



3-1-2012

The Need for Change: Evaluating the Medical Necessity of Gender Reassignment Through International Standards

Chad Ayers

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Recommended Citation

Chad Ayers, *The Need for Change: Evaluating the Medical Necessity of Gender Reassignment Through International Standards*, 18 Wash. & Lee J. Civ. Rts. & Soc. Just. 351 (2012).

Available at: <https://scholarlycommons.law.wlu.edu/crsj/vol18/iss2/9>

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The Need for Change: Evaluating the Medical Necessity of Gender Reassignment Through International Standards

Chad Ayers*

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“Surgery is not what transsexualism is ultimately about. Transsexualism is about life.”

- Jamison Green¹

Introduction

In his book, *Becoming a Visible Man*, Jamison Green discusses his experience of being born a biological female.² While Green’s parents taught him the expected societal conduct of a little girl, such as cleaning and housework, he felt more comfortable wearing his father’s sergeant cap from World War II and climbing trees.³ Green describes 1991 as his year of initiation into manhood.⁴ During that year, he completed sex reassignment surgery (SRS), was reissued his corrected birth certificate, and was “accept[ed] into a community of men.”⁵ The decision to undertake the full series of surgeries for SRS is not for everyone, but Green had a strong desire to live in the body he felt he was meant to have from the start of his life.⁶ He therefore undertook the procedures at a staggering cost.⁷ During the first year, he spent three weeks on disability and paid \$10,038.⁸ The subsequent two years would cost him an additional \$33,025 and ten weeks on disability.⁹ The total cost was \$43,063 with a projected ongoing cost of \$2,700 per year for continued hormone treatment.¹⁰

Many transgender individuals are not as fortunate as Green and cannot afford the high costs associated with hormone therapy and surgeries. Some individuals have taken extreme measures to obtain money and hormones, as evidenced by a 2007 ABC News story about transgender prostitutes.¹¹ The

1. JAMISON GREEN, *BECOMING A VISIBLE MAN* 89 (2004).

2. *See id.* at 11 (explaining his struggle against the societal norms of a female child).

3. *See id.* (providing anecdotes of his childhood struggles but emphasizing that his family encouraged his intellectual development and physical freedom).

4. *Id.* at 28.

5. *See id.* (elaborating upon his initiation into new communities by stating that he took on responsibilities in the newly emerging transgender community).

6. *See id.* at 99 (explaining his strong desire for permanent transition-related surgery in the summer of 1988).

7. *See id.* at 116–18 (outlining the costs of all of the procedures undertaken).

8. *Id.* at 117.

9. *Id.* at 117–18.

10. *Id.*

11. *See* Russell Goldman, *Making Change: The Cost of Being Transgender*, ABC NEWS, May 10, 2007, <http://abcnews.go.com/Health/story?id=3156598&page=1> (last visited Nov. 1, 2011) (providing accounts of transgender prostitutes) (on file with the Washington

report told of young girls, including twenty-two-year-old Kenyatta, who engaged in prostitution a few times per month in order to obtain money to purchase illegal hormones on the black market.¹² Although cheaper than hormones obtained through a physician, illegal hormones carry a higher risk for complications.¹³ Without the supervision of a physician, Kenyatta has an increased chance of developing deadly blood clots in her lungs, legs, heart, and brain.¹⁴

Some transgender individuals take part in medical tourism and travel to other countries.¹⁵ One example is Monika Weiss, who went to Thailand in order to undergo procedures to become a woman.¹⁶ She spent one-third of the amount of money she would have had to pay in the United States.¹⁷ One need spend only a few minutes searching the Internet to find the numerous websites advertising Thailand's cheap and easily accessible gender reassignment procedures.¹⁸ There are consequences for traveling abroad to receive surgery. Many surgeries are advertised on websites,¹⁹ requiring individuals to rely on their own knowledge while shopping for surgeons. A person must, therefore, be extremely knowledgeable in order

and Lee Journal of Civil Rights and Social Justice).

12. *See id.* (discussing the ease of access to hormones on the black market).

13. *See id.* (discussing the increased health risks of taking illegal hormones without supervision from a physician).

14. *See id.* (stating that progesterone has been linked to breast cancer and estrogen use can lead to blood clots).

15. *See* Richard S. Ehrlich, *Everything You Always Wanted to Know About Sex . . . Changes*, CNN, Feb. 24, 2010, <http://www.cnn.com/bangkok/play/everything-youve-ever-wanted-know-about-sex-changes-379486> (last visited Nov. 1, 2011) (discussing the price of surgery in the United States and American people traveling to Thailand for cheaper prices) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

16. *See id.* (describing the personal decision of one transgender individual to travel to Thailand).

17. *See id.* (“I paid one-third of what I would have paid in America for the same procedures,” [Monika] says while recovering in Bangkok.”).

18. *See* Aesthetic Plastic Surgery & Sex Change Surgery Ctr., BANGKOK PLASTIC SURGERY, <http://www.bangkokplasticsurgery.com> (last visited Nov. 1, 2011) (providing a wide range of services including: breast augmentation surgery, sex change surgery, and facial feminization surgery) (on file with the Washington and Lee Journal of Civil Rights and Social Justice); *see also* DOCTOR SARAN, <http://doctorsaran.com/> (last visited Nov. 1, 2011) (providing a package price list for SRS) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

19. *See, e.g.*, Aesthetic Plastic Surgery & Sex Change Surgery Ctr., *supra* note 18 (informing readers about surgeries); *see also* DOCTOR SARAN, *supra* note 18 (describing the various surgeries offered and providing prices).

to ensure adequate medical care abroad. Even if a patient obtains successful surgery, the recovery period could still pose a problem. For example, if a patient does not want to pay additional money, he or she must return home for later portions of the recovery period, which means he or she will not be under the supervision of the doctor who performed the surgery.²⁰

Monika and Kenyatta's stories illuminate a serious issue in the United States: If individuals need medical treatment in order to live in what they feel is their correct biological body, why are United States citizens turning to prostitution, the black market, and cheap procedures in foreign countries? This Note will answer this question and advance a solution by examining international and European standards. Part I will provide an overview of transgender medical needs in the United States. Part II will discuss the current barriers in the United States. Part III will examine standards created by international organizations in order to develop medical standards for the United States. Part IV will study how European countries implement those international standards. Finally, Part V will apply the lessons from international standards and European examples to the situation in the United States in order to remedy the pressing problems affecting transsexuals.

I. Overview of Transgender Medical Needs

Understanding the current state of healthcare for transitioning individuals requires knowledge of the terminology regarding transgender people as well as how the medical community approaches the situation. The term "transgender" is now used as "an umbrella term for anyone whose gender identity is at odds with his [or her] birth gender."²¹ "Transsexual" is a specific classification under the broader term of "transgender" and is used to describe individuals who have an "internal gender identity that does not

20. See SRS (Penile Skin Inversion), PREECHA AESTHETIC INST., <http://pai.co.th/srs-penile-skin-inversion/> (last visited Nov. 1, 2011) (detailing an example of a post-operative recovery period) (on file with the Washington and Lee Journal of Civil Rights and Social Justice). The institute requires that the patient stay in Thailand an additional fifteen days after surgery. *Id.* The recovery period, however, can last 4–8 weeks, during which strenuous activity is discouraged. *Id.* If complications arise after the initial fifteen days, the patient will often be in a different country than his or her original physician.

21. JOHN M. BURDA, GAY, LESBIAN, AND TRANSGENDER CLIENTS: A LAWYER'S GUIDE 156 (2008) (detailing a basic overview of transgender issues).

match the sex assigned at birth.”²² Transsexuals often undergo hormone therapy or SRS in order to correct their biological sex.²³ In order for transsexuals to pursue medical treatment in the United States, they usually must be diagnosed with some type of gender identity disorder.²⁴

Gender Identity Disorder (GID) is defined in the American Psychiatric Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV),²⁵ which lists five necessary criteria:

1. Evidence of a strong and persistent cross-gender identification;
2. Cross-gender identification must be more than a mere desire for the perceived cultural advantages of the other sex;
3. Evidence must exist of either a persistent discomfort with or a sense of inappropriateness in the gender role of one’s assigned sex;
4. The person must not have a concurrent physical intersex condition; and
5. Evidence must exist of clinically significant distress or impairment in social, occupational, or other important areas of functioning.²⁶

Many individuals diagnosed with GID often feel intense distress called gender dysphoria.²⁷ If untreated, gender dysphoria can lead to severe depression and even suicide in serious cases.²⁸ To treat these symptoms, transgender healthcare experts recommend a triadic therapy, which includes a real-life experience in the desired gender role, hormone therapy, and SRS.²⁹

22. *See id.* at 156 (distinguishing transsexuals from cross-dressers because cross-dressers, while dressing as the opposite sex, maintain an identity as a man or a woman and thus conform to societal expectations).

23. *See id.* (stating that transsexuals often feel persistent distress, which is relieved by hormone therapy and SRS).

24. *See* GREEN, *supra* note 1, at 93 (discussing the negative effects of classifying all transsexuals as having a mental disorder).

25. *See* AM. PSYCHIATRIC ASSOC., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 576–82 (4th ed. 2000) [hereinafter DSM-IV] (providing standard criteria for the classification of mental disorders).

26. *Id.* at 581–82.

27. *See* BURDA, *supra* note 21, at 156 (“Gender dysphoria refers to the persistent distress that transsexuals feel toward the gender assigned to them at birth.”).

28. *See id.* at 157 (“Untreated, the condition causes severe depression and, in some profound cases, leads to suicide.”).

29. *See id.* at 156 (outlining the usual prescribed treatment for gender dysphoria).

The real-life experience is an extended period of time during which a patient must live in his or her preferred gender role.³⁰ Physicians use the real-life experience, often for a twelve-month minimum, to test whether there is further consolidation of gender identity in the patient.³¹ Coupled with the real-life experience, psychotherapy helps to further the goal of a stable lifestyle.³² Therapy helps to illuminate the patient's history as well as his or her current expectations.³³ The goal of these two procedures is to ensure that the patient actually wants to undergo gender reassignment and that he or she is psychologically prepared for the start of the process.³⁴

Once a patient has begun the real-life experience and completed three months of psychotherapy, a physician may prescribe hormone treatment.³⁵ The positive effects of hormones often take years to develop; hormones are administered over a period of time before, during, and after SRS.³⁶ Numerous medical risks are associated with hormone therapy, including adverse effects on liver function and an increased risk of hyperprolactemia.³⁷ As a result of these risks, there is a strong need for

30. See RACHEL ANN HEATH, *THE PRAEGER HANDBOOK OF TRANSSEXUALITY: CHANGING GENDER TO MATCH MINDSET* 80 (Judy Kuriansky ed., 2006) (stating that the real-life experience is often for a minimum of twelve months but can be extended up to two years).

31. See WORLD PROF. ASSOC. OF TRANSGENDER HEALTH [WPATH], *STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS* 14 (2001), available at <http://www.wpath.org/documents2/socv6.pdf> (outlining the three readiness criteria for hormone therapy).

