

ADMINISTRATIVE CONTEXTS OF
ACCESS TO GENDER-CONFIRMATION
SURGERY

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ABSTRACT

The federal government tracks and provides for its people through the federal administrative state. The Obama Administration significantly increased access to gender-confirmation surgery through agency action, arguing that increased medical understanding of the origins of transgender identities required the government to categorize some gender confirmation surgeries as “medically necessary.” This was opposed by some trans-rights activists who countered that greater ties to medicine would further stigmatize transgender identities. This note argues that, amid potentially overwhelming political and administrative change, trans-rights activists should prioritize arguments to increase access to important medical procedures over arguments regarding stigmatization of trans identities because people with gender dysphoria should receive medically necessary treatment without delay.

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I. INTRODUCTION

The day after she was sentenced to thirty-five years in prison for leaking secret government files in violation of the Espionage Act, Chelsea Manning publicly identified as female for the first time.¹ Ms. Manning had suffered from gender dysphoria dating back at least to her time serving in

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¹ Emmarie Huetteman, 'I Am a Female,' *Manning Announces, Asking Army for Hormone Therapy*, N.Y. TIMES (Aug. 22, 2013), <http://www.nytimes.com/2013/08/23/us/bradley-manning-says-he-is-female.html> (last visited Mar. 16, 2018); Chris Geidner, *Chelsea Manning Told She Will Receive Gender Transition Surgery, Her Lawyer Says*, BUZZFEED NEWS (Sept. 13, 2016), <https://www.buzzfeed.com/chrisgeidner/chelsea-manning-told-she-will-receive-gender-transition-surg>.

Iraq.² In February 2015, she was approved to receive hormone therapy and was recognized by a military court as a woman.³ In September 2016, Ms. Manning was the first person incarcerated by the military to be told by the Department of Defense that she was approved to undergo gender-confirmation surgery.⁴ Although a California state prisoner recently became the first U.S. inmate to undergo government-paid gender-reassignment surgery,⁵ no Federally incarcerated person has received gender-confirmation surgery.⁶ While incarcerated, Ms. Manning attempted suicide twice, including once in October 2016⁷ after the military approved her request to undergo gender-confirmation surgery.⁸

Ms. Manning's battle to receive gender-confirmation surgery as treatment for her gender dysphoria involves the operation of administrative law. Administrative law guides our understanding about how the federal government alters law at a minute and responsive level. Regulation is, at least theoretically, more responsive and narrowly tailored so that it may respond to specific issues quickly, without relying on the slow, generalist

² Charlie Savage, *Chelsea Manning Tried Committing Suicide a Second Time in October*, N.Y. TIMES (Nov. 4, 2016), <http://www.nytimes.com/2016/11/05/us/chelsea-manning-tried-committing-suicide-a-second-time-in-october.html>.

³ Jonah Engel Bromwich, *Chelsea Manning Told She Can Have Gender Reassignment Surgery, Lawyer Says*, NY TIMES (Sep. 13, 2016), <http://www.nytimes.com/2016/09/14/us/chelsea-manning-told-she-can-have-gender-reassignment-surgery-lawyer-says.html>.

⁴ See Geidner, *supra* note 1 (the "ban on open service by transgender people in the military" was overturned on June 30, 2016).

⁵ Kristine Phillips, *A convicted killer became the first U.S. inmate to get state-funded gender-reassignment surgery*, WASH. POST (Jan. 10, 2017), <https://www.washingtonpost.com/news/post-nation/wp/2017/01/10/a-transgender-inmate-became-first-to-get-state-funded-surgery-advocates-say-fight-is-far-from-over>.

⁶ *Id.*; Geidner, *supra* note 1; see also Loren S. Schechter, 'Gender Confirmation Surgery': What's in a Name?, HUFFINGTON POST (April 20, 2012, 11:14 PM), https://www.huffingtonpost.com/loren-s-schechter-md-facs/gender-confirmation-surgery_b_1442262.html (discussing various terms used for "gender confirmation surgery," including "gender reassignment surgery" and "sex change operation.").

⁷ *Id.* See also Charlie Savage, *Chelsea Manning to Be Released Early as Obama Commutes Sentence*, N.Y. TIMES (Jan. 17, 2017), <https://www.nytimes.com/2017/01/17/us/politics/obama-commutes-bulk-of-chelsea-mannings-sentence.html> (explaining that in January 2017, President Obama commuted Ms. Manning's sentence and that due to the commutation, Ms. Manning will not receive gender confirmation surgery from the United States Military).

⁸ *Id.* On January 17, 2017, President Obama commuted Ms. Manning's sentence, and will be freed on May 17. As a result of the commutation, Ms. Manning will not receive gender confirmation surgery from the United States Military. The federal government thus has still never covered gender-confirmation surgery for an incarcerated person, though California became the first state to provide gender-confirmation surgery for an incarcerated person in January 2017; Melissa Chan, *Chelsea Manning Says U.S. Military Has Agreed to Her Gender Surgery*, TIME (Sept. 20, 2016), <http://time.com/4500941/chelsea-manning-military-gender-surgery/>.

sledgehammer of legislation. In that sense, administrative law is a way to understand how the federal government controls access to gender-confirmation surgery. Under the Obama Administration, agency action increased access to gender-confirmation surgery.⁹ Newer arguments about the etiology of trans identities and the medicalization of those identities justified this change. In response, trans-rights activists argued over the source of trans identity¹⁰ and whether connecting trans identities' etiology to medicine and psychology would increase access at the cost of further stigmatizing those identities. Amid overwhelming change in the Trump administration,¹¹ trans rights activists should prioritize arguments that promote greater access to gender-confirmation surgery over arguments that such policies could further stigmatize trans identities to ensure that trans people with gender dysphoria will have access to necessary medical treatment.

Part I of this Note examines different conceptions of trans identities and gender-confirmation surgery to create a common context and lexicon for communication and understanding. Part II examines the administrative regulations and rules of the Office of Personnel Management ("OPM"), Department of Health and Human Services ("HHS"), Department of Defense ("DoD"), and Department of Veterans' Affairs ("VA") to elucidate how the federal government influences access to gender-confirmation surgery for trans persons across the country in various contexts. Part III tracks changes in the medical consensus over the treatment of trans people through gender-confirmation surgery to determine how socio-legal debates regarding trans identities have changed. Finally, Part IV considers whether that conception of trans identity provides greater access to gender-confirmation surgery at the cost of further stigmatizing trans identities,

⁹ See, e.g., *Know Your Rights: Healthcare*, NAT'L CTR. FOR TRANSGENDER EQUALITY, <https://transequality.org/know-your-rights/healthcare> ("While many transgender people continue to face discrimination in health care and coverage, [laws including the Affordable Care Act] may provide options for avoiding or resolving discrimination and make it easier for transgender people to get access to [necessary] health care.").

¹⁰ See *GLAAD Media Reference Guide: Transgender Issues*, GLAAD, <http://www.glaad.org/reference/transgender> (discussing that "trans" is "used as shorthand to mean transgender or transsexual") (last visited Mar. 16, 2018) [hereinafter GLAAD].

¹¹ See, e.g., Rebecca Klein, *Trump Admin To Transgender Kids: We Won't Deal With Your Civil Rights Complaints*, HUFFPOST (Jan. 16, 2018, 5:45 AM), https://www.huffingtonpost.com/entry/transgender-office-for-civil-rights_us_5a568ade4b08a1f624b2144 (explaining how the "Trump administration's view of [transgender students' discrimination complaints] diverges sharply" from the view of the Obama administration, which asserted that "Title IX – the federal law that deals with sex discrimination – included discrimination based on gender identity.").

particularly in the context of the Trump administration. Discussing how administrative law reflects our greater cultural conception of trans identities will create a better understanding of why diversity and inclusion are so important to our legal system, as well as encourage further discussion that leads to a greater understanding of trans identities.

II. TRANS IDENTITIES

“Trans” encompasses a wide variety of identities and experiences relative to one’s gender.¹² “Transgender” is typically used as an umbrella term that can include any person whose gender identity or expression does not match the gender identity or expression usually associated with the person’s sex at birth.¹³ Transgender identities can thus encompass people who identify as “transsexuals, cross-dressers, androgynous people, and gender non-conforming individuals.”¹⁴ “Transsexual is not an umbrella term” and typically refers to people who have changed, or endeavor to change, their bodies in response to their feelings of incongruity.¹⁵ Because “transsexual” is an adjective with certain outdated or pejorative connotations,¹⁶ the term “trans” is used to include both transgender and transsexual identities.¹⁷ This Note uses “trans” to refer to persons with any gender identity or expression that is not congruent with identities or expressions typically associated with their sex assigned at birth. Therefore, a trans man is a person who, although not assigned male at birth, identifies as a man, regardless of anatomical or biological factors. While it is important to use an individual’s preferred identity descriptors and pronouns, this Note uses trans as an umbrella term—yet remains cognizant of each individual’s unique experience and identity—when discussing many individuals with roughly similar experiences: here, a shared experience to seek gender-confirmation surgery.

¹² See GLAAD, *supra* Note 10.

¹³ *Id.*

¹⁴ Rachel C. Kurzweil, “Justice is What Love Looks Like in Public”: How the Affordable Care Act Falls Short on Transgender Health Care Access, 21 WASH. & LEE J. CIVIL RTS. & SOC. JUST. 199, 203 (2014).

¹⁵ GLAAD, *supra* note 10 (noting that transsexual is a term originating from older medical communities and may not be preferred by some people who otherwise identify as transgender).

¹⁶ PFLAG National Glossary of Terms, PFLAG, <https://www.pflag.org/glossary>.

¹⁷ GLAAD, *supra* note 10.

A. WHO WE TALK ABOUT WHEN WE TALK ABOUT THE NEED FOR ACCESS

Not all transgender people seek gender-confirmation surgery. The World Professional Association for Transgender Health (“WPATH”), the leading organization for the treatment of trans people, has published a series of Standards of Care intended “to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people.”¹⁸ The Standards of Care delineate a difference between gender nonconformity and gender dysphoria.¹⁹ While many transgender persons do not conform to societal gender norms, thus fitting the definition of “gender nonconformity,” persons with gender dysphoria experience “discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth.”²⁰ Transgender persons do not inherently experience gender dysphoria, and therefore not all transgender persons will seek medical care related to their transgender status.²¹

Those who do seek care may choose a variety of therapeutic options, including changes in gender expression and role, hormone therapy, psychotherapy, and gender-confirmation surgery.²² The Standards of Care note that “[w]hile many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria.”²³ Thus, WPATH intends to empower various pathways to “lasting personal comfort with [trans persons’] gendered selves.”²⁴ While some trans persons do not seek medical care, and some seek only hormone therapy, others seek gender-confirmation surgery;²⁵ for many trans persons, gender-confirmation surgery is the “essential and medically necessary” treatment for gender

¹⁸ *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, WPATH, (7th ver. 2011), <https://www.wpath.org/media/cms/Documents/Web%20Transfer/SOC/Standards%20of%20Care%20V7%20-%202011%20WPATH.pdf> [hereinafter WPATH Standards].

¹⁹ *See id.* at 5.

²⁰ *Id.*

²¹ *See id.* (discussing that “only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives” and treatment for the dysphoria-related stress can be individualized).

²² *Id.* at 9-10.

²³ *Id.* at 54.

²⁴ *Id.* at 1.

²⁵ Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731, 754 (2008).

dysphoria.²⁶ Thus, those seeking gender-confirmation surgery are a subset of those who experience gender dysphoria, who are in turn a subset of people who have a trans identity.

B. THE GENDER/SEX PARADIGM

Virginia Prince, founder of *Transvestia* magazine, once described the relation between gender and sex as “gender is what’s above the neck and sex is what’s below the neck.”²⁷ That is to say, gender is how we conceptualize the importance and function of the differences in human biology, whereas sex is categorization of those biological differences.²⁸ Therefore, “gender” and “sex” are not synonymous; “sex” is typically biological and refers to one’s anatomy or other biological and physiological factors, whereas “gender” refers to identity and the way one thinks (“what’s above the neck”).

Gender has traditionally been thought of as a male/female binary, where one with a male biology was expected to act, think, and identify in a way consistent with other biological males.²⁹ In fact, gender can consist of two components: gender identity and gender expression.³⁰ Gender identity is entirely internal and represents how individuals perceive their gender, whereas gender expression is the external manifestation of gender.³¹ However, trans people do not have a gender identity considered consistent with their biology and may not seek that consistency. For example, many trans people do not seek gender-confirmation surgery. Further, some people do not have gender identities that would be considered “male” or “female,” which is sometimes referred to as “gender non-binary.”³² These people may or may not also identify as trans.³³

²⁶ WPATH, *supra* note 18, at 54.

²⁷ DEBORAH RUDACILLE, *THE RIDDLE OF GENDER: SCIENCE, ACTIVISM, AND TRANSGENDER RIGHTS* xvi (1st ed. 2005).

²⁸ *See id.* (explaining that gender is “what we make of the differences in our bodies and their reproductive and anatomical capabilities”).

²⁹ *See* Jennifer Rellis, “Please write ‘E’ in this box” *Toward Self-Identification and Recognition of a Third Gender: Approaches in the United States and India*, 14 MICH. J. GENDER & L. 223, 258 (2008) (“The societal belief that sex is a male-female binary fixed at birth leads to human rights abuses for individuals, particularly males, who do not conform to this model.”).

³⁰ *See* GLAAD, *supra* note 10.

³¹ *Id.*

³² *Id.*

³³ *See id.* (explaining that the term non-binary “is not a synonym for transgender or transsexual”).

Sex has also been traditionally considered a male/female binary, where one has a set of either male or female biological characteristics.³⁴ Usually, sex is determined at birth by identifying external anatomy, but sex is also made up of a combination of biological characteristics that include “chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics.”³⁵ Like gender, sex is not purely binary, as that paradigm ignores a variety of biological and anatomical configurations, such as intersex. Gender, therefore, is more accurately described as a “spectrum” that allows for great individuality and fluidity, while sex can be described as a series of biological phenomena that includes male, female, and intersex.³⁶

C. WHAT IS GENDER-CONFIRMATION SURGERY?

Gender-confirmation surgery is another umbrella term that encompasses a variety of medical procedures designed to bring a person’s sex and gender identity into harmony.³⁷ For a trans person who was assigned male at birth (also sometimes referred to during or after transition as male-to-female, or “MtF”), surgical procedures for gender-confirmation include three categories: (1) “breast/chest surgery” (augmentation mammoplasty); (2) genital surgery (“penectomy, orchiectomy, vaginoplasty, clitoroplasty, and vulvoplasty”); and (3) “non-genital, non-breast surgical interventions” (including facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation, and hair reconstruction).³⁸

For a trans person who was assigned female at birth (also sometimes referred to during or after transition as female-to-male, or “FtM”), surgical procedures for gender-confirmation include the same three categories (breast/chest surgery, genital surgery, and “non-genital, non-breast surgical interventions”) but different particular procedures.³⁹ These different procedures under each of the three categories, respectively, include: (1) “subcutaneous mastectomy” and “creation of a male chest”; (2)

³⁴ See *id.*; but see Veronica Meade-Kelly, *Male or Female? It’s Not Always So Simple*, UCLA Newsroom (Aug. 20, 2015), <http://newsroom.ucla.edu/stories/male-or-female> (describing that sex is not always binary “even at the most basic physical level”).

³⁵ *Id.*

³⁶ Meade-Kelly, *supra* note 34.

³⁷ See, e.g., WPATH, *supra* note 18, at 54-58 (discussing various medical procedures, including “[g]enital and breast/chest surgical treatments”).

³⁸ *Id.* at 57.

³⁹ *Id.* at 57-58.

“hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra,” “metoidioplasty,” “phalloplasty,” “vaginectomy, scrotoplasty, and implantation of erection and/or testicular prosthesis;” and (3) “voice surgery (rare), liposuction, lipofilling,” and “pectoral implants.”⁴⁰

Because trans healthcare is particularized and individualized, each person (in consultation with their care providers) may choose a different treatment plan.⁴¹ While this Note refers to the chosen treatment plan under the umbrella term “gender-confirmation surgery,” in reality, a trans individual will have a tailored combination of surgeries. Consequently, the costs of gender-confirmation surgery vary greatly, but is expensive and generally ranges from \$7,000-\$50,000.⁴² However, that price may vary greatly, as phalloplasties alone can cost up to \$100,000.⁴³

Each surgery requires that a certain set of criteria be met in order for a patient to be medically qualified.⁴⁴ For example, for a trans woman to qualify medically for breast augmentation, the patient must: experience “persistent, well-documented gender dysphoria;” have the “capacity to make a fully informed decision” and consent to the surgery; be in the “age of majority” in the country of treatment; and if “significant medical or mental health concerns are present, they must be reasonably controlled.”⁴⁵ Trans women are also recommended to undergo at least twelve months of hormone therapy before an augmentation procedure to achieve the best results.⁴⁶

In sum, a trans person who requires gender-confirmation surgery to treat gender dysphoria may undergo a variety of operations to harmonize their biology and/or anatomy with their gender identity. These operations aim to reconstruct the chest/breasts, genitals, and other parts of the body that are considered gender identity markers in society. Because these procedures are expensive, cost alone may make access difficult or impossible for many people. Furthermore, even if someone can afford gender-confirmation surgeries, they are heavily regulated.

⁴⁰ *Id.*

⁴¹ *See id.* at 59 (stating that “[t]he number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.”).

⁴² Kurzweil, *supra* note 14, at 211.

⁴³ *Id.*

⁴⁴ *See* WPATH, *supra* note 18, at 58-61.

⁴⁵ *Id.* at 59.

⁴⁶ *Id.*

III. ADMINISTRATIVE CONTEXTS

The United States administrative regime primarily serves two functions: the collection of standardized data regarding its population, and subsequent “population-level interventions” in service of “caretaking functions” “focused on ensuring the health and well-being of the population.”⁴⁷ The federal administration interacts with the health and well-being of the trans population through a variety of contexts. This Part examines various federal government agencies’ regulations and how they control access to gender-confirmation surgery.

A. THE OFFICE OF PERSONNEL MANAGEMENT AND GENDER-CONFIRMATION SURGERY

The Office of Personnel Management (“OPM”) is a federal agency in charge of the hiring practices of the employees of the federal government.⁴⁸ The OPM provides healthcare and insurance for federal employees.⁴⁹ As part of a diversity and inclusion initiative, the OPM published a guidance document regarding transgender employees in the federal government.⁵⁰ The OPM’s “Core Concepts” discuss that some trans persons will require medical treatment to transition to their gender identity.⁵¹ The OPM emphasizes, “[m]anagers and supervisors should be aware that not all transgender individuals will follow the same pattern,” but all are entitled to the same consideration as they undertake the appropriate transition steps, and “all employees should be treated with dignity and respect.”⁵²

As part of its diversity and inclusion initiative, the OPM published Federal Employee Health Benefit (“FEHB”) Program Carrier Letter 2011-12, titled *Gender Reassignment*, requiring that federal government employees who have already undergone gender-confirmation surgery should still receive appropriate healthcare as needed—such as a trans man

⁴⁷ Spade, *supra* note 25, at 742.

⁴⁸ See *About*, U.S. OFF. OF PERSONNEL MGMT, <https://www.opm.gov/about-us/> (last visited Nov. 14, 2016).

⁴⁹ *Our Mission, Role & History*, U.S. OFFICE OF PERS. MGMT., <https://www.opm.gov/about-us/our-mission-role-history/what-we-do/#url=Benefits>.

⁵⁰ See generally *Gender Identity Guidance*, U.S. OFFICE OF PERS. MGMT., <https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/reference-materials/gender-identity-guidance/> (discussing the federal government’s anti-discrimination policy that includes gender identity).

⁵¹ See *id.*

⁵² *Id.*

who “still needs routine mammograms and pap smears.”⁵³ FEHB Program Carrier Letters are letters sent to healthcare carriers that provide healthcare to federal employees. In 2014, the OPM sent another FEHB Program Carrier Letter removing the requirement that FEHB excludes “services, drugs, or supplies related to sex transformations.”⁵⁴ In 2015, another FEHB Program Carrier Letter was sent to clarify that carriers may not have a general exclusion of “services, drugs, or supplies related to sex transformations,” because treatment may be “medically necessary” to address a diagnosis of gender dysphoria.⁵⁵

The OPM has reported that all plans have complied with these directives. As a result, plans for federal employees in every state “will offer mental health services, hormone therapy, and gender re-assignment surgery.”⁵⁶

B. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND GENDER-CONFIRMATION SURGERY

The Department of Health and Human Services (“HHS”) is a federal department responsible for administering various healthcare and human service programs.⁵⁷ Agencies under the HHS umbrella include: Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services (“CMS”), Food and Drug Administration, National Institute of Health (“NIH”), and Administration for Children and Families, among others.⁵⁸ In all, HHS is responsible for eight public health agencies and three human services agencies.⁵⁹ As a result of its focus on ensuring the health of

⁵³ U.S. OFFICE OF PERS. MGMT., FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM CARRIER LETTER 2011-12, GENDER REASSIGNMENT (2011).

⁵⁴ U.S. OFFICE OF PERS. MGMT., FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM CARRIER LETTER 2014-17, GENDER IDENTITY DISORDER/GENDER DYSPHORIA (2014).

⁵⁵ U.S. OFFICE OF PER. MGMT., FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM CARRIER LETTER 2015-12, COVERED BENEFITS FOR GENDER TRANSITION SERVICES (2015).

⁵⁶ *Frequently Asked Questions: Benefits for LGBT Federal Employees and Annuitants*, U.S. OFFICE OF PERSONNEL MGMT., <https://www.opm.gov/FAQs/QA.aspx?fid=3f64bd3d-1107-44e7-9962-c8b652848f14&pid=bbf2019c-707d-4469-8366-0921df6928f5>.

⁵⁷ See HHS Agencies & Offices, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, <https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html> (last visited Mar. 17, 2018) [hereinafter, HHS Agencies & Offices].

⁵⁸ See *id.* See HHS Organizational Chart, U.S. DEP'T OF HEALTH AND HUM. SERVICES, <https://www.hhs.gov/about/agencies/orgchart/index.html>.

⁵⁹ See HHS Agencies & Offices, *supra* note 57.

the American people, HHS controls access to gender-confirmation surgery through public healthcare providers, namely Medicare and Medicaid.⁶⁰

In 2010, Congress passed the Patient Protection and Affordable Care Act (“ACA”), a significant overhaul of the American healthcare system.⁶¹ As part of the ACA, Congress enacted a nondiscrimination provision known as Section 1557.⁶² Section 1557 mandates, in part, that an individual may not “be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance” based on provisions in Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973.⁶³ Section 1557 is “the first federal civil rights law to broadly prohibit discrimination on the basis of sex in federally funded health programs.”⁶⁴ Previously, civil rights laws enforced by HHS’s Office for Civil Rights (“OCR”) broadly barred discrimination based only against “race, color, national origin, sex, age, or disability.”⁶⁵ Section 1557 also empowers the Secretary of HHS to enact regulations to implement the statute.⁶⁶

In 2014, the HHS Departmental Appeals Board heard a case challenging a National Coverage Determination (“NCD”) from 1981 that denied Medicare coverage of all gender-confirmation surgery as treatment for “transsexualism.”⁶⁷ According to the NCD, “[b]ecause of the lack of well controlled, long-term studies of the safety and effectiveness of the surgical procedures and attendant therapies for transsexualism, the treatment is considered experimental.”⁶⁸ In reviewing the NCD, the

⁶⁰ See *id.*

⁶¹ See Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, With a Flourish*, N.Y. TIMES (Mar. 23, 2010), <http://www.nytimes.com/2010/03/24/health/policy/24health.html>.

⁶² 42 U.S.C. § 18116 (2016); see *Section 1557 of the Patient Protection and Affordable Care Act*, U.S. DEP’T OF HEALTH AND HUM. SERVICES, <http://www.hhs.gov/civil-rights/for-individuals/section-1557/> [hereinafter Section 1557].

⁶³ 42 U.S.C. § 18116(a) (2016) (stating that federal financial assistance includes “credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).”).

⁶⁴ *Section 1557: Frequently Asked Questions*, U.S. DEP’T OF HEALTH AND HUM. SERVICES 1, <https://www.hhs.gov/sites/default/files/section-1557-final-rule-faqs.pdf> [hereinafter FAQ].

⁶⁵ See Section 1557 *supra* note 62.

⁶⁶ 42 U.S.C. § 18116(c) (2016).

⁶⁷ Transsexual Surgery, H.H.S. Decision No. 2576, HHS (2014), <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf>.

⁶⁸ *Id.* at 4.

Departmental Appeals Board used a “reasonableness standard.”⁶⁹ The aggrieved party, a Medicare beneficiary who was denied coverage for gender-confirmation surgery, argued that the NCD was “not reasonable in light of the current state of scientific and clinical evidence and current medical standards of care.”⁷⁰ The Departmental Appeals Board agreed, ruling that the NCD was “invalid because a preponderance of the evidence in the record as a whole supports a conclusion that the NCD’s stated bases for its blanket denial of coverage for transsexual surgery are not reasonable.”⁷¹

In ruling that denial of coverage for transsexual surgery was unreasonable, the Departmental Appeals Board relied, in part, on the expertise of the CMS.⁷² Because the CMS decided not to support the NCD, and because the Departmental Appeals Board defers to the expertise of CMS “in the area of coverage requiring the exercise of clinical or scientific judgment,” the scales tipped in favor of overruling the NCD.⁷³ Furthermore, the Departmental Appeals Board also relied on new scientific evidence. One of the aggrieved party’s witnesses, a clinical psychologist, pointed to the existence of “gender identity disorder” in important medical databases, particularly the Diagnostic and Statistical Manual and the International Classification of Diseases.⁷⁴ The Departmental Appeals Board also reasoned that evidence shows gender-confirmation surgery is a safe⁷⁵ and effective treatment for gender dysphoria.⁷⁶ Thus, the NCD determination to the contrary was unreasonable.⁷⁷ As a result, Medicare could not broadly exclude coverage of gender-confirmation surgery.⁷⁸

Pursuant to her power delegated in Section 1557, the HHS Secretary promulgated a notice-and-comment rule.⁷⁹ The rule—particularly its new prohibition on sex discrimination—was intended to implement Section

⁶⁹ *Id.* at 7.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² *See id.* at 8.

⁷³ *Id.* at 8.

⁷⁴ *Id.* at 9.

⁷⁵ *Id.* at 11.

⁷⁶ *Id.* at 15.

⁷⁷ *Id.* at 21.

⁷⁸ *Id.* at 1.

⁷⁹ 45 C.F.R. § 92.207.

1557 to HHS programs.⁸⁰ This rule was designed to clarify the responsibilities of covered entities that administer under the HHS “health-related insurance or other health-related coverage”⁸¹ or receive funds from HHS.⁸²

In general, the rule states that covered entities may not “discriminate on the basis of race, color, national origin, sex, age, or disability.”⁸³ Specifically, the final rule states that an entity cannot “[h]ave or implement a categorical coverage exclusion or limitation for all health services related to gender transition.”⁸⁴ Furthermore, a covered entity may not deny or limit coverage of a service, that is ordinarily “available to individuals of one sex, to a transgender individual based on the fact that an individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.”⁸⁵ Finally, a covered entity may not deny or limit coverage of a service relating to gender transition if that denial would result “in discrimination against a trans individual.”⁸⁶ In addition to a nondiscrimination rule, HHS also promulgated an equal access rule.⁸⁷ This rule prohibits unequal access to healthcare on the basis of sex, which expressly includes gender identity and trans identity.⁸⁸

As a part of notice-and-comment rulemaking, an agency hears comments from the public regarding its proposed rule and chooses whether to incorporate those comments into its final rule.⁸⁹ This process can help clarify a rule and provide a form of regulatory analogue to legislative history.⁹⁰ As part of the proposed rule, HHS noted that “coverage for medically appropriate health services must be made available on the same terms and conditions under the plan or coverage for all individuals,

⁸⁰ *Id.* See also Section 1557, *supra* note 62 (discussing that “Section 1557 builds on long-standing and familiar Federal civil rights laws” and “extends nondiscrimination protections to individuals participating in” health programs or activities administered by HHS”).

⁸¹ 45 C.F.R. § 92.207.

⁸² FAQ, *supra* note 64, at 1.

⁸³ 45 C.F.R. § 92.207(a).

⁸⁴ 45 C.F.R. § 92.207(b)(4).

⁸⁵ 45 C.F.R. § 92.207(b)(3).

⁸⁶ 45 C.F.R. § 92.207(b)(5).

⁸⁷ 45 C.F.R. § 92.206.

⁸⁸ *See id.*

⁸⁹ *See* Stephen G. Breyer et al., ADMINISTRATIVE LAW AND REGULATORY POLICY: PROBLEMS, TEXT, AND CASES, 519 (7th ed. 2011).

⁹⁰ *See id.* (“In framing these procedures, the APA drafters sought to emulate the model of legislative hearings.”).

regardless of sex assigned at birth, gender identity, or recorded gender.”⁹¹ Therefore, if gender-confirmation surgery is medically appropriate, it must be made available.⁹² Furthermore, explicit and generalized exclusions on gender-confirmation surgery are “outdated and not based on current standards of care.”⁹³

In summary, HHS first banned the broad exclusion of coverage of gender-confirmation surgery in Medicare through a Departmental Appeals Board ruling in 2014. Then, in 2016, HHS implemented Section 1557 of the Affordable Care Act through notice-and-comment rulemaking. These rules explicitly banned transgender discrimination in any program administered by the HHS or receiving funding from HHS, which includes Medicare, Medicaid, the Children’s Health Insurance Program, the federal and state Health Insurance Marketplaces, and all insurance carriers selling plans through the Marketplaces⁹⁴

C. THE DEPARTMENT OF DEFENSE AND GENDER-CONFIRMATION SURGERY

The Department of Defense (previously defined as “DoD”) is the largest federal agency in the United States.⁹⁵ The DoD is responsible for the administration of the United States Army, Navy, Air Force, Marine Corps, Coast Guard, and National Reserve.⁹⁶ It is the nation’s largest employer.⁹⁷

⁹¹ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31429 (May 18, 2016) (to be codified at 45 C.F.R. Part 92).

⁹² See *id.* at 31435 (discussing that covered entities are not affirmatively required to “cover any particular treatment,” so long as the reason for excluding treatment is evidence-based and nondiscriminatory” but “if a covered entity covers certain types of elective procedures that are beyond those strictly identified as medically necessary or appropriate, it must apply the same standards of coverage of comparable procedures related to gender transition.”). See also, NAT’L CTR FOR TRANSGENDER EQUALITY, *Final HHS Regulations on Health Care Discrimination: Frequently Asked Questions*, <http://www.transequality.org/know-your-rights/healthcare> (“[A]n insurance company may be breaking the law if it covers breast reconstruction for cancer treatment, hormones to treat post-menopause symptoms, or genital surgery after accidents but won’t cover those treatments to treat gender dysphoria.”).

⁹³ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31429 (May 18, 2016) (to be codified at 45 C.F.R. Part 92).

⁹⁴ NAT’L CTR FOR TRANSGENDER EQUALITY, *supra* note 92.

⁹⁵ *About the Department of Defense*, U.S. DEP’T OF DEFENSE, <http://www.defense.gov/About-DoD>.

⁹⁶ See *id.*

⁹⁷ *Id.*

On June 30, 2016, the DoD issued Directive-type Memorandum 16-005 titled “Military Service of Transgender Service Members.”⁹⁸ A Directive-type Memorandum is a time-sensitive document that immediately implements policy from documents such as “DoD Directives, Federal laws, and Executive orders.”⁹⁹ It will then become an official Directive or Instruction within 180 days.¹⁰⁰ Under Memorandum 16-005, the Secretary of Defense notified the Department of his intent to “implement a construct by which transgender Service members may transition gender while serving[.]”¹⁰¹ Furthermore, the Department was notified that a system would be put in place to provide “necessary medical care and treatment to transgender Service members.”¹⁰² Until the issuance of further guidance, the Department was directed to treat requests for transition-related care on a “case-by-case basis,” thus removing any general exceptions to access to gender-confirmation surgery.¹⁰³

Also on June 30, 2016, the DoD issued Instruction 1300.28, titled “In-Service Transition for Transgender Service Members.”¹⁰⁴ A DoD Instruction is an implementation of DoD policy.¹⁰⁵ Instruction 1300.28 provided that “Service members with a diagnosis from a military medical provider indicating that gender transition is medically necessary, will be provided medical care and treatment for the diagnosed medical condition.”¹⁰⁶ The military medical provider is charged with developing a treatment plan for medically necessary care to submit to the commander.¹⁰⁷ The commander is then responsible for ensuring that the transition plan complies with DoD policies, considers the facts and circumstances of the Service member, ensures the military readiness of the Service member, and is consistent with the medical treatment plan.¹⁰⁸ As defined in the Instruction, a transition “may or may not include feminization or

⁹⁸ DEP’T OF DEF., DIRECTIVE TYPE MEMORANDUM 16-005, MILITARY SERV. OF TRANSGENDER SERV. MEMBERS (2016) [hereinafter DIRECTIVE TYPE MEMORANDUM].

⁹⁹ *What are the DoD Issuances?*, WASH. HEADQUARTERS SERVICES, <http://biotech.law.lsu.edu/blaw/dodd/general.html>.

¹⁰⁰ *Id.*

¹⁰¹ DIRECTIVE TYPE MEMORANDUM 16-005, *supra* note 98.

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ DEP’T OF DEF., INSTRUCTION 1300.28, IN-SERV. TRANSITION FOR TRANSGENDER SERV. MEMBERS, 1 (2016) [hereinafter INSTRUCTION 1300.28].

¹⁰⁵ WASH. HEADQUARTERS SERVICES, *supra* note 99.

¹⁰⁶ INSTRUCTION 1300.28, *supra* note 104, at 3.

¹⁰⁷ *Id.* at 9.

¹⁰⁸ *Id.*

masculinization of the body through cross-sex hormone therapy or *other medical procedures*.”¹⁰⁹

On September 30, 2016, the DoD issued a handbook titled “Transgender Service in the U.S. Military,” which explains the policy to members of the military.¹¹⁰ This handbook further defines “medical treatment” for trans service members as including gender-confirmation surgery.¹¹¹ Department of Defense Spokesman Air Force Major Ben Sakrisson further clarified that gender-confirmation surgery will be available and that “gender reassignment surgeries for active-duty personnel will be conducted at either a military hospital or, if qualified care is unavailable at a military facility, at a private hospital paid by Tricare.”¹¹²

In sum, as of 2016, the DoD has begun implementing a plan that will not only allow for the service of openly trans soldiers but will also provide a path for their care during transition. As these trans service members transition, they will be allowed to craft a plan with a military medical professional for the access of medically necessary treatment, including gender-confirmation surgery.

D. THE DEPARTMENT OF VETERANS AFFAIRS AND GENDER-CONFIRMATION SURGERY

The Department of Veterans Affairs (previously defined as “VA”) is responsible for the benefits and care given to veterans of the armed forces after their service.¹¹³ This includes health care, pension, disability compensation, burial services, and survivor benefits.¹¹⁴ Trans veterans will look to the VA’s health benefits to understand the availability of gender-confirmation surgery. However, the VA’s health benefits plan currently expressly excludes “gender alterations.”¹¹⁵ In a 2013 directive published by

¹⁰⁹ *Id.* at 17 (emphasis added).

¹¹⁰ Transgender Service in the U.S. Military, U.S. DEP’T OF DEF., 1 (2016).

¹¹¹ *Id.* at 31.

¹¹² Ashley May, *Military Could Spend Up to \$8.4 Million Annually on Gender Reassignment Treatments*, USA TODAY (Sept. 29, 2016), <http://www.usatoday.com/story/news/nation-now/2016/09/29/military-could-spend-up-84-million-annually-reassignment-treatments/91218672/>.

¹¹³ *See About VA*, U.S. DEP’T OF VETERANS AFF., http://www.va.gov/landing2_about.

¹¹⁴ *See*, U.S. DEP’T OF VETERANS AFF., <http://www.va.gov/> (displaying services and benefits provided to veterans by the VA12, 2016).

¹¹⁵ 38 C.F.R. 17.38(c)(4).

the Veterans Health Administration (VHA),¹¹⁶ it was reasserted that the “VA does not provide sex reassignment surgery...for strictly cosmetic purposes.”¹¹⁷ While the VHA notes that “it is VHA policy that medically necessary care is provided to enrolled or otherwise eligible intersex and transgender Veterans....Sex reassignment surgery cannot be performed or funded by VA.”¹¹⁸

However, with the changing administrative consensus of what is “medically necessary,” in May 2016, Lambda Legal and the Transgender Law Center filed a rulemaking petition with VA to change this exclusion, on the behalf of two trans veterans.¹¹⁹ As a part of its Spring 2016 Regulatory Agenda, VA announced its intention to remove the restriction on gender-confirmation surgery in a “proposed-proposed rule,” RIN 2900-AP69.¹²⁰ However, no further action was taken. Instead, the “proposed-proposed rule” was rejected by the Office of Management and Budget (OMB), “because the VA didn’t have a plan for paying for surgeries.”¹²¹ This is inconsistent with President Obama’s Executive Order 13563, which requires every agency that proposes a regulation deemed “significant” by OIRA¹²² to provide an analysis of the costs and benefits of the regulation, as well as reasonable alternatives and reasons that the Agency is proceeding with the proposed rule over the alternatives.¹²³

In sum, the VA remained an outlier in the Obama Administration’s regulatory scheme regarding gender-confirmation surgery. Despite the

¹¹⁶ See *Veterans Health Administration*, U.S. DEP’T OF VETERANS AFF., <http://www.va.gov/health> (displaying health benefits provided to veterans).

¹¹⁷ U.S. DEP’T OF VETERANS AFF., VHA DIRECTIVE 2013-003, PROVIDING HEALTH CARE FOR TRANSGENDER AND INTERSEX VETERANS, 1 (2013).

¹¹⁸ *Id.* at 2.

¹¹⁹ *Transgender Law Center and Lambda Legal Petition VA to Provide Surgery for Transgender Veterans*, TRANSGENDER LAW CTR (May 10, 2016), <https://transgenderlawcenter.org/archives/12898>.

¹²⁰ *Removing Gender Alterations Restriction from the Medical Benefits Package*, RIN 2900-AP69, U.S. DEP’T OF VETERANS AFF., <https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201604&RIN=2900-AP69>.

¹²¹ See Exec. Order No. 13563, 76 Fed. Reg. 3821 (Jan. 18, 2011); Trudy Ring, *VA Plan to Cover Gender-Confirmation Surgery Scrapped*, ADVOCATE (Nov. 14, 2016), <http://www.advocate.com/transgender/2016/11/14/va-plan-cover-gender-confirmation-surgery-scrapped>.

¹²² A significant agency action is defined in the Executive Order as having an annual economic effect of \$100 million or more; creating a serious inconsistency or interfere with action of another agency; materially altering the budgetary impact of entitlements, grants, user fees, or loan programs, or the rights and obligations of recipients; or raising novel legal or policy issues. Exec. Order No. 12866 § 3(f), 58 Fed. Reg. 190 (Sept. 30, 1993)

¹²³ Exec. Order No. 12866 § 6(a)(3)(C).

urging of many important non-administrative organizations, the VA's attempt to overturn a blanket exclusion of the availability of gender-confirmation surgery stalled in the President's Office, particularly OIRA. It remains vexing that an administration that was otherwise friendly to the expansion of access to gender-confirmation surgery halted the efforts of an agency to expand access to surgery.

IV. CHANGES IN THE MEDICAL CONSENSUS

One common thread in the changes that have occurred to administrative access to gender-confirmation surgery is administrative reliance on the "medical consensus." In the past, when an agency has declined access to surgery, it has noted a lack of medical consensus of necessity.¹²⁴ When an agency has expanded access to gender-confirmation surgery, it has cited the "evolving professional consensus that [gender-confirmation surgery] is considered medically necessary."¹²⁵ Therefore, it is important to understand how exactly the medical community has formed a consensus regarding trans healthcare and gender-confirmation surgery, especially as it may reveal important background to the increased access to gender-confirmation surgery in the Obama Administration.

A. WPATH STANDARDS OF CARE

As discussed above, the WPATH's Standards of Care are the leading publication of trans health care needs. The Standards of Care emphasize the individuality of each person's trans identity, as well as the importance of understanding how that individuality can leave room for the medical necessity of gender-confirmation surgery.¹²⁶ The scientific-medical basis for the necessity of gender-confirmation surgery is the diagnosis of "gender dysphoria."¹²⁷ For some people, "relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity."¹²⁸

¹²⁴ See, e.g., H.H.S. Decision No. 2576, *supra* note 67 at 5 (holding the NCD's denial of Medicare coverage of all transsexual surgery as invalid under the reasonableness standard).

¹²⁵ See, e.g., U.S. OFFICE OF PERS. MGMT, FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM CARRIER LETTER 2014-17, *supra* note 54 (providing guidance for treatment of individuals who meet criteria for diagnosis of Gender Identity Disorder/Gender Dysphoria).

¹²⁶ See WPATH, *supra* note 18, at 54.

¹²⁷ *Id.*

¹²⁸ *Id.* at 55.

B. THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is “the authoritative guide to the diagnosis of mental disorders,” published by the American Psychiatric Association (APA).¹²⁹ Periodically, the APA publishes a new version, reflecting changes in the psychiatric community’s understanding of mental illnesses. The last edition, the DSM-IV, included a section on “gender identity disorder.”¹³⁰ However, the current edition, the DSM-V, replaces “gender identity disorder” with “gender dysphoria.”¹³¹ The APA notes that the reason for the shift in terminology is to avoid stigma, and that “[t]he critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.”¹³²

Not all trans people feel distress in relation to their identity, and those that do may, or may not, seek surgical treatment. Furthermore, the “diagnosis” of gender dysphoria allows people who do choose to seek surgery to get insurance coverage for their treatment.¹³³ Ultimately, “the changes regarding gender dysphoria in DSM-5 respect the individuals identified by offering a diagnostic name that is more appropriate to the symptoms and behaviors they experience without jeopardizing their access to effective treatment options.”¹³⁴

C. INTERNATIONAL CLASSIFICATION OF DISEASES

The International Classification of Diseases (ICD), published by the World Health Organization, is “the diagnostic classification standard for all clinical and research purposes.”¹³⁵ Like the DSM, the ICD recently shifted its classification of mental anguish in association with trans identities; the ICD-10 outlined a series of “gender identity disorders,” including

¹²⁹ DSM-5 FAQ, AM. PSYCHIATRIC ASS’N, <https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions>.

¹³⁰ *Gender Dysphoria Fact Sheet*, AM. PSYCHIATRIC ASS’N (2013), <http://www.ca1.uscourts.gov/sites/ca1/files/citations/Gender%20Dysphoria%20Fact%20Sheet%20202.pdf>.

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.* at 2.

¹³⁴ *Id.*

¹³⁵ *International Classification of Diseases*, WORLD HEALTH ORG., <http://www.who.int/classifications/icd/en/>.

“transsexualism,”¹³⁶ whereas the ICD-11 (which is yet to be officially published, but is available online in beta form) has replaced “gender identity disorders” with “gender incongruence.”¹³⁷

While the ICD-11 does not contain specific symptoms or treatment plans at this time, the change in terminology is significant. It reflects the growing consensus that trans identities are not “disorders,” while maintaining medical paradigms that allow trans people to gain access to gender-confirmation surgery through the current medical insurance system. It is not too speculative to postulate that the ICD-11, when officially published, will reflect the shift seen in the DSM in that it will call for treatment for those experiencing gender dysphoria while asserting that their identities are not “disorders.”

D. THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE

In 2011, the Institute of Medicine—a private nonprofit research organization created under Congressional charter in 1863—published *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, “to assess the current state of knowledge about the health of lesbian, gay, bisexual, and transgender people, as well as to identify research gaps and formulate a research agenda that could guide NIH in enhancing and focusing its research in this area.”¹³⁸ In promulgating § 92.207, the regulation implementing nondiscrimination provisions of the Affordable Care Act, HHS cited the Institute of Medicine’s book to support the proposition that “the across-the-board categorization of all transition-related treatment, for example as experimental, is outdated and not based on current standards of care.”¹³⁹

The Institute of Medicine followed WPATH’s guidelines on the treatment of gender dysphoria.¹⁴⁰ The study notes that the medical consensus has moved toward an individualized approach for treating gender dysphoria, and that gender-confirmation surgery is merely the end of a

¹³⁶ ICD-10, WORLD HEALTH ORG., 168–70 (1992), <http://www.who.int/classifications/icd/en/bluebook.pdf>.

¹³⁷ ICD-11 Beta Draft, WORLD HEALTH ORG., <https://icd.who.int/dev11/l-m/en>.

¹³⁸ INSTITUTE OF MEDICINE, *THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDING*, ix (2011).

¹³⁹ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31429 (May 18, 2016) (to be codified at 45 C.F.R. Part 92).

¹⁴⁰ See INSTITUTE OF MEDICINE, *supra* note 138 at 199–200.

process that begins with hormone therapy and only one of a variety of options for alleviating gender dysphoria.¹⁴¹ This shift in the medical paradigm cannot be proven to be the only factor in the recent administrative shift to greater access to gender-confirmation surgery for trans people, but it has been cited explicitly and implicitly by various agencies. It is certainly at least one consideration agencies have been analyzing as they evaluate their policies on gender-confirmation surgery.

V. THE CURRENT STATE OF TRANS RIGHTS ACTIVISM AND GENDER-CONFIRMATION SURGERY POLICY

As of the date of this note, the state of American law and politics is in great flux, as the federal government shifts from Democratic control under President Obama to Republican control under President Trump. Thus, predicting future outcomes and policy changes are difficult. With any presidency, there can be a discrepancy between what is promised and discussed during the campaign, and what actually transpires during the term.

In this section, I will begin by exploring how trans rights activist strategy has shifted during the Obama administration, namely through the relatively new internal debate over the medicalization of trans identities. Then, I will look at the campaign promises, platforms, and early actions of President Trump and his administration to explore how the change in administrative regime will further shift trans rights activist strategy. Based on the promises and actions of President Trump and his administration, I suggest that trans rights activists subordinate arguments against medicalization of trans identities to arguments that will support the maintenance or expansion of access to gender-confirmation surgery.

A. DEBATE OVER MEDICALIZATION

The new medical consensus is not a welcome change for all trans rights activists. One potential argument against Obama administration-era trans policy and medicalization is that it necessarily reduced trans identity to a hegemonic authenticity that was predicated on the acquisition of gender-confirmation surgery.¹⁴² It is indeed important not to conflate “a trans identity” with “*the* trans identity,” but that responsibility falls outside the

¹⁴¹ See *id.* at 201.

¹⁴² See ANDREW N. SHARPE, *TRANSGENDER JURISPRUDENCE: DYSPHORIC BODIES OF LAW* 35 (1st ed. 2002).

scope of the Executive Branch in this instance. If the Obama administration privileged a particular version of trans identity (that is, the trans identity of sex/gender harmony), it did so because that identity is necessarily related to gender-confirmation surgery. A trans identity that does not seek sex/gender harmony is less likely to seek gender-confirmation surgery. The Obama administration, therefore, cannot be faulted for seeking to take care of a group of people requesting policy change.

Another anxiety of a legal reliance on medical paradigms is that doing so is pathologizing social identity at the expense of solidifying/creating a legal identity.¹⁴³ In other words, the law is forcing trans persons to assert that there is a medical “issue” with their identity, in order to gain access to a procedure that will allow them to live comfortably. This could “put the interests of individual transsexuals potentially at odds with the interests of the transgender community as a whole.”¹⁴⁴ Furthermore, there could be a legitimate concern that reliance on psychiatric understandings of gender dysphoria (say, through the DSM-V) will bring with it the social stigma of mental illness.

However, the fact remains that we live in a society where surgery requires medical approval and the general medical standard for government-funded surgery is “medical necessity.” One clever solution is to broaden the understanding of “necessity.” Jerry L. Dasti writes that this broader understanding of necessity should be one that “takes into account the legal and social—as well as the strictly medical—ramifications of sex reassignment surgery.”¹⁴⁵ This is indeed appealing, because the new medical consensus regarding gender dysphoria is that it has, at least to some degree, a social etiology; that is, the discomfort that one feels with their gender/sex incongruence is at least partially the result of social expectations of gender performance correlating with one’s sex.

Another argument against the medical paradigm of gender-confirmation surgery is that “a legal regime that permits and even encourages surgical sex reassignment merely serves to enforce this inaccurate bimodal system of sex classification, in which the ‘male’ physiology and ‘male’ gender identity are essentially always paired in a single person, as are the ‘female’ biology and ‘female’ gender identity - so that the distinct conceptions of sex and gender are collapsed into two basic

¹⁴³ Jerry L. Dasti, *Advocating a Broader Understanding of the Necessity of Sex-Reassignment Surgery Under Medicaid*, 77 N.Y.U. L. REV. 1738, 1743 (2002).

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

human types.”¹⁴⁶ In other words, gender-confirmation surgery and greater access to gender-confirmation surgery reinforce the gender/sex binary. These critics also believe that having a diagnostic model, far from allowing individuation of experiences, creates “an incentive for patients seeking treatment to tailor their identities and ‘symptoms’ to match the model.”¹⁴⁷ This argument against greater access to gender-confirmation surgery seems to ignore the plight of those persons who suffer greatly from gender dysphoria and assumes that gender-confirmation surgery only serves to further the gender/sex binary. In other words, this argument asserts a theoretical or ideological good at the expense of ignoring the very real suffering that people experience every day. Although American society should reevaluate its concepts of gender and sex, a more feasible goal is to broaden access to gender-confirmation surgery for those experiencing gender dysphoria, especially in light of a recent study by the National Transgender Discrimination Survey that discovered that 41 percent of respondents have attempted suicide.¹⁴⁸

B. THE TRUMP ADMINISTRATION AND THE FUTURE OF ACCESS TO GENDER-CONFIRMATION SURGERY

The argument over proper trans identity discourse is further complicated by the election of President Donald J. Trump. On the campaign trail, candidate Trump had a cloudy record on LGBT rights: on the one hand, he broke rank with the general Republican Party opinion by stating that trans people should “use the bathroom they feel is appropriate.”¹⁴⁹ However, as President, Trump has surrounded himself with politicians who have a history of opposing LGBT rights. For example, Vice President Mike Pence, as Governor of Indiana, opposed marriage equality and signed a bill that made it legal for businesses to refuse service to trans people under the guise of “religious freedom.”¹⁵⁰ As a member of Congress, Vice President

¹⁴⁶ *Id.* at 1765.

¹⁴⁷ *Id.* at 1766.

¹⁴⁸ Ann P. Haas, Philip L. Rodgers & Jody L. Herman, *Suicide Attempts Among Transgender and Gender Non-Conforming Adults*, AMERICAN FOUNDATION FOR SUICIDE PREVENTION AND THE WILLIAMS INSTITUTE, 2 (2014), <http://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf>.

¹⁴⁹ Liam Stack, *Trump Victory Alarms Gay and Transgender Groups*, N.Y. TIMES (Nov. 10, 2016), <http://www.nytimes.com/2016/11/11/us/politics/trump-victory-alarms-gay-and-transgender-groups.html>.

¹⁵⁰ *Id.*

Pence also opposed nondiscrimination laws that protected LGBT people.¹⁵¹ LGBT rights activists have voiced concern that the Trump administration will share its platform with that of the Republican Party, which includes “opposition to same-sex marriage, support for state laws limiting which public bathroom transgender people can use, and support for a parent’s right to subject gay and transgender children to ‘conversion therapy’ to change their sexual orientation or gender identity.”¹⁵²

Since election, President Trump has acted to limit access to gender confirmation surgeries and has called for the implementation of policies that would discriminate against transgender military service members. On August 25, 2017, President Trump directed the Pentagon to ban transgender people from joining the military.¹⁵³ President Trump also gave the Pentagon the authority to determine the future of transgender troops who are currently serving,¹⁵⁴ even though transgender people had been allowed to serve in the military since June 2016 under President Obama.¹⁵⁵ The directive came after a series of inflammatory tweets from President Trump, who claimed that transgender troops’ military service entailed “tremendous medical costs and disruption[.]” despite evidence from a 2016 RAND Corporation study that estimated that providing transition-related medical coverage to military members would increase military health-care spending by only .04-.13 percent, or about \$2.4 million to \$8.4 million.¹⁵⁶

On October 30, 2017, Judge Colleen Kollar-Kotelly of the District Court for the District of Columbia issued a preliminary injunction against the Trump Administration’s ban on transgender service members. The suit was filed by six service members who claim that their Fifth Amendment rights to equal protection were being violated by the ban.¹⁵⁷ The court found that the plaintiffs would have a strong chance of prevailing in their suit, noting that the reasons given for the ban “do not appear to be supported by any facts.”¹⁵⁸ While the injunction addresses something more fundamental

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ Julie Watson and Jennifer McDermott, *Trump Directive Sparks Criticism Among Transgender Troops*, ASSOCIATED PRESS NEWS (Aug. 26, 2017), <https://www.apnews.com/f3ba1c1f8f8e4867998b9628ffe12809/Trump-directive-sparks-criticism-among-transgender-troops>.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Doe v. Trump*, 275 F.Supp.3d 167, 176–77 (D.D.C. 2017); Justin Jouvenal, *Federal Judge in D.C. Blocks Part of Trump’s Transgender Military Ban*, WASH. POST (Oct. 30, 2017),

than access to gender confirmation surgeries (that is, the ability to serve in the armed forces to begin with), this challenge to the Trump Administration's policy regarding transgender people could serve to set the tone for transgender rights activism and the Trump Administration's larger policy toward LGBT Americans for the rest of President Trump's time in office.¹⁵⁹ The lawsuit also challenged the prohibition of military funding for gender-confirmation surgery, but Judge Kollar-Kotelly's order found that none of the plaintiffs had standing to challenge that aspect of military policy.¹⁶⁰ Other challenges to the directive were filed in the Northern District of Alabama (where the suit was dismissed without prejudice),¹⁶¹ the Western District of Washington,¹⁶² and the District of Maryland.¹⁶³

Despite the directive, an active-duty service member received gender-confirmation surgery on November 14, 2017.¹⁶⁴ DoD spokesperson Dana White said that the service member "had already begun a sex-reassignment course of treatment, and the treating doctor deemed this surgery medically necessary, [so] a waiver was approved by the director of the Defense Health Agency."¹⁶⁵ The waiver allowed the surgery to occur in a private hospital that was better suited to perform the surgery.¹⁶⁶

Beyond President Trump's ill-fated ban on transgender military service members, he has often stated his opposition toward federal government regulation. During an August 2016 speech at the Detroit Economic Club, then-candidate Trump pledged a "temporary moratorium" on new agency regulation.¹⁶⁷ Further, early in his presidency, President Trump issued Executive Order 13771, which requires that for every new

https://www.washingtonpost.com/local/public-safety/federal-judge-in-dc-blocks-part-of-trumps-transgender-military-ban/2017/10/30/41d41526-bd94-11e7-959c-fe2b598d8c00_story.html.

¹⁵⁹ *Id.*

¹⁶⁰ *Doe*, 275 F.Supp.3d at 177.

¹⁶¹ *Williamson v. Trump*, Case No. 7:17-cv-01490-LSC, 2017 U.S. Dist. LEXIS 167865 (N.D. Ala., Oct. 11, 2017).

¹⁶² *Karnoski v. Trump*, Case No. 2:17-cv-1297 (W.D. Wa., Oct. 6, 2017), https://www.lambdalegal.org/sites/default/files/legal-docs/downloads/pi_motion.pdf.

¹⁶³ *Stone v. Trump*, Case No. 1:17-cv-02459 (D. Md., Aug. 28, 2017), https://www.aclu.org/sites/default/files/field_document/aclu_complaint_0.pdf.

¹⁶⁴ Lolita C. Baldor, *A Transgender Soldier Just Got Gender-Reassignment Surgery That was Paid for by the Military*, TIME (Nov. 15, 2017), <https://www.yahoo.com/news/transgender-soldier-just-got-gender-130336153.html>.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ Philip Bump et al., *Donald Trump's Economic Speech, Annotated*, WASH. POST (Aug. 8, 2016), <https://www.washingtonpost.com/news/the-fix/wp/2016/08/08/donald-trumps-economic-speech-annotated/>.

regulation promulgated, an agency must eliminate two regulations.¹⁶⁸ The same executive order directed the heads of agencies that the total cost of new regulations for 2017 shall not exceed zero, unless required by law or approved by the Director of the OMB.¹⁶⁹ Furthermore, under the same executive order, starting in 2018, all proposed regulations must be first published in the Unified Regulatory Agenda, unless they get approval from the Director of the OMB.¹⁷⁰

Executive Order 13771 likely will have two effects on regulation: first, it will likely limit new regulation from being promulgated, and second, it will almost certainly result in the elimination of many regulations existing on the books. It is difficult to speculate exactly how Executive Order 13771 will affect access to gender-confirmation surgery. It seems likely that because new regulations will be harder to promulgate, particularly if they will result in expenditure of government money, rules such as the abandoned VA proposed rule RIN 2900-AP69 will not be promulgated. Furthermore, it is possible that antidiscrimination provisions, such as HHS's §§92.206 and 92.207, become easy targets for elimination by agencies that will prioritize regulations that are less politically controversial.

President Trump also claimed on the campaign trail that he would nullify all of the executive orders issued by President Obama, including one that bans anti-LGBT discrimination by federal contractors and another that protects the rights of transgender students.¹⁷¹ But once in office, President Trump announced that he would extend an executive order that "banned companies that do federal work from discriminating against gay, lesbian, bisexual and transgender employees."¹⁷² At the same time, in a two-page memo to U.S. Attorneys and other officials, Attorney General Sessions ordered the Department of Justice to take the position that Title VII of the Civil Rights Act of 1964, which bans employment discrimination, does not cover transgender persons.¹⁷³ Attorney General Sessions ordered the Department of Justice to argue that the word "sex" means only

¹⁶⁸ Exec. Order No. 13771 § 2(a), 82 Fed. Reg. 9339 (Feb. 03, 2017).

¹⁶⁹ Exec. Order No. 13771 § 2(b).

¹⁷⁰ *Id.* at § 3(b)-(c).

¹⁷¹ Stack, *supra* note 149.

¹⁷² Jeremy W. Peters, *Obama's Protections for L.G.B.T. Workers Will Remain Under Trump*, N.Y. TIMES (Jan. 30, 2017), <https://www.nytimes.com/2017/01/30/us/politics/obama-trump-protections-lgbt-workers.html>.

¹⁷³ Charlie Savage, *In Shift, Justice Dept. Says Law Doesn't Bar Transgender Discrimination*, N.Y. TIMES (Oct. 5, 2017), <https://www.nytimes.com/2017/10/05/us/politics/transgender-civil-rights-act-justice-department-sessions.html>.

“biologically male or female,” such that Title VII does not prevent “discrimination based on gender identity per se, including transgender status.”¹⁷⁴ While the Supreme Court has not addressed whether “sex” discrimination includes transgender people, the 1989 case of *Price Waterhouse v. Hopkins* ruled that sex discrimination includes people who fail to conform to gender norms and stereotypes.¹⁷⁵

Yet another concern regarding President Trump’s administrative policy is his pledge to repeal the Affordable Care Act (ACA). About two weeks before his inauguration, President Trump called for Congress to repeal the ACA “probably some time next week.”¹⁷⁶ However, President Trump and Republican Congressmembers have since changed their stance on the immediacy of the ACA repeal, with Trump stating that the repeal may not occur until 2018.¹⁷⁷ In March 2017, Republican leaders in the House formulated an ACA replacement plan, known as the American Health Care Act (AHCA).¹⁷⁸ However, the AHCA never received the requisite support in Congress, and House leaders pulled the bill from the floor before a vote could take place.¹⁷⁹ After cancelling the vote, House Speaker Paul Ryan told reporters, “[w]e’re going to be living with Obamacare for the foreseeable future.”¹⁸⁰

Efforts to repeal the ACA were renewed in late July when momentum was gathered for a “skinny repeal,” which was intended to “abolish the individual and employer insurance mandates and perhaps just one tax.”¹⁸¹ Conservative Republicans hoped to gain the support of more moderate

¹⁷⁴ *Id.* (emphasis omitted).

¹⁷⁵ *Id.*; *Price Waterhouse v. Hopkins*, 490 U.S. 228, 250–51 (1989).

¹⁷⁶ Maggie Haberman and Robert Pear, *Trump Tells Congress to Repeal and Replace Health Care Law ‘Very Quickly’*, N.Y. TIMES (Jan. 10, 2017), <https://www.nytimes.com/2017/01/10/us/repeal-affordable-care-act-donald-trump.html>.

¹⁷⁷ Alison Kodjak, *Trump, GOP Lawmakers Back Off from Immediate Obamacare Repeal*, NAT’L PUB. RADIO (Feb. 6, 2017), <http://www.npr.org/sections/health-shots/2017/02/06/513718166/trump-congressional-gop-back-off-from-immediate-obamacare-repeal>.

¹⁷⁸ See Mike DeBonis et al., *GOP health-care bill: House Republican leaders abruptly pull their rewrite of the nation’s health-care law*, WASH. POST (Mar. 24, 2017), https://www.washingtonpost.com/powerpost/house-leaders-prepare-to-vote-friday-on-health-care-reform/2017/03/24/736f1cd6-1081-11e7-9d5a-a83e627dc120_story.html (discussing Republican leaders’ decision to abruptly pull their overhaul of Obamacare).

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ Juliet Eilperin et al., *GOP Momentum Grows for More Modest Plan to Overhaul Obamacare*, WASH. POST (July 26, 2017), https://www.washingtonpost.com/powerpost/senate-embarks-on-new-round-of-voting-to-peel-back-affordable-care-act/2017/07/26/a7206f62-71e8-11e7-9eac-d56bd5568db8_story.html.

lawmakers by asking for the “skinny repeal” without the replacement legislation of the AHCA.¹⁸² The “skinny repeal” was defeated in the Senate.¹⁸³

Despite the significant failure of Congressional Republican leadership to repeal the ACA, both with and without replacement plans, it is unclear how long the Congress will focus on issues other than healthcare. Therefore, it is unclear whether an ACA repeal will take place, and what kind of effect it would have on trans access to gender-confirmation surgery. However, one potential effect of repeal could be that HHS’s regulations (preventing discrimination against trans people in Medicare and Medicaid) would not apply to as many health insurance plans with federal money removed. Therefore, trans people on plans that would not be subject to those rules may not have federally-mandated access to gender-confirmation surgery. Even without federally required access to gender-confirmation surgery, a repeal of the individual mandate of the ACA would likely result in fewer people having affordable health insurance. The immediate result of this, too, would be that fewer people would have access to gender-confirmation surgery.

The future of the federal administrative regime of greater access to gender-confirmation surgery is unclear at best. Given President Trump’s disdain toward greater government regulation, it does not seem likely that access to gender-confirmation surgery will increase under his administration. The most likely options are that President Trump will ignore the issue while focusing on other policies and/or that regulations providing access will be cut as part of the policy of decreasing regulation under Executive Order 13771. President Trump has already limited access to gender confirmation surgeries for those serving in the military, and it is possible that he will attempt to find other ways to limit access.

VI. CONCLUSION

As the Trump administration begins restricting access to gender-confirmation surgery, the arguments against the medicalization of trans identities will feel less urgent to many. The fact remains that many trans people feel great discomfort in connection with their identity, and that a

¹⁸² *Id.*

¹⁸³ Robert Pear & