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SYMPOSIUM

MEDICAID ACT PROTECTIONS FOR GENDER-AFFIRMING CARE

*Katherine Wood**

INTRODUCTION

As of June 2024, ten states explicitly and categorically exclude coverage of gender-affirming care ("GAC")[1] for transgender Medicaid beneficiaries of all ages.[2] Another two states exclude coverage for transgender minor beneficiaries but presumably approve medically necessary treatment for adults.[3] Coverage policies are unclear or not explicit in another eleven states and four U.S. territories.[4] In total, at least

* Acting Assistant Professor of Lawyering, NYU School of Law. Thank you to my legal aid Medicaid mentors: Jamie Andree, Jon Laramore, Crystal Francis, Dennis Frick, Adam Mueller, as well as the National Health Law Program. In honor of Tom Frohman, my first supervising attorney, whose service and generosity to others will forever inspire my legal career and life.

[1] GAC is not just treatment for transgender people; it is also sought by cisgender patients. See Theodore E. Schall & Jacob D. Moses, Gender-Affirming Care for Cisgender People, 53 Hastings Ctr. Rep. 15, 16, 20–21 (2023), https://doi.org/10.1002/hast.1486 [https://perma.cc/LQA4-EY84]. However, for the sake of clarity, in this Essay "GAC" and/or "gender-affirming treatments" refer to treatments for transgender patients.

[2] Healthcare Laws and Policies: Medicaid Coverage for Transgender-Related Health Care, Movement Advancement Project, https://www.lgbtmap.org/img/maps/citations-medicaid.pdf [https://perma.cc/42RD-CNGA] [hereinafter Medicaid Coverage Map] (last updated May 21, 2024).

[3] Id.

[4] Id.

twelve states[5] deny medically necessary GAC based solely on the diagnosis for which beneficiaries seek treatment: gender dysphoria. Yet several states provide coverage to cisgender beneficiaries for the same gender-affirming procedures to treat other diagnoses.[6] These exclusions violate the Medicaid Act's (the "Act") availability and comparability requirements, which mandate equality of coverage for medically necessary treatments without discrimination on the basis of diagnosis, type of illness, or condition.[7] Over the past decade, at least five courts heard challenges to GAC exclusions and held that they violate the Act because GAC is the consensus treatment for gender dysphoria and is medically necessary.[8] To the Author's knowledge, no court has held otherwise during that time. At the time of writing, a petition for a writ of certiorari on the issue is pending before the Supreme Court.[9]

Exclusions differ in form between jurisdictions. Some states exclude coverage statutorily, some through agency regulations or guidance, and still others through shadow bans, unpromulgated policies generally known only within state Medicaid medical review offices.[10] Regardless of the form, these exclusions violate the Act.[11]

Two issues are at the heart of these cases. A challenger must show that coverage for the categorically excluded treatment falls under a mandatory service category in the Act or that the state covers the treatment for diagnoses other than gender dysphoria. Upon that showing, the first issue is whether the excluded GAC treatment is medically necessary for the

[5] Id. Exclusions that were blocked by federal courts are pending further litigation in four states: Arkansas, Florida, North Carolina, and West Virginia. Id.

[6] See, e.g., Kadel v. Folwell, 100 F.4th 122, 140 (4th Cir. 2024) (finding that West Virginia's Medicaid program covers many GAC procedures for diagnoses other than gender dysphoria). See generally Dannie Dai et al., Prevalence of Gender-Affirming Surgical Procedures Among Minors and Adults in the US, 7 JAMA Network Open 2 (2024) (the majority of gender-affirming surgeries are chest-related procedures, and the majority of those are performed on cisgender males).

[7] 42 U.S.C.A. § 1396a(a)(10)(A)–(B) (West 2024); see Cruz v. Zucker, 116 F. Supp. 3d 334, 343–45 (S.D.N.Y. 2015).

[8] See infra Section III.B. See generally Medical Organization Statements, Advocs. for Trans Equal., https://transhealthproject.org/resources/medical-organization-statements/ [https://perma.cc/2U2S-EKKP] (last visited Sept. 27, 2024) (listing thirty major U.S. and global medical associations and societies endorsing the medical necessity of GAC).

[9] Petition for Writ of Certiorari, Crouch v. Anderson, No. 24-90 (U.S. July 25, 2024).

[10] Christy Mallory & Will Tentindo, Williams Inst., UCLA Sch. of L., Medicaid Coverage for Gender Affirming Care 3–4 (2022).

[11] See infra Section III.B.

treatment of gender dysphoria. The second is whether the exclusion is a legitimate utilization control procedure.

This Essay proceeds in three Parts. First, it reviews the history of GAC coverage in state Medicaid plans. Second, it describes the availability and comparability jurisprudence requiring coverage of medically necessary care and equality of benefits. Third, it analyzes cases applying that jurisprudence in challenges to GAC exclusions, demonstrating a unanimous trend of finding the exclusions unlawful under the Act. While the Supreme Court is expected to decide only the broader issue of whether GAC bans violate the Equal Protection Clause of the Fourteenth Amendment in its anticipated *United States v. Skrmetti* opinion,[12] the Medicaid Act framework and reasoning should be part of that broader consideration, as it demonstrates the arbitrariness of GAC bans regardless of whether transgender people are a suspect class entitled to heightened scrutiny.

I. EFFORTS TO BAN MEDICAID COVERAGE FOR GAC

Medicaid exclusions of GAC are not new. Beginning in the 1980s, exclusions became nearly universal in both private and public health coverage, as gender dysphoria treatments were incorrectly disparaged as "experimental" and "controversial" despite over seventy years of practice in the United States by that time.[13] Exclusions in private health coverage have largely disappeared over the past twenty years, allowing greater access to treatment for transgender people.[14] Recent anti-transgender backlash, however, threatens this access to care.[15]

Many states continue to arbitrarily deny transgender people access to GAC, while permitting it for cisgender people.[16] Here, the focus is on state efforts to categorically deny GAC to low income and medically needy transgender people through Medicaid exclusions.[17]

[12] L.W. ex rel. Williams v. Skrmetti, 83 F.4th 460, 491 (6th Cir. 2023), *cert. granted sub nom*. United States v. Skrmetti, 144 S. Ct. 2679 (2024).

[13] See infra Section I.A.

[14] See infra Section I.B.

[15] See Timothy Wang & Sean Cahill, Antitransgender Political Backlash Threatens Health and Access to Care, 108 Am. J. Pub. Health 609, 609 (2018).

[16] See Medicaid Coverage Map, supra note 2. As this symposium demonstrates, these efforts are not limited to Medicaid coverage.

[17] Self-pay GAC procedures generally must be pre-paid. See Andrew Mohama, More Hospitals Want Patients to Pay in Advance. Is That Radical Transparency—or Unfair to Patients?, Advisory Bd., https://www.advisory.com/daily-briefing/2021/10/13/advance-paym

A. A Brief History of Medicaid GAC Exclusions

GAC in the United States dates back to at least 1910.[18] Its practice advanced throughout the 20th century, most notably with Harry Benjamin's development of GAC protocols.[19] This 115-year-long practice, influenced by Karl Heinrich Ulrichs[20] in the 1860s, Richard von Krafft-Ebing[21] in the 1880s, and Magnus Hirschfeld[22] in the 1900s, is beyond the scope of this Essay. The standards of care and medical necessity of GAC are discussed below in Section III.A. This Section focuses on the development of health insurance coverage exclusions.

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ent#:~:text=Many%20hospitals%20say%20they%20only,with%20high%2Ddeductible%20health%20plans [https://perma.cc/QAJ9-5EVN] (last updated Mar. 20, 2023). Medicaid beneficiaries may be unable to access services without Medicaid coverage, as they could exceed program asset limits and lose Medicaid coverage entirely by accumulating savings to fund treatment. See Martin Schamis, How to Restructure Your Assets to Qualify for Medicaid, Kiplinger Pers. Fin. (Nov. 7, 2021), https://www.kiplinger.com/personal-finance/insurance/health-insurance/603705/how-to-restructure-your-assets-to-qualify-for [https://perma.cc/43LR-UXJE].

[18] Melany Fritz & Nat Mulkey, The Rise and Fall of Gender Identity Clinics in the 1960s and 1970s, Am. Coll. of Surgeons (Apr. 1, 2021), https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/bulletin/2021/04/the-rise-and-fall-of-gender-identity-clinics-in-the-1960s-and-1970s/ [https://perma.cc/6GZA-K85X].

[19] Id.; see also Stacey D. Jackson-Roberts, Pushed to the Edge: The Treatment of Transsexuals Through Time: A Behavioral Discourse Analysis of the Diagnostic and Treatment Protocols for Transsexuals and the Implications for Contemporary Social Work Practice 12–13 (2013) (Master's thesis, Smith College), https://scholarworks.smith.edu/theses/960/ [https://perma.cc/JCU4-AH6W] (describing the "pioneering attempts" of Harry Benjamin).

