN: GENDER REASSIGNMENT SURGERY (2012), *available at* http://www.aetna.com/cpb/medical/data/600_699/0615.html.
[21] *See* Private Insurance Companies with Medical Policies Recognizing the Medical Necessity of Transgender Care (Ex. 7). Additionally, New York-based insurer MVP recently denied a claim for genital reassignment surgery claiming it was cosmetic, only to reverse its position after the Transgender Legal Defense and Education Fund intervened and provided proof of its medical necessity. TLDEF, Victory! Transgender Woman Wins Insurance Coverage for Sex Reassignment Surgery (2012), http://transgenderlegal.org/headline_show.php?id=384 (Ex. 8).
[22] Human Rights Campaign, Corporate Equality Index 2013, *available at* http://www.hrc.org/files/assets/resources/CorporateEqualityIndex_2013.pdf (Ex. 9).
[23] *See Davidson v. Aetna*, 420 N.Y.S.2d 450 (N.Y. Sup. Ct. 1979) (sex reassignment surgeries are not "cosmetic surgeries" under an employee benefit plan); *Mario v. P & C Food Markets*, 313 F.3d 758, 765 (2nd Cir. 2002) (deferring to insurer's determination that transgender care was not medically necessary in general, but noting that "medical necessity" is necessarily an individualized concept and the plaintiff did have the opportunity to show the care was medically necessary for him—something foreclosed to Medicaid recipients by § 505.2(l).).
[24] Transgender Law & Policy Institute, *Colleges and Universities that Cover Transition-Related Medical Expenses Under Student Health Insurance*, *available at* http://www.transgenderlaw.org/college/index.htm#health (Ex. 10); Richard Pérez-Peña, *College Health Plans Respond as Transgender Students Gain Visibility*, N.Y. TIMES, Feb. 12, 2013, *available at* http://www.nytimes.com/2013/02/13/education/12sexchange.html (Ex. 11).
[25] *O'Donnabhain v. C.I.R.*, 134 T.C. 34, 61 (2010) *recommendation regarding acq.*, 2011 WL 5198999 (Nov. 3, 2011), *acq.*, 2011-47 I.R.B. 789 (November 21, 2011).

passports and Consular Reports of Birth Abroad.[26] U.S. Citizen and Immigration Services also similarly cites to the World Professional Association for Transgender Health ("WPATH") *Standards of Care* in its policies regarding transgender individuals.[27] Additionally, the U.S. Office of Personnel Management issued *Guidance Regarding the Employment of Transgender Individuals in the Federal Workplace*, which established protocols for transgender employees based on the WPATH *Standards of Care*.[28] The U.S. Department of Veterans Affairs mandates that transgender veterans are eligible to receive hormone therapy.[29] Transgender individuals detained by U.S. Immigration and Customs Enforcement are entitled to receive hormones and "[t]reatment shall follow accepted guidelines regarding medically necessary transition-related care."[30]

Gender dysphoria is also recognized as a medical condition by the Federal Bureau of Prisons, which has in place a policy to evaluate inmates with gender dysphoria and provide treatment in accordance with current standards of care.[31] Many states also have policies to provide hormones such as Alaska,[32] Alabama,[33] Arizona,[34] California,[35] Colorado,[36] Idaho,[37]

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[26] *See* U.S. Dep't of State, Foreign Affairs Manual, 7 FAM 1310 Appendix M: Summary, §(b), *available at* http://www.state.gov/documents/organization/143160.pdf (noting that the new policy and procedures are "based on standards and recommendations of the World Professional Association for Transgender Health (WPATH), recognized as the authority in this field by the American Medical Association.") (Ex. 12).

[27] U.S. Citizenship & Immigration Services, Adjudication of Immigration Benefits for Transgender Individuals; Addition of Adjudicator's Field Manual (AFM) Subchapter 10.22 and Revisions to AFM Subchapter 21.3 (AFM Update AD12-02), *available at* http://www.uscis.gov/USCIS/Outreach/Feedback%20Opportunities/Interim%20Guidance%20for%20Comment/Transgender_FINAL.pdf (Ex. 13).

[28] *See* U.S. Office of Personnel Management, *Guidance Regarding the Employment of Transgender Individuals in the Federal Workplace*, www.OPM.gov, *available at* http://www.opm.gov/diversity/transgender/guidance.asp (Ex. 14).

[29] Department of Veterans Affairs, *Providing Health Care for Transgender and Intersex Veterans*, VHA Directive 2013-003 (2013), *available at* http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2863 (Ex. 15).

[30] U.S. Immigration and Customs Enforcement, *Performance-Based National Detention Standards* 296 (2011), *available at* http://www.ice.gov/doclib/detention-standards/2011/pbnds2011.pdf (Ex. 16).

[31] *See* Fed. Bureau of Prisons, U.S. Dep't of Justice, Memorandum re: Gender Identity Disorder Evaluation and Treatment, May 31, 2011, *available at* http://www.glad.org/uploads/docs/cases/adams-v-bureau-of-prisons/2011-gid-memo-final-bop-policy.pdf ("Current, accepted standards of care will be used as a reference for developing the treatment plan. All appropriate treatment options prescribed for inmates with GID in currently accepted standards of care will be taken into consideration during evaluation . . . .") (Ex. 17).

[32] Sydney Tarzwell, *The Gender Lines are Marked With Razor Wire: Addressing State Prison Policies and Practices for the Management of Transgender Prisoners*, 38 COLUMBIA HUMAN RIGHTS LAW REVIEW 167, 194 n.125 (2006) (Ex. 18).

[33] Alabama Department of Corrections Administrative Regulation Number 637 (2005), *available at* http://web.archive.org/web/20100318163119/http://www.doc.state.al.us/docs/AdminRegs/AR637.pdf (Ex. 19).

Illinois,[38] Michigan,[39] New York,[40]and Pennsylvania.[41] Moreover, federal courts have recognized that gender dysphoria constitutes a "serious medical need" and that withholding treatment from inmates with gender dysphoria can be considered cruel and unusual punishment under the Eighth Amendment.[42] Indeed, courts have rejected blanket bans on transgender surgery and at least one has ordered a prison to pay for genital reassignment surgery.[43]

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[34] Tarzwell, *supra* note 32 at 194 n.125.

[35] Cal. Dep't Corr. & Rehab., Operations Manual § 1020.26 (1995), *available at* http://www.cdcr.ca.gov/Regulations/Adult_Operations/docs/DOM/Ch%209-Printed%20Final%20DOM%202011.pdf (Ex. 20); Ally Windsor Howell, *A Comparison of the Treatment of Transgender Persons in the Criminal Justice Systems of Ontario, Canada, New York, and California*, 28 BUFFALO PUBLIC INTEREST LAW JOURNAL 133, 174 (2010) (describing a program in which 3000 inmates over six years received care that could include hormones) (Ex. 21).

[36] Colorado Department of Corrections Administrative Regulation Number 700-14 (2010), *available at* http://www.doc.state.co.us/sites/default/files/ar/0700_14_0.pdf (Ex. 22).

[37] Idaho Department of Correction Directive Number 401.06.03.501 (2009), *available at* http://www.idoc.idaho.gov/sites/default/files/webfm/documents/about_us/policies_and_forms/policy public/4010603501.pdf (Ex. 23).

[38] Tarzwell, *supra* note 32 at 206; Department of Corrections Administrative Directive Number 04.03.104 (2003).

[39] Michigan Department of Corrections Policy Directive Number 04.06.184 (2010), *available at* http://www.michigan.gov/documents/corrections/0406184_340784_7.pdf (Ex. 24).

[40] New York State Department of Correctional Services, Division of Health Services Policy 1.31, *Brooks v. Berg*, 270 F. Supp. 2d 302, 312 (N.D.N.Y. 2003) ("This blanket denial of medical treatment is contrary to a decided body of case law.")

[41] Tarzwell, *supra* note 32 at 200.

[42] Nine of the U.S. Courts of Appeals have concluded or assumed that severe gender dysphoria constitutes a "serious medical need" for purposes of the Eighth Amendment. *See Battista v. Clarke*, 645 F.3d 449, 455 (1st Cir. 2011) (finding that gender dysphoria can be extremely dangerous and upholding injunction requiring hormone therapy for inmate); *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir.2000) (assuming without deciding that gender dysphoria constitutes a serious medical need); *De'lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003) (finding that self-harm directly resulting from denial of hormone treatment constitutes a serious medical need); *Praylor v. Texas Dept. of Criminal Justice*, 430 F.3d 1208, 1209 (5th Cir. 2005) (assuming without deciding that gender dysphoria does present a serious medical need); *Phillips v. Michigan Dept. of Corrections*, 731 F. Supp. 792, 800 (W.D. Mich. 1990), *decision aff'd*, 932 F.2d 969 (6th Cir. 1991) (upholding lower court finding that gender dysphoria presents a serious medical need and reaffirming injunction entitling inmate to hormone therapy); *Meriwether v. Faulkner*, 821 F.2d 408, 411-13 (7th Cir. 1987) (holding that gender dysphoria presents a serious medical need and noting that sex reassignment surgery has been found to be a medical necessity for treatment of gender dysphoria rather than being a cosmetic surgery); *Fields v. Smith*, 653 F.3d 550, 555 (7th Cir. 2011), cert. denied, 132 S. Ct. 1810 (U.S. 2012) (finding that gender dysphoria presents a serious medical need and that hormone therapy is the only effective treatment); *White v. Farrier*, 849 F.2d 322, 325-27 (8th Cir. 1988) (acknowledging that gender dysphoria is a serious medical condition); *Allard v. Gomez*, 9 Fed. Appx. 793, 794 (9th Cir.2001) (finding it undisputed that gender dysphoria presents a serious medical need); *Brown v. Zavaras*, 63 F.3d 967, 970 (10th Cir.1995) (finding

New York State has also recognized gender dysphoria as a medical condition in a variety of contexts. It qualifies as a disability under the State Human Rights Law,[44] which is the case in other states as well.[45] New York prisons have a policy, in line with the Eighth Amendment's

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that gender dysphoria presents a medical need entitling inmate to treatment). *See also Wolfe v. Horn*, 130 F. Supp. 2d 648, 652 (E.D. Pa. 2001) (assuming without deciding that gender dysphoria presents a serious medical need). No U.S. Court of Appeals has held otherwise. 134 T.C. No. 4 (2010), acq., 2011-047 (Nov. 21, 2011).

[43] *Kosilek v. Spencer*, 889 F. Supp. 2d 190 (D. Mass. 2012) (noting that the decision to deny Kosilek surgery was "not the result of a good faith balancing judgment . . . Rather, that decision was based on fear of criticism and controversy, articulated at times as a concern about cost to the taxpayer. Neither cost nor fear of controversy is a legitimate penological objective. This court may not defer to the defendant's decision to deny Kosilek sex reassignment surgery because deference does not extend to 'actions taken in bad faith and for no legitimate purpose.'"); *Soneeya v. Spencer*, 851 F.Supp.2d 228, 247 (D. Mass. 2012) ("This blanket ban on certain types of treatment, without consideration of the medical requirements of individual inmates, is exactly the type of policy that was found to violate Eighth Amendment standards in other cases both in this district and in other circuits."). *See also De'lonta v. Johnson*, No. 11-7482 (4th Cir. Jan. 28, 2013), *available at* http://www.ca4.uscourts.gov/Opinions/Published/117482.P.pdf (declining to dismiss an Eight Amendment claim where the prison provided psychological counseling and hormones but not surgery).

[44] *Doe v. Bell*, 194 Misc. 2d 774, 778 (N.Y. Sup. Ct. 2003) (finding that gender dysphoria met the State Human Rights Law definition of disability: 'a physical, mental or medical impairment resulting from anatomical, physiological, genetic or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques.' (Executive Law § 292 [21].)").