32. See *id.* at 12 (explaining that the goal of psychotherapy is not to cure GID but to help provide a stable lifestyle with realistic chances for relationships, work, and gender identity expression).

33. See *id.* (“[Therapy] enable[s] the patient’s history [to] be appreciated, current dilemmas to be understood, and unrealistic ideas and maladaptive behaviors to be identified.”).

34. See *id.* (defining the process of psychotherapy). The author notes:

The therapist should make clear that it is the patient’s right to choose among many options. The patient can experiment over time with alternative approaches. Ideally, psychotherapy is a collaborative effort. The therapist must be certain that the patient understands the concepts of eligibility and readiness, because the therapist and patient must cooperate in defining the patient’s problems, and in assessing progress in dealing with them.

Id.

35. See HEATH, *supra* note 30, at 113 (stating that transsexed men begin taking testosterone and transsexed women begin taking estrogen once a diagnosis of transsexualism is made).

36. See *id.* (stating that the positive effects of hormone therapy takes two or more years to develop).

37. See *id.* at 116–17 (concluding that hormone therapy is reasonably safe for both

close observation by a physician or endocrinologist throughout the entire period of hormone therapy.³⁸

The final part of the suggested triadic therapy is the surgery itself, which many patients do not choose.³⁹ SRS may include a number of different procedures. Genital reconstruction surgery is complex for both sexes.⁴⁰ For transsexual women, one procedure is called a vaginoplasty, which involves the creation of a vagina using both penile skin and a urethral flap.⁴¹ For transsexual men, phalloplasty, or the creation of a penis, is accomplished through a variety of intricate methods.⁴² Men can additionally receive a hysterectomy, oophorectomy, vaginectomy, and mastectomy.⁴³ After the primary surgical procedures, transsexual

transsexed women and men, but that the risks associated with it require observation by an endocrinologist). Hyperprolactemia is a disorder of the pituitary gland that results in an excess secretion of prolactin. *Id.* at 116.

38. *See id.* at 116 (stating that an endocrinologist should be aware of the possible complications associated with hormone therapy and make the risks clear to the patient).

39. *See id.* at 82 (explaining Harry Benjamin's categories of transvestites and transsexuals). A nonsurgical transsexual frequently dresses as the opposite biological sex and requests hormone therapy to maintain a satisfactory quality of life. *Id.* What Benjamin terms as a "true transsexual" requests gender reassignment surgery and hormone therapy. *Id.*

40. *See id.* at 124 ("The surgical procedures required to transform the male genitals into their female equivalent are complex."). Even though complex, genital reconstruction surgery "for transsexed women provides a satisfying outcome both cosmetically and functionally in most cases." *Id.* at 134. The procedures for transsexed men, however, "involve an unreasonable degree of cost, risk, and compromise." *Id.* Much of the complication results from the goal of phalloplasty, which is to "create a penis that has erotic sensation and is capable of both sexual intercourse and urination while standing." *Id.* Since the procedures for transsexed men are so complex and uncertain, many men are content with hormone therapy and cosmetic surgeries. *Id.*

41. *See id.* at 124–29 (describing the surgical procedure of a vaginoplasty in detail).

42. *See id.* at 134–37 (detailing the different options for the phalloplasty surgery). One method for phalloplasty "uses a bony skin graft from the underside of the forearm." *Id.* at 134. Another method produces a tube from "innervated skin from the lower abdomen." *Id.* at 135. The urethra is then constructed using a fold of skin from the labia majora and placed within the penis to allow urination while standing. *Id.* As an alternative to phalloplasty, men can undergo metoidioplasty, which creates a penis by using the enlarged clitoris that results from prolonged testosterone use. *Id.* at 136.

43. *See id.* (discussing a new surgical procedure that uses a one-stage procedure). The study notes:

Mastectomy and chest contouring are performed at the same time as oophorectomy (removal of the ovaries) and hysterectomy. The procedure concludes with phalloplasty, the penis being formed from a skin flap obtained from the anterior abdomen wall.

Id.

individuals can also receive treatment in the form of speech therapy, voice box surgery, and facial feminization therapy.⁴⁴

The costs and extent of psychological evaluations, hormone therapy, and surgical procedures make them difficult to obtain for a large portion of the transgender community.⁴⁵ A 2001 survey found that the average cost for male to female SRS was approximately \$10,400.⁴⁶ Prices of well-known surgeons ranged from \$4,500 to \$26,000 for male to female surgeries.⁴⁷ Female to male surgeries ranged from \$4,000 up to \$60,000 and averaged \$18,000 in 2001.⁴⁸ In addition to surgeries, the study estimated mental therapy sessions at a rate of \$125 per hour and assumed the average person to need at least four sessions annually.⁴⁹ Patients who have already transitioned and are functioning well in their new gender roles will need approximately two or three sessions per year, whereas a newly transitioned or transitioning individual may need up to twenty sessions per year.⁵⁰

Hormones are also costly.⁵¹ Male to female patients could spend well over \$1,000 for the first year of hormone treatment and over \$2,000 for the second year.⁵² After transitioning, the price for hormones remains fairly

44. *See id.* at 141–54 (discussing the various ancillary procedures available to transsexual patients).

45. *See* BURDA, *supra* note 21, at 157 (stating that SRS is expensive and often not covered by many Medicaid statutes and private insurance companies, resulting in many transsexuals not being able to afford the procedures).

46. *See* MARY ANN HORTON, THE COST OF TRANSGENDER HEALTH BENEFITS, OUT & EQUAL WORKPLACE SUMMIT 1 (2008), <http://www.tgender.net/taw/thb/THBCost-OE2008.pdf> (last visited Oct. 18, 2011) (estimating the cost of Transgender Health Benefits for United States residents) (on file with the Washington and Lee Journal of Civil Rights and Social Justice). The study notes:

The author sent a survey in 2002 to all surgeons and clinics who were members of HBIIGDA (Harry Benjamin International Gender Dysphoria Association), asking for data of primary surgeries performed in 2001: number, cost, and fraction who were US residents, separately for MTF (male to female) and FTM (female to male) patients.

Id. at 2.

47. *Id.*

48. *Id.* at 1–2.

49. *See id.* (estimating that a total first year cost of mental health therapy would total \$750).

50. *Id.* at 5–6.

51. *See id.* at 6–7 (discussing the costs associated with hormone therapy).

52. *See id.* at 6 (detailing the typical path of hormone treatment and the total cost of medicines per year). The study notes:

In the first year, the Premarin dose gradually increases from .625 mg/day to

consistent at approximately \$400 per year.⁵³ Female to male patients have a simpler regimen that costs approximately \$229 per year.⁵⁴ Transitioning individuals face additional charges for doctor's visits and yearly blood tests to determine hormone levels.⁵⁵

II. Barriers to Transition-Related Medical Care in the United States

Transsexuals seeking medical treatment in the United States face difficulties inherent in the transgender experience as well as difficulties resulting from the lack of uniform medical standards among the states.⁵⁶ For example, an October 2010 survey evaluating transgender discrimination in health care found that study participants were less likely than the general population to have health insurance and more likely to be covered by state programs such as Medicaid.⁵⁷ Medicaid statutes among the states differ as to whether or to what extent SRS and related services qualify as "medically necessary."⁵⁸ Private insurance companies also pose problems for transgender individuals because most of them either expressly exclude

3.75 mg/day, the dosage of Spironolactone remains steady at 100 mg/day, for a total cost of \$1,088. In the second year, .5 mg/day of Premarin, 100 mg/day of Spironolactone, and 200 mg/day of Prometrium is assumed, costing a total of \$2,376.

Id.

53. *See id.* ("In years 3 and on, a maintenance dose of 1.25 mg of Premarin, costing \$382 per year is assumed.")

54. *See id.* (assuming that it is a constant dosage of 1.0 cc of injectable Depo-Testosterone every two weeks that does not change over the lifetime of the patient).

55. *See id.* at 7–8 (stating that costs for doctor's visits will typically be \$510 in the first year, \$385 the second year, and \$225 in subsequent years).

56. *See* HEATH, *supra* note 30, at 169 (stating that transsexuals often "experience prejudice and . . . negative responses from caregivers").

57. *See* JAIME M. GRANT ET AL., THE NAT'L CTR. FOR TRANSGENDER EQUAL. & THE NAT'L GAY AND LESBIAN TASK FORCE, NAT'L TRANSGENDER DISCRIMINATION SURVEY REPORT ON HEALTH AND HEALTH CARE 8 (2010), available at http://transequality.org/PDFs/NTDSReportonHealth_final.pdf [hereinafter NCTE] (stating that 19% of the survey sample lacked any health insurance compared to 15% of the general population).

58. *See Know Your Rights—Transgender People and the Law*, AM. CIVIL LIBERTIES UNION (ACLU), Nov. 19, 2009, http://www.aclu.org/hiv-aids_lgbt-rights/know-your-rights-transgender-people-and-law (last visited Oct. 18, 2011) (stating that it is difficult to get Medicaid coverage of transition-related care) (on file with the Washington and Lee Journal of Civil Rights and Social Justice). The article further states that "[n]o state explicitly permits it, and many states explicitly deny it. In those that do not explicitly permit or deny it, coverage may still be denied under the rationale that transition-related treatment is 'experimental' or 'cosmetic.'" *Id.*

transition-related services or are unclear about the services covered.⁵⁹ A lack of federal legislation providing for uniform medical standards among the states contributes to the difficulty of funding coverage for transition-related care.⁶⁰

A. State Medicaid Statutes

Medicaid statutes vary from state to state.⁶¹ The federal Medicaid statute does not exclude reimbursement of treatments related to SRS, but states can choose whether to reimburse certain medical procedures under their programs.⁶² There are some favorable regulations and case law maintaining that states cannot categorically deny compensation for SRS under Medicaid programs, but there is also case law upholding states' denial of reimbursement for treatment related to SRS.⁶³

Although states may choose which medical procedures to reimburse under Medicaid, regulations constrain that choice.⁶⁴ For example, states may not deny services to an otherwise eligible individual solely because of diagnosis, type of illness, or condition.⁶⁵ The United States Court of Appeals for the Eighth Circuit has held that states cannot absolutely exclude the only known available medical treatment for a gender identity disorder because that would be considered an arbitrary denial of benefits based solely on the diagnosis, type of illness, or condition.⁶⁶ In *Pinneke v.*

59. *See id.* (stating that coverage of transition-related surgery or treatment depends on the specific contract with the health insurance companies).

60. *See id.* (stating that the two government programs addressing transition-related care, Medicare and the Civilian Health and Medical Program of the Uniformed Services, exclude transition-related services).

61. *See* BURDA, *supra* note 21, at 174 (providing some examples of states that excluded SRS).

62. *See id.* (stating that there is some favorable case law, but that it is difficult to obtain reimbursement through Medicaid).

63. *See* discussion *infra* at notes 64–83 (discussing case law allowing states to deny reimbursement for transition-related services).

64. *See* 42 U.S.C. § 1396(a)(A)(10) (2010) (providing a list of care and services that must be provided in order for medical assistance).

65. *See* 42 C.F.R. § 440.230(c) (2011) (“The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.”).

66. *See* *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980) (stating that there cannot be an irrebuttable presumption that SRS is never medically necessary). Appellee-Plaintiff Pinneke underwent extensive testing and doctors concluded that she had a

Preisser, the court stated that the Iowa Department of Social Services could not create an irrebuttable presumption that SRS can never be medically necessary and that it must take into account the applicant's diagnosed condition, the prescribed treatment, and the knowledge of the medical community.⁶⁷ The Supreme Court of Minnesota, in *Doe v. State*,⁶⁸ required an unbiased medical evaluation of whether SRS is medically necessary as determined on a case-by-case basis.⁶⁹

Although cases such as *Pinneke* and *Doe* illustrate that there have been some successes in obtaining funding for SRS, there are also numerous cases reaching the opposite result under a variety of rationales. In *Casillas v. Daines*,⁷⁰ Terri Casillas claimed that the New York Commissioner of Health deprived her of rights protected by the Constitution and federal law when he denied her Medicaid coverage for surgeries and services to treat her GID.⁷¹ The New York State Department of Health adopted a regulation that prohibits state Medicaid reimbursement for services related to gender reassignment.⁷² Casillas, with the support of her current psychologist and

transsexual personality. *Id.* at 547. Eligible under the Medicaid program, she applied for funding of her SRS, but was denied. *Id.* The court found that sex conversion surgery is the only medical treatment available to relieve the problems of a true transsexual. *Id.* at 548. Furthermore, the court concluded that the state plan was an arbitrary denial of benefits based solely on the "diagnosis, type of illness, or condition" since it absolutely excluded the only known treatment. *Id.* at 549.

67. *See id.* at 549–50 (stating that the decision of whether a certain treatment is "medically necessary" rests with the individual's physician and not with government officials).

68. *See Doe v. State*, 257 N.W.2d 816, 821 (Minn. 1977) (finding that the Minnesota Welfare Department's denial of medical assistance benefits to an adult male transsexual was arbitrary and unreasonable). Jane Doe was selected to undergo sex conversion surgery at one of the University of Minnesota Hospitals. *Id.* at 817. The federal funding for the program ended before Doe could undertake surgery. *Id.*

69. *See id.* at 820 ("The determination of medical necessity through a thorough medical evaluation of the individual applicant will ensure that those individuals genuinely requiring sex conversion surgery will be able to obtain it but will deny benefits to persons not demonstrating such medical necessity.").

70. *See Casillas v. Daines*, 580 F. Supp. 2d 235, 247 (S.D.N.Y. 2008) (granting the motion of the defendant for judgment on the pleadings). Terri Casillas claimed that the New York Commission of Health violated her equal protection rights by denying her reimbursement under Medicaid for services related to GID. *Id.* at 237. The state agency cited "serious complications" from the surgeries and the administration of estrogen. *Id.* at 247. The court found that the state agency's rationale provided a more than sufficient rational basis related to the government interest of protecting the health of its citizens and the conservation of limited medical resources. *Id.*

71. *See id.* at 237 (arguing that SRS, hormone therapy, and real-life experience together are an effective treatment for transsexualism or profound GID).

72. *See id.* at 237 (citing 18 N.Y.C.R.R. § 505.2(1) (2011)).

her prior treating psychiatrist, argued that the treatments were medically necessary.⁷³ Casillas argued that she had been denied equal protection on the basis of her diagnosis, but the court disagreed.⁷⁴ The state agency cited serious complications from the surgery and from the administration of estrogen.⁷⁵ The court ruled against Casillas and found that the agency's explanation survived rational basis review because it was protecting the health of state citizens and conserving limited medical resources.⁷⁶

Other courts have upheld the categorical denial of reimbursement for transition-related medical care on the grounds that SRS is "experimental" and that there is disagreement with regards to the efficacy of such procedures.⁷⁷ The court in *Rush v. Parham*⁷⁸ stated that the federal Medicaid statute gives states broad discretion for adopting standards and only requires that those standards be reasonable and consistent with the objectives of the Act.⁷⁹ In *Rush*, the United States Court of Appeals for the Fifth Circuit found that Georgia could reasonably exclude reimbursement of experimental treatments and remanded for the district court to determine if the specific procedures could be classified as such.⁸⁰ In *Smith v. Rasmussen*,⁸¹ the United States Court of Appeals for the Eighth Circuit upheld Iowa's prohibition on funding of SRS.⁸² Instead of concluding that

73. *See id.* at 238 ("In January 2007, plaintiff was examined by a medical doctor who is Professor and Chairman of Plastic and Reconstructive Surgery at the Philadelphia College of Osteopathic Medicine who has opined that hormones, orchiectomy and vaginoplasty are medically necessary to treat plaintiffs with GID.").

74. *See id.* at 246–47 (stating that the state agency satisfied a rational basis related to a legitimate government interest).

75. *See id.* at 247 (citing the agency's rationale for denying reimbursement of gender reassignment surgeries and associated treatments).

76. *See id.* ("This provided a more than sufficient rational basis which was related to legitimate government interests—the health of its citizens and the conservation of limited medical resources.").

77. *See Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980) (holding that Georgia could exclude SRS because of its status as an experimental treatment).

78. *See id.* (finding that Georgia's definition of "medically necessary" could reasonably exclude experimental treatment).

79. *See id.* at 1155 (giving broad discretion to states when deciding which treatments to cover under Medicaid programs).

80. *See id.* at 1156–57 (remanding the case to determine if the specific procedures could be classified as experimental).

81. *See Smith v. Rasmussen*, 249 F.3d 755, 762 (8th Cir. 2010) (finding that the rulemaking process resulted in a reasonable regulation that overcame the presumption in favor of the treating psychiatrist).

82. *See id.* at 760–61 (describing the rulemaking process that caused the exclusion of SRS).

the procedures were categorically experimental, the court cited the Department of Health's research that demonstrated differing opinions regarding the efficacy of SRS.⁸³

As evidenced by the decisions in *Rush* and *Smith*, there is disagreement in the United States medical community over the efficacy of both SRS and the various other components of transition-related care. A further complication caused by the Medicaid program is that states may place reasonable limits on a physician's discretion as to which medical procedures qualify as medically necessary.⁸⁴ Even if a doctor does decide that transition-related care is medically necessary for a patient, a state may still deny coverage as long as it has a legitimate interest, such as conserving resources.⁸⁵

B. Private Insurance Companies

The difficulties associated with coverage under state Medicaid programs leave many transsexuals relying on private insurance in order to fund transition-related medical care.⁸⁶ The first obstacle is affording private insurance. Transgender people often find economic and educational opportunities inaccessible due to persistent discrimination throughout their lifetimes.⁸⁷ Many transgender individuals drop out of school before finishing high school due to a lack of uniform anti-discrimination policies.⁸⁸ A large portion of the transgender community therefore faces financial hardships that make affording private insurance nearly impossible.⁸⁹

83. See *id.* at 761 (noting that the efficacy of surgery has been questioned).

84. See *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980) (detailing the ability of states to establish standards for individual physicians in determining what services are appropriate).

85. See *Smith*, 249 F.3d at 761 (noting the relevance of economic concerns and the state's interests in a state's decision whether to cover SRS).

86. See NCTE, *supra* note 57, at 8 (providing the percentages of respondents' source of insurance). While 3% of respondents received insurance through Medicaid, 7% of respondents purchased insurance. *Id.* In addition, 51% of respondents had insurance through either their own employer or through someone else's employer. *Id.*

87. See Dean Spade, *Compliance is Gendered: Struggling for Gender Self-Determination in a Hostile Economy*, in *TRANSGENDER RIGHTS* 217, 218–19 (Paisley Currah, Richard M. Juang, & Shannon Price Minter eds., 2006) (stating that much of the economic and educational discrimination against transgender individuals remains legal).

88. See *id.* at 219 (stating that harassment is widespread in schools). Many transgender people do not pursue higher education out of fear of applying to schools and needing to fill out applications, which will reveal their previous sex and name. *Id.*

89. See *id.* (“Furthermore, trans people face severe discrimination in the job market

Even if an individual can acquire private health care, there are still the additional obstacles of discrimination and exclusion of procedures. There has been some progress in protecting transgender individuals from discrimination in general.⁹⁰ One example is the Patient Protection and Affordable Care Act which bans insurance companies from dropping or denying coverage because of a pre-existing condition.⁹¹ While the bill prevents discrimination because someone is transgender or diagnosed with GID, it does not prevent insurance companies from excluding certain types of medical procedures.⁹² Because contract law governs private insurance, it is often up to the individual to ensure that the plan he or she purchases includes coverage for transition-related care.⁹³ Most insurance carriers either exclude many forms of transition-related care or are unclear about whether those services are covered.⁹⁴

Insurance companies commonly state that SRS is a cosmetic procedure and therefore not coverable under insurance plans.⁹⁵ In *Davidson v. Aetna Life & Casualty Co.*,⁹⁶ Victoria Davidson had an insurance policy through his employer stating that cosmetic surgeries would be covered only if the “surgery is necessary for the repair of non-occupational injury.”⁹⁷ Aetna attempted to argue that sex-reassignment surgery is cosmetic and not necessary to repair an injury.⁹⁸ The court ruled for Davidson, finding that

and are routinely fired for transitioning on the job or when their gender identities or expressions come to their supervisor’s attention.”).

90. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1205, 124 Stat. 119 (2010) (preventing discrimination based on one’s transgender identity); see also *Davidson v. Aetna Life & Cas. Ins. Co.*, 420 N.Y.S.2d 450, 453 (N.Y. 1979) (finding that SRS is not merely cosmetic surgery).

91. See Patient Protection and Affordable Care Act § 1205 (banning denial of coverage due to a previous condition); see also THE HENRY J. KAISER FAM. FOUND., SUMMARY OF NEW HEALTH REFORM LAW 1 (April 15, 2011), available at <http://www.kff.org/healthreform/upload/8061.pdf> (stating that the new bill extends Medicaid coverage to all individuals under the age of sixty-five).

92. See Patient Protection and Affordable Care Act §§ 1557, 2704 (prohibiting exclusion of preexisting conditions and preventing discrimination in coverage).

93. See ACLU, *supra* note 58 (stating that coverage depends upon the individual contract with the individual insurance company).

94. See *id.* (“Today, most insurance contracts either expressly exclude many forms of transition-related services or are unclear about whether such services are covered.”).

95. See *Davidson*, 420 N.Y.S.2d at 451 (stating that the defendant argued that the transsexual surgery in question was cosmetic).

96. See *id.* at 453 (finding that the SRS in question was necessary for the treatment of gender dysphoria).

97. *Id.* at 451.

98. See *id.* at 452–53 (stating that Aetna’s Medical Director maintained that there is

the procedure is performed in order to correct a psychological defect, not solely to improve muscle tone or physical appearance.⁹⁹ While *Davidson* was a victory for transgender individuals, the case also illuminates the fact that the outcome is dependent upon whether courts view transition-related care as medically necessary.¹⁰⁰

C. Consequences of the Difficulty to Access Transition-Related Care

Because of the difficulties associated with financing SRS and related treatment, many transsexuals turn to negative coping mechanisms.¹⁰¹ In a 2010 survey conducted by the National Center for Transgender Equality and the National Gay and Lesbian Task Force, surveyors asked participants about drug and alcohol use as a coping strategy for dealing with mistreatment and discrimination.¹⁰² Among respondents, 26% currently use or have used alcohol and drugs to cope with discrimination.¹⁰³ When asked about suicide, 41% of respondents said they had attempted suicide.¹⁰⁴

Numerous individuals avoid doctors and insurance companies in the United States by seeking alternative sources for surgery and funding for surgery.¹⁰⁵ One alternative is traveling to Thailand, which offers cheap and easy access to transition-related treatments.¹⁰⁶ Hormones are particularly easy to find and individuals can often obtain them without a doctor's

nothing physically wrong with a transsexual's body). He went further to say that the surgery was attempting to change the body to fit the transsexual's mind. *Id.* at 453.

99. *See id.* at 453 (stating that the court did not want to interfere with the professional judgment of medical experts). The court characterized cosmetic surgery as "optional or elective." *Id.* The medical diagnosis for the plaintiff indicated that the surgery was imperative in order for the plaintiff to live a normal life. *Id.*

100. *See id.* at 451–53 (analyzing the current understanding of transsexualism as a medical diagnosis). Ultimately, the decision to require coverage under an insurance plan depends on each individual's case.

101. *See* NCTE, *supra* note 57, at 14 (describing the damaging coping mechanisms to which transsexuals turn).

102. *See id.* (stating that the survey did not ask about general use of alcohol and drugs, only about use as a coping strategy).

103. *Id.*

104. *See id.* (estimating that only 1.6% of currently living Americans have attempted suicide).

105. *See* discussion *supra* Introduction (describing the personal stories of transsexuals who travelled to other countries for treatment).

106. *See* discussion *supra* Introduction (discussing the experience of Monika Weiss who spent one-third of what she would have in the United States).

prescription.¹⁰⁷ SRS is easier to obtain due to the lack of medical standards associated with the Western transgender experience.¹⁰⁸ Primarily, the requirement that a person live in his or her desired gender for a period of time, as well as the three-month psychological counseling, are not mandatory in Thailand.¹⁰⁹ After surgery in another country, the patient faces the further problem of arranging follow-up care.¹¹⁰ Traveling back to the United States requires a patient to undergo the healing process, as well as continued hormone therapy, under the supervision of a doctor who did not perform the surgery and who does not have an extensive knowledge of the patient's medical history.¹¹¹ Ultimately, SRS has become a commercially driven enterprise.¹¹² Patients seek out the cheapest procedures without considering the risks associated with those procedures.¹¹³

While some transsexuals travel to other countries to obtain SRS, others turn to prostitution in order to afford hormones on the black market.¹¹⁴ One can obtain hormones from Mexico at a reduced price and without a doctor's prescription.¹¹⁵ Because of the complexity of administering hormones over a transsexual's lifetime, endocrinologists and physicians are crucial to ensuring that a person is not subject to adverse side effects.¹¹⁶ These side effects include nausea, vomiting, headaches, mood swings, blood clots,

107. See Sam Winter, *Country Report: Thailand*, TRANSGENDERASIA (Feb. 5, 2002), http://web.hku.hk/~sjwinter/TransgenderASIA/country_report_thailand.htm (last visited Nov. 3, 2011) (stating that local chain drug stores can carry as many as twenty-three hormonal preparations, which are available without a prescription) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

108. See *id.* (stating that the WPATH Standards of Care are not followed in Thailand).

109. See *id.* (stating that the requirements for the real life test and for psychiatric counseling are not needed in Thailand).

110. See HEATH, *supra* note 30, at 114 (emphasizing the need for transitioning patients to remain under the care of a physician).

111. See discussion *supra* Introduction (reporting the story of Monika Weiss who traveled to Thailand to undergo SRS).

112. See HORTON, *supra* note 46, at 2 (finding that some SRS treatments cost as much as \$60,000).

113. See discussion *supra* Introduction (recounting stories of people who sought treatment in other countries due to cost).

114. See Goldman, *supra* note 11 (discussing how some New York City transsexuals turn to prostitution to afford treatments).

115. See *id.* (stating that hormones on the black market are usually hormones prescribed for menopause).

116. See HEATH, *supra* note 30, at 114 (stating that the patient should be in constant contact with a medical advisor throughout hormone therapy).

liver damage, and heart and lung complications, as well as problems with blood circulation and an increased chance of breast cancer.¹¹⁷

There are significant consequences to a lack of uniform medical standards. Transgender individuals already face significant discrimination and inequalities in most aspects of life, including housing, employment, and education.¹¹⁸ The high costs associated with the full transition experience make full treatment unobtainable for a large portion of the transgender community who seek to transition.¹¹⁹ Without an easy way to obtain medical care, many transsexuals face serious risks.

III. The International Organizational Approach to Transgender Healthcare

Although there is division within the United States over how to approach transsexual medical care, the international medical community has begun to formulate standards of care.¹²⁰ International communities, particularly in Europe, have seen great progress in providing protections for sexual orientation and gender identity, but the community has remained “fragmented and inconsistent.”¹²¹

A. Addressing Discrimination in Healthcare: The Yogyakarta Principles

In order to remedy these inconsistencies, human rights experts met in Yogyakarta, Indonesia in November 2006 and adopted the Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity.¹²² The Yogyakarta

117. *See id.* (detailing the risks associated with prolonged hormone therapy).

118. *See* CHRISTOPHER A. SHELLEY, *TRANSPeople: Repudiation, Trauma, Healing* 82–91 (2008) (discussing the difficulties transsexuals face in employment and education).

119. *See supra* Part I (discussing the costs of transition-related services).

120. *See supra* Part II.B (discussing differing court decisions and jurisdictions in the United States).

121. *See* THE YOGYAKARTA PRINCIPLES ON THE APPLICATION OF INTERNATIONAL HUMAN RIGHTS LAW IN RELATION TO SEXUAL ORIENTATION AND GENDER IDENTITY 6 (Mar. 2007), http://www.yogyakartaprinciples.org/principles_en.pdf (last visited Nov. 3, 2011) [hereinafter *YOGYAKARTA*] (discussing the current state of the international community as it has approached issues of gender identity and sexual orientation) (on file with the Washington and Lee University Journal of Civil Rights and Social Justice).

122. *See id.* at 6–7 (introducing the reasons for creating the principles, stating that “[a]ll human beings are born free and equal in dignity and rights” and “[a]ll human rights are universal, interdependent, indivisible and interrelated”).

Principles are a broad set of standards that recognize that all state actors should promote and protect human rights.¹²³

Principle Seventeen of the Yogyakarta Principles is particularly important in the healthcare context and addresses the right to the highest attainable standard of health.¹²⁴ The signatories conclude that states should take all necessary measures to ensure enjoyment of the highest standard of health regardless of sexual orientation or gender identity.¹²⁵ Subsection C emphasizes the need of states to “[e]nsure that healthcare facilities, goods, and services are designed to improve the health status of, and respond to the needs of, all persons”¹²⁶ The recognition of the need to provide adequate healthcare to all is important to the current discussion because much of the discord among United States courts and insurance carriers involves disagreement about which procedures are medically necessary for gender variant individuals.¹²⁷ Subsection G of the Yogyakarta Principles provides some possible clarification of this question by urging states to facilitate access to body modification related to gender reassignment.¹²⁸

The Yogyakarta Principles reflect international recognition of the need for standards in the area of transgender medical care. The United States, as a participant in a larger international community, can therefore look to international examples as a way of developing domestic medical standards. It is true that inconsistent standards exist both in the United States medical communities and among some international medical communities, but examination of recently accepted international standards, in Europe and in certain areas of the United States, begin to reveal growing continuity.¹²⁹ In order to understand the complex and emerging standards of care for transgender health, a good starting point is to examine relevant international organizations and the standards developed by them. Countries and medical

123. *See id.* at 7 (explaining the purpose and scope of the principles).

124. *See id.* at 22 (“Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity.”). “Sexual and reproductive health is a fundamental aspect of this right.” *Id.*

125. *See id.* (stating that states should “[t]ake all necessary legislative, administrative and other measures” to ensure access to healthcare without discrimination).

126. *Id.*

127. *See supra* Part II.B (discussing United States court decisions and varying approaches insurance carriers take).

128. *See supra* note 121, at 22 (stating that states should facilitate access to competent, non-discriminatory treatment, care, and support).

129. *See* discussion *infra* Part IV (discussing the European approach to funding transition-related care).

care providers can then implement the standards or use them as flexible guides for their respective medical systems.¹³⁰

B. Addressing Specific Needs of Transgender Individuals: The World Professional Association for Transgender Health

The World Professional Association for Transgender Health (WPATH) is the most widely known professional organization devoted to the understanding and treatment of GID.¹³¹ WPATH strives to bring together international professionals in order to develop the best practices and policies to promote the health, research, education, and overall equality of transgender, transsexual, and gender-variant people.¹³² The organization has developed a set of standards and has released a number of statements and clarifications that countries around the world have adopted or implemented.¹³³

WPATH published the first version of its Standards of Care in 1979, with the most recent revision in February 2001.¹³⁴ The Standards of Care

130. See Dr. Anne Lawrence, *Practice Information*, <http://www.annelawrence.com/practice/index.html> (last visited Oct. 4, 2011) (providing the practice information for Anne A. Lawrence, located in Seattle, Washington, among which is a provision stating that she regards the WPATH standards as flexible guidelines) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

131. See WORLD PROF. ASS'N FOR TRANSGENDER HEALTH, <http://www.wpath.org> (last visited Oct. 18, 2011) (describing the organization) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

132. See *Mission Statement*, WORLD PROF. ASS'N FOR TRANSGENDER HEALTH, http://www.wpath.org/about_mission.cfm (last visited Oct. 18, 2011) (outlining the mission statement of the organization) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

133. See WORLD PROF. ASS'N FOR TRANSGENDER HEALTH, THE HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION'S STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS (6th ed. 2001) [hereinafter STANDARDS OF CARE], available at <http://www.wpath.org/documents2/socv6.pdf> (providing flexible standards of care for Gender Identity Disorders); see also *Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.*, WORLD PROF. ASS'N FOR TRANSGENDER HEALTH (2008) [hereinafter WPATH CLARIFICATION], <http://www.wpath.org/documents/Med%20Nec%20on%202008%20Letterhead.pdf> (last visited Nov. 3, 2011) (clarifying that sexual reassignment surgery and hormone therapy for transgender individuals should be classified as a medical necessity and covered under U.S. insurance plans) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

134. See STANDARDS OF CARE, *supra* note 133, at 1 (discussing the history of the standards of care, which originated as the Harry Benjamin International Gender Dysphoria Association's Standards of Care).

are meant to serve as flexible instructions for the treatment of individuals with GID.¹³⁵ By providing a set of minimum standards for psychotherapeutic, endocrine, and surgical therapy, WPATH hopes to further “lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfillment.”¹³⁶

The Standards of Care begin by describing the history of gender identity disorders and by providing criteria for diagnoses.¹³⁷ Individuals are classified as suffering from a gender identity disorder when they meet specified conditions in one of two official nomenclatures: the International Classification of Diseases-10 (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).¹³⁸ Under the DSM-IV committee criteria, a person with a “strong and persistent cross-gender identification and a persistent discomfort with their sex or a sense of inappropriateness in the gender role of that sex” is diagnosed with gender identity disorder.¹³⁹ Under the ICD-10, other criteria provide more specific diagnoses.¹⁴⁰ In order for an individual to be classified as “transsexual,” the individual must have a desire to live and be accepted as a member of the opposite sex; the transsexual identity must have been present for at least two years; and the disorder must not be the symptom of another mental disorder or chromosomal abnormality.¹⁴¹ The ICD-10 criteria also state that transsexuals usually undertake surgery and hormone therapy as treatment.¹⁴²

135. *See id.* at 1–2 (stating that the eligibility requirements are supposed to be minimums, which the individual professionals may modify).

136. *See id.* at 1 (explaining the overarching treatment goal of psychotherapeutic, endocrine, and surgical therapies).

137. *See id.* at 1–2 (outlining how professionals diagnose gender identity disorders).

138. *See id.* at 2 (describing the clinical threshold in gender identity cases). The author notes:

A clinical threshold is passed when concerns, uncertainties, and questions about gender identity persist during a person’s development, become so intense as to seem to be the most important aspect of a person’s life, or prevent the establishment of a relatively unconflicted gender identity.

Id.

139. *Id.* note 133, at 4 (noting that the term “transgender” has been used in various ways and is not a formal diagnosis, but many professionals use it because it is often easier to use than the formal diagnosis).

140. *See id.* at 4–6 (detailing the criteria for transsexualism, dual-role transsexualism, gender identity disorder of childhood, and other gender disorders).

141. *See id.* at 4–5 (listing the three criteria for transsexualism specifically).

142. *See id.* at 5 (“The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the

Recognizing the difficulties transgender individuals face when pursuing surgery in the United States, WPATH released a “Clarification on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.”¹⁴³ This document calls for changes in the way the United States views and handles SRS and hormone therapy.¹⁴⁴ Numerous large employers have already negotiated contracts with insurance carriers to enable medically necessary treatment for transsexualism and/or GID to be covered under their plans.¹⁴⁵ More and more carriers are realizing the effectiveness of the treatment, and coverage is increasingly offered at no additional premium cost.¹⁴⁶

Despite this trend, there are still many instances in which transsexual individuals are turned away from coverage because the surgery and hormone therapy are not universally classified as “medically necessary.”¹⁴⁷ By contrast, the WPATH statement lists a number of procedures as medically necessary, including complete hysterectomies, genital reconstruction, facial hair removal, and certain facial plastic reconstruction.¹⁴⁸ The WPATH Board of Directors has urged insurance carriers and healthcare providers in the United States not to exclude transgender or transsexual individuals from coverage and to provide for prescribed sex reassignment services.¹⁴⁹

IV. The European Approach to Transition-Related Medical Care

preferred sex through surgery and hormone treatment.”).

143. See WPATH CLARIFICATION, *supra* note 133, at 2–3 (defining the medically necessary sex reassignment procedures).

144. See *id.* at 1–4 (stating that qualifying procedures as “medically necessary” is important in terms of access to U.S. insurance coverage and sex reassignment surgeries and hormone therapies should be classified as such).

145. See *id.* at 3 (stating that the City and the County of San Francisco, the University of California, the University of Michigan, and IBM have all negotiated contracts with their insurance carriers to provide coverage for medically necessary treatment in relation to transsexualism).

146. See *id.* (stating that Aetna, Cigna, and other carriers now have protocols recognizing the validity and effectiveness of treatment).

147. See discussion *supra* Part II.A (providing United States case law in which sexual reassignment surgery has been ruled not “medically necessary”).

148. See WPATH CLARIFICATION, *supra* note 133, at 2 (enumerating various techniques which may vary from patient to patient including skin flap removal and penile and testicular prostheses).

149. See *id.* (emphasizing the need to provide ongoing healthcare, both routine and specialized, that is readily accessible).

A number of European countries adhere to the WPATH Standards and have increased access to critical surgeries and hormone therapies.¹⁵⁰ Most European countries fund some aspects of sexual reassignment surgery, hormone therapy, or a combination of both.¹⁵¹ Thirteen of the twenty-seven European Union member states provide funding for psychotherapy, which extends beyond a mental health evaluation of the patient and continues to ensure the patient's mental health throughout the transition period and afterward.¹⁵² Some countries offer psychotherapy only occasionally because of its high costs.¹⁵³ Hormone replacement therapy, both before and after surgery, is provided by at least seventeen countries.¹⁵⁴

Many of the countries fund surgical procedures to alter primary and secondary sex characteristics.¹⁵⁵ Primary sex characteristics include vaginoplasty and phalloplasty.¹⁵⁶ Approximately half of the EU countries fund each of these surgeries.¹⁵⁷ For procedures such as phalloplasty, the quality of the surgery is important in assessing the country's willingness to provide funding.¹⁵⁸ If the phalloplasty is accomplished through minimal procedures, a state could be more likely to classify it as cosmetic.¹⁵⁹ Conversely, a more extensive surgery might have a better chance at obtaining funding.¹⁶⁰ Funding of primary sex characteristics may therefore

150. See STEPHEN WHITTLE ET AL., *TRANSGENDER EUROSTUDY: LEGAL STUDY AND FOCUS ON THE TRANSGENDER EXPERIENCE OF HEALTH CARE* 25 (2008), available at http://www.ilga-europe.org/home/issues/trans/ie_resources/transgender_eurostudy_legal_survey_and_focus_on_the_transgender_experience_of_health_care_april_2008 (stating that many European countries follow the WPATH standards in providing for psychotherapy).

151. See *id.* (providing general statistics regarding the funding of surgeries and hormone therapy provided by governments of various European countries).

152. See *id.* (explaining the comprehensive psychotherapy funded by various European countries for transitioning patients).

153. See *id.* (stating that the notable exception to providing psychotherapy is the United Kingdom because of the high cost of the treatment and the fiscal limitations of the National Health Service).

154. *Id.*

155. See *id.* (citing that up to thirteen countries provide genital reconstruction surgeries for both men and women).

156. *Id.*

157. See *id.* (stating that thirteen countries fund vaginoplasty for transsexual women, with a similar figure providing phalloplasty for men).

158. See *id.* at 25–26 (addressing the impossibility of accessing the quality of treatments provided).

159. See *id.* (citing vaginoplastics in the Czech Republic as an example of a minimal, purely cosmetic procedure, that is not funded).

160. See *id.* (stating that the Czech Republic provides for phalloplasty, which is four to five times the cost of vaginoplasty, but does not fund vaginoplasties). This may be because

depend on the surgical method. The secondary sex characteristics include breast augmentation, bilateral mastectomies, and hysterectomies.¹⁶¹ Over half of the European Union countries fund bilateral mastectomies and hysterectomies.¹⁶²

A. The Changing Legal Landscape

The increase in public funding for sex reassignment procedures is attributable in part to the changing legal views towards transsexuals in European courts and law-making bodies.¹⁶³ Although there were general successes in combating discrimination against transgender individuals prior to 2002,¹⁶⁴ a wider movement for change began with the European Court of Human Rights (ECHR) case of *Goodwin v. United Kingdom*.¹⁶⁵ Goodwin was a post-operative male to female transsexual who alleged that her employer had dismissed her from work because of her transsexuality.¹⁶⁶ The court found that there were violations of Articles 8, 12, and 14 of the Convention for the Protection of Human Rights and Fundamental Freedoms (the Convention).¹⁶⁷ The ECHR decision upheld protections for

the Czech Republic does not offer the most extensive surgery possible. *Id.*

161. *See id.* (stating that six countries fund breast augmentation surgery for transsexual women).

162. *See id.* (stating that sixteen countries publicly fund bilateral mastectomies and fifteen countries fund hysterectomies).

163. *See id.* at 17–21 (providing an overview of European Union anti-discrimination legislation including decisions by the European Court of Human Rights and the European Court of Justice on transgender rights).

164. *See id.* at 17 (discussing the emergence of protection against discrimination to transgender people in employment and protection in goods and services).

165. *See id.* at 18 (stating that *Goodwin v. United Kingdom* began a broader movement for transgender legal rights); *see also* *Goodwin v. United Kingdom*, App. No. 28957/95, Eur. Ct. H.R. (2002), [http://archive.equal-jus.eu/74/1/Christine_Goodwin_v._The_United_Kingdom_\(GC\)%2C_no._28957:95.pdf](http://archive.equal-jus.eu/74/1/Christine_Goodwin_v._The_United_Kingdom_(GC)%2C_no._28957:95.pdf) (last visited Oct. 18, 2011) (recognizing the right to private life and the right to marry for transgendered individuals, and acknowledging that the United Kingdom national health service and a majority of contracting states, recognize the condition of gender identity disorder and provide or permit surgery) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

166. *See Goodwin*, App. No. 28957/95, § 15 (stating that although her dismissal was supposedly connected with her health, applicant argued that it was actually because of her transsexuality). Applicant also argued that she suffered past discrimination at jobs because of her transsexuality. *Id.* In addition, she feared that employers would discriminate against her without issuance of a new National Insurance number. *Id.* § 16.

167. *See id.* § 59 (explaining that Article 8 of the Convention states that “[e]veryone has the right to respect for his private . . . life”). The court found through a balancing test

transsexuals for the right to marry, to found a family, and to have their private lives protected.¹⁶⁸

The court in *Goodwin* also addressed the notion of transsexualism as a “choice.”¹⁶⁹ It stated that most European states acknowledge the existence of the condition of transsexualism, with the vast majority providing, or at least permitting, treatment, including irreversible surgeries.¹⁷⁰ The court additionally reasoned that the level of commitment necessary to undergo gender reassignment surgeries is proof that the decision to undertake surgery is not an “arbitrary and capricious” decision.¹⁷¹ Because of the widespread acceptance of transsexualism as a medical diagnosis, the ongoing debate as to the specific cause is decreasing in relevance since the most important factor is that transsexuals do not choose the condition.¹⁷²

The European Court of Human Rights’ acknowledgement of the importance of gender reassignment surgery paved the way for additional cases expanding the rights of transsexuals.¹⁷³ One such case was *L v. Lithuania*¹⁷⁴; L was a transitioning female to male.¹⁷⁵ He underwent partial

that there were no significant factors of public interest to weigh against the interest of providing Christine Goodwin with legal recognition of her gender reassignment. *Id.* § 93; *see also id.* § 94 (stating that Article 12 of the Convention provides for the right to marry). The court concluded that a violation of Article 12 had occurred because of the government’s denial of applicant’s new insurance number. *Id.* § 104; *see also id.* § 105 (stating that Article 14 of the Convention provides for the rights set forth in the Convention to be secured without discrimination). The court found that this issue had been examined under Article 8 of the Convention. *Id.* § 108.