[20] Ulrichs was a lawyer, a leading pioneer of the study of sexuality, father of the modern gay rights movement, and is credited with inspiring Europe's first gay rights protest. See Liam Stack, Overlooked No More: Karl Heinrich Ulrichs, Pioneering Gay Activist, N.Y. Times (July 1, 2020), https://www.nytimes.com/2020/07/01/obituaries/karl-heinrich-ulrichs-overlooked.html [https://perma.cc/29P6-SW52]. For an English transcript of Ulrichs's protest speech made before the Congress of German Jurists in 1868, see Karl Heinrich Ulrichs, A Challenge to the Association of German Jurists, *in* 1 The Riddle of "Man-Manly" Love: The Pioneering Work on Male Homosexuality 261, 261–71 (Michael A. Lombardi-Nash trans., 1994).

[21] Von Krafft-Ebing was a psychiatrist and the author of *Psychopathia Sexualis*, a study of all forms of sexual behavior and possibly the first western medical text to theorize that queer sexuality is a naturally occurring, unchangeable condition. See Richard, Baron von Krafft-Ebing, Encyc. Britannica (Aug. 10, 2024), https://www.britannica.com/biography/Richard-Freiherr-von-Krafft-Ebing [https://perma.cc/UU8H-HWDB]; Harry Oosterhuis, Sexual Modernity in the Works of Richard von Krafft-Ebing and Albert Moll, 56 Med. Hist. 133, 133 (2012).

[22] Hirschfeld was the founder of the Institute of Sexual Science in Berlin, which opened in 1919 and was the first target of the Nazi book burnings in May 1933. U.S. Holocaust Mem'l Museum, Magnus Hirschfeld, Holocaust Encyc., https://encyclopedia.ushmm.org/content/en/article/magnus-hirschfeld-2 [https://perma.cc/8MHU-NQAV] (last updated Dec. 17, 2021).

Widespread awareness of transgender people entered the popular American consciousness on December 1, 1952, with the New York Daily News headline about Christine Jorgensen, titled "Ex-GI Becomes Blonde Beauty."[23] Jorgensen became an international sensation.[24] Media attention hyper-focused on how her medical treatment had transformed her into an adult human female.[25] GAC became a deeply explored topic in the years that followed, with clinics launching across the United States and the development of an international society for the study of GAC and universalization of treatment protocols.[26]

Insurance coverage for GAC during the 1950s–1970s is unclear, but coverage can be inferred based on the insertion of explicit exclusions in the early 1980s.[27] Two events triggered the emergence of exclusions. First, in 1979, a study led by Dr. Jon K. Meyer, former director of the Sexual Behaviors Consultation Unit at Johns Hopkins Medicine, claimed that there was "objective evidence that there is no real difference in the transsexual's adjustment to life in terms of jobs, educational attainment, marital adjustment and social stability."[28] The findings were refuted by leading clinicians with experience treating transgender patients.[29] Yet after Meyer's study, Paul McHugh became chair of Johns Hopkins's Department of Psychiatry and closed the university's gender identity

[23] See Ben White, Ex-GI Becomes Blonde Beauty, N.Y. Daily News (Dec. 1, 1952), https://www.newspapers.com/article/daily-news-ex-gi-becomes-blonde-beauty/25375703/ [https://perma.cc/474R-96U6].

[24] Life Story: Christine Jorgensen (1926–1989), N.Y. Hist. Soc'y Museum & Libr., https://wams.nyhistory.org/growth-and-turmoil/cold-war-beginnings/christine-jorgensen/ [https://perma.cc/A3RR-ZSWV] (last visited Sept. 20, 2024).

[25] See White, supra note 23.

[26] Erin Gifford, Constructing the Transsexual: Medicalization, Gatekeeping, and the Privatization of Trans Healthcare in the U.S., 1950–2019, at 27–28, 35 (2019) (Senior project, Bard College), https://digitalcommons.bard.edu/senproj_s2019/146/ [https://perma.cc/PL79-YWFH].

[27] See Cristan Williams, Fact Checking Janice Raymond: The NCHCT Report, Trans Advoc., https://www.transadvocate.com/fact-checking-janice-raymond-the-nchct-report_n_14554.htm [https://perma.cc/2DE5-YC24] (last visited Sept. 20, 2024) (recounting interviews with former doctors at the University of Texas confirming that indigent transgender patients received publicly funded GAC until at least the late 1970s).

[28] Aaron Wiegand, Barred from Transition: The Gatekeeping of Gender-Affirming Care During the Gender Clinic Era, 15 Intersect 1, 5 (2021).

[29] See Jackson-Roberts, supra note 19, at 19 (explaining that a researcher "refuted these findings by asserting that the value of the surgery should be measured via the qualitative subjectivities of the patients, and not . . . against normative expectations of success," such as "a transsexual woman's ability to conform to the heteronormative middle class expectation of a woman").

clinic in 1979.[30] The largest GAC provider in the world disappeared, quickly followed by most other institution-based gender-affirming clinics in the country.[31]

Simultaneously, Janice Raymond, author of the transphobic book *The Transsexual Empire*,[32] began to set forth an "exclusionary feminist argument against the existence of trans people."[33] The federal government, through its newly established National Center for Health Care Technology ("NCHCT"), commissioned a report from Raymond and relied on *The Transsexual Empire* to conclude that GAC was "controversial."[34] This was one of the primary reasons that NCHCT recommended that insurance providers exclude coverage.[35] After NCHCT released its report, many insurance providers inserted explicit exclusions in health coverage plans, including state Medicaid plans.[36]

NCHCT also recommended excluding coverage because GAC was "experimental."[37] There likely was some merit to this idea, though whether it was reason for categorically excluding coverage is doubtful. Despite GAC's centuries of study and medical practice,[38] much of the scholarship was destroyed in 1933 by the Nazis.[39] Knowledge was lost and needed replicating. This influenced the U.S. gender identity clinic era of the 1950s–1970s, during which some providers, to advance their careers, aimed not to treat gender dysphoria, but to experiment on

[30] Id.

[31] See id.; Wiegand, supra note 28, at 5.

[32] Janice G. Raymond, The Transsexual Empire: The Making of the She-Male (Tchrs. Coll. Press 1994) (1979).

[33] See Alejandra Caraballo, To Protect Gender-Affirming Care, We Must Learn from Trans History, Harvard Pub. Health Mag. (June 21, 2023), https://harvardpublichealth.org/equity/to-protect-gender-affirming-care-we-must-learn-from-trans-history/ [https://perma.cc/39LZ-896J].

[34] Williams, supra note 27.

[35] Id.

[36] Gifford, supra note 26, at 55–56.

[37] Id. at 55 (quoting NCD 140.3, Transsexual Surgery, No. A-13-87, Decision No. 2576, at 4 (H.H.S. May 30, 2014)).

[38] Transgender people were first described in a medical text, the *Sushruta Samhita*, around 600 B.C.E., but their existence may be recorded in ancient Sumerian texts as far back as 2500 B.C.E. See Vedic Third-Gender Types and Terms, Gay & Lesbian Vaishnava Ass'n (Mar. 13, 2024), https://galva108.org/f/vedic-third-gender-types-and-terms [https://perma.cc/TNV7-CLNX]; Natalia Mesa, Trans Medicine, 1919, The Scientist (Nov. 1, 2022), https://www.the-scientist.com/trans-medicine-1919-70587 [https://perma.cc/3HHB-WFPW].

[39] United States Holocaust Memorial Museum, supra note 22; Caraballo, supra note 33.

transgender people.[40] But the public policy response was disproportionate to the severity of this issue.[41]

B. Landscape of Medicaid Coverage Exclusions of GAC

Exclusions remained the norm into the 2010s. Few challenges were litigated, and those that were litigated were largely unsuccessful.[42] By 1994, 36 of 44 states surveyed admitted to categorically excluding all gender-affirming surgeries.[43] During these years, GAC was in practice accessible only to those with the means to self-pay. In spite of reduced access to treatment, the standards of care and diagnostic criteria continued to evolve, improving the accuracy in identifying individuals experiencing gender dysphoria and the efficacy of treatment.[44] By the 2010s, the medical necessity of GAC was not in doubt: thirty leading medical associations have now endorsed GAC as medically necessary treatment for gender dysphoria.[45]

The tide turned against insurance exclusions in 2001, when the City and County of San Francisco removed its GAC exclusion from its public benefits plan.[46] After five years, the City determined that coverage for GAC did not increase overall premiums or attributable plan costs, and was in fact relatively less expensive compared to other health needs of

[40] See Wiegand, supra note 28, at 3.

[41] For example, not all clinicians sought personal gain. Dr. Paul Walker, director of the University of Texas Medical Branch Gender Clinic, provided high-quality medical assistance to transgender people and demonstrated through his research that being transgender "is not a form of mental illness." Aviv Rau, Uncovering Transgender History in Texas, Hogg Found. for Mental Health (June 12, 2023), https://hogg.utexas.edu/uncovering-transgender-history-in-texas [https://perma.cc/CX73-7X2G].

[42] See, e.g., Rush v. Parham, 625 F.2d 1150, 1154–55 (5th Cir. 1980); Smith v. Rasmussen, 249 F.3d 755, 761 (8th Cir. 2001); Casillas v. Daines, 580 F. Supp. 2d 235, 237 (S.D.N.Y. 2008). But see, e.g., Doe v. Minn. Dep't of Pub. Welfare, 257 N.W.2d 816, 820–21 (Minn. 1977) (holding categorical exclusion of "transsexual surgery" void under Medicaid Act and the decision to deny treatment arbitrary and unreasonable).

[43] *Rasmussen*, 249 F.3d at 760–61.

[44] Jackson-Roberts, supra note 19, at 21–23. But see Henri Feola, It's Time to Stop Gatekeeping Medical Transition, Am. Scientist: Macroscope (Feb. 18, 2022), https://www.americanscientist.org/blog/macroscope/its-time-to-stop-gatekeeping-medical-transition#:~:text=Gatekeeping%20is%20nothing%20new%20for,was%20eligible%20for%20medical%20transition [https://perma.cc/K2XG-K2VU] (arguing that the WPATH Standards of Care continue to impede equitable medical care for transgender people).

[45] Advocates for Trans Equality, supra note 8.

[46] San Francisco Transgender Benefit, Hum. Rts. Campaign Found. (Mar. 10, 2010), https://www.thehrcfoundation.org/professional-resources/san-francisco-transgender-benefit [https://perma.cc/UNV6-8CN6].

San Francisco employees.[47] This inspired other health insurers to follow suit. Employers soon began to offer coverage for GAC.[48] In 2004, only one of the Fortune 1000 employers provided coverage.[49] By 2012, 165 provided coverage, along with 81 of the AmLaw 200.[50] As of 2023, 73% of Fortune 500 employers provide coverage.[51]

Still, GAC exclusions remained common in state Medicaid plans. Medicaid exclusions take various forms. When exclusions appeared in the late 1970s and early 1980s, many were unwritten policies or unpromulgated rules.[52] Eventually, some states inserted the exclusion directly into the state Medicaid plan.[53] States also promulgated regulations.[54] In the last four years, some states have begun to impose the exclusion by statute.[55]

But with medical consensus about the necessity of GAC and development of Medicaid medical necessity case law, many states now explicitly cover GAC and legal challenges to these exclusions now succeed.[56] GAC treatments have higher success and satisfaction rates

[47] Id.; San Francisco Transgender Benefit: Actual Cost & Utilization (2001–2006), Hum. Rts. Campaign Found., https://web.archive.org/web/20220404184650/https://www.thehrcfoundation.org/professional-resources/san-francisco-transgender-benefit-actual-cost-utilization-2001-2006 [https://perma.cc/H6SV-X9L9] (last visited Jan. 15, 2025).

[48] See Transgender-Inclusive Benefits for Employees and Dependents, Hum. Rts. Campaign Found., https://www.thehrcfoundation.org/professional-resources/transgender-inclusive-benefits-for-employees-and-dependents [https://perma.cc/JX8G-3XSF] (last visited July 31, 2024).

[49] Id.

[50] Id.

[51] Corporate Equality Index 2023–2024, Hum. Rts. Campaign Found. (Nov. 2023), https://reports.hrc.org/corporate-equality-index-2023 [https://perma.cc/9GSN-MVH4].

[52] See, e.g., Pinneke v. Preisser, 623 F.2d 546, 549 (8th Cir. 1980) (noting that Iowa's Department of Social Services "established an irrebuttable presumption" that GAC is never medically necessary for transgender individuals "[w]ithout any formal rulemaking proceedings or hearings").

[53] See, e.g., State of Ga., Georgia Medicaid State Plan 1c (Aug. 1991), https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/State_Plan_Attachment_3.pdf [https://perma.cc/98XW-FASH] (listing "transsexual surgery" as an "experimental or investigational" non-covered procedure in its Medicaid plan). Currently, at least Kentucky, Missouri, and Texas exclude coverage through Provider or Physician Manual policy alone. See Medicaid Coverage Map, supra note 2.

[54] Medicaid Coverage Map, supra note 2 (indicating that Arizona, Florida (litigation pending), Hawai'i, Nebraska, Ohio, and West Virginia (litigation pending) presently exclude GAC by state regulation).

[55] States excluding Medicaid coverage for adolescents by statute include Arkansas (litigation pending), Mississippi, North Carolina (litigation pending), and Ohio; two states exclude coverage for all ages by statute (Idaho and South Carolina). Id.

[56] Id.

compared to other surgical procedures and major life decisions.[57] Courts consistently interpret the availability and comparability requirements to mean that medically necessary treatments must be covered without diagnosis discrimination and that utilization control procedures cannot categorically exclude treatments on the basis of diagnosis.[58] Since 2016, at least five courts have reviewed the question, and all found GAC exclusions to be unlawful.[59]

II. MEDICAID REQUIRES COVERAGE FOR GAC

Equality of coverage—providing everyone access to medically necessary treatments in covered service categories, regardless of diagnosis—is a key requirement going straight to the heart of the Act's primary purpose. Equal access to medically necessary services is statutorily mandated by two complementary requirements, colloquially called the availability and comparability requirements.[60]

[57] See Sarah M. Thornton, Armin Edalatpour & Katherine M. Gast, A Systemic Review of Patient Regret After Surgery—A Common Phenomenon in Many Specialties but Rare Within Gender-Affirmation Surgery, 234 Am. J. Surgery 68, 71–72 (2024) (presenting a systemic review of 55 studies demonstrating that "there is lower regret after [gender-affirming surgery], which is less than 1%, than after many other decisions, both surgical and otherwise," including regret rates of 11% for hernia repair, 7–8% for having children, and 16.2% for getting a tattoo); see also Maria Anna Theodora Catharina van der Loos, Sabine Elisabeth Hannema, Daniel Tatting Klink, Martin den Heijer & Chantal Maria Wiepjes, Continuation of Gender-Affirming Hormones in Transgender People Starting Puberty Suppression in Adolescence: A Cohort Study in the Netherlands, 6 Lancet Child & Adolescent Health 869, 870 (2022) (finding that 98% of minors diagnosed with gender dysphoria who received GAC when younger than 18 years old continued treatment throughout adulthood).

[58] See, e.g., Bontrager v. Ind. Fam. & Soc. Servs. Admin., 697 F.3d 604, 610–11 (7th Cir. 2012).

[59] See infra Section III.B.

[60] See Mallory & Tentindo, supra note 10, at 11. There is a relevant distinction between eligibility groups in the analysis of whether a state Medicaid agency must provide two different beneficiaries the same level of benefits. Medicaid eligibility categories can be understood separately as "categorically needy" and "medically needy" beneficiaries. Categorically needy beneficiaries are specified in 42 U.S.C. § 1396a(a)(10)(A)(i)–(ii) and § 1396d(a). See 42 C.F.R. § 436.3 (2024). Medically needy beneficiaries are specified in id. § 436.301. Whether Medicaid beneficiaries are receiving the appropriate level of coverage is a question of whether the benefits are equal among beneficiaries in the same eligibility category. 42 U.S.C. § 1396a(a)(10)(B)(i)–(ii).

A. Purpose of the Medicaid Act and Coverage Requirements

The central purpose of the Act is to enable each state, as far as practicable, to furnish medical assistance to those "whose income and resources are insufficient to meet the costs of necessary medical services."[61] Medicaid is the primary source of health insurance for low-income people in the United States, providing approximately 74.6 million Americans with health coverage.[62]

The federal government appropriates sufficient funds each year to the states for administering state Medicaid plans.[63] When a state participates in the Medicaid program, that state is bound by the statutory[64] and regulatory[65] requirements of the joint federal-state program.[66] Two of those requirements are availability and comparability, which act in concert to mandate coverage of medically necessary covered services for all beneficiaries, regardless of diagnosis, type of illness, or condition.[67]

The availability requirement necessitates that all state Medicaid plans "provide . . . for making medical assistance available [to all eligible individuals], including at least" the services in the enumerated list of mandatory benefit categories.[68] The comparability requirement states that "the medical assistance made available to any [eligible] individual . . . shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual [in the same eligibility category]."[69]

Federal regulations implement the availability and comparability requirements, providing in relevant part:

> (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

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[61] 42 U.S.C. § 1396-1.