[45] Connecticut, Florida, Illinois, Massachusetts, New Hampshire, New Jersey and Washington have also recognized gender dysphoria as a disability. *Comm'n on Human Rights & Opportunities v. City of Hartford*, No. CV094019485S, 2010 WL 4612700, at *13 (Conn. Super. Ct. Oct. 27, 2010) (finding gender dysphoria to be a "physical disability," giving rise to a cognizable claim under Connecticut state nondiscrimination law), *Conway v. City of Hartford*, No. CV 950553003, 1997 WL 78585 (Conn. Super. Ct. Feb. 4, 1997) (recognizing gender dysphoria as a mental disability); *Dwyer v. Yale University, Commission on Human Rights & Opportunities*, No. 0130315; 0230323 (November 29, 2005), available at http://www.ct.gov/chro/cwp/view.asp?A=2528&Q=316044 (recognizing gender dysphoria as a mental disability under the Connecticut Fair Employment Practices Act); *Smith v. City of Jacksonville Corr. Inst.*, No. 88-5451, 1991 WL 833882 (Fla. Div. Admin. Hrgs. 1991); *Evans v. IL Dep't of Human Rights*, No. 1994CF0270, 1997 WL 377118 (Ill. Hum. Rts. Com. May 5, 1997), 1999 ILHUM LEXIS 260 (Ill. Hum. Rts. Com. Nov. 18, 1999); *Doe v. Yunits*, No. 001060A, 2000 WL 33162199 (Mass. Super. Ct. Oct. 11, 2000); Jette v. Honey Farms Mini Market, No. 95 SEM 0421, 2001 WL 1602799 (M.C.A.D. Oct. 10, 2001); Lie v. Sky Publishing Corp., No. 013117J, 2002 WL 31492397 at *6 (Mass. Super. Ct. Oct. 7, 2002) (holding gender dysphoria to be a physical or mental impairment that in its unmitigated form substantially impairs one or more major life activities); *Doe v. Electro-Craft Corp.*, No. 87-B-132, 1988 WL 1091932 (N.H. Super. Apr. 8, 1988); *Enriquez v. West Jersey Health Systems*, 777 A.2d 365, 367 (N.J. Super. Ct. App. Div. 2001) ("[G]ender dysphoria is a recognized mental or physical disability that can be demonstrated psychologically by accepted clinical diagnostic techniques and qualifies as a handicap…."). See also *Evans v. Hamburger Hamlet*, No. 93-E-177, 1996 WL 941676 (Chi. Com. Hum. Rel. May 8, 1996) (recognizing GD as a disability under Chicago law). See also *Blackwell v. U.S. Dep't of Treasury*, 830 F.2d

requirements, to provide psychological and hormonal treatments to inmates; the denial of all care is unreasonable.[46] The New York State Department of Financial Services has overturned denials and mandated coverage of transgender care under private insurance plans through the external appeals process in which the Division reviews claims denied on the basis of medical necessity.[47]

The New York State Department of Health itself actually requires transgender individuals to undergo hormone treatment and surgery in order to correct the sex designation on their birth certificates.[48] DOH also requires a "[p]sychological report diagnosing gender identity disorder or that you meet the [WPATH] transsexual criteria."[49] New York City's Department of Health and Mental Hygiene similarly requires genital surgery to correct a birth certificate.[50] Surely health departments would not require transgender individuals to place themselves at risk and undergo unsafe or ineffective treatments simply to correct a document.

Finally, both New York City and New York State offer employee health insurance plans that cover transgender care.[51] Other state and local governments provide or mandate coverage as well. Governments providing transgender care for their employees include Oregon,[52]

1183 (D.C.Cir.1987) (recognizing an employment discrimination claim based on the handicap of transvestism as covered by the federal Rehabilitation Act prior to the addition of an explicit exclusion); *Doe v. United States Postal Service*, 37 F.E.P. Cases 1867, 1985 WL 9446 (D.C.Cir.1985) (recognizing an employment discrimination claim on the basis of transsexualism under the Rehabilitation Act prior to the addition of an explicit exclusion).

[46] *Brooks v. Berg*, 270 F. Supp. 2d 302, 312 (N.D.N.Y 2003) *vacated in part*, 289 F. Supp. 2d 286 (N.D.N.Y. 2003) ("Prisons must provide inmates with serious medical needs some treatment based on sound medical judgment. . . . Prison officials are thus obliged to determine whether Plaintiff has a serious medical need and, if so, to provide him with at least some treatment. . . .In light of the numerous cases which hold that prison officials may not deny transsexual inmates all medical attention, especially when this denial is not based on sound medical judgment, the Court finds that Defendants have failed to establish as a matter of law that their actions were objectively reasonable.")

[47] Personal communication with successful appellants. *See also* N.Y. Ins. Law §§ 4900-4917 (2013).

[48] Letter from Robert Pennacchia requiring hysterectomy and hormone treatment for transgender men (Ex. 25); Letter from Robert Pennacchia requiring "proof of removal of penis and testes" and hormone treatment for transgender women (Ex. 26).

[49] *Id.*

[50] NYC Department of Health and Mental Hygiene, Edna Timbers checklist (June 14, 2012) (requiring transgender individuals to provide proof of "convertive surgery" such as "penectomy, orchiectomy, vaginoplasty, hysterectomy, and/or phalloplasty" to correct the sex on a birth certificate) (Ex. 27).

[51] Personal communication with state and city employees. *See also* Human Rights Campaign, 2012 Municipal Equality Index Scorecard 189, *available at* http://www.hrc.org/files/assets/resources/MEI_2012_Scorecards.pdf (Ex. 28).

[52] Lambda Legal, *State of Oregon Agrees to Remove Gender Identity Exclusion for Transgender Employees from State Health Plan* (Jan. 17, 2013), *available at* http://www.lambdalegal.org/news/or_20130117_state-agrees-to-remove-gi-exclusion-for-transgender-employees-from-health-plan (Ex. 29).

Berkeley, California;[53] Minneapolis, Minnesota;[54] Multnomah County, Oregon;[55] Portland, Oregon,[56] and the City and County of San Francisco;[57] and Seattle, Washington.[58] Regulations in California,[59] Oregon[60] and Washington, DC[61] prohibit the exclusion of transgender care in insurance policies. Exclusions have also been removed from local government-sponsored health plans and essential health benefit plans.[62]

Internationally, most European countries provide transgender-related surgery and hormones in their government-funded health care plans including: Austria, Belgium, the Czech Republic, Denmark, Finland, France, Germany, Hungary, Ireland, Italy, Latvia, the Netherlands,

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[53] State of California Department of Insurance, *Economic Impact Assessment Gender Nondiscrimination in Health Insurance* (File Number: REG-2011-00023) 7 (2012) (Ex. 30).
[54] 2012 Municipal Equality Index Scorecard, *supra* note 51 at 143.
[55] Multnomah County, 2013 ODS Major Medical Plan, *available at* http://web.multco.us/node/45853 (Ex. 31).
[56] Beth Slovic, *Portland City Hall Wrap Up: Commissioners Approve Transgender Benefits, Dignity Village Extension,* OREGONLIVE (June 8, 2011), http://blog.oregonlive.com/portlandcityhall/2011/06/portland_city_hall_wrap_up_com_1.html (Ex. 32).
[57] Human Rights Campaign, *San Francisco Transgender Benefit* (2010), *available at* http://www.hrc.org/resources/entry/san-francisco-transgender-benefit (Ex. 33).
[58] Mike Andrew, *Seattle Adds Transgender Health Care to Employee Benefits*, SEATTLE GAY NEWS, Oct. 7, 2011, *available at* http://www.sgn.org/sgnnews39_40/page2.cfm (Ex. 34).
[59] Cal. Code Regs. Tit. 10, §§ 2561.1-2561.2 (2013) (prohibiting limiting coverage based on transgender status).
[60] Oregon Insurance Division Bulletin INS 2012-01 re: Application of Senate Bill 2 (2007 Legislative Session) to Gender Identity Issues in the Transaction and Regulation of Insurance in Oregon (2012), *available at* http://www.cbs.state.or.us/ins/bulletins/bulletin2012-01.html ("An insurer cannot simply exclude 'Gender Identity Disorders' or 'Treatment for Gender Identity Disorder' because this is on its face discrimination.") (Ex. 35).
[61] District of Columbia Department of Insurance, Securities and Banking, *13-IB-01-30/15 Prohibition of Discrimination in Health Insurance Based on Gender Identity or Expression* (2013) *available at* http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/Bulletin13-IB-01-30-15.pdf (noting that exclusions for services related to sex reassignment violate DC's prohibition on discrimination based on gender identity or expression and are no longer enforceable) (Ex. 36).
[62] *See* Lisa Leff, *San Francisco Plans to Provide Transgender Surgeries for Uninsured Residents*, MERCURYNEWS.COM, Nov. 8, 2012, http://www.mercurynews.com/breaking-news/ci_21960300/san-francisco-plans-provide-transgender-surgeries-uninsured-residents (exclusion for sex reassignment surgery removed from Healthy San Francisco plan, which provides care for uninsured residents) (Ex. 37); District of Columbia Department of Insurance, Securities and Banking, *Department of Insurance, Securities and Banking and the Office of GLBT Affairs Announce Prohibition on Discrimination in Health Insurance on the Basis of Gender Identity or Expression* (Mar. 18, 2013) *available at* http://disb.dc.gov/release/department-insurance-securities-and-banking-and-office-glbt-affairs-announce (noting removal of exclusion from "CareFirst, the District government's own Essential Health Benefit" benchmark plan) (Ex. 38).

Poland, Portugal, Spain, Sweden, and the United Kingdom.[63] Indeed, a UK court found a blanket ban to be unlawful.[64] Other countries that publicly fund surgeries include Argentina,[65] Brazil,[66] Cuba,[67] Iran,[68] and Canada.[69]

B. Mortality and morbidity is associated with lack of access to medically-supervised treatments of gender dysphoria

There are substantial risks to leaving gender dysphoria untreated. In most individuals, gender dysphoria can indeed "cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap."[70] Examples of these problems follow.

1. Untreated gender dysphoria is associated with depression, suicidal ideation and attempts to commit suicide

In addition to the aforementioned physical and psychological distress that is associated with gender dysphoria, individuals without access to treatment for gender dysphoria experience higher rates of mental health problems relative to the general population,[71]

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[63] Stephen Whittle et al., *Transgender EuroStudy: Legal Survey and Focus on the Transgender Experience of Health Care* (April 2008), *available at* http://www.pfc.org.uk/pdf/eurostudy.pdf (Ex. 39); Daniel Woolls, *Spanish Teen Undergoes Sex Change Operation*, THE SEATTLE TIMES, Jan. 12, 2010, http://seattletimes.com/html/nationworld/2010771868_apeuspainteensexchange.html (noting that three regional systems provide coverage) (Ex. 40).

[64] A. Jain & C. Bradbeer, *Gender Identity Disorder: Treatment and Post-Transition Care in Transsexual Adults*, 18 INT'L J. OF STD & AIDS 147, 149 (2007).

[65] Associated Press, *In Argentina, sex change surgery becomes a right*, SFGATE (May 11, 2012), http://www.sfgate.com/world/article/In-Argentina-sex-change-surgery-becomes-a-right-3550708.php (Ex. 41).

[66] Associated Press, *Brazil to Provide Free Sex-Change Operations: Court Rules the Surgery is a Constitutional Right for Residents*, NBCNEWS.COM, Aug. 17, 2007, http://www.nbcnews.com/id/20323334/ns/health-health_care/t/brazil-provide-free-sex-change-operations (Ex. 42).

[67] Shasta Darlington, *Cuban Enjoys New Benefit of Free Sex-Change Operation*, CNN, June 1, 2011, http://articles.cnn.com/2011-06-01/world/cuba.sex.change_1_transsexual-factory-cnn?_s=PM:WORLD (Ex. 43).

[68] Vanessa Barford, *Iran's 'Diagnosed Transsexuals'*, BBC NEWS, Feb. 28, 2008, http://news.bbc.co.uk/2/hi/7259057.stm (noting the government will pay up to half the cost) (Ex. 44).

[69] Noreen Fagan, *Overview of SRS Coverage in Canada,* XTRA, Oct. 26, 2009, http://www.xtra.ca/public/National/Sex_reassignment_surgery_in_Canada_whats_covered_and_where-7706.aspx (coverage is regional, but it is covered in most of the country); Canadian Press, *Alberta Reinstates Funding for Gender Reassignment after Delisting Surgery in 2009*, NATIONAL POST, Jun. 7, 2012, *available at* http://news.nationalpost.com/2012/06/07/alberta-gender-reassignment-surgery (Ex. 45).

[70] N.Y. Soc. Serv. Law § 365-a(2).

[71] *See* Annelou L.C. de Vries *et al*., *Comparing Adult and Adolescent Transsexuals: An MMPI-2 and MMPI-A Study*, 186 PSYCHIATRY RESEARCH 414, 416 (2011) (finding the majority of adult trans people

including depression[72] and high rates of suicide attempt.[73] These conditions are improved with treatment.[74]

2. Self-surgery: penile or testicular auto-amputation

Another risk of untreated gender dysphoria is attempted self-surgery. Some transgender women who cannot access surgery will perform (or will struggle with the urge to perform) self-surgery in the form of damaging or removing their testicles and, in some cases,

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scored "in the clinical range" on two or more clinical scales of the MMPI-2, a widely used mental health assessment questionnaire, and 35% were in the clinical range for four or more scales); Tiffiny A. Ainsworth & Jeffrey H. Spiegel, *Quality of Life of Individuals with and without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 QUAL. LIFE RES. 1019, 1021 (2010) (finding trans women who had not undergone GRS performed significantly worse on a measure of mental health than non-transgender women); Emily Newfield, *Female-to-Male Transgender Quality of Life,* 15 QUALITY OF LIFE RESEARCH 1447, 1451 (2006) (finding trans men had lower mental health scores than non-transgender men and women).

[72] Kristen Clements-Nolle et al., *HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention*, 91 AMERICAN JOURNAL OF PUBLIC HEALTH, 915, 919 (2001) (finding nearly 2 out of 3 of trans women and more than half of trans men experienced depression and nearly one-third of both had attempted suicide).