168. *See id.* § 103 (stating that the court found no justification for barring transsexuals the right to marry).

169. *See id.* § 81 (stating that there are no conclusive findings as to the cause of transsexualism and whether it is psychological or associated with physical differentiation in the brain).

170. *See id.* (finding that transsexualism has wide international recognition as a medical condition with a prescribed treatment).

171. *See id.* (stating that the numerous painful procedures necessary for gender reassignment make it unlikely that people undertake the surgery arbitrarily and capriciously).

172. *See id.* (finding that the ongoing medical and scientific debate as to the exact causes of transsexualism is of diminishing importance).

173. *See L. v. Lithuania*, App. No. 27527/03, Eur. Ct. H.R., §§ 59–60 (2008), <http://cmi.skp.echr.coe.int/tkp197/view.asp?action=html&documentId=823071&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649> (last visited Oct. 18, 2011) (finding that Lithuania violated the Convention for the Protection of Human Rights and Fundamental Freedoms by not allowing procedures for gender reassignment surgery) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

174. *See id.* (finding a violation of the Convention for the Protection of Human Rights and Fundamental Freedoms by the Lithuanian government).

175. *See id.* § 7 (stating that the applicant knew from an early age that he was aware his

gender reassignment surgery by having his breasts removed and agreed with his doctors that further surgeries were appropriate.¹⁷⁶ In order to receive the further treatment he needed in Lithuania, L was waiting on the passage of a Gender-Reassignment Bill.¹⁷⁷ The government delayed passing the bill, which meant that the surgery could not be conducted in Lithuania.¹⁷⁸ Without the additional surgery, L remained female under domestic law.¹⁷⁹ The court found that the government had waited too long to implement the laws that would allow for the completion of gender reassignment surgery.¹⁸⁰ By not allowing this type of surgery in the country, the Lithuanian government violated Article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms.¹⁸¹ With a majority of European Union states offering gender reassignment surgery, *L v. Lithuania* gave strong support to transsexuals seeking all aspects of the transition process.

There have also been significant gains relating directly to insurance coverage for transition-related care. An issue paper by Thomas Hammerberg, the Council of Europe Commissioner for Human Rights, examines the current ability of transgender individuals to access transition-related services, if they choose to transition.¹⁸² The case law of the ECHR requires states to at least provide for the possibility of surgeries that will eventually lead to full gender reassignment, as was the case in *L v. Lithuania*.¹⁸³ Additionally, the Commissioner notes that case law also

mental state was male).

176. *See id.* § 19 (stating that L underwent breast removal from May 3 to May 9, 2000).

177. *See id.* §§ 25–30 (describing the Civil Code adopted in 2001, which provided that an unmarried adult had the right to gender reassignment surgery, and noting that the Gender Reassignment Bill, which was to be added to the Civil Code, was omitted from the Parliament’s agenda).

178. *See id.* § 30 (stating that the government dropped the Gender Reassignment Bill from the Parliament’s agenda).

179. *See id.* § 39 (detailing L’s argument that the removal of the Gender Reassignment Bill left him without the ability to finish his transition).

180. *See id.* § 59 (finding that budgetary constraints do not justify four years of inaction on legislation).

181. *See id.* § 60 (concluding the government violated Article 8).

182. *See* Thomas Hammerberg, *Human Rights and Gender Identity*, OFFICE OF COMMISSIONER FOR HUMAN RIGHTS, 7–8 (July 29, 2009), <https://wcd.coe.int/com.instranet.InstraServlet?Index=no&command=com.instranet.CmdBlobGet&InstranetImage=1824655&SecMode=1&DocId=1433126&Usage=2> (stating that the paper addressed the human rights concerns regarding transgender person).

183. *See id.* at 26 (“The European Court of Human Rights has established as a positive duty that states provide for the possibility of undergoing surgery leading to full gender-

states that insurance plans in the European Union should cover “medically necessary” treatment in general, which includes gender reassignment surgery.¹⁸⁴ The Commissioner goes further to say that all Council of Europe member states should apply that standard to insurance plans in their respective countries.¹⁸⁵

B. Coverage of Transition-Related Procedures in Specific Countries

While standards for the transition-related care have clearly begun to emerge in Europe, there are still inadequacies in many European Union countries. Ultimately 80% of transgender people in the EU were refused state funding for hormone treatment, and 86% of transgender people are refused state funding for surgical procedures.¹⁸⁶ Because of the persistent difficulty in obtaining state funds, 50% of transgender individuals in the EU must individually pay for their procedures.¹⁸⁷ These statistics are surprising given the recent successes for the European transgender community.¹⁸⁸ One of the biggest reasons for the high rate of refusal for funding is the European Union’s lack of enforcement.¹⁸⁹ It is therefore necessary to examine some important European countries in detail, in order to see which surgeries they most often fund, the processes for state funding, and why countries might be failing at the implementation phase.

1. The United Kingdom

reassignment.”).

184. *See id.* (stating that European Court of Human Rights case law calls for coverage under insurance plans).

185. *See id.* (stating that the standards should be adopted by all Council of Europe states).

186. *See* WHITTLE, *supra* note 150, at 54 (finding that more respondents who transitioned less than five years ago had been refused funding for hormones than those who transitioned more than ten years ago).

187. *See id.* at 56–57 (providing the percentage of respondents who were refused treatment and paid themselves).

188. *See id.* at 54 (“This is a worrying finding as the assumption would be that access to funding for treatment would be improving.”).

189. *See id.* at 68 (“One of the most frustrating aspects of the EU for trans people has been its failure to ensure that Member States are meeting their obligations under the directives, regulations, policies and case law.”).

The United Kingdom has established one of the most universal healthcare systems in the world. All people “ordinarily resident” in the United Kingdom are entitled to health care.¹⁹⁰ The National Health Services (NHS) of England, Scotland, Wales, and Northern Ireland accounts for 86% of total health expenditure and is funded through general taxation.¹⁹¹ In England, the Department of Health holds the management responsibility, while decisions about service delivery and local priority lie with the Strategic Health Authorities and the Primary Care Trusts.¹⁹²

In the United Kingdom, the treatment referral pathway for gender reassignment surgery is often similar to the one utilized in the United States and generally follows the WPATH standards.¹⁹³ The Worcestershire Commissioning Policy and Referral Guidelines for Gender Dysphoria Services gives an example of this pathway.¹⁹⁴ A physician must first diagnose the patient with Gender Identity Disorder.¹⁹⁵ Leading up to the commencement of hormone therapy, the patient must perform the real life test (RLT), which includes a minimum of two years living as the opposite gender to that assigned at birth.¹⁹⁶ After three months of the RLT, the patient begins the initial phases of hormone therapy.¹⁹⁷ Surgery is allowed only if the patient meets strict qualifications, including performing the RLT, obtaining ongoing hormone therapy, and changing his or her name legally.¹⁹⁸ There are problematic qualifications in parts of the United

190. See Sean Boyle, *The UK Health Care System*, THE COMMONWEALTH FUND (2008), http://www.commonwealthfund.org/usr_doc/UK_Country_Profile_2008.pdf?section=4061 (last visited Oct. 18, 2011) (“Coverage is universal.”) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

191. See *id.* (stating that the NHS is mainly funded by general taxation, as well as by national insurance contributions and user charges).

192. See WHITTLE, *supra* note 150, at 33 (discussing the National Health System in the United Kingdom).

193. See *supra* Part III.B (discussing the WPATH Standards of Care).

194. See WORCESTERSHIRE PRIMARY CARE TRUST, COMMISSIONING POLICY AND REFERRAL GUIDELINES FOR GENDER DYSPHORIA SERVICES AND GENDER REASSIGNMENT SURGERY IN ADULTS 2 (July 2008), available at <http://www.worcestershire.nhs.uk/search.aspx?q=%22GENDER+DYSPHORIA+SERVICES%22&type=docs> [hereinafter COMMISSIONING POLICY] (stating that the guidelines describe the criteria for referral to gender identity services and for gender reassignment surgery).

195. See *id.* at 4 (stating that patients must have an initial diagnosis of transsexualism or GID by a local consultant psychiatrist).

196. See *id.* at 5 (stating that periods of returning to their original gender should be excluded from the two year RLT).

197. See *id.* (including the criteria that patients demonstrate knowledge of what hormones can and cannot do medically).

198. See *id.* (requiring that the patient change his or her name to one “appropriate to the

Kingdom. One such qualification is the requirement that the patient maintain employment or education in the desired gender role for a minimum of one year.¹⁹⁹ This is often difficult due to discrimination in areas of employment and education.²⁰⁰ Additionally, patients may be forced to wait up to three years for surgery due to the current demand for the procedures.²⁰¹

Despite some shortcomings in the specific referral process, the United Kingdom provides funding for most aspects of transition-related care under the NHS.²⁰² Among the funded procedures are hormone replacement therapy, bilateral mastectomies, hysterectomies, vaginoplasties, and phalloplasties.²⁰³ Assuming that full gender reassignment constitutes surgery to augment the genitals and hormone replacement therapy, funding for these procedures is a success for transgender individuals living in the United Kingdom because it provides for the minimum number of procedures to achieve full gender reassignment.²⁰⁴ Some individuals may feel that other procedures are crucial to his or her complete transition. Psychotherapy, often seen as a crucial part of the gender reassignment process, is not available from the NHS because of the therapy's high cost and the fiscal limits of the NHS.²⁰⁵ In addition, procedures such as permanent hair removal and breast augmentation surgeries are not considered crucial aspects to the gender reassignment process and are not covered by the NHS.²⁰⁶ There are therefore notable shortcomings since numerous procedures are not covered under the national health plan. Transsexual individuals desiring to undergo those procedures may find aid, however, from the strong

transgendered self”).

199. *See id.* (“Patients should have found employment, or been in education or training, in their desired gender role for a minimum period of one year, including employment in the voluntary sector.”).

200. *See* discussion *supra* note 166 (discussing *Goodwin v. United Kingdom* and the difficulties Christine Goodwin faced in terms of employment).

201. *See* HEATH, *supra* note 30, at 93 (stating that many clients seek private surgical arrangements because the National Health Service waiting time is three years).

202. *See* WHITTLE, *supra* note 150, at 25 (detailing the procedures publically funded by the United Kingdom).

203. *Id.*

204. *Id.*

205. *See id.* (stating that the fiscal limitations of the NHS prevent some funding for psychotherapy).

206. *See* COMMISSIONING POLICY, *supra* note 194, at 6 (stating that “breast presence or size is not a defining characteristic of sex or gender”).

suggestion that insurance plans should cover all “medically necessary” procedures.²⁰⁷ While breast augmentation and hair removal are still largely seen as cosmetic, psychotherapy may have a better chance at being classified as “medically necessary” because it is one of the prerequisites for surgery.

Other shortcomings exist for transsexual individuals after surgery. For many years, the government refused to change identification documents to match the new sex.²⁰⁸ In 2002, the ECHR issued a statement to the British government telling it to recognize new gender statuses on government documents.²⁰⁹ While there have been some successes in the United Kingdom with legislation such as the Gender Recognition Act of 2004, there are still areas of protection that need improvement.²¹⁰ One example of necessary improvements is in the area of pension rights. The Council of Europe Commissioner for Human Rights has found that transgender women have been denied the same pension rights received by other women in the United Kingdom.²¹¹ Even with the need for improvements in areas after surgery, the United Kingdom is still a prime example of how European countries are expanding rights for transgender individuals and recognizing most aspects of gender reassignment surgery as “medically necessary.”

2. Germany and Sweden

Unlike the United Kingdom, Germany and Sweden provide funding for every aspect of the gender reassignment process.²¹² In Germany, care is

207. See discussion *supra* note 182 and accompanying text (discussing Thomas Hammerberg’s call for all European Union members to cover SRS under insurance plans).

208. See GREEN, *supra* note 1, at 92 (stating that prior to 2002 transsexuals faced difficulties in obtaining employment, pensions, and marriage licenses).

209. See *id.* (stating that the order resulted from a thirty-year battle involving numerous petitions from British citizens).

210. See Gender Recognition Act, 2004, c. 7, § 9 (U.K.) (stating that when a full gender recognition certificate is issued, the person’s gender becomes the acquired gender).

211. See *Discrimination Against Transgender Persons Must No Longer be Tolerated*, STOP TRANSPHOBIA (Jan. 11, 2009) <http://stoptransphobia.wordpress.com/2009/01/11/%E2%80%9Cdiscrimination-against-transgender-persons-must-no-longer-be-tolerated%E2%80%9D/> (last visited Nov. 3, 2011) (providing an excerpt from the Commissioner for Human Rights detailing the failures of the United Kingdom government) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

212. See WHITTLE, *supra* note 150, at 22 (detailing the procedures publicly funded by Germany and Sweden).

financed by a combination of statutory health insurance, general taxation, private health insurance, and some user co-payments.²¹³ Compulsory contributions, split between employers and employees, are put into one of a large number of sickness funds.²¹⁴ The type of sickness fund determines how much a person must contribute and the type of healthcare services available.²¹⁵ Sweden has a similar universal healthcare structure. Services are covered based on three main principles: equal access, care based on need, and cost effectiveness.²¹⁶ Approximately 70% of healthcare services in Sweden are funded through local government taxes.²¹⁷ In 2007, only 3% of the Swedish population was covered by private insurance.²¹⁸

German and Swedish transsexuals have the possibility to obtain state-sponsored funding of all transition-related treatments.²¹⁹ Providing public funding for hair removal is a unique and important success.²²⁰ Hair removal is similar in cost to full genital surgery and is often considered essential in order to live successfully as a woman.²²¹ In addition to hair removal procedures, Germany provides breast augmentation surgery for transsexual women.²²² Both Germany and Sweden provide funding for psychotherapy, vaginoplasty, mastectomy, phalloplasty, and metoidioplasty.²²³

213. See REINHARD BUSSE, THE COMMONWEALTH FUND, THE GERMAN HEALTH CARE SYSTEM 2–3, <http://www.allhealth.org/briefingmaterials/CountryProfiles-FINAL-1163.pdf> (last visited Nov. 3, 2011) (stating that the publicly funded scheme is operated by over 200 competing health insurance funds) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

214. See WHITTLE, *supra* note 150, at 31–32 (“Currently, the healthcare system is funded by compulsory contributions that are split between employers and employees and are put into one of a large number of sickness funds.”).

215. See *id.* (stating that the 252 sickness funds insure approximately 90% of the population).

216. See *Sweden’s HealthCare System*, SWEDISH HEALTHCARE ACADEMY, <http://www.swedishhealthcare.se/sida1.html> (last visited Nov. 3, 2011) (stating that those included are not actually enumerated) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

217. See *id.* (stating that most of the public financing comes from county council taxes).

218. See *id.* (suggesting that private insurance is on the rise).

219. See WHITTLE, *supra* note 150, at 22 (providing a chart of all the procedures Germany and Sweden publicly fund).

220. See *id.* at 25 (stating that only Germany and Sweden publicly fund hair removal).

221. See *id.* (stating that the cost of hair removal greatly exceeds the cost of breast augmentation and that it is similar to the cost of full genital surgery).

222. See *id.* (including Germany as one of six countries that provided public funds for breast augmentation).

223. *Id.*

While both countries allow for the possibility of government funding for all procedures, the systems have some limitations and drawbacks. For example, both countries fund the surgeries, but still require sterilization in order to have birth records changed after surgery.²²⁴ In the United Kingdom, a person can easily change his or her name, but Germany and Sweden require all aspects of surgery and hormone treatment in addition to permanent sterility in order for a name change to be granted.²²⁵ There is, however, a trend towards greater protection for transitioned individuals. Swedish Prime Minister Fredrik Reinfeldt and the National Board of Health and Welfare are making efforts to remove the law in Sweden that requires permanent sterility.²²⁶ The transsexual community in Germany is hopeful that the new government will reform the “Transsexual Law” and deal with some of these issues within the next legislative period.²²⁷

Finally, both systems are constrained by monetary issues. Sweden’s system is based on need and cost effectiveness.²²⁸ Even if all of the procedures are determined to be necessary to an individual patient, cost effectiveness could play a role and eliminate more traditionally “cosmetic” surgeries, such as breast augmentation and hair removal.²²⁹ The same is true for Germany, where long-term affordability of healthcare reform remains a strong concern.²³⁰ If costs are too high, it may mean that national

224. See WHITTLE, *supra* note 150, at 26 (stating that France, Germany, Lithuania, and Sweden can sometimes require permanent sterility).

225. See *id.* (stating that the United Kingdom has no legal obstruction to changing a person’s name to something that is more appropriate to their new gender, while Germany and Sweden require medical intervention up to and including treatment to render permanent sterility).

226. See *Sex Change Sterilization “A Dark Chapter”*: Reinfeldt, THE LOCAL (Jul. 13, 2010), <http://www.thelocal.se/28114/20100731/> (last visited Nov. 3, 2011) (stating that leaders of Sweden’s seven political parties have expressed support to amend legislation that forces compulsory sterilization in order to get a divorce after a sex change) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

227. See C. Balzer & A. Suess, *TvT Research Project Country Results: Germany—Elaborated Version*, TRANS RESPECT VERSUS TRANSPHOBIA WORLDWIDE (Jan. 2010) http://www.transrespect-transphobia.org/en_US/countries/germany-1/germany-2.htm (last visited Nov. 3, 2011) (providing a list of initiatives regarding the recognition of transgender rights in the national constitution) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

228. See discussion *supra* at note 216 and accompanying text (describing Sweden’s healthcare system).

229. See *id.* (describing Sweden’s healthcare system).

230. See WHITTLE, *supra* note 150, at 32 (stating that long-term affordability remains an important concern for Germany’s healthcare system).

health insurances will not cover breast augmentation or hair removal.²³¹ What is important, however, is that transgender individuals in Germany and Sweden have some options for funding under a national insurance plan, a private insurance plan, or a combination of the two. These choices are in stark contrast to the situation in the United States, where insurance providers can exclude coverage as they see fit.²³²

3. Italy and Spain

Several European countries, such as Italy and Spain, are severely lacking in provisions for transgender needs, but even these countries have shown some positive trends. Italy provides for gender reassignment surgery free of charge in hospitals, but the procedures are subject to the authorization of courts.²³³ Surgical procedures to alter both primary and secondary sex characteristics are funded by the Italian government.²³⁴ Italy applies its own set of standards for determining eligibility and providing reassignment procedures.²³⁵ The Italian standards state that SRS can be carried out after obtaining a court order.²³⁶ In order to get a court order, individuals must meet certain qualifications, including the criteria for reassignment established in DSM-IV and ICD-10.²³⁷ Hormone replacement

231. See Balzer & Sues, *supra* note 227 (stating that health insurance in Germany does not often cover hair removal or breast augmentation).

232. See *supra* Part II.B (discussing how insurance companies can exclude coverage for various medical procedures).

233. See Submission to the United Nations Human Rights Council for its Universal Periodic Review of Italy, *Italy: The Status of Lesbian, Gay, Bisexual and Transgender Rights* 5 (Seventh Session) http://lib.ohchr.org/HRBodies/UPR/Documents/Session7/IT/J1_UPR_ITA_S07_2010_JointSubmission1.pdf (last visited Nov. 3, 2011) (stating that gender reassignment surgery is subject to the authorization of courts) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

234. See WHITTLE, *supra* note 150, at 22 (providing a chart of the procedures Italy publicly funds, including vaginoplasties, hysterectomies, and phalloplasties).

235. See Anna R. Ravenna, *Italian Standards of Care for Sex Reassignment in Gender Identity Disorder*, 2 INT'L J. OF TRANSGENDERISM 4 (1998), available at [http://www.iiv.nl/eazines/web/IJT/97-03/numbers/symposion/ijtc0602.htm#STANDARDS%20OF%20CARE%20FOR%20SEX%20REASSIGNMENT%20IN%20GENDER%20IDENTITY%20DISORDER%20\(DSM%20IV%20302.85\)](http://www.iiv.nl/eazines/web/IJT/97-03/numbers/symposion/ijtc0602.htm#STANDARDS%20OF%20CARE%20FOR%20SEX%20REASSIGNMENT%20IN%20GENDER%20IDENTITY%20DISORDER%20(DSM%20IV%20302.85)) (stating that the standards are to be minimal requirement recommendations only).

236. See *id.* at Procedure Criteria B5 (stating that a court order and a common agreement of the operators must be obtained in order to undergo surgery).

