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**COMMENT ON NEW YORK STATE DEPARTMENT OF HEALTH'S  
PROPOSED AMENDMENT OF SECTION 505.2(I) CONCERNING  
TRANSGENDER RELATED CARE AND SERVICES**

**COMMITTEE ON LESBIAN, GAY, BISEXUAL AND  
TRANSGENDER RIGHTS**

On October 5, 2016, the New York State Department of Health (“DOH”) published proposed rulemaking to amend 18 N.Y.C.R.R. § 505.2(I) (the “Regulation”) concerning state Medicaid coverage for transgender-related care and services. The Association of the Bar of the City of New York (“City Bar”), through its Committee on Lesbian, Gay, Bisexual, and Transgender Rights, submits the following comments concerning the proposed rule, in order to ensure coverage for all medically necessary treatment for transgender individuals, including both minors and adults.

In brief, the proposed Regulation would improve upon existing Medicaid coverage for transgender care, but it remains inadequate. The Regulation’s continued lack of clarity regarding coverage for trans youth and for certain gender reassignment procedures threatens to impede access to seamless and timely necessary care. Consistent with the treatment of other medical diagnoses, the Regulation should be revised simply to state that any and all treatments for gender dysphoria that are consistent with contemporary standards of care must be covered.<sup>1</sup> This standard is necessary to end the discriminatory provision of healthcare services under Medicaid historically faced by transgender people.

**Background and Need for Coverage of Gender Transition-Related Treatments**

Gender dysphoria is a serious medical condition recognized by leading medical authorities including, inter alia, the American Psychiatric Association.<sup>2</sup> It is a psychological condition in which

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<sup>1</sup> On October 25, 2016, the United States District Court for the Southern District of New York issued an order in the ongoing *Cruz* litigation, a challenge to New York State’s Medicaid coverage for transgender-related healthcare, granting the plaintiffs’ motion for reconsideration of the Court’s prior denial in part of plaintiffs’ motion for summary judgment. *See Cruz v. Zucker*, C.A. No. 14-cv-4456, Dkt. No. 150 (S.D.N.Y. Oct. 25, 2016). The order appears to resolve all outstanding issues in that litigation and may require the DOH to further modify the proposed Regulation. While the Regulation may be subject to additional change in light of this development, those changes may not occur prior to the closing of the comment period for the Regulation. The importance of the issues at stake in the proposed Regulation has compelled the City Bar to offer the following comments on the Regulation in its current form.

<sup>2</sup> For additional information, see *Gender Dysphoria Fact Sheet*, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (“DSM-5”), <http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf> (last accessed November 4, 2016). Similarly, the World Health Organization’s International Classification of Diseases recognizes “transsexualism” – 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

an individual experiences a marked difference between his/her expressed/experienced gender and the gender others assign to him or her.<sup>3</sup> For transgender people who live with gender dysphoria, treatment is necessary to alleviate the distress resulting from the mismatch between gender identity and their sex assigned at birth and the attendant “gender role and/or primary and secondary sex characteristics.”<sup>4</sup>

Since the time New York adopted a regulatory exclusion from state Medicaid insurance coverage for care, services, drugs or supplies for the purpose of gender reassignment,<sup>5</sup> medical authorities have firmly established that transition-related medical services are medically necessary and effective for some transgender people who experience gender dysphoria. In 2008, the American Medical Association (“AMA”), the largest professional association of physicians, residents, and medical students in the United States, passed resolutions to affirm that, without medical treatment, gender identity disorder (“GID”)<sup>6</sup> can result in clinically significant psychological distress, debilitating depression, and even suicide.<sup>7</sup>

Other medical and professional associations, including the American Academy of Family Physicians, the American Psychological Association, the National Association of Social Workers, and the World Professional Association for Transgender Health (“WPATH”) concur.<sup>8</sup> They also recognize the efficacy and medical necessity of transition-related health care and have called upon

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and hormonal treatment to make one’s body as congruent as possible with one’s preferred sex” – as one of a number of “gender identity disorders.” WORLD HEALTH ORG. INTERNATIONAL CLASSIFICATION OF DISEASES F64 (10th Revision 2007).

<sup>3</sup> *Gender Dysphoria Fact Sheet*, *supra* note 2; WORLD HEALTH ORG., *supra* note 2.

<sup>4</sup> World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7th ed. 2011) (hereinafter *WPATH Standards of Care*) at 5.

<sup>5</sup> New York’s Medicaid exclusion of medical services for gender reassignment was adopted in 1997, based on the assumption that such treatment was “not medically necessary” and “experimental.” Dep’t of Health, Notice of Adoption: Gender Reassignment, 20 N.Y. Reg. 5 (Mar. 25, 1998). As described below, this assumption has been invalidated by several medical authorities and organizations, including the American Medical Association.

<sup>6</sup> The APA referred to gender dysphoria as “gender identity disorder” in the DSM until the release of the DSM-V in 2012. See Camille Beredjick, *DSM-V To Rename Gender Identity Disorder ‘Gender Dysphoria’*, ADVOCATE (July 23, 2012), <http://www.advocate.com/politics/transgender/2012/07/23/dsm-replaces-gender-identity-disorder-gender-dysphoria>.

<sup>7</sup> American Medical Association House of Delegates, Resolution 122 (A-08): Removing Financial Barriers to Care for Transgender Patients, *available at* [http://www.tgender.net/taw/ama\\_resolutions.pdf](http://www.tgender.net/taw/ama_resolutions.pdf).

<sup>8</sup> American Academy of Family Physicians, Summary of Actions, 2009 National Conference of Special Constituencies, 2009 Resolutions; American Psychological Association, Policy Statement: Transgender, Gender Identity, & Gender Expression Non-Discrimination (Aug. 2008), <http://www.apa.org/about/policy/transgender.aspx>; National Association of Social Workers, *Transgender and Gender Identity Issues*, *available at* <https://www.socialworkers.org/da/da2008/finalvoting/documents/Transgender%202nd%20round%20-%20Clean.pdf>; World Professional Association for Transgender Health, *Clarification on the Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.* (June 17, 2008), *available at* <http://www.tgender.net/taw/WPATHMedNecofSRS.pdf>.

both public and private insurance companies to remove discriminatory exclusions to care.<sup>9</sup> The consensus is clear that treatments for gender dysphoria *must be covered* as medically necessary health care.<sup>10</sup>

The WPATH is the leading authority, both nationally and internationally, on transgender health care and the treatment of gender dysphoria.<sup>11</sup> WPATH has authored evidence-based standards, now in their seventh edition, for the diagnosis and treatment of gender dysphoria in adolescents and adults.<sup>12</sup> The WPATH Standards of Care have long recommended, and the AMA endorses, a combination of mental health care, hormone therapy and surgery to treat gender dysphoria. A range of surgeries and therapies may be necessary and appropriate. The goal of these treatments is to bring the patient's body into better alignment with their gender identity and to help the patient to live a full life, including being recognized by others in the gender role consistent with the patient's gender identity.<sup>13</sup>

Perhaps most significant for the recommendations that follow later in this comment, the WPATH Standards make clear that the treatment of gender dysphoria, and what constitutes medically necessary treatment, is a highly individualized process that can vary significantly from one person to another.<sup>14</sup> For some transgender people, hormones provide adequate treatment for gender dysphoria. For “many others, surgery is essential and medically necessary to treat their gender dysphoria.”<sup>15</sup> What surgery is required will depend on the clinical needs and overall health of a particular person. Being able to live publicly, including being recognized by oneself and others, as the gender in consonance with one's gender identity is crucial to treating gender dysphoria. For that reason, procedures affecting visible aspects of an individual's body (like the face or chest) can be as important—or even *more* important—for some patients, than treatment affecting less-visible aspects of the body (like genitals).<sup>16</sup>

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<sup>9</sup> See, e.g., American Academy of Family Physicians, *supra* note 8; American Psychological Association, *supra* note 8; National Association of Social Workers, *supra* note 8; World Professional Association for Transgender Health, *supra* note 8.

<sup>10</sup> See, e.g., American Academy of Family Physicians, *supra* note 8; American Psychological Association, *supra* note 8; National Association of Social Workers, *supra* note 8; World Professional Association for Transgender Health, *supra* note 8.

<sup>11</sup> See, e.g., *Cruz*, C.A. No. 14-cv-4456, 2016 U.S. Dist. LEXIS 87072, at \*14 n.4 (S.D.N.Y. Jul. 5, 2016) (noting significant weight accorded the WPATH Standards of Care and citing expert report that referred to it as the “most widely recognized and utilized international standard for treating transgender people”).

<sup>12</sup> See *WPATH Standards of Care*, *supra* note 4.

<sup>13</sup> See *WPATH Standards of Care*, *supra* note 4, at 9-10.

<sup>14</sup> See, e.g., *WPATH Standards of Care*, *supra* note 4, at 58-59 (“The [Standards of Care] do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.”).

<sup>15</sup> See, e.g., *WPATH Standards of Care*, *supra* note 4, at 54.

<sup>16</sup> See, e.g., S.J. Langer, *Our Body Project: From Mourning to Creating the Transgender Body*, 15 INT'L J. TRANSGENDERISM 22, 66-75 (2014) (one patient prioritized facial feminization surgery (“FFS”) over a vaginoplasty, citing how “emotionally painful” it was for her to see a “male” face in the mirror and “the pain of inconsistent public

A lack of access to appropriate health care services has drastic consequences for transgender people.<sup>17</sup> Transgender people without access to transition-related care are up to thirty (30) times more likely to attempt suicide than those who have successfully accessed care.<sup>18</sup> Depression, anxiety, and substance use increase dramatically among transgender people who are denied access to medically necessary care.<sup>19</sup> Some turn to illegal providers to obtain hormones or silicone injections, risking illness, disfigurement, and death.<sup>20</sup> Ensuring access to transition-related health care would likely reduce transgender people's reliance on unsafe and unregulated black market services, thus decreasing the need for care for complications from these procedures. Moreover, providing access to transition-related services would ameliorate mental health and substance abuse issues, and in this manner reduce the costs of that care as well.

Early access to health care is physician-recommended and particularly essential for trans youth, whose bodies will undergo permanent, potentially traumatic changes without appropriate intervention.<sup>21</sup> Many young trans people are surrounded by parents and providers who do not understand their identities, and accessing mentally and physically supportive services is critical to their well-being. Standards of care espoused by many in the medical community are consistent in the view that individual doctors, rather than blanket policies, are best able to evaluate precisely what treatment is warranted before and during adolescence, and that many of the available treatments are appropriate for children under 18.<sup>22</sup> When trans youth have access to such care, they

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recognition”).

<sup>17</sup> Pooja S. Gehi & Gabriel Arkles, *Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People*, 4 SEXUALITY RES. & SOC. POL'Y 7, 12-15 (2007), <http://www.srlp.org/files/SRLPmedicaidarticle.pdf>.

<sup>18</sup> Sylvia Rivera Law Project, *Eliminating the Medicaid Exclusion For Transition-Related Care in NYS: Good Public Health, the Right Thing to Do and Ultimately a Cost-Saving Measure* (2011), <http://srlp.org/files/Health%20Costs%20Final%20Memo.pdf>.

<sup>19</sup> JAIME M. GRANT, LISA A. MOTTET & JUSTIN TANIS, THE NAT'L GAY & LESBIAN TASK FORCE & THE NAT'L CTR. FOR TRANSGENDER EQUAL., *INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 81* (2011), available at [http://endtransdiscrimination.org/PDFs/NTDS\\_Report.pdf](http://endtransdiscrimination.org/PDFs/NTDS_Report.pdf); Mohammad Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Metaanalysis of Quality of Life and Psychosocial Outcomes*, 72 CLINICAL ENDOCRINOLOGY 214 (2010) (meta-analysis of 28 studies found 78% of individuals with Gender Identity Disorder reported significant improvements in psychological symptoms following treatment, including hormone therapy and gender-affirming surgery).

<sup>20</sup> Gehi & Arkles, *supra* note 17, at 14; see also Laura Rena Murray, *The High Price of Looking Like a Woman*, N.Y. TIMES (Aug. 21, 2011), <http://www.nytimes.com/2011/08/21/nyregion/some-transgender-women-pay-a-high-price-to-look-more-feminine.html>.

<sup>21</sup> See *WPATH Standards of Care*, *supra* note 4, at 20; Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLIN. ENDOCRINOL. METAB. 3132 (Sept. 2009).

<sup>22</sup> See Center of Excellence for Transgender Health, Department of Family and Community Medicine, University of California San Francisco, *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People* (2d ed. June 2016), <http://transhealth.ucsf.edu/trans?page=guidelines-youth>; Norman P. Spack et al., *Children and Adolescents with Gender Identity Disorder Referred to a Pediatric Medical Center*, 129 PEDIATRICS 418, 423 (Feb. 2012), <http://pediatrics.aappublications.org/content/early/2012/02/15/peds.2011-0907.full-text.pdf> (“Preventing endogenous secondary sexual characteristics from fully developing not only relieves distress but enables

are less at risk for behavioral and emotional problems, risk-taking behaviors, and suicidal thoughts,<sup>23</sup> benefits that are likely to last a lifetime. Delaying transition, meanwhile, effectively prolongs gender dysphoria, increasing the risks to trans youth.<sup>24</sup>

Transgender people without access to appropriate health care face crises in all aspects of their lives and work, resulting in disproportionately large human costs. Transgender individuals who cannot avail themselves of medically necessary transition-related health care may not be able to present themselves in a manner consistent with their gender identity, making them more vulnerable to acts of violence, discrimination and harassment. For example, without access to transition-related health care, a transgender person may not be able to obtain gender-matched identification.<sup>25</sup> Transgender people who do not have identification matching their gender identity or expression report very high levels of harassment (40% of respondents in a 2011 survey), violence, and discrimination when presenting identification documents.<sup>26</sup> Similarly, transgender and gender non-conforming employees report that they are often forced to present in the wrong gender to keep their jobs (32% of respondents in the same 2011 survey).<sup>27</sup> Access to health insurance coverage for transition-related care may change these results, reduce the risk of violence, and increase employment rates in the transgender community.<sup>28</sup>

Of particular relevance to DOH's proposed rule is the fact that a disproportionate number of transgender individuals are low-income and are more likely than cisgender individuals to rely upon

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the individual with GID to live in the phenotype of the affirmed gender.”).

<sup>23</sup> See, e.g., Spack, *supra* note 22, at 422.

<sup>24</sup> See Gabe Murchison et al., *Supporting and Caring for Transgender Children*, HUMAN RIGHTS CAMPAIGN (Sept. 2016), <http://hrc.im/supportingtranschildren>, at 13-17 (describing risks of delaying transition and benefits of early treatment).

<sup>25</sup> Most government-issued identification permits a change in gender, but not without proof of medical treatment of some kind. For example, in 2010 the U.S. Department of State changed its policies, allowing transgender individuals to obtain a new passport with a corrected gender identity based on a certification from an attending physician that the applicant has undergone appropriate clinical treatment for gender transition. Proof of sex reassignment surgery, however, is no longer required. Press Release, U.S. Dep't of State, *New Policy on Gender Change in Passports Announced* (June 9, 2010), available at <http://www.state.gov/r/pa/prs/ps/2010/06/142922.htm>. This policy is helpful, but a passport change would be out of reach for anyone who cannot afford the clinical treatment and is otherwise Medicaid-eligible.

<sup>26</sup> GRANT, MOTTET & TANIS, *supra* note 19, at 5 (40% of survey participants who presented ID when it was required in the ordinary course of life that did not match their gender identity/expression reported being harassed, 3% reported being attacked or assaulted, and 15% reported being asked to leave), 132 (41% of survey respondents whose driver's licenses did not reflect the gender they have transitioned to reported denial of equal treatment or service and 48% reported harassment/disrespect in retail stores).

<sup>27</sup> GRANT, MOTTET & TANIS, *supra* note 19, at 60.