[62] Ctrs. for Medicare & Medicaid Servs., April 2024 Medicaid and CHIP Enrollment Trends Snapshot, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/april-2024-medicaid-chip-enrollment-trend-snapshot.pdf [https://perma.cc/UA9T-96NB] (last visited Jan. 11, 2025).

[63] 42 U.S.C. § 1396-1.

[64] Id. § 1396–1396w-5 are the statutory requirements.

[65] 42 C.F.R. §§ 430–456.725 (2024) are the regulatory requirements.

[66] Cong. Rsch. Serv., R43357, Medicaid: An Overview 1, 27–28 (2023).

[67] 42 U.S.C. § 1396a(a)(10)(A)–(B); 42 C.F.R. 440.230 (2024).

[68] 42 U.S.C. § 1396a(a)(10)(A).

[69] Id. § 1396a(a)(10)(B)(i).

> (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.
>
> (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.[70]

The statute's availability requirement and its implementing regulations have been interpreted to require that states provide all eligible beneficiaries with coverage for all medically necessary covered services when requests comply with utilization control procedures.[71] The comparability requirement assures that states do not provide a medically necessary service in a covered benefit category to some eligible Medicaid beneficiaries but not to others.[72] If medically necessary treatment in a covered service category is categorically excluded, the coverage is not sufficient in amount, duration, and scope to fulfill the purpose of the Act or the purpose of providing the service.[73]

B. Medicaid Act Availability and Comparability Requirements

"[S]erious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage."[74] This statement by the Supreme Court is consistently interpreted to require that state Medicaid plans cover all non-experimental, medically necessary covered services for all beneficiaries in the same eligibility category.[75] While states have discretion to determine the scope of covered services in the state Medicaid plan, every beneficiary is guaranteed a minimum set

[70] 42 C.F.R. § 440.230(b)–(d) (2024).

[71] See Bontrager v. Ind. Fam. & Soc. Servs. Admin., 697 F.3d 604, 608 (7th Cir. 2012).

[72] See Schweiker v. Hogan, 457 U.S. 569, 573 n.6 (1982) ("comparability" requires that "the benefits provided to each categorical group of the medically needy were required to be equal in amount, duration, and scope").

[73] *Bontrager*, 697 F.3d at 610. States must also provide mandatory covered services when they are medically necessary. See Moore ex rel. Moore v. Reese, 637 F.3d 1220, 1232–33 (11th Cir. 2011); Dexter v. Kirschner, 984 F.2d 979, 983 (9th Cir. 1992); Meusberger v. Palmer, 900 F.2d 1280, 1282 (8th Cir. 1990).

[74] Beal v. Doe, 432 U.S. 438, 444 (1977).

[75] See, e.g., Lankford v. Sherman, 451 F.3d 496, 511 (8th Cir. 2006) ("While a state has discretion to determine the optional services in its Medicaid plan, a state's failure to provide Medicaid coverage for non-experimental, medically-necessary services within a covered Medicaid category is both per se unreasonable and inconsistent with the stated goals of Medicaid."); *Bontrager*, 697 F.3d at 608; Hern v. Beye, 57 F.3d 906, 911 (10th Cir. 1995).

of benefits.[76] Certain categories of benefits, including most inpatient hospital services, some outpatient hospital services, and physician's services, must be covered.[77] Optional service categories, including services rendered by other licensed professionals (e.g., Nurse Practitioners) and prescription drug coverage,[78] are not required to be covered, but if the state does cover these services for any beneficiary, then they must be covered for all beneficiaries.[79] State Medicaid programs "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures,"[80] but if the service is medically necessary and in a covered service category it must be covered.

Neither "medical necessity" nor "utilization control procedures" is defined in the Act or regulations; instead, defining medical necessity is left to the states.[81] That definition can be as broad or narrow as necessary to fulfill state policy goals, so long as the definition comports with the Act's purpose and requirements.[82] That definition must not exclude coverage "solely because of the diagnosis, type of illness, or condition."[83]

Whatever the definition of utilization control procedure, courts have repeatedly held that it cannot be interpreted to allow a state to shirk its obligation to cover medically necessary treatments in covered service categories.[84] Any limiting criteria other than medical necessity must serve

[76] See 42 U.S.C. § 1396a(a)(10)(A).

[77] See id. § 1396d(a)(1)–(2), (5).

[78] Though pharmacy coverage is optional under the Act, all state Medicaid plans provide prescription drug coverage. Prescription Drugs, Medicaid, https://www.medicaid.gov/medicaid/prescription-drugs/index.html [https://perma.cc/2N5K-TVDL] (last visited Jan. 11, 2025, 5:44 PM).

[79] 42 U.S.C. § 1396a(a)(10)(A)–(B); see, e.g., Eder v. Beal, 609 F.2d 695, 702 (3d Cir. 1979) (noting that "once a state elects to participate in an 'optional' program, it becomes bound by the federal regulations which govern it" (citation omitted)); Doe v. Chiles, 136 F.3d 709, 714 (11th Cir. 1998); *Lankford*, 451 F.3d at 504.

[80] 42 C.F.R. § 440.230(d) (2024).

[81] Rush v. Parham, 625 F.2d 1150, 1155 (5th Cir. 1980) (noting that "the Medicaid statutes and regulations permit a state to define medical necessity in a way tailored to the requirements of its own Medicaid program" and that "[t]he Supreme Court has interpreted [42 U.S.C. § 1396a(a)(17)] as conferring 'broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be "reasonable" and "consistent with the objectives" of the Act'" (quoting Beal v. Doe, 432 U.S. 438, 444 (1977))).

[82] 42 C.F.R. § 440.230 (2024); see Alexander v. Choate, 469 U.S. 287, 303 (1985).

[83] 42 C.F.R. § 440.230(c) (2024).

[84] Bontrager v. Ind. Fam. & Soc. Servs. Admin., 697 F.3d 604, 609–11 (7th Cir. 2012) (reviewing cases interpreting "utilization control procedures").

the broader purpose of the Act: "assuring that individuals will receive necessary medical care."[85]

Case law offers some insight into what appropriate utilization control procedures might be, including procedures requiring beneficiaries to obtain prior authorization for certain treatments, procedures for evaluating medical necessity, or presumptive limits on the amount of medical encounters or prescriptions a beneficiary can receive during a defined timespan so long as that presumption does not outright exclude coverage and is rebuttable on a case-by-case basis.[86] Conversely, case law indicates that utilization control procedures cannot be used to justify excluding funding for medically necessary procedures or as arbitrary caps on services applicable only to a subgroup of Medicaid beneficiaries.[87] This illustrates that utilization control procedures are the procedures by which service requests must be made and reviewed, not categorical coverage exclusions for medically necessary treatments applicable only to specific diagnoses.

1. Availability Requirement

The availability requirement affirmatively obliges states to make medically necessary mandatory services (the minimum set of benefits guaranteed to every Medicaid beneficiary) and any optional services that the state covers available to every beneficiary.[88] A state Medicaid plan must provide all covered services in "sufficient . . . amount, duration, and scope to reasonably achieve its purpose."[89]

While a state has flexibility in structuring its Medicaid plan, it is a per se violation of the availability requirement to categorically deny medically necessary treatment in a covered service category on the basis

[85] *Alexander*, 469 U.S. at 303.

[86] *Bontrager*, 697 F.3d at 610–11 (discussing Charleston Mem'l Hosp. v. Conrad, 693 F.2d 324, 330 (4th Cir. 1982); Curtis v. Taylor, 625 F.2d 645, 652 (5th Cir. 1980); Grier v. Goetz, 402 F. Supp. 2d 876, 913 (M.D. Tenn. 2005); Ladd v. Thomas, 962 F. Supp. 284, 294–95 (D. Conn. 1997); Semerzakis v. Comm'r of Soc. Servs., 873 A.2d 911, 929 (Conn. 2005); Jeneski v. Myers, 163 Cal. App. 3d 18, 31 (1984)).

[87] Id. at 609, 611 (first citing Montoya v. Johnston, 654 F. Supp. 511, 514 (W.D. Tex. 1987); then citing DeLuca v. Hammons, 927 F. Supp. 132, 136 (S.D.N.Y. 1996); and then citing Allen v. Mansour, 681 F. Supp. 1232, 1239 (E.D. Mich. 1986)).

[88] 42 U.S.C. § 1396a(a)(10)(A); 42 C.F.R. § 440.230(d) (2024).