237. See *id.* (explaining the requirements for obtaining a court order).

therapy is also not provided by the Italian government even though it is required before a court will allow surgery.²³⁸

Spain is another example of a European country that does not offer much protection for its transgender community, especially funding for gender reassignment surgery.²³⁹ At the time of the Transgender Eurostudy, Spain provided public funding only for hormone therapy and psychotherapy.²⁴⁰ Occasionally the government has provided funding for vaginoplasties, but it does not provide funding for primary and secondary surgical procedures, hair removal, or breast augmentation.²⁴¹

There have been recent movements in Spain to include gender reassignment procedures in the public health services.²⁴² The political parties *Bloque Nacionalista Gallego* and *Esquerra Republicana Catalunya* have supported proposals that would include the gender reassignment process in the national Public Health System.²⁴³ There are several autonomous communities within Spain that have included gender reassignment procedures as covered services, including Aragon, Asturias, Basque Country, Canary Islands, Catalonia, Community of Madrid, Community of Valencia, and Extremadura.²⁴⁴ While there are no standard protocols for all of these communities, the process largely adheres to the WPATH Standards of Care.²⁴⁵ If a surgery is not offered in an area, patients are referred to units that provide them.²⁴⁶ In some cases, if a person is referred

238. See WHITTLE, *supra* note 150, at 22 (stating that Italy does not provide public funding for hormone therapy).

239. See *id.* (indicating that Spain provides public funds for psychotherapy and hormone therapy).

240. *Id.*

241. See *id.* (stating that Spain has occasionally provided funding for vaginoplasties).

242. *Id.*

243. See *TVT Research Project Country Results: Spain—Elaborated Version*, TRANS RESPECT VERSUS TRANSPHOBIA WORLDWIDE, (May 2010) http://www.transrespect-transphobia.org/en_US/countries/spain-1/spain-2.htm (last visited Nov. 3, 2011) (stating that the political parties have pressed for coverage of gender reassignment process on the national level) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

244. See *id.* (providing a list of autonomous communities that have opted to cover the gender reassignment process).

245. See *id.* (stating that “Gender Identity Disorders Units” are set up according to the WPATH Standards of Care).

246. See *id.* (explaining that patients are referred to units if the unit they are currently in does not perform the needed surgery).

to a different area, the public health system will pay for the referral costs, but that payment is not a guarantee.²⁴⁷

Italy and Spain are therefore two examples of European countries that provide the least in terms of funding for gender reassignment procedures.²⁴⁸ Despite those failures, both countries show evidence of change towards greater protection for transgender individuals. Italy provides funding for surgeries subject to court approval.²⁴⁹ Transgender individuals have access to surgeries, but improvements in financing hormone therapy and long-term care are necessary. Spain, on the other hand, offers little national funding for gender reassignment, but specific communities have begun to cover transition-related procedures.²⁵⁰ The evidence of political parties attempting to include gender reassignment procedures under the national health scheme provides another example of the changing attitude similar to other European countries.

4. Summary of the Country-by-Country Analysis

While current statistics show that many transitioning individuals in Europe are denied funding for their treatments, there are a few explanations and important lessons from the experiences in the United Kingdom, Germany, Sweden, Italy, and Spain.²⁵¹ First, monetary constraints are an important factor in providing adequate care.²⁵² Transsexuals in the United Kingdom face long waiting lists because of a lack of resources, while those in Germany and Sweden are denied funding for certain procedures in order to save costs.²⁵³ Second, there is a problem with enforcement of health standards, especially from the European Union.²⁵⁴ There is an immense

247. See *id.* (stating that a national fund called *Fondo de Cohesión Sanitaria* provides funding for referrals).

248. See WHITTLE, *supra* note 150, at 22 (indicating the publicly funded procedures provided in Spain and Italy).

249. See discussion *supra* note 233 and accompanying text (explaining the need for Court approval).

250. See discussion *supra* note 244 and accompanying text (indicating communities willing to cover transgender surgeries).

251. See *supra* Part IV.B (providing the statistics of transsexuals denied funding in Europe).

252. See *supra* Part IV.B.2 (describing the monetary constraints of Germany and Sweden).

253. See *supra* Part IV.B.1 (describing the waiting list of the United Kingdom).

254. See *supra* Part IV.B (discussing the lack of enforcement).

difficulty in preventing all types of discrimination, including by individual insurance agencies and medical facilities.

The country-by-country analysis demonstrates that a majority of European countries are recognizing the need for some form of coverage of Gender Reassignment Surgery. Even in Italy and Spain, countries that fund very few procedures, there are large movements pushing for reform.²⁵⁵ Additionally, examination of the European countries provides a strong argument in favor of classifying all of the procedures associated with gender reassignment as “medically necessary.”²⁵⁶ The lessons of the European community should be used as a framework for providing transsexuals in the United States with adequate care.

V. Conclusion: Applying Lessons from the International Community to the United States

There is already significant evidence that the American medical community is amenable to the standards established by the WPATH and in Europe.²⁵⁷ First, the American Medical Association (AMA) passed a resolution on June 16, 2008, supporting public and private health insurance coverage for treatment of gender identity disorder.²⁵⁸ The resolution states that an established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy, and SRS.²⁵⁹ Further, the categorical exclusion of surgical treatments for GID in health insurance plans represents discrimination based solely on the patient’s gender identity.²⁶⁰

A second example that the United States is amenable to these standards came with the 2010 decision by the United States Tax Court in

255. *See supra* Part IV.B.3 (describing the current political movements in Italy and Spain).

256. *See supra* Part IV (providing an explanation of the European approach to transgender reassignment procedures).

257. *See* AM. MED. ASS’N, REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS, RES. 122 (June 16, 2008), *available at* <http://www.gires.org.uk/assets/Medpro-Assets/AMA122.pdf> (supporting public and private health insurance coverage for treatment of GID).

258. *See id.* (recognizing WPATH has improved understanding and treatment for GID).

259. *See id.* (stating that health experts, including WPATH have rejected the myth that transition-related procedures are “cosmetic” or “experimental”).

260. *See id.* (stating that delaying treatment can also aggravate and cause serious health problems).

O'Donnabhain v. Commissioner of Internal Revenue.²⁶¹ The court ruled that sex reassignment surgeries qualify as deductible medical expenses under IRS Code § 213.²⁶² This court ruling indicates that hormone therapy and transition-related surgeries are not considered “cosmetic.”²⁶³ The opinion further recognizes that breast augmentation is not cosmetic in certain circumstances.²⁶⁴

Viewing the recent Tax Court decision, the AMA resolution, the differing standards among the states, and the statements by WPATH urging the United States to reform in conjunction, it is clear that uniform change needs to occur in the United States. While there are still a significant number of European transgender individuals who must pay for their own procedures, the recognition that gender reassignment procedures are medically necessary is apparent. Some argue that classification of GID as a mental disorder creates further issues,²⁶⁵ but under current international standards, diagnosis with GID is crucial to obtaining care.²⁶⁶ Once diagnosed with GID, Americans should have adequate access to the necessary treatments.

In order for the United States to meet the standards of care most European countries ascribe to, there can be no categorical exclusion of gender reassignment procedures under insurance plans. Resolving the exclusion problem under state Medicaid statutes ultimately depends on whether the procedures pursued by transgendered individuals qualify as “medically necessary.” The international community studied in this discussion presents an increasingly clear consensus that transition-related procedures are in fact medically necessary for those individuals diagnosed with GID.²⁶⁷ The predominant standards of care are those developed by WPATH which explicitly states that all transition-related processes are

261. See *O'Donnabhain v. Comm'r of Internal Revenue*, 134 T.C. No. 4, at *25 (2010) (finding that petitioner suffered from GID and finding that hormone therapy and SRS were effective treatments).

262. See *id.* at *26 (stating that petitioner showed her surgeries were not cosmetic and that she should be allowed a deduction for them as medical care).

263. *Id.*

264. See *id.* at *23 (stating that breast augmentation surgery can sometimes be required under the Harry Benjamin Standards of Care).

265. See discussion *supra* note 28 and accompanying text (indicating GID can lead to depression and suicide).

266. See WHITTLE, *supra* note 150, at 71 (stating that a medical diagnosis is necessary to ensure treatment).

267. See *supra* Part IV (explaining the various procedures funded by European nations).

necessary for a transsexual to live a complete and full life.²⁶⁸ Although some European countries do not provide funding for all aspects of transition-related care, most acknowledge that the procedures are medically necessary.²⁶⁹ In countries not already acknowledging the necessities of these procedures, such as Italy and Spain, movements have begun to take shape encouraging them to follow the WPATH standards.²⁷⁰

Application of these international lessons can occur at either the federal or the state level. Including the WPATH standards in federal legislation would be ideal to provide uniform coverage. This could be done through the national Medicaid statute or in a national health care bill such as the Patient Protection and Affordable Care Act. Through this method, the WPATH Standards of Care could be enumerated and the specific procedures could be classified as “medically necessary.” Advocates for the transgender community such as Pooja Gehi and Gabriel Arkles have pointed out the difficulties of such a solution.²⁷¹ The topic is one of intense debate and disagreement. Additionally, the current economic conditions in the United States, the national debate over health care, and the unresolved nature of the medical necessity of transition-related procedures in the United States all produce difficulties for creating national legislation on the issue. Instead, Gehi and Arkles have suggested that the focus of change should be on the state level first.²⁷²

States should explicitly declare that transition-related procedures are medically necessary for Medicaid purposes and adopt the WPATH standards. The main challenge is the disagreement among the medical community in the United States.²⁷³ One way to encourage states to adopt uniform legislation is through a body such as the Uniform Law Commission.²⁷⁴ The commission could take the information learned from

268. See *supra* Part III.B (describing the WPATH Standard of Care).

269. See *supra* Part IV (describing the current position of Europe in regards to transition-related care).

270. See *supra* Part IV.B.3 (discussing Italy and Spain).

271. See Dean Spade, Interview, *Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocates*, 8 SEATTLE J. FOR SOC. JUST. 497, 509 (2010) (stating that now is not the time to raise concerns on a federal level).

272. See *id.* (suggesting an approach on the state or local levels).

273. See *supra* Part II (discussing the different approaches to transition-related care in the United States).

274. See UNIFORM LAW COMMISSION, <http://www.nccusl.org/Default.aspx> (last visited Nov. 3, 2011) (stating that the Uniform Law Commission strives to provide uniform legislation to states) (on file with the Washington and Lee Journal of Civil Rights and Social Justice).

the international community and use it to create legislation that is uniform across states. While individual states will have to be convinced to adopt the legislation, the Uniform Law Commission is a convenient way to present the current information to them. States need uniformity under their Medicaid statutes in order to prevent court decisions such as *Casillas* and *Smith*.²⁷⁵ Standardization would also help to provide more support to transsexual individuals through private health insurance. Because private insurance operates under contract law, the individual purchasing the insurance must ensure that there is adequate coverage for his or her needs. When the contract is ambiguous, as in *Davidson*, having uniform medical standards would provide aid to transgender individuals arguing that transition-related procedures are not cosmetic.²⁷⁶

The situation is dire and calls for action. The lack of uniform medical standards for transition-related services leaves many transsexuals without necessary procedures and causes some to turn to such extremes as prostitution or traveling to countries with less restrictive medical standards.²⁷⁷ European countries are already seeing this trend and recognizing the need to provide for the medical procedures. The United States should follow the international example. While it may be difficult to promote federal legislation at the moment, states should adopt the international standards and apply them to state Medicaid programs. Hopefully, once the medical community in the United States has recognized the necessity of these procedures, the national government will be able to follow suit and provide even further protection. These measures will help to fulfill the fact that transsexualism is not about surgery, but about life.

275. See *supra* Part II.A (discussing the differing approaches for upholding denials of reimbursements for transition-related procedures).

276. See *supra* Part II.B (discussing *Davidson v. Aetna Life & Cas. Ins. Co.*).

277. See *supra* Part II.C (discussing the serious consequences of denying reimbursement for transition-related services).