[73] *See* Shira Maguen and Jillian C. Shipherd, *Suicide Risk Among Transgender* Individuals, 1 PSYCHOLOGY & SEXUALITY 34, 39 (2010) (finding a suicide attempt rate of 41% for trans men and 20% for trans women relative to 4.6% in the general population); Clements-Nolle, *supra* note 72 at 919 (2001) (noting that the "prevalence of suicide attempts among male-to-female and female-to-male transgender persons in [the] study was much higher than that found in US household probability samples and a population-based sample of adult men reporting same-sex partners."); Ann P. Haas et al., *Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations*, 58 J. OF HOMOSEXUALITY 10, 27 (2011) ("More recent data from nonrandom surveys of self-identified transgender people found that up to one third of respondents report making one or more lifetime suicide attempts."); Jaime M. Grant et al., *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 79 (2011) *available at* http://www.thetaskforce.org/downloads/reports/reports/ntds_full.pdf (participants noted, "I cannot afford gender reassignment surgery which is crucial to my mental well being and thoughts of suicide are always present," and "I have also [] had several bouts with depression and anxiety disorders and once ended up in the emergency room for depression. I still bounce in and out of depression due to not being able to get the appropriate surgical procedures.") (Ex. 46). *See also* Mass. Dept. of Public Health, *The Health of Lesbian, Gay, Bisexual and Transgender (LGBT) Persons In Massachusetts: A survey of health issues comparing LGBT persons with their heterosexual and non-transgender counterparts*, at 10 (2009), *available at* http://www.mass.gov/eohhs/docs/dph/commissioner/lgbt-health-report.pdf (finding nearly 31% of transgender people had seriously considered attempting suicide in the past 12 months—nearly nine times the rate of non-transgender people at 2.3%) (Ex. 47).

[74] *See* Section III below.

their penises.[75] One study found that 8% of transgender women and 1% of transgender men have attempted to damage their genitals or breasts.[76]

3. Silicone injection

When denied access to proper medical treatment, some transgender women attempt to alleviate their gender dysphoria by reshaping their body through the use of highly dangerous injections of industrial-grade silicone purchased on the black market.[77] Silicone injection prevalence approaches 1 in 3 among the vulnerable subpopulations that comprise Medicaid recipients.[78] These injections can cause severe disfigurement, chronic pain and complications

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[75] *See, e.g.*, George R. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder*, 12 INT'L J. OF TRANSGENDERISM 31, 37-38 (2010); S. Haleem, *Self-castration: A Case Report*, 7 GRAND ROUNDS 9 (2007); Danilo Antonio Baltieri, *Transsexual Genial Self-Mutilation*, AM. J. FORENSIC MEDICINE AND PATHOLOGY 268 (2005); Darren B. Russell, *Genital Self-Mutilation by Radio-Frequency in a Male-To-Female Transsexual, 2* SEXUAL HEALTH 203 (2005); D. Murphy *et al.*, *Self-castration (a Case Report)*, 170 IRISH J. OF MED. SCI. 195 (2001); S.J. McGovern, *Self-castration in a Transsexual*, 12 J. OF ACCIDENT AND EMERGENCY MED. 57(1995); A. Rana, *Sequential Self-castration and Amputation of Penis*, 71 BRITISH J. OF UROLOGY 750 (1993) (performed in response to learning there was a many-year waiting list for genital reassignment surgery); Marilyn J. Krieger, *Self-performed Bilateral Orchiectomy in Transsexuals*, 43 J. CLINICAL PSYCHIATRY 292 (1982) (reporting on "three cases of self-performed bilateral orchiectomy [in trans women] seen within a 2-year period at San Francisco General Hospital."); Frederick H. Lowy, *Autocastration by a Male Transsexual*, 16 CANADIAN PSYCHIATRIC ASSOC. J. 399 (1971).

[76] Collier M. Cole et al., *Comorbidity of Gender Dysphoria and Other Major Psychiatric Diagnoses*, 26 ARCHIVES OF Sexual BEHAVIOR 13, 19 (1997).

[77] J. Joris Hage et al., *The Devastating Outcome of Massive Subcutaneous Injection of Highly Viscous Fluids in Male to Female Transsexuals*, 107 PLASTIC AND RECONSTRUCTIVE SURGERY 734, 735 (2001) (noting trans women injected in order to achieve a female body shape and the complications did not alter their desire to have female bodies); Laura Rena Murray, *The High Price of Looking Like a Woman*, N.Y. TIMES, Aug. 19, 2011, *available at* http://www.nytimes.com/2011/08/21/nyregion/some-transgender-women-pay-a-high-price-to-look-more-feminine.html?pagewanted=all&_r=0 (Ex. 48); Alex Roth, *Silicone Endangers Transgender Group*, THE SAN DIEGO UNION TRIBUNE, July 3, 2005, *available at* http://www.utsandiego.com/uniontrib/20050703/news_1m3silicone.html (Ex. 49).

[78] *See* Cathy J. Reback et al., THE LOS ANGELES TRANSGENDER HEALTH STUDY: COMMUNITY REPORT 17 (2001) *available at* http://friendscommunitycenter.org/documents/LA_Transgender_Health_Study.pdf (finding one-third of trans women injected silicone or oil) (Ex. 50); Robert Garofalo, *Overlooked, Misunderstood and At-risk: Exploring the Lives and HIV Risk of Ethnic Minority Male-To-Female Transgender Youth*, 38 J. OF ADOLESCENT HEALTH 230, 233 (2006) (finding 29% of participants had injected liquid silicone); Society for Public Health Education, *Health Impact of Adulterated Silicone on Transgender Health*: *Call for Education and Awareness about Adulterated Injection Silicone Use* (2012), *available at* http://www.sophe.org/Sophe/PDF/transgender_policy_approved_letterhead.pdf (noting prevalence rates of 25% in Washington, DC, 30% in New York, and 33% in Los Angeles) (Ex. 71); Paul Kobrak, Bureau of HIV/AIDS Prevention and Control, New York City Department of Health and Mental Hygiene, TRANSGENDER WOMEN AND HIV PREVENTION IN NEW YORK CITY: A NEEDS ASSESSMENT 17 (2009) (finding 22% of participants in this NYC needs assessment had received silicone injections) (Ex. 51).

such as pulmonary emboli, silicone pneumonitis, acute respiratory distress syndrome, abscesses, liver disease, septic shock, puncture of internal organs, and death.[79] Costly treatment for these complications would be covered under Medicaid.

[79] *See, e.g.,* Ian K. Komenaka, *Free Silicone Injection Causing Polyarthropathy and Septic Shock*, 10 BREAST J. 160 (2004) (ongoing infections in the breast that cause arthritis and septic shock are common after injections of silicone); Lindy Peta Fox, *et al*., *Mycobacterium Abscessus Cellulitis And Multifocal Abscesses of the Breasts in a Transsexual from Illicit Intramammary Injections of Silicone*, 50 J. OF AM. ACADEMY OF DERMATOLOGY at 450 (2004) (infections, which cause chronic lung disease and post-traumatic wound infections, can be added to the potential complications of silicone injections, which also "include cellulitis, granulomatous reactions, migration of material, ulceration, scarring, pneumonitis, granulomatous hepatitis, reactive systemic illnesses, and iatrogenic infection"); Richard F. Clark, *Subcutaneous Silicone Injection Leading to Multi-system Organ Failure*, 46 CLINICAL TOXICOLOGY 834 (2008) (describing five trans women who attended a "pumping party" resulting in the death of one of them); Hage *supra* note 77 (subcutaneous injections of massive quantities of mineral oil or silicone lead to complications ranging from a change in skin color to death, and there are no available treatments to alleviate the effects); Anupam M. Desai, *Etanercept Therapy for Silicone Granuloma*, 5 J. OF DRUGS IN DERMATOLOGY 894 (2006) (injecting silicone leads to difficult-to-treat silicone granulomas that not only cause a local inflammatory response at the injection site, but spread widely throughout the body); Marianna Shvartsbeyn, *Silicon-associated Subcutaneous Lesion Presenting as a Mass: A Confounding Histopathologic Correlation*, 42 HUMAN PATHOLOGY 1364 (2011) (discussing the harmful effects and risks of unskilled practitioners using silicone of questionable purity); Antonio Villa, *Severe Pulmonary Complications after Silicone Fluid Injection*, 18 THE AMERICAN JOURNAL OF EMERGENCY MEDICINE 336 (2000) (determining that "the risk of adverse systemic effects, particularly severe pulmonary involvement, can be very high for silicone fluid injection, especially when delivered in large volume and when injections are given without medical precautions as with transsexual [women]"); Andreas Schmid, *Silicone Embolism Syndrome a Case Report, Review of the Literature, and Comparison With Fat Embolism Syndrome*, 127 CHEST 2276 (2005) (presenting data from thirty-two patients who were hospitalized after illegal silicone injections, six of whom died, while twenty-six were discharged within three weeks after experiencing respiratory symptoms); Ayke L. Oen, *Magnetic Resonance Imaging of Injected Silicone: Findings in Seven Male-to-Female Transsexuals*, 12 EUROPEAN RADIOLOGY 1221 (2002) (triggering local as well as systemic reactions, sometimes many years after injection, silicone injections have devastating effects that indicate that silicone is not as inert as previously thought); Tan Duong, *Acute Pneumopathy in a Nonsurgical Transsexual*, 113 CHEST 1127 (1998) (discussing the risk of acute and latent pneumopathy for individuals after illicit silicone injections); E. Pastor, *[Acute Pneumonitis and Adult Respiratory Distress Syndrome after Subcutaneous Injection of Liquid Silicone],* 41 ARCHIVOS DE BRONCONEUMOLOGÍA 702 (2005) (emphasizing the threat of pneumonitis, which is the potentially fatal inflammation of the lung tissue, following a silicone injection); F. Sanz-Herrero, *[Acute Pneumonitis after Subcutaneous Injection of Liquid Silicone as a Breast Implant in a Male-To-Female Transsexual],* 42 ARCHIVOS DE BRONCONEUMOLOGÍA 205 (2006) (noting silicone injected into the breast threatens to reach the bloodstream and spread widely throughout the body risking severe systemic (mainly pulmonary) adverse effects).

4. Other health problems associated with untreated gender dysphoria

There is a lack of published research on the numerous other problems that untreated gender dysphoria can cause, but anecdotally, many seemingly unrelated medical problems have resolved themselves once a person transitioned medically. Such problems include severe anxiety, depression, panic attacks, migraines, drug and alcohol abuse, eczema, obesity, anorexia, cutting behavior, and countless others.

Additionally, transgender women, particularly transgender women of color, experience high rates of HIV infection and low rates of HIV treatment.[80] Access to doctor-administered hormones improves compliance with HIV treatment, which improves health and lessens the spread of HIV.[81]

C. Generally accepted professional standards recognize sex reassignment as the safe, effective and appropriate treatment for gender dysphoria

Transgender care meets the remainder of the Medicaid medical necessity definition as it safely and effectively treats the symptoms of gender dysphoria described above. Medically necessary care is "necessary to prevent, diagnose, correct or cure" a condition, here gender dysphoria.[82] Transgender care also meets the criteria that coverage is limited to "services and supplies which are medically necessary and appropriate, consistent with quality care and generally accepted professional standards."[83] Federal Medicaid regulations further specify that the services that New York chooses to provide under Medicaid "must be sufficient in amount, duration, and scope to reasonably achieve its purpose."[84]

The only recognized effective treatment of gender dysphoria is sex reassignment, also known as gender reassignment or transitioning. Treatments can include hormone therapy, sex reassignment surgeries, socially transitioning from one sex to the other, as well as supportive psychological counseling throughout the process. Transgender care works at the root of the problem by eliminating gender dysphoria rather than attempting to manage its symptoms, such as depression.

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[80] *See, e.g.*, Clements-Nolle *supra* note 72 at 917 (2001) (noting an HIV prevalence of 35% among trans women with only 50% receiving treatment for HIV).

[81] Jae M. Sevelius et at., *Antiretroviral Therapy Adherence Among Transgender Women Living with HIV*, 21 J. OF ASSOC. OF NURSES IN AIDS CARE 256 (2010). PMC Author manuscript at 7 *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2859994/pdf/nihms175292.pdf ("Clinicians who serve transgender women have found that hormone treatment can serve as an incentive for patients to seek and adhere to ART."); J. Grimaldi & J. Jacobs, *The HIV Hormone Bridge: Connecting Impoverished HIV+ Transsexual Sex Workers to HIV Medical Care* (abstract no. 571/44225), 12 INT'L. CONFERENCE ON AIDS 981 (1998), *available at* http://www.aegis.com/aidsline/1998/dec/m98c1575.html

[82] N.Y. Soc. Serv. Law § 365-a(2).

[83] 18 NYCRR § 500.1.

[84] 42 C.F.R. § 440.230(b).

Efforts to "cure" gender dysphoria through psychotherapy or suppression of one's self-identified sex have not been successful, are not regarded as appropriate medical treatment and can be harmful.[85] As described by Joshua D. Safer and Vin Tangpricha in their article in *Endocrine Practice*: "Many physicians share the misconception that transgender treatment is a psychologic issue best managed with psychiatric intervention (behavioral therapy, psychotropic medication, or both). The assumption is that gender identity can be reversed. Nevertheless, available data do not support the notion that gender identity can be reversed by external forces. Rather, the data in the medical literature to date are consistent with gender identity being fixed."[86] The failure of psychotherapy to effectively treat gender dysphoria provides ample clinical evidence of the medical necessity of hormones and surgeries.[87] Courts also have long recognized that psychotherapy alone cannot resolve gender dysphoria.[88]

The largest professional association for health care professionals who specialize in transgender health care is the World Professional Association for Transgender Health (WPATH). WPATH is recognized by the AMA as "the leading international, interdisciplinary professional organization devoted to the understanding and treatment of gender identity disorders," and notes that its "internationally accepted Standards of Care . . . are recognized within the medical

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[85] C. Richards & J. Barrett, *The Case for Bilateral Mastectomy and Male Chest Contouring for the Female-To-Male Transsexual*, 95 ANNALS OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND 93, 94 (2013) (noting "mandatory psychological interventions have failed repeatedly and, indeed, have proven to be harmful. Thus, as the mind may not be altered in line with the body, the body must be altered to be in line with the mind.") (citations omitted).

[86] Joshua D. Safer & Vin Tangpricha, *Out of the Shadows: It Is Time to Mainstream Treatment for Transgender Patients*, 14 ENDOCRINE PRACTICE 248, 248 (2008).

[87] *See e.g.*, Peggy T. Cohen-Kettenis & Stephanie H.M. van Goozen, *Sex Reassignment of Adolescent Transsexuals: A Follow-up Study*, 36 J. OF AM. ACADEMY OF CHILD ADOLESCENT PSYCHIATRY 263, 264 (1997).

[88] *See, e.g.*, *Richards v. U.S. Tennis Ass'n*, 400 N.Y.S. 2d 267, 271 (N.Y. Sup. Ct. 1977) ("Medical Science has not found any organic cause or cure (other than sex reassignment surgery and hormone therapy) for transsexualism, nor has psychotherapy been successful in altering the transsexual's identification with the other sex or his desire for surgical change."); *Doe v. State of Minn., Dep't of Pub. Welfare*, 257 N.W. 2d 816, 819 (Minn. 1977) ("Given the fact that the roots of transsexualism are generally implanted early in life, the consensus of medical literature is that psychoanalysis is not a successful mode of treatment for the adult transsexual."); *Doe v. McConn*, 489 F. Supp. 76, 77 (S.D. Tex. 1980) (making a factual finding that "[t]reatment of this condition in adults by psychotherapy alone has been futile" and that "[a]dministration of hormones of the opposite sex followed by sex-conversion operations has resulted in better emotional and social adjustment by the transsexual individual in the majority of cases." Because transsexualism is not a "choice," "it has been found that attempts to treat the true adult transsexual psychotherapeutically have consistently met with failure."); *Sommers v. Iowa Civil Rights Comm'n*, 337 N.W.2d 470, 473 (Iowa 1983) ("It is generally agreed that transsexualism is irreversible and can only be treated with surgery to remove some of the transsexual feelings of psychological distress; psychotherapy is ineffective."); *In re* Heilig, 816 A.2d 68, 78 (Md. 2003) ("Although psychotherapy may help the transsexual deal with the psychological difficulties of transsexualism, courts have recognized that psychotherapy is not a 'cure' for transsexualism. Because transsexualism is universally recognized as inherent, rather than chosen, psychotherapy will never succeed in 'curing' the patient.").

community to be the standard of care for treating people with GID."[89] WPATH's *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* "are based on the best available science and expert professional consensus."[90] The *Standards of Care* provide guidelines for providing mental health treatment, hormone therapy, and surgeries.[91]

The consensus-based *Standards of Care* "unequivocally reflect [WPATH's] conclusion that treatment [of gender dysphoria] is medically necessary."[92] WPATH explains that "medical procedures attendant to sex reassignment are not 'cosmetic' or 'elective' or for the mere convenience of the patient. These reconstruction procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition."[93] WPATH notes that "[m]edically necessary sex reassignment procedures also include complete hysterectomy, bilateral mastectomy, chest reconstruction or augmentation as appropriate to each patient (including breast prostheses if necessary), genital reconstruction (by various techniques which must be appropriate to each patient, including, for example, skin flap hair removal, penile and testicular prostheses, as necessary), facial hair removal, and certain facial plastic reconstruction as appropriate to the patient."[94] The *Standards of Care* recognize that for those who do not experience relief due to other measures, surgery is an essential part of treating gender dysphoria: "surgery is essential and medically necessary to alleviate their gender dysphoria . . . relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity."[95]

The AMA articulates in Resolution 122 that an "established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID."96 The AMA also opposes limitations placed on patient care by third-party payers when "such care is based upon sound scientific evidence" and thus supports "public and private health insurance coverage for treatment of gender identity disorder."[97] According to the AMA,

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[89] AMA Resolution 122, *supra* note 16 at ¶ 4.
[90] WPATH, *Standards of Care*, *supra* note 10 at 1.
[91] *Id.* at 9-10.
[92] WPATH Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. (June 17, 2008), *available at* http://www.wpath.org/documents/Med%20Nec%20on%202008%20Letterhead.pdf (Ex. 52).
[93] *Id.*
[94] *Id.*
[95] WPATH, *Standards of Care*, *supra* note 10, at 54-55.
[96] *See* AMA Resolution 122, *supra* note 16 at ¶¶ 5-6, ("Health experts in GID, including WPATH, have rejected the myth that such treatments are 'cosmetic' or 'experimental' and have recognized that these treatments can provide safe and effective treatment for a serious health condition.").
[97] *Id.* at ¶¶ 8, 12.

denial of these benefits "represents discrimination based solely on a patient's gender identity."[98]

The American Psychiatric Association "[a]dvocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment" as well as "[o]pposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician. It formed a Task Force on Treatment of Gender Identity Disorder, which issued its report in 2012.[99] Citing numerous studies, the Task Force concluded that "sex reassignment is associated with an improved sense of well-being in the majority of cases . . . ."[100]

Similarly, the American Psychological Association—the largest scientific and professional organization of psychologists in the United States and the world—has recognized "the efficacy, benefit and medical necessity of gender transition treatments" and supports "access to appropriate treatment in institutional settings for people of all gender identities and expressions; including *access to appropriate health care services*," and the "provision of adequate and *necessary mental and medical health care treatment* for transgender and gender variant individuals."[101] The APA further "calls upon public and private insurers to cover these *medically necessary* treatments."[102]

The American College of Obstetricians and Gynecologists—the nation's leading group of professionals providing health care for women—"urges public and private health insurance plans to cover the treatment of gender identity disorder" and notes that evidence indicates "such treatments are safe and effective and that cross-gender behavior and gender identity issues are not an issue of choice for the individual and cannot be reversed with psychiatric treatment."[103]

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[98] *Id.* at ¶ 10.

[99] *See* William Byne *et al*., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 ARCHIVES OF SEXUAL BEHAVIOR 759, 760 (2012).

[100] *Id.* at 766.

[101] Barry S. Anton, *Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives*, *February 22-24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the Board of Directors*, 64 AMERICAN PSYCHOLOGIST 372-453 (2009), *available at* http://www.apa.org/about/policy/transgender.aspx, (noting that "gender variant and transgender people may be denied appropriate gender transition related medical and mental health care despite evidence that appropriately evaluated individuals benefit from gender transition treatments") (Ex. 53).

[102] *Id.* (emphasis added).

[103] The American College of Obstetricians and Gynecologists, *Health Care for Transgender Individuals,* Committee Opinion No. 512, *available at* http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Health_Care_for_Transgender_Individuals.aspx (first published in 118 OBSTETRICS & GYNECOLOGY 1454 (2011)) (Ex. 54).

The National Association of Social Workers "supports the rights of all individuals to receive health insurance and other health coverage without discrimination on the basis of gender identity, and specifically without exclusion of services related to transgender or transsexual transition."[104] The NASW also recognizes that there is active discrimination against transgender individuals when they are denied "appropriate medical care and health coverage."[105]

The Endocrine Society—the world's oldest, largest, and most active organization devoted to research on hormones and the clinical practice of endocrinology—has published clinical guidelines, *Endocrine Treatment of Transsexual Persons*, which provide detailed guidance for hormone treatment consistent with the WPATH *Standards of Care*. The guidelines emphasize that hormone therapy for gender dysphoria is safe, effective, and similar to hormone protocols for many non-transgender patients.[106] The guidelines also note that "[s]ex reassignment is a multidisciplinary treatment. It requires five processes: diagnostic assessment, psychotherapy or counseling, real-life experience, hormone therapy, and surgical therapy."[107]

The Center of Excellence for Transgender Health, University of California, San Francisco has developed a Primary Care Protocol for Transgender Patient Care.[108] The Protocol notes that "over 50 years of clinical experience have shown that [hormone therapy] is effective in treating gender dysphoria."[109]

In addition to the above standards of care, medical centers that specialize in transgender health care have developed their own protocols based on their direct experience of treating thousands of transgender individuals. These include Callen-Lorde Community Health Center in New York City,[110] Fenway Health in Boston,[111] the San Francisco Department of Public

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[104] NASW, *Transgender and Gender Identity Issues*, *supra* note 18 at 347.
[105] *Id.* at 346.
[106] Wylie C. Hembree *et al.*, Endocrine Treatment of Transsexual Persons: Endocrine Society Clinical Practice Guideline, *Journal of Clinical Endocrinology & Metabolism*, 94(9): 3132–3154 (2009), *available at* http://www.endo-society.org/guidelines/final/upload/endocrine-treatment-of-transsexual-persons.pdf (Ex. 55).
[107] Hembree, *supra* note 106, at 27.
[108] Center of Excellence for Transgender Health, University of California, San Francisco, Department of Family and Community Medicine, Primary Care Protocol for Transgender Patient Care (2011), http://transhealth.ucsf.edu/trans?page=protocol-00-00.
[109] *Id. at Hormone Administration*, http://transhealth.ucsf.edu/trans?page=protocol-hormones (Ex. 56).
[110] Callen-Lorde Community Health Center, Transgender Health Program Protocols, *available at* http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf.
[111] Fenway Health, Transgender Health Program, Protocol for Hormone Therapy (September 2007), *available at* http://www.fenwayhealth.org/site/DocServer/Fenway_Protocols.pdf?docID=2181 (Ex. 57).

Health's Tom Waddell Health Center,[112] and the Vancouver Coastal Health Authority in Canada.[113]

The U.S. Department of Veterans Affairs has issued detailed protocols for administering hormones, which it provides to transgender veterans.[114]

The National Commission on Correctional Health Care (NCCHC), which began as a program founded by the AMA to improve the quality of health care in jails, prisons, and juvenile confinement facilities, has widely accepted guidelines and an accreditation program for institutions. In its position statement on transgender health care, NCCHC notes, "[t]he health risks of overlooking the particular needs of transgender inmates are so severe that acknowledgment of the problem and policies that assure appropriate and responsible provision of health care are needed. . . . Because prisons, jails, and juvenile justice facilities have a responsibility to ensure the physical and mental health and well-being of transgender people in their custody, correctional health staff should manage these inmates in a manner that respects the biomedical and psychological aspects of a gender identity disorder (GID) diagnosis."[115]

Finally, numerous other states cover transgender care under their Medicaid programs. Courts and administrative bodies that have considered the rationality of a blanket exclusion of transgender care from public health insurance plans and have universally rejected such coverage bans.[116] This legal consensus is reflected in the New York City Bar Association's

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[112] The San Francisco Department of Health has been operating the Transgender Clinic of Tom Waddell Health Center since November of 1994. As a result of the expertise developed while treating over 1200 patients over a 12-year-period, the Center published its Protocols for Hormonal Reassignment of Gender in 2006. Transgender Team, Protocols for Hormonal Reassignment of Gender (Dec. 12, 2006), *available at* http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf (Ex. 58).

[113] Vancouver Coastal Health Authority has helped publish numerous clinical protocol guidelines for transgender individuals, including *Endocrine Therapy for Transgender Adults in BC: Suggested Guidelines* and *Care of the Patient Undergoing Sex Reassignment Surgery (SRS)*, *available at* http://transhealth.vch.ca/resources/library.

[114] VA Pharmacy Benefits Management Services, Medical Advisory Panel, and VISN Pharmacist Executives, *Transgender Cross-Sex Hormone Therapy Use* (February 2012) (Ex. 59), *Cross-Sex Hormone Therapy for Transgender Male-to-Female (MtF) Patients: Criteria for Use* (February 2012) (Ex. 60), *Cross-Sex Hormone Therapy for Transgender Female-to-Male (FtM) Patients: Criteria for Use* (February 2012) (Ex. 61).

[115] National Commission on Correctional Health Care, Transgender Health Care in Correctional Settings (2009), *available at* http://www.ncchc.org/transgender-health-care-in-correctional-settings (Ex. 62).

[116] *See*, *e.g.*, *Doe v. State, Dep't of Public Welfare*, 257 N.W.2d 816, 820 (Minn. 1977) ("the total exclusion of transsexual surgery . . . is void."); *J. D. v. Lackner*, 80 Cal. App. 3d 90, 94-95 (Cal. App. 1st Dist. 1978) (finding surgery was "medically reasonable and necessary and that there is no other effective treatment method" even in the presence of a blanket exclusion: "All medical services directly related to the diagnostic workup, surgical procedure, hormonal therapy or psychiatric care involved in transsexual surgery are not payable under the Medi-Cal Program."); *G. B. v. Lackner*, 80 Cal. App. 3d 64, 71 (Cal. App.

Committee on Lesbian, Gay, Bisexual and Transgender Rights' long-standing position that § 505.2(l) should be repealed as detailed in their most recent report, *Report on Repealing the Medicaid Exclusion of Medically Necessary Health Services for Transgender New Yorkers*.[117]

The institutional recognition of transgender care as part of the medically necessary treatment of gender dysphoria is supported by evidence-based, peer-reviewed medical literature, summarized below.

II. Section 505.2(l) is Arbitrary, Capricious, Irrational and Animus-Based

A. The transgender care exclusion is exceptional, unnecessary, and animus-based

There is no need to single out transgender care for exclusion because the definition of medically necessary treatment is sufficient to ensure that only medically necessary services are provided. Coverage under Medicaid is limited to "services and supplies which are medically necessary and appropriate, consistent with quality care and generally accepted professional standards."[118] This definition fittingly ties medical necessity to dynamic and evolving professional standards and ensures that Medicaid recipients always have access to the "high-quality medical assistance services" as the Legislature intended.[119] This functional definition also obviates the need for DOH to evaluate the merits of tens of thousands of individual medical treatments – an impossible task that DOH has not undertaken.

Although federal law provides that limitations on service can be based on medical necessity or utilization control procedures,[120] that does not provide a basis for a transgender care exclusion. If it were the case that transgender care was either (1) not medically necessary, (2) not medically appropriate, (3) inconsistent with quality care, (4) inconsistent with generally accepted professional standards, or (5) not necessary to prevent, diagnose, correct or cure a condition that (6) that causes acute suffering, endanger life, result in illness or infirmity, it would be excluded from coverage under N.Y. Soc. Serv. Law § 365-a or 18 NYCRR § 500.1, and there would be no need for a separate transgender care exclusion. There are countless forms of purported medical care that do not meet these criteria, but DOH did not provide a list of such excluded treatments. If a particular treatment for a medical condition does not meet those

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1st Dist. 1978) (rejecting agency's assertion that transgender surgery is "cosmetic."); *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980) (rejecting a coverage ban on all transgender care); *M.K. v. Division of Medical Assistance and Health Services, State of N.J.,* 92 N.J.A.R.2d (DMA) 38, 1992 WL 280789, 9 (N.J. Adm. May 7, 1992)(finding a phalloplasty to be medically necessary, not cosmetic and not experimental).

[117] New York City Bar Association, Committee on Lesbian, Gay, Bisexual and Transgender Rights, *Report on Repealing the Medicaid Exclusion of Medically Necessary Health Services for Transgender New Yorkers* (2013), *available at* http://www2.nycbar.org/pdf/report/uploads/20072423-TransgenderAffirmingHospitalPolicies.pdf (Ex. 63).

[118] 18 NYCRR § 500.1 (2013).

[119] *See* 35 N.Y. Register 128, 134 (Jan. 2, 2013).

[120] 42 C.F.R. § 440.230(d) (2013).

criteria, that treatment will not be covered. For this reason, there is no need to explicitly exclude transgender care.

Indeed, the reason transgender care is excluded is *precisely because* it is medically necessary, not experimental, not cosmetic, and is medically appropriate according to accepted standards of medical practice. Absent an explicit exclusion, *for at least some* transgender individuals,[121] this care would be considered medically necessary and therefore covered under Medicaid just like any other surgical, drug, or mental health benefit.

Freedom of Information Law requests show that DOH has never produced any evidence to justify an exclusion nor has it ever conducted its own review of the medical literature. In 2011, the New York *Post* reported that a Health Disparities Work Group simply proposed to submit a proposal to Governor Cuomo's Medicaid Redesign Team to eliminate § 505.2(l).[122] The story was widely reported elsewhere and within two days, the *Post* reported: "The Cuomo administration killed a controversial proposal that would have required taxpayers to foot the bill for transgender patients to get sex-change surgery."[123] Dr. Nirav Shah, the Cuomo-appointed Health Department Commissioner, stated flatly, "No consideration is being given to any change in current state policy and *any proposal to have gender reassignment surgery funded by Medicaid would be rejected*."[124] Transgender advocates found themselves shut out of the administrative process, as reported in the *Times Union*:

> But after a Sept. 29 New York Post story touched off a firestorm of protest, the proposal for Medicaid coverage of transgender surgery was quietly taken off the table prior to a Nov. 1 meeting of a Medicaid Redesign Team that reports to Cuomo, according to Lang [director of government projects for Empire State Pride Agenda].
>
> "It was unilaterally removed by the health commissioner," Lang said.
>
> Lang said previously productive and cordial meetings with Dr. Nirav Shah, the Cuomo-appointed Health Department Commissioner, turned cold after the

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[121] The vast majority of transgender individuals report a need to undergo surgery. *See* Grant, *supra* note 73 at 79 (noting 87% need vaginoplasty, 93% need male chest reconstruction, 74% need breast reconstruction, and 79% need hysterectomy).

[122] Carl Campanile, *Let Taxpayers Foot Sex-op Bill: Panel*, N.Y. POST, Sept. 29, 2011, *available at* http://www.nypost.com/p/news/local/let_taxpayers_foot_sex_op_bill_panel_syVzH88veFSKLnSXA76w9O (Ex. 64).

[123] Carl Campanile, *Cuomo Chops Off Sex-Change Funds*, N.Y. POST, Oct. 1, 2011, *available at* http://www.nypost.com/p/news/local/cuomo_chops_off_sex_change_funds_AfIIbCkXD1kqYkOkoW33YI (Ex. 65).

[124] Paul Grondahl, *Attention Turning to Equal Rights Fight*, TIMES UNION, Dec. 7, 2011, *available at* http://www.timesunion.com/local/article/Attention-turning-to-equal-rights-fight-2376855.php (emphasis added) (Ex. 66).

> Post article. "We were told our proposal would not be considered anymore," Lang said.[125]

This response illustrates that rather than being based on any weighing of evidence, § 505.2(l) exists and persists because of political concerns and anti-transgender animus.

B. The transgender care exclusion deprives Medicaid recipients of the individualized assessment required under federal law

New York's medical necessity criteria also ensures that the medical needs of any given individual and the medical judgment of that individual's physician are taken into account rather than unlawfully applying a one-size-fits all policy that cannot account for the varying medical needs of Medicaid recipients.[126] WPATH recognizes that treatment needs are not identical and individual needs must be taken into account.[127] When evaluating and treating individuals with gender dysphoria, two endocrinologists with expertise in transgender care note:

> To grasp the essence of this distressing condition and the implications of living with it, face-to-face conversation with a person suffering from gender dysphoria is a *condition sine qua non.* Clinical medicine is not practiced in a vacuum. The personal accounts of the patients' suffering are an essential part of the decision-

[125] *Id.*

[126] *See Doe*, 257 N.W.2d at 820 ("The medical necessity of each applicant requesting funding of transsexual surgery must be considered individually, on a case-by-case basis. Such a requirement is consistent with applicable Federal statutes concerning the funding of Title XIX. . . . The determination of medical necessity through a thorough medical evaluation of the individual applicant will ensure that those individuals genuinely requiring sex conversion surgery will be able to obtain it but will deny benefits to persons not demonstrating such medical necessity."); *Pinneke*, 623 F.2d 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."); *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989) (rejecting a blanket exclusion for AZT noting: "The Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.").

[127] WPATH has explained that a blanket surgery requirement is inappropriate for updating identity documents because "not every patient will have a medical need for identical procedures; clinically appropriate treatments must be determined on an individualized basis with the patient's physician." WPATH, Identity Recognition Statement, June 16, 2010, *available at* http://www.wpath.org/documents/Identity%20Recognition%20Statement%206-6-10%20on%20letterhead.pdf; WPATH, *Standards of Care*, *supra* note 10 at 5 ("Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person.") (Ex. 67).

making process when practicing in a manner governed by evidenced-based medicine."[128]

Yet § 505.2(l) denies transgender individuals the ability to have their needs assessed under current standards of medical practice.

An *a priori* exclusion also deprives transgender individuals of their right to a fair hearing as required under the federal Medicaid Act. Under the Act, states must "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied."[129] Although transgender individuals may have this right on paper,[130] due to § 505.2(l), the result of the hearing is a foregone conclusion. It cannot reasonably be classified as "fair" since individual medical circumstances are not taken into account.

C. The transgender care exclusion is a diagnosis-based exclusion that violates federal law

The transgender care exclusion is an unlawful diagnosis-based exclusion. Such a diagnosis-based exclusion is anomalous. DOH regulations contain no diagnosis-specific exclusions other than the transgender care exclusion.[131] There are no exclusions, for example, for all treatments related to diabetes, AIDS, or any other particular medical condition. Yet *all* recognized treatments for gender dysphoria are currently excluded. If a treatment is designed to reassign sex, it is excluded. Only people experiencing gender dysphoria need to undergo sex reassignment and any treatment provided for the purpose of sex reassignment is, by definition, a treatment for gender dysphoria. A hysterectomy, for example, is covered under Medicaid for treating myriad conditions such as endometriosis, uterine cancer, or heavy bleeding. There is no treatment-based exclusion for hysterectomies. It is only excluded if the diagnosis is gender dysphoria and it is performed for the purpose of sex reassignment. Federal regulations prohibit

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[128] Louis J. Gooren & Henriette A. Delemarre-van de Waal, *Hormone Treatment of Adult and Juvenile Transsexual Patients* in PRINCIPLES OF TRANSGENDER MEDICINE AND SURGERY 73, 85 (Randi Ettner et al. eds., 2007).

[129] 42 U.S.C. § 1396a(a)(3) (2013). See also, 42 C.F.R. § 431.220(a)(1) (2013).

[130] 18 NYCRR § 358-3.1 (2013).

[131] While there is an exclusion for hysterectomies performed for the sole purpose of sterilization, 18 NYCRR § 505.2(h), hysterectomies themselves may still be performed for medically necessary reasons. There is no *per se* ban on treatment of hysterectomies as there is for transgender care. Moreover, other forms of family planning and voluntary sterilization are explicitly covered. N.Y. Soc. Serv. Law § 365-a(3)(d); 18 NYCRR § 505.13. Additionally, while there is an exclusion for treatments "solely to promote fertility," 18 NYCRR § 505.1(a)(1), and drugs solely used for weight reduction or promotion of fertility, 18 NYCRR § 505.3(g)(3) or sexual or erectile dysfunction, N.Y. Soc. Serv. Law § 365-a(4)(f), these target symptoms rather than any specific medical condition. In contrast, treatments "for the purpose of gender reassignment" are used solely for one and only one medical diagnosis: gender dysphoria.

arbitrary diagnosis-based exclusions,[132] and courts have found that transgender exclusions like New York's violate that regulation.[133]

As noted in a recent U.S. Supreme Court case examining interpretations of the Medicaid statute, "[u]nder the Supremacy Clause, [w]here state and federal law directly conflict, state law must give way."[134] To the extent that § 505.2(l) conflicts with federal law, it is pre-empted.[135]

III. Transgender Care is Demonstrated to be Safe, Effective and of Material Clinical Benefit in Evidence-Based, Peer-Reviewed Medical Literature

Given the medical and legal consensus described in Section I that sex reassignment is the treatment of choice for gender dysphoria, DOH has not and will not be able provide a rational, non-discriminatory reason for singling out transgender care for exceptional exclusion. Even assuming for the sake of argument that there are uncertainties about the long-term safety and efficacy of transgender-related care, there are uncertainties about the long-term safety and efficacy of many other forms of treatment that Medicaid currently covers.[136] DOH may not justify its exclusion by pointing to concerns over specific treatments or alleged deficiencies in the medical literature without simultaneously demonstrating that *no other covered treatment*

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[132] States may not "arbitrarily deny or reduce the amount, duration, or scope of a required service . . . beneficiary solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c).

[133] *Doe*, 257 N.W.2d at 820 ("The total exclusion of transsexual surgery from eligibility for M.A. benefits is directly related to the type of treatment involved and, therefore, is in direct contravention of the aforestated regulation."); *Pinneke*, 623 F.2d at 549 (finding "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 based solely on the 'diagnosis, type of illness, or condition.'"); *Rush v. Parham*, 625 F.2d 1150, 1157 (5th Cir. 1980) ("We caution, however, that if defendants simply denied payment for the proposed surgery because it was transsexual surgery, Georgia should now be required to pay for the operation, since a 'state may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . solely because of the diagnosis, type of illness, or condition.'"). *Cf. Smith v. Rasmussen*, 249 F.3d 755, 761-762 (8th Cir. 2001) (declining to find a surgery exclusion an arbitrary diagnosis-based exclusion because that regulation did not apply to plaintiff who was medically needy but not categorically needy); *Casillas v. Daines*, 580 F. Supp. 2d 235 (S.D.N.Y. 2008) (finding no enforceable right under 42 U.S.C.A. § 1983 and declining to rule on whether the transgender exclusion was an unlawful diagnosis exclusion); *Ravenwood v. Daines*, No. 06-CV-6355-CJS, 2009 WL 2163105 (W.D.N.Y. July 17, 2009) (same).

[134] *Wos v. E.M.A. ex rel. Johnson*, No. 12–98. slip op. at 7 (U.S. Mar. 20, 2013) (internal quotations and citation omitted) (striking down a North Carolina law that conflicted with federal Medicaid law).

[135] *Id.* at 8 ("A State may not evade the pre-emptive force of federal law by resorting to creative statutory interpretation or description at odds with the statute's intended operation and effect.")

[136] Indeed, DOH has not evaluated the long-term safety and efficacy of each form of treatment that is covered. This would be an impossible task, which is why for all other treatments, DOH expects physicians to determine what is medically necessary according to "generally accepted professional standards." 18 NYCRR § 500.1 (2013).

suffers from the same limitations or concerns. The discussion of the medical literature that follows is offered only to illustrate the arbitrary nature of excluding care that is widely regarded as the gold standard of treatment.