<sup>28</sup> See GRANT, MOTTET & TANIS, *supra* note 19, at 118 (reporting that 42% of transgender and gender non-conforming respondents were forced to present in the wrong gender to access shelter and those who had had surgery had slightly lower rates (35%) of forced gender coercion), 126-28 (reporting that survey respondents who are visual non-conformers reported higher rates of physical attack or assault in places of public accommodation (10%) than those who are visual conformers (6%)).

public health insurance programs. As a result, any limitations on Medicaid coverage beyond a standard inquiry into medical necessity particularly and disproportionately affect transgender people.<sup>29</sup> A September 2009 survey by the National Center for Transgender Equality and the National Gay and Lesbian Task Force found that fifteen percent (15%) of transgender people surveyed lived on \$10,000 per year or less, a rate double that of the general population, and that twenty-seven percent (27%) had incomes of \$20,000 or less.<sup>(18)</sup> Those surveyed were also unemployed at a rate nearly double the national average at the time of the survey – 13%.<sup>30</sup>

### **While the Regulation is an Improvement Upon Past Iterations, It Is Inadequate to Ensure Access to Medically Necessary Healthcare for All Transgender People**

The version of the proposed Regulation published on October 5, 2016 is a notable improvement upon the previous versions of the Regulation proposed and adopted by DOH in May and August of this year, respectively. However, the continued lack of clarity regarding care and requirement of prior approval both for transgender youth and access to certain gender reassignment procedures make the regulation inadequate.

*First*, the proposed Regulation properly provides for coverage of hormone therapy and gender reassignment surgeries for minors, which is a marked improvement over the prior version. However, it confusingly and unnecessarily appears to distinguish between individuals older than 16 and those younger than 16 with regard to hormone therapy while ostensibly permitting both groups to access that care if they meet identical requirements (with the additional requirement that those under 16 have prior approval). It also requires coverage of gender reassignment surgeries for those over 18, while providing only that those under 18 “may” be covered. This odd and confusing structure is not in line with current medical authority, which calls for determining the appropriateness of hormone therapy based on a variety of factors other than age, including the stage of the patient’s physical development of primary and secondary sex characteristics.<sup>31</sup> Furthermore, to the extent that the wording of the proposed regulation would lead to the denial of medically necessary care simply because the patient is under 18, it is likely unlawful.

The existing regulation must be changed to comply with the recent decision in *Cruz v. Zucker*,<sup>32</sup> a class action that was brought against the State for categorically denying coverage for medically necessary surgery to state Medicaid subscribers on the basis of age alone. In July 2016, the court granted summary judgment to the class regarding the State’s unlawful categorical cosmetic exclusions, but the court found that there were still genuine disputes of material fact regarding the

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<sup>29</sup> See Somjen Frazer, Empire State Pride Agenda Found., LGBT Health and Human Services Needs in New York State 12 (2009), available at <http://www.prideagenda.org/Portals/0/pdfs/LGBT%20Health%20and%20Human%20Services%20Needs%20in%20New%20York%20State.pdf> (“[P]reliminary research suggests that transgender people are . . . more likely to be unemployed and very low income.”).

<sup>30</sup> NAT’L CTR. FOR TRANSGENDER EQUALITY & THE NAT’L GAY & LESBIAN TASK FORCE, NATIONAL TRANSGENDER DISCRIMINATION SURVEY 2 (2009), available at [http://www.thetaskforce.org/downloads/reports/fact\\_sheets/transsurvey\\_prelim\\_findings.pdf](http://www.thetaskforce.org/downloads/reports/fact_sheets/transsurvey_prelim_findings.pdf).

<sup>31</sup> Hembree et al., *supra* note 21.

<sup>32</sup> C.A. No. 14-cv-4456, Dkt. No. 150 (S.D.N.Y. Oct. 25, 2016).

youth exclusions at that time.

On October 25, 2016, the court granted Plaintiffs' motion for reconsideration of the July summary judgment decision, finding that there were in fact no disputes of fact on the youth exclusion issue. Ruling in Plaintiffs' favor, the court wrote:

Specifically, on October 5, 2016, defendant published a Notice of Proposed Rulemaking, which if adopted, would "explicitly" authorize the New York Medicaid Program to "cover medically necessary surgeries and hormone therapies to treat gender dysphoria in individuals under 18." Def's Mem. in Opp. to Pls.' Mot. for Recons. at 1.<sup>33</sup>

This is a huge victory for the interests of youth Medicaid subscribers. Now, children who experience gender dysphoria can be saved from the pain of going through puberty in the wrong gender. Hormone blockers, cross-sex hormones and surgeries will be available to minors so long as they can show that the care is medically necessary to treat gender dysphoria. Ultimately, the decision of when to embark on transition-related care should be left up to the patient and their medical provider.

**Second**, the proposed Regulation changes the presumption against coverage for certain medical therapies that previously were excluded from coverage as "cosmetic." These changes represent an improvement but still do not go far enough to ensure equal access to medically necessary care for gender dysphoria.

The previous version of the regulation, at subsection (5), created a default rule that certain procedures were cosmetic and therefore excluded from coverage. The subsection went on to list thirteen distinct surgeries, services, and procedures that were presumed to be cosmetic, including breast augmentation and surgeries to change the structure of the face, referred to in this comment as Facial Feminization Surgeries ("FFS").

Classifying certain procedures as presumptively cosmetic misunderstands the essential purpose of transgender care, which is to treat gender dysphoria. As discussed above, untreated gender dysphoria can have serious consequences and even be fatal.<sup>34</sup> Some treatments for gender dysphoria are also procedures that non-transgender people may undergo for purely aesthetic reasons. However, for some transgender people, these procedures are medically necessary treatment for gender dysphoria. For example, some transgender women experience gender dysphoria as a result of their facial features. Facial feminization surgery ("FFS"), a set of surgeries that often includes rhinoplasty, alleviates their dysphoria by converting a masculine face to a more feminine one.<sup>35</sup> For a transgender woman, a rhinoplasty can have a "radical and permanent effect

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<sup>33</sup> *Id.* at 2.

<sup>34</sup> *Carcano v. McCrory*, Expert Declaration of Deanna Adkins, M.D. in support of Plaintiffs' Motion for a Preliminary Injunction, dated 5/13/2016. Stating that "with the exception of some childhood cancers, gender dysphoria is the most fatal condition that I treat."

<sup>35</sup> K. Altman, "Facial Feminization Surgery: Current State of the Art," 41:8 INT'L J. ORAL & MAXILLOFACIAL SURGERY, 885 (2012), available at <https://www.ncbi.nlm.nih.gov/pubmed/22682235>.

on their quality of life” and therefore is medically necessary for that person, even though the same procedure would not be medically necessary for someone without gender dysphoria.”<sup>36</sup> The current version of the Regulation, however, sets the default rule that a rhinoplasty is cosmetic. This creates a significant harmful barrier to transgender people, particularly transgender women, receiving medically necessary treatment for gender dysphoria.

In contrast, the proposed Regulation relaxes and re-words, but does not eliminate, the presumption against coverage for certain procedures. At proposed subsection (4), the Regulation now begins by listing numerous surgeries, services, and procedures for which “Medicaid coverage will be available,” including breast augmentation, a surgery previously contained in the excluded list in the Regulation’s prior version. At proposed subsection (5), the Regulation goes on to state that for procedures not expressly stated in subsection (4), including “those done to change the patient’s physical appearance to more closely conform secondary sex characteristics to those of the patient’s identified gender,” coverage will be provided when medically necessary *and* when prior approval is received. The subsection concludes with a reiteration of the “presumed cosmetic” idea found in the previous version of the Regulation, and states that “coverage is not available for surgeries, services, or procedures that are purely cosmetic.”

The proposed Regulation is an improvement in that it allows for coverage, in some circumstances, of certain treatments that Medicaid previously deemed to be presumptively cosmetic and so excluded from coverage (e.g., breast augmentation). Even in so doing, however, the Regulation effectively continues to suggest, erroneously, that certain treatments are presumptively cosmetic and therefore require additional steps to establish eligibility for coverage. The proposed Regulation provides that hormone therapy and a finite list of specific surgeries, services, and procedures will be covered based on a determination of medical necessity. All other treatments are grouped into a separate section of the Regulation and require prior authorization and a “demonstration” of medical necessity for the patient in question in order to be covered. That section reiterates that “coverage is not available for surgeries, services, or procedures that are purely cosmetic.” This framework perpetuates a fundamental misunderstanding with respect to treatment for gender dysphoria and retains pernicious barriers to coverage for medically necessary treatment.

**Third**, the proposed regulation leaves in place unnecessarily burdensome requirements for mastectomy and breast augmentation (“chest surgery”). The proposed regulation continues to require two letters of referral for all gender affirming surgeries. The letters must be from providers who have independently assessed the patient, and one of the providers must be a psychiatrist, psychologist or psychiatric nurse practitioner with whom the patient has an ongoing relationship. This requirement has no basis in contemporary standards of care, which call for only one referral letter for chest surgery and do not require that it be from a psychiatrist, psychologist, or psychiatric nurse practitioner.<sup>37</sup> Moreover, the requirement of a second letter is a significant impediment to obtaining surgery. Many mental health providers lack basic familiarity with transgender people.<sup>38</sup>

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<sup>36</sup> *WPATH Standards of Care*, *supra* note 4, at 58.

<sup>37</sup> *WPATH Standards of Care*, *supra* note 11, at 27, 59.

<sup>38</sup> American Psychological Association, *Guidelines for Psychological Practice with Transgender and Gender Non-Conforming People*, 72 *American Psychologist* 832, 832 (Dec. 2015) (citing a survey of psychologists and graduate students that found that less than thirty percent of respondents had “familiarity with issues that [transgender and gender non-conforming] people experience”), available at <https://www.apa.org/practice/guidelines/transgender.pdf>.



Therefore, finding even one provider competent to treat gender dysphoria and refer the patient for surgery can be difficult, particularly in rural areas.<sup>39</sup> The cost of mental health care and the relative difficulty of finding a provider who accepts Medicaid create an additional challenge for low-income people. The proposed regulation also limits coverage of breast augmentation to situations where the patient is unable to take hormones or has had “negligible” breast growth after two years of continuous hormone therapy. Contemporary standards of care do not require these pre-requisites for breast augmentation.<sup>40</sup> The heightened standard under the proposed regulation would require some patients for whom breast augmentation is medically necessary to delay treatment for two years.

These requirements are likely unlawful. NYS Medicaid does not require two letters of referral—including one from a mental health practitioner—for patients having chest surgery not related to gender dysphoria. And federal Medicaid regulations prohibit discrimination on the basis of diagnosis.<sup>41</sup> Moreover, the New York State Human Rights Law prohibits discrimination against transgender people under both the sex and disability provisions.<sup>42</sup> Therefore, placing additional burdensome requirements only on transgender people who need chest surgery contravenes both federal and state law.

**The Proposed Regulation Should Adopt a Simple “Medical Necessity” Standard for All Gender-Affirming Surgeries, Services, and Procedures.**

In order to provide adequate coverage for all medically necessary treatment for transgender individuals, the proposed Regulation should remove subsections (4) and (5) – and the distinctions they make as to specific procedures, as set forth above – and simply state that Medicaid coverage shall be provided for all surgeries, services, or procedures to treat gender dysphoria that are consistent with contemporary standards of care. This simple, straightforward approach presents the following advantages when compared to the current structure of the proposed Regulation.

*First*, such an approach would bring the Regulation in line with the standard regulatory approach Medicaid typically adopts for other medical diagnoses. As a general matter, Medicaid coverage is limited to medically necessary care to “prevent, diagnose correct or cure” a condition that is “consistent with quality care and generally accepted professional standards.”<sup>43</sup> Given this general approach, importing a more detailed discussion into the regulation of approved procedures versus those requiring prior approval, or “therapeutic” procedures versus those presumptively considered

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<sup>39</sup> Dickey, Lore M. et al., *Mental Health Considerations with Transgender and Gender Nonconforming Clients*, Center of Excellence for Transgender Health University of California, San Francisco (2016), available at <http://transhealth.ucsf.edu/trans?page=guidelines-mental-health>.

<sup>40</sup> *Id.*

<sup>41</sup> 42 CFR § 440.230(c).

<sup>42</sup> 9 NYCRR 466.13; *Wilson v. Phoenix House*, 42 Misc. 3d 677, 700, 703 (Sup. Ct. Kings Co. 2013) (disability - citing cases); *Richards v. United States Tennis Ass'n*, 93 Misc. 2d 713 (Sup. Ct. NY Co. 1977) (sex).

<sup>43</sup> NY Soc. Serv. Law § 365-a(2); 18 § NYCRR 500.1.

cosmetic, takes a uniquely burdensome approach to the public coverage of a specific diagnosis—gender dysphoria.<sup>44</sup> Indeed, the City Bar has struggled to locate other portions of New York’s Medicaid regulations setting standards for medical coverage that single out particular medical interventions as per se “cosmetic” and, on that basis, prohibit their coverage.<sup>45</sup> In light of the general principle that Medicaid covers all medically necessary treatments for a medical diagnosis, any additional discussion in the proposed Regulation is unnecessary, harmful, and likely to cause problems in construction and interpretation, to the detriment of Medicaid-eligible transgender individuals.

**Second**, such an approach would better meet the medical needs of people of any age with gender dysphoria. As noted above, there is a range of effective treatments for gender dysphoria, and whether a particular surgery, service, or procedure is medically necessary will also depend upon the individual, in consultation with mental health and medical providers.<sup>46</sup> DOH’s proposed amendments to the Regulation would expand access to certain surgeries – e.g., genital surgeries – but retain arbitrary and unnecessary barriers to others, like facial feminization or breast augmentation. Given the varied treatment needs of people with gender dysphoria, regulating payment in this manner does not make sense. Simply providing coverage on equal footing for all medically necessary care is therefore a regulatory framework that better provides adequate coverage.

**Third**, the City Bar’s straightforward proposal described above would also prevent the Regulation from freezing into law coverage restrictions for treatments that are highly individualized and for which medical and therapeutic approaches are continuously evolving.<sup>47</sup>

**Fourth**, the City Bar’s proposal accords with the recent resolution of a similar Medicaid regulation coverage dispute in a neighboring state. In February 2016, a man who is transgender and a Medicaid recipient filed suit against the Pennsylvania Department of Human Services because the state’s Medicaid regulation categorically excluded coverage for “surgical procedures and medical care provided in connection with sex reassignment.”<sup>48</sup> Less than five months later, the parties voluntarily dismissed the lawsuit, with prejudice, and the Department took the simple approach of simply rescinding its prior exclusion. This resolution did not seek to parse or dictate what procedures would be covered, presumed cosmetic, or subject to additional burdens of prior

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<sup>44</sup> Such an additional burden placed upon this mental health diagnosis may also run afoul of the parity principles underlying state and federal mental health parity laws. *See, e.g.*, 29 U.S.C.S. § 1185(a); 45 C.F.R. § 146.136 (Mental Health Parity and Addiction Equity Act of 2008 and implementing regulations); N.Y. Ins. L. §§ 3221(l) (New York Mental Health Parity Law).

<sup>45</sup> One other section of the Medicaid regulations that expressly references non-coverage of certain care when cosmetic also allows the care when medically necessary. *See* 18 N.Y.C.R.R. § 505.6 (Ophthalmic Services: stating that two pairs of eyeglasses “shall not be provided for personal convenience or for cosmetic purposes” but, notably, shall be provided when a patient’s “particular needs” require it.)

<sup>46</sup> *See WPATH Standards of Care, supra* note 4.

<sup>47</sup> *See WPATH Standards of Care, supra* note 4, at 41 (“Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues.”).

<sup>48</sup> *See Doe v. Dallas*, C.A. No. 2:16-cv-00787-JCJ (E.D. Pa., Feb. 18, 2016).

authorization.<sup>49</sup> New York should follow suit and adopt the straightforward approach taken this year by Pennsylvania.

Committee on Lesbian Gay Bisexual and Transgender Rights Committee  
Anna Pohl, Chair

November 2016

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<sup>49</sup> See Pennsylvania Department of Human Services, “Federal Final Rule, ‘Nondiscrimination in Health Programs and Activities’ and Implication for Coverage of Services Related to Gender Transition,” Medical Assistance Bulletin No. 99-16-11 (Jul. 18, 2016) (“Effective July 18, 2016, the categorical MA regulatory prohibitions on payment for services related to sex reassignment . . . are no longer in effect.”).