[89] 42 C.F.R. § 440.230(b) (2024).

of diagnosis, type of illness, or condition.[90] Categorical exclusions make coverage insufficient in amount, duration, and scope to fulfill the purpose of treatment or the Act.[91] Indeed, when the Second Circuit held such exclusions lawful, it triggered a direct response from the Department of Health and Human Services rejecting that holding, resulting in the Second Circuit's order being vacated while pending certiorari before the Supreme Court.[92]

2. Comparability Requirement

The comparability requirement mandates that a state Medicaid agency must "provide . . . that the medical assistance made available to any [eligible] individual . . . shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual."[93] A state Medicaid plan then "must provide that the services available to any [eligible] individual . . . are equal in amount, duration, and scope for all" covered beneficiaries.[94] Denials or reductions in the amount, duration, or scope of a covered service based solely on the diagnosis, type of illness, or condition to be treated are unlawfully arbitrary.[95]

If a service is covered as medically necessary treatment for any condition, then that service must be available for all other diagnoses when medically necessary and when the request complies with utilization control procedures.[96] Distinctions that try to account for the degree of

[90] See *Bontrager*, 697 F.3d at 608–10; Moore v. Reese, 637 F.3d 1220, 1232–33 (11th Cir. 2011); Meusberger v. Palmer, 900 F.2d 1280, 1282 (8th Cir. 1990); Ellis ex rel. Ellis v. Patterson, 859 F.2d 52, 54 (8th Cir. 1988).

[91] See *Bontrager*, 697 F.3d at 610–12 (concluding that coverage caps without any means of individual exceptions are arbitrary, not proper utilization control procedures, and violate the availability requirement).

[92] DeSario v. Thomas, 139 F.3d 80, 92 (2d Cir. 1998), *vacated and remanded sub nom*. Slekis v. Thomas, 525 U.S. 1098, 1098–99 (1999).

[93] 42 U.S.C. § 1396a(a)(10)(B).

[94] 42 C.F.R. § 440.240(b) (2024) (regulation implementing comparability requirement).

[95] Id. § 440.230(c) (2024).

[96] See, e.g., Davis v. Shah, 821 F.3d 231, 255–56 (2d Cir. 2016) ("As § 1396a(a)(10)(B)(i) establishes and HHS's regulations clarify, the comparability provision . . . prohibits states from discriminating *among* the categorically needy by 'provid[ing] benefits to some categorically needy individuals but not to others.'" (quoting Rodriguez v. City of New York, 197 F.3d 611, 615 (2d Cir. 1999))).

benefit a beneficiary will receive from treatment are suspect under the comparability requirement.[97]

A state's limited Medicaid resources cannot justify diagnosis, type of illness, or condition-based exclusions.[98] While some courts hypothesize that nondiscriminatory exclusions of some medically necessary services on a case-by-case basis could be lawful, an exclusion of service in a covered benefit category is never permissible where it results in the categorical ban of medically necessary treatments for a specific diagnosis, type of illness, or condition.[99] Coverage exclusions must apply equally to all Medicaid beneficiaries *and* further the purpose of the Act.[100]

3. Covered Services and Medically Necessary Treatments

"Medical necessity is a term common to health care coverage and insurance policies globally."[101] Courts construe the act to permit states to

[97] See White v. Beal, 555 F.2d 1146, 1148, 1150–51 (3d Cir. 1977) (enjoining Pennsylvania policy that covered eyeglasses for individuals treated for a listed eye disease or injury, but not for individuals with ordinary refractory errors that necessitated corrective lenses for accurate sight).

[98] See Bontrager v. Ind. Fam. & Soc. Servs. Admin., 697 F.3d 604, 609–11 (7th Cir. 2012) (finding that a monetary coverage cap is not an appropriate utilization control procedure because by effectively denying coverage for all medically necessary treatments above the cap, it unlawfully decreases the amount, duration, and scope of treatment based solely on diagnosis, type of illness, or condition that occasioned the need for treatment with costs above the cap); see also *White*, 555 F.2d at 1148–49 (rejecting cost-saving policy that limited coverage "on the basis of etiology rather than medical necessity" because comparability requirement mandates that "all persons within a given category must be treated equally," requiring equal access to the same treatments for individuals with different diagnoses when that treatment is medically necessary).

[99] 42 C.F.R. § 440.230(c) (2024); see, e.g., Hern v. Beye, 57 F.3d 906, 910 (10th Cir. 1995) (suggesting utilization control procedures could exclude coverage for medically necessary services in limited, individual circumstances, but that singling out a particular medical condition and severely restricting coverage for all but life-or-death situations "crossed the line between permissible discrimination based on degree of need and entered into forbidden discrimination based on medical condition" (quoting Preterm, Inc. v. Dukakis, 591 F.2d 121, 126 (1st Cir. 1979))).

[100] I.e., it could be reasonable to exclude for *all* beneficiaries extremely expensive "experimental" procedures when the efficacy of the treatment is unknown in order to direct that money to less expensive proven treatments. See Ctrs. for Medicare & Medicaid Servs., EPSDT—Guide For States: Coverage in the Medicaid Benefit for Children and Adolescents 25 (2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf [https://perma.cc/BQ75-GNA2] ("States may cover services in the most cost effective mode as long as the less expensive service is equally effective and actually available.").

[101] E. Coleman et al., Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, 23 Int'l J. Transgender Health, 2022, at S1, S16 [hereinafter WPATH SOC 8]. The treating health care professional "asserts and documents that a proposed treatment is

define medical necessity.[102] States express these definitions broadly in statutes or regulations applicable to all treatments, not individually for each specific treatment.[103] State Medicaid agencies may also employ utilization control procedures that set the medical necessity request and review procedures.[104]

For example,[105] a state may define a "medically necessary service" as

> a covered service . . . that is required for the care or well-being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by the office, it must:
>
> > (1) be medically necessary, as determined by the office, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and
> >
> > (2) not be listed in this title as a noncovered service, or otherwise excluded from coverage.[106]

States may define certain services as noncovered so long as those services are not mandatory and are excluded for *all* beneficiaries, rather than on the basis of diagnosis, type of illness, or condition.[107] Exclusions for "experimental" treatments or "[r]econstructive or plastic surgery

medically necessary for treatment of the condition." Id. at S17. Medical necessity is a question of whether the treatment is a generally accepted standard of medical practice for treatment of the individual patient's diagnosed condition; "[g]enerally, 'accepted standards of medical practice' means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, designated Medical Specialty Societies and/or legitimate Medical Colleges' recommendations, and the views of physicians and/or HCPs practicing in relevant clinical areas." Id. (internal citation omitted).

[102] Rush v. Parham, 625 F.2d 1150, 1155 (5th Cir. 1980).

[103] See, e.g., 405 Ind. Admin. Code 5-2-17 (2023).

[104] See, e.g., 405 Ind. Admin. Code 5-3-13(a)(6) (2023) (requiring prior authorization for reconstructive surgery).

[105] Examples are drawn from the Author's experience successfully litigating the unlawfulness of Indiana's Medicaid GAC exclusion. See S.K.J. v. Walthall, No. 49D03-1709-MI-034611, slip op at 5–6, 16–17 (Ind. Super. Ct. Nov. 8, 2018) (concluding that agency policy to deny GAC prior authorization requests without considering medical necessity was a categorical exclusion in violation of the Act).

[106] 405 Ind. Admin. Code 5-2-17 (2023).

[107] See 42 C.F.R § 440.230(c) (2024).

unless related to disease or trauma deformity"[108] are generally considered lawful exclusions.[109]

States may have multiple definitions of medical necessity that apply to different categories of Medicaid eligibility.[110] Additionally, states may define the scope of covered service categories, such as defining the category "practice of medicine" as

> (A) the diagnosis, treatment, correction, or prevention of any disease, ailment, defect, injury, infirmity, deformity, pain, or other condition of human beings;
>
> (B) the suggestion, recommendation, or prescription or administration of any form of treatment, without limitation;
>
> (C) the performing of any kind of surgical operation upon a human being, including tattooing (except for providing a tattoo as defined in IC 35-45-21-4(a)), in which human tissue is cut, burned, or vaporized by the use of any mechanical means, laser, or ionizing radiation, or the penetration of the skin or body orifice by any means, for the intended palliation, relief, or cure; or
>
> (D) the prevention of any physical, mental, or functional ailment or defect of any person.[111]

Taken together, these define the treatments that Medicaid must cover equally for all beneficiaries.[112] If a treatment falls within these definitions and a service request is made pursuant to utilization control procedures, that treatment must be covered.[113]

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[108] 405 Ind. Admin. Code 5-29-1(8), (21) (2023).

[109] See, e.g., Rush v. Parham, 625 F.2d 1150, 1154–56 (5th Cir. 1980) (holding that states may adopt a definition of medically necessary that excludes experimental treatments); Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty, 366 F. Supp. 2d 1050, 1117 (N.D. Okla. 2005) (upholding the exclusion from coverage of a particular medication to treat asthma for children under age twelve because it was not generally accepted by the medical community as an effective and proven treatment and not FDA approved, but emphasizing that FDA approval was not an absolute prerequisite for coverage).