A. Introduction to the Literature

The available peer-reviewed medical literature has overwhelmingly demonstrated that transgender care is effective and of material clinical benefit to individuals with gender dysphoria. Rather than treating symptoms, sex reassignment resolves gender dysphoria at its root by eliminating the conflict between the body and the brain's internal sense of the body.[137] Sex reassignment has been found to lead to a "virtual absence of gender dysphoria,"[138] and is proven to alleviate the psychological symptoms of gender dysphoria, including depression.[139] Genital reassignment surgery ("GRS") and hormone therapy have also been found to lead to a decrease in drug use in post-operative populations and to reduce dramatically the prevalence of suicide attempts.[140] Quality of life improves and remains high over the long term.[141]

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[137] *See* Ramachandran, THE TELL-TALE BRAIN, *supra* note 12 at 259 ("[D]istortions or mismatches in the [superior parietal lobule] can also explain the symptoms of transsexuals. . . . [t]he discrepancy between internally specified sexual body image—which, surprisingly, includes details of sexual anatomy—and external anatomy leads to an intense discomfort, and again, a yearning to reduce the mismatch.")

[138] Yolanda L. S. Smith, *Sex Reassignment: Outcomes and Predictors of Treatment for Adolescent and Adult Transsexuals*, 35 PSYCHOLOGICAL MED. 89, 94 (2005). *See also* Mohammad Hassan Murad, *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 CLINICAL ENDOCRINOLOGY 216 (2010) ("Male-to-female and FM individuals had the same psychological functioning level as measured by the Symptom Checklist inventory (SCL-90), which was also similar to the psychological functioning level of the normal population and better than that of untreated individuals with GID."); Ainsworth, *supra* note 71, at 1021 ("[T]ranswomen without surgical intervention had statistically significant ($P<0.05$) lower mental health scores compared to the mental health scores for the general female population (mean 39.5 (SD 7.3) compared to mean 48.9). The mental health quality of life of transwomen without surgical intervention was significantly lower compared to the general population, while those transwomen who received [facial feminization surgery], GRS, or both had mental health quality of life scores not significantly different from the general female population."); Zoran Rakic, *The Outcome of Sex Reassignment Surgery In Belgrade: 32 Patients of Both Sexes*, 25 ARCHIVES OF SEXUAL BEHAVIOR 515 (1996) (finding "in most transsexuals, the quality of life was improved after surgery inasmuch as four aspects are concerned, i.e., attitude towards the patient's own body; relationships with other people; sexual activity; and occupational functioning.").

[139] *See* Murad, *supra* note 138 at 216 ("Pooling across studies shows that after sex reassignment, 78% of individuals with GID reported significant improvement in psychiatric symptoms.").

[140] *See* Stan Monstrey *et al.*, *Surgery: General Principles*, *in* PRINCIPLES OF TRANSGENDER MEDICINE AND SURGERY 89, 97 (Randi Ettner et al. eds., 2007) ("[T]he data on suicidal behavior pre- and postsurgery confirm significantly less suicidal ideation and fewer attempts in patients after reassignment."); Cecilia Dhejne *et al.*, *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLOS ONE, February 2011, at 2 ("A recent Swedish follow-up study reported no suicides in 60 transsexual patients" and "a Belgian study of 107 transsexual persons followed for 4-6 years found no suicides or deaths from other causes."); G. De Cuypere *et al*., *Long-Term Follow-up:*

In the single controlled, randomized study available on GRS, one group of transsexual women received genital surgery early while another group remained on the ordinary waitlist. Those who had surgery showed significant improvement in psychiatric symptoms, and social and sexual function, while those who had not yet had surgery showed no improvement.[142]

In 1998, a comprehensive review of the literature on sex reassignment outcomes was conducted, which compiled data spanning thirty years of follow-up studies, reporting on eighty studies from twelve countries.[143] Treatment was found to be effective in relieving gender dysphoria. Additionally, "[t]here were few negative consequences, and all aspects of the reassignment process contributed to overwhelmingly positive outcomes."[144]

Sex reassignment is the treatment of choice for gender dysphoria. As published in the journal *Fertility and Sterility*, "[s]ex reassignment surgery has been part of the treatment of transsexuality for >70 years and is widely accepted as therapeutic."[145] GRS is equal or superior to other established therapies, and is considered to be the "treatment of choice"[146] and the

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Psychosocial Outcome of Belgian Transsexuals after Sex Reassignment Surgery, 15 SEXOLOGIES 126, 130 (2006) (88% of transgender women "felt happy to very happy after surgery"); Jamil Rehman et al., *The Reported Sex and Surgery Satisfactions of 28 Postoperative Male-to-Female Transsexual Patients*, 28 ARCHIVES OF SEXUAL BEHAVIOR 71, 83 (1999) (noting a marked decrease in suicide attempts and drug use following surgery); Cole *supra* note 76 at 19 (noting that the reported suicide attempts occurred prior to the individuals entering treatment, but not afterwards); Paul J. M. van Kesteren et al., *Mortality and Morbidity in Transsexual Subjects Treated with Cross-Sex Hormones*, 47 CLINICAL ENDOCRINOLOGY 337, 338 (1997) (tracking the largest cohort of medically and surgically treated transgender patients in Europe wherein 1,109 patients were followed for a total of 10,152 patient years, only 13 deaths from suicide were reported).

[141] Katrien Wierckx, *Quality of Life and Sexual Health after Sex Reassignment Surgery in Transsexual Men*, 8 J. OF SEXUAL MEDICINE 3379, 3387 (2011) (study of 49 men an average of 8 years after phalloplasty found that "most transsexual men generally have a good quality of life and experience a satisfactory sexual functioning after sex reassignment surgery."); Griet De Cuypere, *Sexual and Physical Health after Sex Reassignment Surgery*, 34 ARCHIVES OF SEXUAL BEHAVIOR 679 (2005) (Long-term follow-up study of 55 transsexual patients revealing that the relatively few and minor morbidities that could result after the surgery are mostly reversible with appropriate treatment.); Steven Weyers, *Long-term Assessment of the Physical, Mental, and Sexual Health among Transsexual Women*, 6 J. SEXUAL MEDICINE 752, 759 (2009) (averaging 6 years after surgery, 50 trans women were found to functions well on a physical, emotional, psychological, and social level.")

[142] *See* C. Mate-Kole et al., *A Controlled Study of Psychological and Social Change after Surgical Gender Reassignment in Selected Male Transsexuals*, 157 BRITISH J. OF PSYCHIATRY 261, 264 (1990).

[143] Monstrey, *supra* note 140, at 95.

[144] *Id.*

[145] Annette Kuhn et al., *Quality of Life 15 Years after Sex Reassignment Surgery for Transsexualism*, 92 FERTILITY AND STERILITY 1685, 1685 (2009).

[146] Owe Bodlund & Gunnar Kullgren, *Transsexualism – General Outcome and Prognostic Factors: A Five-Year Follow-Up Study of Nineteen Transsexuals in the Process of Changing Sex*, 25 ARCHIVES OF SEXUAL BEHAVIOR 303, 315 (1996).

"gold standard in the treatment of gender dysphoria."[147] Studies over the last two decades have consistently found that GRS is "the most appropriate treatment to alleviate the suffering of gender dysphoric individuals,"[148] and that GRS "has proved to be the best resolution for primary transsexuals."[149] Sex reassignment "has been demonstrated to be the best solution available for persons affected by gender dysphoria."[150] "[T]here is no comparable alternative to gender reassignment surgery in those who are deemed to be eligible. Many people will have already received psychotherapy and hormonal therapy, and will have remaining gender identity problems and a persistent desire for gender reassignment surgery."[151] There is "little doubt that sex reassignment substantially alleviates the suffering of transsexuals."[152]

Transgender surgeries are "not experimental: decades of both clinical experience and medical research show they are essential to achieving well-being for the transsexual patient."[153] GRS has been performed consistently over the past 40 years,[154] and modern surgical techniques have been in place since the early 1970s.[155] While, as with any surgery, the techniques for GRS

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[147] Piet Hoebeke et al., *Impact of Sex Reassignment Surgery on Lower Urinary Tract Function*, 47 EUROPEAN UROLOGY 398, 398 (2005).

[148] Luk Gijs & Anne Brewaeys, *Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges*, 18 ANNUAL REVIEW OF SEX RESEARCH 178, 215 (2007) ("Summarizing the results from the 18 outcome studies of the last 2 decades, the conclusion that SR is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals still stands . . . .").

[149] Jamil Rehman & Arnold Malman, *Formation of Neoclitoris from Glans Penis by Reduction Glansplasty with Preservaiton of Neurovascular Bundle in Male-to-Female Gender Surgery: Functional and Cosmetic Outcome*, 161 J. OF UROLOGY 200, 205 (1999).

[150] Gennaro Selvaggi, *The 2011 WPATH Standards of Care and Penile Reconstruction in Female-to-Male Transsexual Individuals*, ADVANCES IN UROLOGY Article ID 581712, 2 (2012) *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359659/pdf/AU2012-581712.pdf.

[151] The Wessex Institute for Health Research & Development, Development and Evaluation Committee Report No.88, *Surgical gender reassignment for male to female transsexual people*, at 5 (Sept. 1998) (Ex. 68).

[152] P.T. Cohen-Kettenis & L.J.G. Gooren, *Transsexualism: A Review of Etiology, Diagnosis and Treatment*, 46 J. OF PSYCHOSOMATIC RESEARCH 315 (1999).

[153] WPATH Clarification on Medical Necessity, *supra* note 92 at 3. *See also M.K.*, 92 N.J.A.R. 2d 38, at 5 ("Indeed, all of the information presented by petitioner indicates that the surgery is not experimental but the only successful treatment for a true transsexual.").

[154] *See* Annika Johansson et al., *A Five-Year Follow-Up Study of Swedish Adults with Gender Identity Disorder*, 39 ARCHIVES OF SEXUAL BEHAVIOR 1429, 1430 (2010) (since 1972 between 10 and 15 people each year have had SRS in Sweden); Paul J. van Kesteren et al., *An Epidemiological and Demographic Study of Transsexuals in the Netherlands*, 25 ARCHIVES OF SEXUAL BEHAVIOR 589, 590 (1996) (a study of 1285 transgender people from 1975 to 1992).

[155] *See* F. G. Bouman, *Sex Reassignment Surgery in Male to Female Transsexuals*, 21 ANNALS OF PLASTIC SURGERY, 526, 526 (1988).

may continue to be refined, the expected outcome and effects are clear and the surgery is in no way experimental.[156,157]

1. Transgender surgeries are well-established, safe and effective procedures

Vaginoplasty for transgender women is safe and effective. It has been performed since 1931, with modern vaginoplasty techniques emerging in the 1950s.[158] The safety of vaginoplasty is well-established, and similar procedures are performed for women who were born without vaginas.[159] There is a low rate of complications[160] and a high rate of good clinical outcomes and patient satisfaction with the results.[161]

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[156] *See* Eric B. Gordon, *Transsexual Healing: Medicaid Funding of Sex Reassignment Surgery*, 20 ARCHIVES OF SEXUAL BEHAVIOR 61, 72 (1991) (noting that in 1991 GRS research was in the "'refining' stage") (Ex. 69).

[157] While regret over sex reassignment is commonly cited as a concern in popular culture, this concern is not borne out in the medical literature. Moreover, regret about choice of treatment is not limited to transgender care. Other medical procedures are associated with far higher levels of regret than the small percentage of individuals who are dissatisfied with transgender surgeries. For example, men with prostate cancer can choose radiation or removal of the prostate, with prostate removal being associated with rates of regret up to 31%. Similar regrets over surgery can be found among breast cancer survivors who faced a treatment choice. Concern over regret is not a proper basis to single out transgender care for denial of coverage. Janette Kinsella et al., *Demonstration of Erectile Management Techniques to Men Scheduled for Radical Prostatectomy Reduces Long-Term Regret: A Comparative Cohort Study*, 109 BJU INT'L 254, 254-55 (2012) (noting regret "is an important complication of localized prostate cancer treatment," and finding a 20% regret rate for prostatectomy); Yu-Hua Lin, *Treatment Decision Regret and Related Factors Following Radical Prostatectomy*, 34 CANCER NURSING 417, 420 (2011)(31% regretted prostatectomy); Florian R. Schroeck et al., *Satisfaction and Regret after Open Retropubic or Robot-Assisted Laparoscopic Radical Prostatectomy*, 54 EUR. UROLOGY 785, 787 (2008) (noting "only 19% regretted their choice of treatment") (emphasis added); B. Joyce Davison et al., *Quality of Life, Sexual Function and Decisional Regret at 1 Year After Surgical Treatment For Localized Prostate Cancer*, 100 BJU INT'L 780 (2007) (finding 4% regret, which is comparable to transgender individuals who express some concerns with surgeries); Sara Fernandes-Taylor & Joan R. Bloom, *Post-Treatment Regret among Young Breast Cancer Survivors*, 20 PSYCHOONCOLOGY 506, 511 (2011) (finding 42.5% of breast cancer survivors regretted some aspect of treatment, such as surgery). *Cf.* van Kesteren *supra* note 154 at 599 (In a study of 1285 transgender people from 1975 to 1992, only 5 (0.03%) expressed regret about transitioning.).

[158] *See* Jonathan Charles Goddard, et al., *Development of Feminizing Genitoplasty for Gender Dysphoria*, 4 J. SEXUAL MED. 981, 983-84 (2007).

[159] *See* S. De Stefani et al., *Microlaparoscopy in Sex Reassignment Surgery*, 4 SCIENTIFIC WORLD J. 100, 101 (2004) (Surgical techniques utilized for performing genital reassignment surgery on trans women are "well codified and relatively simple to perform."); Bouman, *supra* note 155 at 531 ("[v]aginal construction in male transsexuals . . . is a reliable technique"); Gennaro Selvaggi et al., *Gender Identity Disorder: General Overview and Surgical Treatment for Vaginoplasty in Male-to-Female Transsexuals*, 116 PLASTIC AND RECONSTRUCTIVE SURGERY 135e, 143e (2005) (describing the variety of modern techniques available and noting that the "penile-scrotal skin flap technique is considered the state of the art for vaginoplasty"). *See also* Cameron Bowman & Joshua M. Goldberg, *Care of the Patient Undergoing Sex*

For some transgender women, breast development from hormone use alone is sufficient to resolve their dysphoria. However, the majority of transgender women do not attain typical female breasts from hormones alone. Their breasts remain small and male-appearing, and breast reconstruction is necessary to alleviate gender dysphoria.[162] This is the same as for non-transgender women in whom breast reconstruction "is aimed at restoring patients' quality of life and body image after mastectomy and has increasingly become an integral part of breast cancer (BC) treatment."[163] The importance of breast reconstruction and having typical female breasts has long been recognized under federal law.[164] The Federal

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Reassignment Surgery, 9 INT'L J. TRANSGENDERISM 135, 142 (2006) (noting that it is safe to perform vaginoplasty and breast augmentation at the same time); Miroslav Djordjevic, *Rectosigmoid Vaginoplasty: Clinical Experience and Outcomes in 86 Cases*, 8 J. SEXUAL MED. 3487, 3493 (2011) ("Rectosigmoid vaginoplasty presents a safe and reasonable choice with acceptable complications and satisfactory results" in both transgender and non-transgender women.); American College of Obstetricians and Gynecologists, *ACOG Committee Opinion: Nonsurgical Diagnosis and Management of Vaginal Agenesis*, 79 INTERNATIONAL JOURNAL OF GYNECOLOGY & OBSTETRICS 167 (2002) (noting the frequency of vaginal agenesis as one in 4,000-10,000 and describing vaginoplasty techniques).

[160] *See* Ji-Xiang Wu et al., *Laparoscopic Vaginal Reconstruction Using an Ileal Segment*, 107 INT'L J. OF GYNECOLOGY AND OBSTETRICS 258, 259 (2009) (finding no complications during surgery and only three post-operation complications, which were resolved, when vaginoplasties were performed on 80 trans and non-trans women); Ladislav Jarolím, *Gender Reassignment Surgery in Male-to-Female Transsexualism: A Retrospective 3-Month Follow-Up Study with Anatomical Remarks*, 6 J. OF SEXUAL MED. 1635, 1641 (2009) (reporting that for 128 trans women who underwent GRS, surgical complications were uncommon and were all successfully resolved); S. V. Perovic et al., *Vaginoplasty in Male Transsexuals Using Penile Skin and a Urethral Flap*, 86 BJU INT'L 843, 849 (2000) (reporting good results and only one major complication in a follow-up of eighty-nine vaginoplasties).

[161] *See* P.A. Sutcliffe et al., *Evaluation of Surgical Procedures for Sex Reassignment: A Systematic Review*, 62 J. OF PLASTIC, RECONSTRUCTIVE & AESTHETIC SURGERY 294, 299 (2009) (reviewing 82 published papers on FTM and MTF surgeries); Ciro Imbimbo et al., *A Report from a Single Institute's 14-Year Experience in Treatment of Male-to-Female Transsexuals*, 6 J. SEXUAL MED. 2736, 2740 (2009) (reporting on the results of 139 patients over a 14-year period in which 94% of patients were satisfied and had no regrets); Anne A. Lawrence, *Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery*, 32 ARCHIVES OF SEXUAL BEHAVIOR 299, 309 (2003) (finding over 96% of trans women participating in the study were happy with their GRS results); A. Michel et al., *The Transsexual: What About the Future?*, 17 EUROPEAN PSYCHIATRY 353, 354-55 (2002) (literature review finding that almost 90% of trans people say they would make the decision to undergo GRS again); De Cuypere *supra* note 140 at 131 (2006) (88% of transgender women "felt happy to very happy after surgery"); Jarolím, *supra* note 160, at 1635 (Czech study of 129 transgender women showed all were satisfied and the procedure was safe).

[162] *See* Selvaggi *supra* note 159 at 141e ("A normal feminine breast volume is rarely obtained by hormonal therapy alone, and as such, breast augmentation is required in the majority of the patients, even after years of hormonal therapy.").

[163] Tim H. C. Damen et al., *Patients' Preferences for Breast Reconstruction: A Discrete Choice Experiment*, 64 J. OF PLASTIC, RECONSTRUCTIVE & AESTHETIC SURGERY 75, 76 (2011).

[164] *Women's Health and Cancer Rights Act of 1997: Hearing on S. 249 before the S. Comm. on Health Care*, 105th Cong. 917 (1997) (prepared statement of Hon. Dianne Feinstein) ("Joseph Aita, Executive Vice President and Medical Direct of LifeGuard, was quoted in the San Jose, CA, Mercury News, as saying

Women's Health and Cancer Rights Act of 1998 mandates that insurance companies covering mastectomies must also cover prosthetic devices and reconstructive surgery incident to a mastectomy.[165] This law was necessary because insurance companies were improperly denying coverage for breast reconstruction on the basis that such surgery was non-functional and cosmetic.[166]

Male genital reconstruction is also safe and effective. Successful techniques are widely reported in the literature for the two main forms: phalloplasty[167] and metoidioplasty.[168] Studies of hundreds of phalloplasties showed it to be a "very reliable technique,"[169] with a high success rate and satisfaction rate.[170] Metoidioplasty also has a high patient satisfaction rate[171] and it

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'Looking normal is not medically necessary.' Let me contradict Mr. Aita. Looking normal is medically necessary. … According to Dr. Ronald Iverson, a Stanford University surgeon, 'Breast reconstruction is a reconstructive and not a cosmetic procedure.'") (Ex. 70).

[165] 29 U.S.C.A. § 1185b.

[166] Sen. D'Amato (NY). *The Women's Health and Cancer Rights Act of 1997*. CONGRESSIONAL RECORD 143 (Jan. 30, 1997) p. S885; Sen. D'Amato (NY). *The Fight Against Breast Cancer*. CONGRESSIONAL RECORD 144 (May 14, 1998) p. S4875; *Women's Health and Cancer Rights Act of 1997: Hearing on S. 249 before the S. Comm. on Health Care*, 105th Cong. 917 (1997).

[167] *E.g.*, Stan Monstrey et al., *Surgery: Female-to-Male Patient* in PRINCIPLES OF TRANSGENDER MEDICINE AND SURGERY 135, 149-164 (Randi Ettner et al. eds., 2007); Alireza Babaei et al. *Penile Reconstruction Evaluation of the Most Accepted Techniques*, 7 UROLOGY JOURNAL 71 (2010) (literature review of current techniques in phalloplasty that notes the limitations of the procedures, but also their importance for trans and non-transgender men); J.J. Hage et al. *Sculpturing the Glans in Phalloplasty*, 92 PLASTIC AND RECONSTRUCTIVE SURGERY 157 (1993) (describing the various ways to safely and effectively perform phalloplasty, the reconstruction of a penis); C. Rubino et al., *Innervated Island Pedicled Anterolateral Thigh Flap for Neo-Phallic Reconstruction in Female-To-Male Transsexuals*, 62 J. OF PLASTIC, RECONSTRUCTIVE & AESTHETIC SURGERY e45 *(*2009) (discussing a safe and reliable technique for phallic reconstruction in female-to-male transsexual patients); C. Rubino *supra* note 167; Juergen Schaff & Nikolaos A. Papadopulos, *A New Protocol For Complete Phalloplasty With Free Sensate and Prelaminated Osteofasciocutaneous Flaps: Experience In 37 Patients*, 29 MICROSURGERY 412, 418 (2009) (describing modern surgical protocols that offer "essential improvement of the quality of life to" transgender patients).

[168] Miroslav L. Djordjevic et al., *Metoidioplasty as a Single Stage Sex Reassignment Surgery in Female Transsexuals: Belgrade Experience*, 6 J. SEXUAL MEDICINE 1306, 1312 (2009) (describing metoidioplasty as a "safe" that creates male genitals with a high rate of satisfaction); A. Takamatsu & T. Harashina, *Labial Ring Flap: A New Flap for Metaidoioplasty in Female-To-Male Transsexuals*, 62 J. OF PLASTIC, RECONSTRUCTIVE & AESTHETIC SURGERY 318 (2009) (satisfactory appearance and urine stream were achieved for transgender men using metaoidoplasty) ; Monstrey, *supra* note 167 at 161-63.

[169] S. Baumeister et al. *[Phalloplasty in Female-To-Male Transsexuals: Experience from 259 Cases] [Abstract]*, 43 HANDCHIRURGIE, MIKROCHIRURGIE, PLASTISCHE CHIRURGIE 215 (2011) (emphasizing the effectiveness and reliability of phalloplasties by evaluating the results of 259 penile reconstruction surgeries from 1993 through 2009).

[170] *E.g.*, Seok-Kwun Kim, *The Etiology and Treatment of the Softened Phallus after the Radial Forearm Osteocutaneous Free Flap Phalloplasty*, 39 Archives of Plastic Surgery 390, 395 (2012) (noting high patient satisfaction with phalloplasty); M. Doornaert et al., *Penile Reconstruction with the Radial*

has proven to be a "method of choice" with long-term efficacy.[172] These procedures were developed from the same types of procedures that are performed on non-transgender men who need genital reconstruction.[173] And given that "[p]enile insufficiency and absence are devastating conditions with significant psychological and physical impact," the techniques developed for transgender men have also been applied to non-transgender men.[174] As with transgender men, despite the complications, theses surgeries in non-transgender men had a high satisfaction rate and improved self-esteem and "physical and psychological well-being."[175]

The use of hysterectomy to treat gender dysphoria dates back nearly 100 years, with the first such surgery performed in the U.S. in 1917.[176] Hysterectomies are a standard procedure covered by insurance. It is commonly performed on women for a variety of reasons such as dysfunctional or abnormal menstrual bleeding, fibroids, pelvic pain, severe menstrual-related mood disorder, dysmenorrhea, postmenopausal bleeding, uterine prolapse, ovarian cysts, endometriosis or adenomyosis, endometrial, ovarian or cervical cancer, and prophylactically due family history of cancer and other reasons.[177] Transgender men often have similar symptoms such as "chronic pelvic pain, dysmenorrhea, pelvic mass, symptomatic leiomyomata [fibroids], or cancer. Hysterectomy with bilateral salpingo-oophorectomy is the most definitive treatment for many gynecologic symptoms" in transgender men, in addition to its role in reducing gender dysphoria.[178] The rate of complications for transgender-related hysterectomies

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Forearm Flap: an Update [abstract], 43 HANDCHIRURGIE, MIKROCHIRURGIE, PLASTISCHE CHIRURGIE 208 (2011); Wierckx, *supra* note 141

[171] S.V. Perovic & M.L. Djordjevic, *Metoidioplasty: a Variant of Phalloplasty in Female Transsexuals*, 92 BJU INT'L 981, 983 (2003) (noting most patients were satisfied with metoidioplasty results in size and voiding position).

[172] J. Joris Hage & Arjen A. W. M. van Turnhout, *Long-Term Outcome of Metaidoioplasty in 70 Female-to-Male Transsexuals* 57 ANNALS OF PLASTIC SURGERY 312, 313, 316 (2006) (following 70 trans man a median of 8 years after surgery and concluding metoidioplasty is a "method of choice.").

[173] Perovic & Djordjevic, *id.* at 982 (noting metoidioplasty was developed from techniques to repair severe hypospadias in non-transgender men); Monstrey, *supra* note 167 at 135-36 (describing the development of phalloplasty for use on non-transgender men).

[174] Nicolaas Lumen et al., *Phalloplasty: A Valuable Treatment for Males with Penile Insufficiency*, 71 UROLOGY 272, 273 (2008) (applying techniques developed for trans men to non-trans men with penile injuries).

[175] *Id*.

[176] J. Allan Gilbert, *Homo-Sexuality and Its Treatment*, 2 J. OF NERVOUS AND MENTAL DISEASE 297, 321 (1920) *available at* https://play.google.com/store/books/details?id=w59HAAAAYAAJ&rdid=book-w59HAAAAYAAJ&rdot=1 (the treating physician of Alan Hart, M.D., the first American trans man to have a hysterectomy, stated: "After long hesitance and deliberation on my part, the only rational course seemed to be the adoption of the procedure. . . . Hysterectomy was performed.")

[177] A. Toma et al., *Hysterectomy at a Canadian Tertiary Care Facility: Results of a One Year Retrospective Review*, 23 BMC WOMENS HEALTH 10 (2004).

[178] Katherine A. O'Hanlan et al. *Total Laparoscopic Hysterectomy for Female-To-Male Transsexuals*, 110 OBSTETRICS & GYNECOLOGY 1096, 1069 (2007).

is not higher than for hysterectomies performed for other reasons,[179] and patient satisfaction is high.[180]

Male chest reconstruction techniques are well-established ; there are high rates of satisfaction and few serious complications.[181] Bilateral mastectomy has been performed for purposes of sex reassignment since 1912.[182] Surgical techniques used for transgender men were developed from the techniques that are used for mastectomies in women and for treating gynecomastia—enlarged breasts—in non-transgender men.[183] A 2013 literature review showed that bilateral mastectomy and male chest reconstruction "is necessary for trans men to live safely and effectively . . . and further that it acts as a prophylaxis against distress, ameliorates extant distress as well as providing improved quality of life and global functioning for this patient group."[184] Having female breasts interferes both with living as male and with transgender men's comfort in their own bodies.[185] Chest surgery improves quality of life.[186] Delaying surgery is problematic because years of binding the breasts—in addition to being physically painful and impeding normal breathing—can damage the skin and result in less favorable outcomes.[187]

2. Hormone therapy is safe and improves quality of life

Hormones are an integral part of sex reassignment. They are used not only to physically align secondary sex characteristics to the individual's affirmed sex,[188] but they have mental

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[179] O'Hanlan, *id.* at 1097; Johannes Ott, *Combined Hysterectomy/Salpingo-Oophorectomy and Mastectomy is a Safe and Valuable Procedure for Female-to-Male Transsexuals*, 7 J. SEXUAL MEDICINE 2130, 2137 (2010) (finding that combined hysterectomy, bilateral salpingo-oophorectomy, and bilateral mastectomy is "safe, feasible, and valuable")

[180] Wierckx, *supra* note 141 at 3384 (91.8% "very satisfied" with hysterectomy/ oophorectomy).

[181] Monstrey, *supra* note 167 at 137-38, 147; Yuzaburo Namba et al., *Mastectomy in Female-to-Male Transsexuals*, 63 ACTA MEDICA OKAYAMA. 243 (2009) (describing three types of chest reconstruction techniques used study of 120 Japanese trans men); Ott, *id.* at 2131 (noting "[v]arious techniques of subcutaneous mastectomy have been reported in the literature with low complication rates and high patient satisfaction with the surgical results."); Wierckx, *supra* note 141 at 3384 (91.8% "very satisfied" with chest reconstruction).

[182] Pfäfflin, *supra* note 13 at 170 (describing the first sex reassignment surgery).

[183] Monstrey, *supra* note 173 at 137.

[184] Richards & Barrett, *supra* note 85 at 93.

[185] *Id.* at 95.

[186] Newfield *supra* note 71 at 1452 (finding chest surgery improved measures of general health in study of 366 trans men); Richards & Barrett, *supra* note 85 at 95 (drawing from clinical experience at "the largest gender identity clinic in the world").

[187] *See id.* at 138; Richards & Barrett, *supra* note 85 at 93.

[188] Marshall Dahl et al., *Physical Aspects of Transgender Endocrine Therapy,* 9 INT'L J. OF TRANSGENDERISM 111, 111-12 (2006).

health benefits as well.[189] Transgender women experience many feminizing changes that help alleviate gender dysphoria such as: female fat redistribution, breast growth, "decreased muscle mass and decreased upper body strength, softening of skin, decreased libido . . . decreased spontaneous/morning erections," finer facial and body hair, slowed hair loss.[190] Conversely, transgender men experience male fat redistribution, increased muscle mass and upper body strength, deeper voice, clitoral growth, cessation of menses, and increased body and facial hair.[191]

Hormone treatment is associated with increased quality of life. Hormones and their effects on secondary sex characteristics are a "fundamental" part of sex reassignment.[192] A 2012 study that took into account transgender people who have and had not undergone hormone therapy, as well as differences between transgender people and the general population, found hormone therapy to be significantly associated with a higher quality of life,[193] echoing earlier studies.[194]

Large, long-term studies demonstrate the safety of hormones. A 1997 study of the largest cohort of medically and surgically treated transgender patients in Europe wherein 1,109 patients were followed for a total of 10,152 patient years, concluded that "present data on the mortality and morbidity rates suggest that gender-reassignment treatment is an acceptably safe procedure."[195] A 2008 study conducted with over 3,100 individuals at the national referral center in The Netherlands found hormone use was safe in the short and medium term and recommended continued study.[196] A 2011 study with a median follow-up time of 18.5 years and over 1,300 participants found testosterone treatment to be safe and found a small increase cardiovascular risk from estrogen use.[197]

While studies have previously documented the higher mortality rate for hormone-treated transgender women, this was "mainly due to increased rates of death from suicide, illicit drugs, AIDS, cardiovascular disease, and unknown causes," rather than from the hormone

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[189] Audrey Gorin-Lazard, *Is Hormonal Therapy Associated with Better Quality of Life in Transsexuals? A Cross-Sectional Study*, 2 J. OF SEXUAL MED. 531, 537 (2012) ("Our results suggest the positive psychological effects of hormonal therapy rarely identified in previous reports. It seems to suggest that treatment with hormones allows individuals to feel as good or better than controls.") (citations omitted).

[190] *Id.* at 113-14.

[191] *Id.* at 118.

[192] Gooren & Delemarre-van de Waal, *supra* note 128 at 75.

[193] Gorin-Lazard, *supra* note 189 at 531.

[194] *E.g.*, Newfield *supra* note 71 at 1452 (finding testosterone use improves quality of life in study of 446 trans men).

[195] van Kesteren, *supra* note 140 at 341.

[196] Louis J. Gooren, *Long-Term Treatment of Transsexuals with Cross-Sex Hormones: Extensive Personal Experience*, 93 J. CLINICAL ENDOCRINOLOGY AND METABOLISM 19 (2008).

[197] Henk Asscheman, A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones, 164 EUROPEAN J. OF ENDOCRINOLOGY 635 (2011).

therapy itself, which is known to improve mental health. [198] Moreover, total mortality for transgender individuals receiving hormone therapy "was not higher than in the general population and, largely, the observed mortality could not be related to hormone treatment."[199] Another study found that estrogen treatment was effective and side effects could be minimized using a proper treatment regimen.[200] Hormone use may increase triglycerides, but the effect is small.[201] Venous thromboembolism is rare.[202]

Finally, whatever the long-term risks of hormone use may be, the reality is that many transgender individuals who cannot access hormones through a doctor, already access them through other sources.[203] In New York City, a needs assessment found that 76% of transgender women had at some point used hormones not under a doctor's care.[204] Another study found only 58% had undergone a medical evaluation before starting hormone treatment and 35% presently obtained hormones other than from a doctor.[205] Self-administered hormones are associated with an increased risk of HIV infection due to needle and hormone sharing[206] as well as side effects caused by taking higher doses than what a doctor would prescribe.[207]

B. Unique barriers to studying transgender care must be taken into account when evaluating the quality of medical evidence available

Several factors affect the quality of research available on transgender care, and these factors must be taken into account when evaluating the medical literature.

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[198] *Id.* at 639, 640 ("Psychological evaluation has shown that sex reassignment increases the well-being of transsexuals, but it should not be considered as a cure-all; it is rehabilitative relieving gender dysphoria, but some transsexual subjects may still experience other problems (e.g. comorbid psychiatric problems, social isolation, troubled relationships, prejudice, and discrimination).")

[199] van Kesteren, *supra* note 140 at 337.

[200] Kathrin Schlatterer, et al., *A Follow-Up Study for Estimating The Effectiveness of a Cross-Gender Hormone Substitution Therapy on Transsexual Patients*, 27 ARCHIVES OF SEXUAL BEHAVIOR 475, 490 (1998) (demonstrating "a low incidence of severe complications" in 88 trans men and women).

[201] Mohamed B. Elamin, *Effect of Sex Steroid Use on Cardiovascular Risk in Transsexual Individuals: A Systematic Review and Meta-Analyses*, 72 CLINICAL ENDOCRINOLOGY 1 (2010) (meta-analysis of 16 studies showing "hormone therapies increase serum triglycerides in [trans women] and [trans men] and have a trivial effect on HDL-cholesterol and systolic blood pressure in" trans men.)

[202] Johannes Ott, *Incidence of Thrombophilia and Venous Thrombosis In Transsexuals Under Cross-Sex Hormone Therapy* 93 FERTILITY & STERILITY 1267, 1272 (2010) ("[O]ur data indicate that cross-sex hormone therapy in FtM and MtF transsexuals with thrombophilia is safe.")

[203] Nelson F. Sanchez et al., *Health Care Utilization, Barriers to Care, and Hormone Usage Among Male-to-Female Transgender Persons in New York City*, 99 Am. J. of Public Health 713 (2009) (compiling studies showing 29% to 63% of trans women in urban groups self-administer hormones);

[204] Kobrak, *supra* note 78 at 17.

[205] Sanchez, *supra* note 203 at 716, 717.

[206] *Id.* at 713.

[207] *Id.*

Gender dysphoria is rare, which means that study population sizes are necessarily small. The prevalence of transgender people who seek medical assistance with transition most commonly ranges from 1:11,900 to 1:45,000 for transgender women (male-to-female individuals) and 1:30,400 to 1:200,000 for transgender men (female-to-male individuals).[208] Studies involving transgender care cannot be held to the same sample sizes as more common conditions.

Stigma and exclusions like § 505.2(l) have created a circular logic that restricts research on transgender care. Insurance exclusions are directly related to the lack of high-quality studies in a number of ways:

- Insurance exclusions dramatically restrict the number of patients who can access transgender care;
- Insurance exclusions reinforce the idea that appropriate treatment is to dissuade someone from transitioning rather than to provide sex reassignment care;
- Because few patients are able to afford surgery out-of-pocket, surgeons have less experience with transgender surgery;
- Because surgeries are not commonly reimbursed, the more specialized surgeries are performed by only a handful of surgeons in the U.S. The small surgeon supply and large patient demand coupled with the lack of constraint by insurance company payments allow many doctors to charge premium rates, further restricting access to this care;
- Fewer doctors have the knowledge to perform research or publish regarding their experiences;
- Surgeons are in private practice as opposed to being associated with a research hospital;
- Social prejudice limits research money for transgender issues;

[208] WPATH, *Standards of Care*, *supra* note 10 at 6-8. In the UK, the current prevalence of people seeking treatment is 0.02% (20:100,000). B. Reed *et al*., *Gender Variance in the UK: Prevalence, Incidence, Growth, and Geographic Distribution*. Gender Identity Research and Education Society, June 2009, http://www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf (Ex. 72); W.F. Tsoi, *The Prevalence of Transsexualism in Singapore,* 78 ACTA PSYCHIATRICA SCANDINAVICA, 501 (1988) (finding a prevalence of 1:2900 for trans women and 1:8300 for trans men, with the higher prevalence of people seeking treatment being attributed to the availability of surgery and greater societal acceptance of trans people than in other countries).

- Transgender care is not part of typical medical school curricula;[209] and

- Transgender surgical patients are not commonly seen by many doctors or medical students since these surgeries are concentrated at a few hospitals.

These factors combine to mean there is less research available on transgender care as compared to other conditions, and this relative lack of research is then used to justify exclusions like § 505.2(l).

While transgender individuals could certainly benefit from more research, a call for further study cannot be used to justify an exclusion of transgender care. Sufficient data exists to demonstrate the benefits of hormonal and surgical care for transgender patients.[210]

C. The Benefits of Transgender Care Outweigh Any Risks

Risk is inherent in the nature of all medical treatment. The risks of treatment cannot be evaluated in a vacuum, but must instead be weighed against the risks of leaving the condition untreated. As shown in Section I. B. above, there are significant risks associated with untreated gender dysphoria. The expected health benefits of sex reassignment are extensive and materially exceed and outweigh any expected health risks caused by undergoing surgery or taking hormones or by abstaining from surgery or hormones.[211]

Additionally, the safety of particular procedures themselves is not at issue. Most of the treatments transgender people utilize were developed for non-transgender people and are routinely performed and covered by Medicaid. Hysterectomy, bilateral mastectomy, hormone therapy,[212] and even genital reconstruction are all performed for non-transgender reasons. If a treatment is provided to non-transgender individuals, the safety and efficacy of the procedure itself can be assumed and does not need to be proven separately for transgender individuals. The only remaining question is whether or not the treatments alleviate gender dysphoria, something that is well-established.

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[209] Norman P. Spack, *Management of Transgenderism*, 309 JAMA: J. AMERICAN MEDICAL ASSOCIATION 478, 483 (2013) (citing the need for physicians and medical students to educate themselves on transgender issues).

[210] *See, e.g.*, *id.*; Louis Gooren, *Care of Transsexual Person*, 364 NEW ENGLAND J. OF MEDICINE, 1251, 1256 (2011) (recommending sex reassignment even in the face of research limitations and questions about long-term risks).

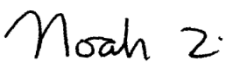
[211] Dahl *supra* note 188 at 111 ("While there are risks associated with taking feminizing/masculinizing medications, when appropriately prescribed they can greatly improve mental health and quality of life for transgender people."); Louis Gooren *supra* note 210 at 1256 (recommending sex reassignment even in the face of research limitations and questions about long-term risks).

[212] *See* Gooren, *supra* note 210 at 1253 ("Treatment strategies resemble those used for [non-transgender] hypogonadal patients.").

IV. Conclusion

Section 505.2(l) lacked evidentiary support when it was passed in 1998, and it lacks support today. In the past 15 years, the medical and legal consensus that transgender care is medically necessary, safe and effective has grown even stronger. Excluding transgender care has no lawful basis. We urge DOH to immediately repeal § 505.2(l) and thereby ensure that all New Yorkers have equal access to the health care they need.

Very truly yours,



Noah E. Lewis

Enclosures