[110] See, e.g., 405 Ind. Admin. Code 10-2-1(31) (2018).

[111] Ind. Code § 25-22.5-1-1.1 (2023).

[112] As the Medicaid Act requires participating states to cover medically necessary physician services, these state definitions in turn require Indiana Medicaid to cover all treatments and surgeries performed by a physician for the care or well-being of the patient in accordance with generally accepted standards of care. See 405 Ind. Admin. Code 10-2-1(31) (2018).

[113] Some cases hypothesize that utilization control procedures could exclude medically necessary covered services. See, e.g., Hern v. Beye, 57 F.3d 906, 911 (10th Cir. 1995). An

III. CATEGORICAL EXCLUSIONS OF GAC VIOLATE THE MEDICAID ACT

Medicaid beneficiaries have a private right of action to enforce the availability and comparability requirements.[114] Exclusions are ripe for challenge under 42 U.S.C. § 1983 even before a beneficiary receives an explicit coverage denial.[115]

A. GAC Is Medically Necessary Treatment

Being transgender is not a medical condition. Instead, gender dysphoria is a medical condition experienced by transgender people, described as the "clinically significant distress or impairment in social, occupational, or other important areas of functioning" that "may accompany the incongruence between one's experienced or expressed gender and one's

example: imagine a request for a $500,000 medically necessary covered service, but the patient will invariably die in the immediate future. The theory is utilization control procedures could result in a denial so long as those procedures do not categorically exclude specific diagnoses, illnesses, or conditions. That $500,000 could fund other medically necessary services, furthering the purpose of the Act to provide medical services to the state's total Medicaid population.

That is not a utilization control procedure, but a medical necessity denial. The hypothetical asks whether treatment is medically necessary for the individual patient based on the expected condition improvement, not whether procedures were properly followed. This hypothetical is dissimilar to rebuttable presumptive limits on the number of service requests a beneficiary can submit, which still provides the medically necessary service to all beneficiaries in equal amount. In the hypothetical, the otherwise covered service is totally denied for an individual patient based on expected improvement from treatment, not noncompliance with procedure. *Bontrager*'s review of case law suggests that the only valid exclusion of medically necessary care under a utilization control procedure would be when required procedures are not met, taking no account of the medical condition. Bontrager v. Ind. Fam. & Soc. Servs. Admin., 697 F.3d 604, 609–11 (7th Cir. 2012). Thus, if all treatments not expected to extend life are not excluded from the definition of medical necessity, the denial is wrongful.

[114] Federal circuit courts routinely hold that 42 U.S.C. § 1396a(a)(10), by itself or in conjunction with other statutory subsections, confers a private right of action. See Waskul v. Washtenaw Cnty. Cmty. Mental Health, 979 F.3d 426, 448 (6th Cir. 2020); Davis v. Shah, 821 F.3d 231, 255 n.12 (2d Cir. 2016); *Bontrager*, 697 F.3d at 607; S.D. ex rel. Dickson v. Hood, 391 F.3d 581, 604–06 (5th Cir. 2004); Watson v. Weeks, 436 F.3d 1152, 1159 (9th Cir. 2006); Sabree v. Richman, 367 F.3d 180, 183 (3d Cir. 2004); cf. Lankford v. Sherman, 451 F.3d 496, 505, 509 (8th Cir. 2006) (proceeding on merits of the comparability claim while finding that the Act's reasonable standards clause did not confer private right of action); Mandy R. ex. rel. Mr. & Mrs. R. v. Owens, 464 F.3d 1139, 1142–43 (10th Cir. 2006) (assuming without deciding that 42 U.S.C. § 1396a(a)(8) and (10) confer private right of action).

[115] See Kadel v. Folwell, 100 F.4th 122, 141 n.15 (4th Cir. 2024).

assigned gender."[116] The DSM-V TR explains that "not all [transgender] individuals will experience distress from incongruence," but notes that distress can increase if "physical interventions using hormones and/or surgery are not available."[117]

Gender dysphoria is also recognized as a serious medical condition in the International Classification of Diseases ("ICD-11") (referring to the condition as "gender incongruence").[118] Gender incongruence is included in the ICD-11 to "ensure transgender people's access to gender-affirming health care, as well as adequate health insurance coverage for such services."[119] The ICD-11 describes GAC as "any single or combination of a number of social, psychological, behavioural or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity."[120]

Together, the DSM-V TR and the ICD-11[121] set the reference standards for medical diagnosis used by medical providers in the United States.[122] The DSM-V TR is published by the American Psychiatric Association and the ICD-11 by the World Health Organization.[123]

Gender dysphoria standards of care are developed by the World Professional Association of Transgender Health ("WPATH").[124] WPATH is an international, interdisciplinary organization founded in 1979 that is devoted "to promot[ing] evidence-based care, education,

[116] Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 511–14 (5th rev. ed. 2022) [hereinafter DSM-V TR].

[117] Id. at 512.

[118] World Health Org., International Classification for Mortality and Morbidity Statistics 1168–69 (11th rev. 2022) [hereinafter ICD-11] (calling the condition "marked and persistent").

[119] Frequently Asked Questions: Gender Incongruence and Transgender Health in the ICD, World Health Org., https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd [https://perma.cc/2G85-DT8S] (last visited Aug. 1, 2024).

[120] Id.

[121] The ICD-11 was made available for use globally on January 1, 2022, but uniform implementation of the changes is estimated to take at least 4–5 years, during which time many health care systems will likely continue to use diagnostic codes from the ICD-10. See James A. Feinstein, Peter J. Gill & Brett R. Anderson, Preparing for ICD-11 in the US Healthcare System, JAMA Health F., July 2023, at 1–3. The ICD-10 identifies the diagnosis for gender dysphoria as "transsexualism." 1 World Health Org., International Statistical Classification of Diseases and Related Health Problems 327 (5th ed. 2016).

[122] DSM-V TR, supra note 116, at xxiii.

[123] Id.

[124] WPATH SOC 8, supra note 101, at S5.

research, public policy, and respect in transgender health."[125] The WPATH Standards of Care "are recognized as authoritative standards of care by the American Medical Association, the American Psychiatric Association, and the American Psychological Association."[126]

The Endocrine Society also develops and publishes standards of care addressing hormone treatment and surgical timing.[127] The "evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence" on two systematic reviews and the best available evidence from other published studies and reviews.[128] Those standards recommend treatment for adults and adolescents.[129]

GAC aims to reduce the distress symptoms associated with gender dysphoria. "Gender-affirming interventions are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of a patient."[130] Extensive evidence demonstrates that GAC, "including endocrine and surgical procedures, properly indicated and performed," improves quality of life for transgender people experiencing gender dysphoria.[131] With very high patient satisfaction rates, GAC is one of the safest and most effective modern medical treatments.[132]

When inadequately treated, the consequences of gender dysphoria are dire, leading to "severe emotional and psychological distress" including anxiety, depression, negative self-image, poor self-esteem, post-traumatic

[125] Id.

[126] Norsworthy v. Beard, 87 F. Supp. 3d 1164, 1170 (N.D. Cal. 2015).

[127] See generally Wylie C. Hembree et al., Endocrine Treatment of Gender-Dysphoric / Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, 102 J. Clinical Endocrinology & Metabolism 3869 (2017) (updating the Endocrine Society's guidelines).

[128] Id. at 3869.

[129] Id. at 3870–72.

[130] WPATH SOC 8, supra note 101, at S18.

[131] Id. (citing many studies demonstrating the safety and effectiveness of GAC).

[132] See supra note 57. Compare Kiandra B. Scott, Jenna Thuman, Abhishek Jain, Matthew Gregoski & Fernando Herrera, Gender-Affirming Surgeries: A National Surgical Quality Improvement Project Database Analyzing Demographics, Trends, and Outcomes, 88 Annals Plastic Surgery S501, S502 (2022) (overall 30-day complication rate for gender-affirming surgery in the United States is 6%), with Sarah E. Tevis, Alexander G. Cobian, Huy P. Truong, Mark W. Craven & Gregory D. Kennedy, Implications of Multiple Complications on the Postoperative Recovery of General Surgery Patients, 263 Annals Surgery 1213, 1214 (2016) (overall complication rate for general surgery in the United States is 15%).

stress disorder (PTSD), shame, and social isolation.[133] In 2008, the American Medical Association officially recognized that inadequate access to GAC increases risk of death.[134]

B. Recent Case Trends

Since 2016, at least five courts have reviewed challenges to state Medicaid exclusions of GAC. All five found that GAC is medically necessary according to prevailing standards of practice and within covered service categories, making categorical exclusions unlawful.[135] Appeals continue in two cases, including a petition for certiorari.[136]

The first of these cases, *Cruz v. Zucker*,[137] laid out a clear analytic framework. Less than eight years earlier, the same New York Medicaid exclusion of GAC was upheld in *Casillas v. Daines*.[138] The *Casillas* court found the exclusion was a reasonable utilization control procedure, wholly ignoring that 42 C.F.R. § 440.230(c) prohibits arbitrary denials or reductions of required services solely because of the diagnosis, type of illness, or condition, despite the fact that the plaintiff had urged the court to take account of the regulation.[139] The *Casillas* decision gave no

[133] Transgender: Ensuring Mental Health, Cleveland Clinic, https://my.clevelandclinic.org/health/articles/21963-transgender-ensuring-mental-health [https://perma.cc/J7H4-3EEZ] (last visited Oct. 10, 2021).

[134] See Am. Med. Ass'n House of Delegates, Resol. 122 (A-08), Removing Financial Burdens to Care for Transgender Patients 2 (2008); Editorial, No Reason to Exclude Transgender Medical Care, N.Y. Times (Dec. 9, 2015), https://www.nytimes.com/2015/12/09/opinion/no-reason-to-exclude-transgender-medical-care.html [https://perma.cc/24ZZ-FU7W].

[135] Kadel v. Folwell, 100 F.4th 122, 133–34 (4th Cir. 2024); Dekker v. Weida, 679 F. Supp. 3d 1271, 1277, 1285–88 (N.D. Fla. 2023); Flack v. Wis. Dep't of Health Servs., 395 F. Supp. 3d 1001, 1015–16, 1019 (W.D. Wis. 2019); S.K.J. v. Walthall, No. 49D03-1709-MI-034611, slip op. at 11, 13, 17; (Ind. Super. Ct. Nov. 8, 2018); Cruz v. Zucker (*Cruz III*), 218 F. Supp. 3d 246, 247–49 (S.D.N.Y. 2016).

[136] Petition for Writ of Certiorari, Crouch v. Anderson, No. 24-90 (U.S. July 25, 2024); Dekker v. Weida, 679 F. Supp. 3d 1271 (N.D. Fla. 2023), *appeal filed sub nom.* Dekker v. Sec'y, No. 23-12155 (11th Cir. June 27, 2023).

[137] The district court ruled in three separate iterations of *Cruz*. By the conclusion of the case, New York had ended its Medicaid exclusion of GAC. See generally Cruz v. Zucker (*Cruz I*), 116 F. Supp. 3d 334 (S.D.N.Y. 2015) (holding that plaintiffs may pursue a private right of action); Cruz v. Zucker (*Cruz II*), 195 F. Supp. 3d 554 (S.D.N.Y. 2016) (holding that GAC exclusions as applied to adults and procedure-type restrictions are illegal, but age restrictions on hormone replacement therapy are legal); *Cruz III*, 218 F. Supp. 3d 246 (state changed rules to provide coverage of all GAC treatments regardless of age, mooting the case).

[138] 580 F. Supp. 2d 235, 237 (S.D.N.Y. 2008).

[139] Id. at 241.

consideration to whether GAC is medically necessary, appearing to assume that even if it was, the state could deny GAC while providing coverage for the same treatments to other beneficiaries.[140]

The *Cruz* opinions aptly demonstrate the flaws in that reasoning. The court in *Cruz I* acknowledged that, while the Supreme Court has not expressly held that all medically necessary treatment must be covered, the *Casillas* court had misapplied *Beal v. Doe* to uphold the GAC exclusion without consideration of medical necessity.[141] *Beal* was a case considering the denial of non-medically necessary treatment.[142] *Beal* did not indicate that Medicaid plans could categorically exclude medically necessary treatment; it instead suggested the opposite.[143] The *Cruz I* court concluded, in agreement with the majority of other courts to consider the issue, that the availability and comparability requirements mandate coverage of medically necessary treatments in mandatory and covered optional categories.[144]

Still, the *Cruz II* court did not accept that *every* medically necessary treatment must be covered. The court acknowledged that "[t]he Availability Provision and its implementing regulations do allow a state to say 'only sometimes' and to limit coverage of specific treatments when the state has good reasons for doing so—reasons that ultimately uphold the provision of necessary medical care to needy individuals."[145] Rather, the court adopted the "never-say-never" rule, under which "[a] categorical ban on medically necessary treatment for a specific diagnosis" is always unlawful because it does not "adequately . . . meet the needs of the Medicaid population of the state."[146] There was no dispute between the parties that the excluded gender-affirming procedures listed in state regulations were potentially medically necessary for the treatment of gender dysphoria in adults.[147]

There was, however, a dispute in *Cruz II* about whether treatments were medically necessary for adolescents.[148] First, the court found that

[140] Id. at 242–44, 244 n.4.
[141] *Cruz I*, 116 F. Supp. 3d at 343.
[142] Beal v. Doe, 432 U.S. 438, 440 (1977).
[143] *Cruz I*, 116 F. Supp. 3d at 343 (citing *Beal*, 432 U.S. at 444–45).
[144] Id.; see also id. at 345 n.5 ("In so holding, the Court joins the overwhelming majority of courts, both before and after *Gonzaga*, that have considered this question.").
[145] *Cruz II*, 195 F. Supp. 3d at 571.
[146] Id. (quoting Desario v. Thomas, 139 F.3d 80, 96 (2d Cir. 1998)).
[147] Id.
[148] Id. at 573.

puberty blockers and hormone therapy were "off-label" uses of outpatient drugs for adolescents, and that the Act permits exclusion if the prescribed use is not for a medically accepted indication.[149] Here, the court made a questionable finding—that the off-label use made treatment of gender dysphoria in adolescents "not a medically accepted indication" for these medicines.[150] But an FDA-approved diagnosis is not the only source for whether a drug is medically indicated to treat a diagnosis; standards of care must also be considered.[151] The standards of care demonstrate that those medicines are medically indicated for the treatment of gender dysphoria in adolescents, making diagnosis-based exclusion unlawful.[152] Only total exclusion of off-label coverage as a utilization control procedure could save the hormone exclusion for adolescents under the comparability requirement.[153] Factual questions would remain to determine whether the state Medicaid plan had a bona fide exclusion of all off-label uses of outpatient drugs and whether that exclusion was applied consistently. If not, the exclusion of hormone treatment for adolescents would be unlawful.

In terms of surgical treatment for adolescents, the *Cruz II* court found a genuine issue of material fact regarding medical necessity.[154] Surgery is a mandatory covered service, so the state lacked discretion to exclude medically necessary surgeries based on diagnosis.[155] This factual question was ultimately not addressed, as the state capitulated before trial by promulgating rules to explicitly cover all GAC for adults and adolescents, mooting the case.[156]

[149] Id. at 572–73.

[150] Id. at 573.

[151] See Kadel v. Folwell, 100 F.4th 122, 136–37, 136 n.6 (4th Cir. 2024); see also Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty, 366 F. Supp. 2d 1050, 1116 (N.D. Okla. 2005) (noting that FDA approval cannot be an absolute prerequisite for coverage).

[152] WPATH SOC 8, supra note 101, at S45–47 (discussing the body of evidence on GAC for adolescents, including research demonstrating that puberty suppression and hormone replacement therapies are effective treatments of gender dysphoria in adolescents).

[153] For example, if a state provides coverage for off-label use of outpatient drugs for any diagnosis, it may not then deny off-label use for any other medically necessary treatments, as that would provide beneficiaries a different set of benefits based solely on their diagnosis. See, e.g., *Cruz II*, 195 F. Supp. 3d 554, 571, 577 (S.D.N.Y. 2016) ("Proper utilization control procedures, as distinct from medical necessity, may limit the provision of services.").

[154] Id. at 573.

[155] See 42 U.S.C. § 1396a(a)(10)(A) (mandating coverage of physician's services provided by a physician); id. § 1395x(r) (defining physician as a medical or osteopathic doctor authorized to practice medicine and surgery).

[156] *Cruz III*, 218 F. Supp. 3d 246, 247 (S.D.N.Y. 2016).

Like in *Cruz*, states in most cases addressing categorical exclusions of GAC do not seriously dispute that the treatment is medically necessary for *adults* in appropriate circumstances.[157] But when state Medicaid agencies argue that GAC is not medically necessary, courts have found those arguments unreasonable and meritless.[158] The standards of care are "well-established" and "widely followed by well-trained clinicians."[159] GAC is not "experimental"—it is the prevailing treatment used by medical providers.[160] This is true for adults and adolescents.[161] On the question of exclusions for adolescents, a later case found that puberty blockers and hormones are medically indicated in spite of their off-label use.[162]

One court has also found that expert witnesses who assert contrary positions are "deeply biased advocate[s], not . . . expert[s] sharing relevant evidence-based information and opinions."[163] Indeed, these witnesses rarely have any experience treating gender dysphoria.[164] Even

[157] See, e.g., Good v. Iowa Dep't of Hum. Servs., 924 N.W.2d 853, 862–63 (Iowa 2019) (holding that Iowa exclusion of gender-affirming care in cases of medical necessity violated state civil rights act protections for "gender identity"); Kadel v. Folwell, 100 F.4th 122, 162 (4th Cir. 2024) (holding that West Virginia's exclusion of all surgeries to treat gender dysphoria "regardless of [their] medical necessity" was impermissible).

[158] See, e.g., Dekker v. Weida, 679 F. Supp. 3d 1271, 1283 (N.D. Fla. 2023); Flack v. Wis. Dep't of Health Servs., 395 F. Supp. 3d 1001, 1018 (W.D. Wis. 2019).

[159] *Dekker*, 679 F. Supp. 3d at 1284; see also *Flack*, 395 F. Supp. 3d at 1016 (noting that "the medical profession has reached a formal consensus as to the safety *and* efficacy of surgical treatments for severe gender dysphoria").

[160] See *Flack*, 395 F. Supp. 3d at 1015 ("'[T]he best indicator that a procedure is experimental is its rejection by the professional medical community as an unproven treatment'; put another way, '[i]f "authoritative evidence" exists that attests to a procedure's safety and effectiveness, it is not "experimental."'" (quoting Miller ex rel. Miller v. Whitburn, 10 F.3d 1315, 1320 (7th Cir. 1993)).

[161] See, e.g., *Dekker*, 679 F. Supp. 3d at 1285 (noting that "[t]he overwhelming weight of medical authority supports treatment of transgender patients with . . . hormones in appropriate circumstances" and that hormones are appropriate for adolescents with gender dysphoria in part because hormone therapy is "routinely used to treat . . . children who have begun puberty prematurely").

[162] Id. at 1285–86 (writing that hormones "have been used for decades to treat other conditions. Their safety records and overall effects are well known. The Food and Drug Administration has approved their use, though not specifically to treat gender dysphoria," and that, in this case, "[t]he record includes testimony of well-qualified doctors who have treated thousands of transgender patients with . . . hormones over their careers and have achieved excellent results").

[163] Id. at 1279 n.8.

[164] See, e.g., id. at 1278–79 (noting that only one defense expert "ha[d] actually treated a significant number of transgender patients"); *Flack*, 395 F. Supp. 3d at 1013 (defense expert

when those experts have experience, their methods and opinions have been found to be out-of-step with modern medical practice.[165]

Unsurprisingly, much of the literature opposing GAC is produced by affiliation groups with long histories of publishing scientifically discredited claims that perpetuate health-harming conspiracy theories, such as the false claim that HIV does not cause AIDS, that autism is caused by vaccinations, and that GAC "devalues self-restraint."[166] Literature from hate groups cannot seriously be considered objective evaluations or relied upon by a tribunal considering the legality of GAC bans.

Some also argue that two recent cases in a different context upholding categorical exclusions of medically necessary gender-affirming surgery demonstrate that Medicaid exclusions are lawful.[167] Those two cases challenged exclusions by state departments of corrections under the Eighth Amendment.[168] The issues were substantively different: the cases did not consider whether the departments of corrections could categorically prohibit all medically necessary treatment; rather, they considered whether providing treatment short of surgery was sufficient medical care as to not be cruel and unusual punishment.[169] Eighth Amendment plaintiffs have a much higher burden of proof that expands

lacked a medical degree and any medical experience whatsoever and had no familiarity with the standards of care regarding gender dysphoria).

[165] See, e.g., Kadel v. Folwell, 100 F.4th 122, 157 (4th Cir. 2024) (noting that testimony by Dr. Stephen B. Levine that "no reliable medical studies show that Plaintiffs' desired treatments . . . improve the health and wellbeing of patients with gender dysphoria over time" was found "unpersuasive" in light of extensive expert testimony and medical literature to the contrary (quoting Brief of Appellants at 47, id. (No. 22-1721)).

[166] Two of the primary groups are the Association of American Physicians and Surgeons, a political advocacy group that frequently pushes disproven conspiracy theories, and the American College of Pediatricians, a Southern Poverty Law Center-identified hate group. See Stephanie Mencimer, The Tea Party's Favorite Doctors, Mother Jones (Nov. 18, 2009), https://www.motherjones.com/politics/2009/11/tea-party-doctors-american-association-physicians-surgeons/ [https://perma.cc/2NT5-QCDA]; Ryan Lenz, American College of Pediatricians Defames Gays and Lesbians in the Name of Protecting Children, S. Poverty L. Ctr.: Intel. Rep. (Mar. 1, 2012), https://www.splcenter.org/fighting-hate/intelligence-report/2012/american-college-pediatricians-defames-gays-and-lesbians-name-protecting-children [https://perma.cc/28RT-FXS5].

[167] See Kosilek v. Spencer, 774 F.3d 63, 77–78, 92 (1st Cir. 2014); Gibson v. Collier, 920 F.3d 212, 221–22, 226–27 (5th Cir. 2019).

[168] *Kosilek*, 774 F.3d at 89; *Gibson*, 920 F.3d at 220.

[169] *Kosilek*, 774 F.3d at 82; *Gibson*, 920 F.3d at 220.

the issue beyond a question of medical necessity.[170] Notably, the conclusion that prohibiting inmates from receiving medically necessary gender-affirming surgery did not result in deliberate indifference was not supported by contemporary medical standards of care in either case, but was supported by the testimony of the same expert found in more recent cases to be unpersuasive.[171] Whether these opinions have any continued weight is unlikely, particularly in light of the improvements to the standards of care and greater consensus that GAC is medically necessary.

CONCLUSION

In terms of Medicaid coverage, court opinions from the past decade have agreed that GAC is medically necessary, efficacious, and appropriate when patients meet the relevant criteria. When those treatments are mandatory under the Act or otherwise covered for other diagnoses, exclusion of GAC violates the availability and comparability requirements. State Medicaid plans must provide sufficient GAC to achieve the purpose of alleviating gender dysphoria for the individual patient. Courts have also found that providing GAC imposes no additional fiscal burden on the states.[172] Utilization control procedures may set the requirements that beneficiaries must follow to make coverage requests and that the state must follow in reviewing requests, but those procedures cannot exclude particular treatments for specific diagnoses, illnesses, or conditions.

Petitioners challenging Medicaid exclusions should focus primarily on claims under the Act itself, rather than relying on constitutional or other statutory arguments. The Act mandates equality of benefits for all beneficiaries. Denying medically necessary GAC while simultaneously

[170] See *Kosilek*, 774 F.3d at 82 (noting that, to prove a violation, "a prisoner must satisfy both of two prongs: (1) an objective prong that requires proof of a serious medical need, and (2) a subjective prong that mandates a showing of prison administrators' deliberate indifference to that need").

[171] See id. at 77–79, 87–89 (discussing Dr. Levine's testimony); *Gibson*, 920 F.3d at 222 (same). Contra Kadel v. Folwell, 100 F.4th 122, 157–58 (4th Cir. 2024) (finding Dr. Levine's testimony to be "unpersuasive").

[172] Flack v. Wis. Dep't of Health Servs., 395 F. Supp. 3d 1001, 1021–22 (W.D. Wis. 2019) (noting that "analyses reveal such small estimated savings resulting from the Challenged Exclusion that they are both practically and actuarially immaterial," such that removing the GAC exclusion would save the state only "one hundredth to three hundredth of one percent of the State's share of Wisconsin Medicaid's annual budget").

covering the same treatments for other diagnoses denies that equality in violation of the availability and comparability requirements.

As *United States v. Skrmetti*[173] is considered this Term on the broader issue of equal protection for GAC under the Fourteenth Amendment, the Medicaid Act analysis further demonstrates the patent arbitrariness of state efforts to deny medically necessary treatment to transgender people, both adults and adolescents. State arguments against medical necessity are consistently found meritless in cases with well-developed records of competing expert witness testimony. Qualified and unbiased medical experts are in consensus that GAC is medically necessary for both adults and adolescents. State policy decisions to more broadly criminalize medically necessary treatment for a specific diagnosis experienced by transgender people while permitting that treatment as an elective procedure for cisgender people have no connection to a rational state interest. They reveal clear animus toward a politically vulnerable minority. State laws that criminalize medically necessary GAC conflict with the Medicaid Act and violate the Supremacy Clause.

[173] L.W. ex rel. Williams v. Skrmetti, 83 F.4th 460, 491 (6th Cir. 2023), *cert. granted sub nom*. United States v. Skrmetti, 144 S. Ct. 2679 (2024).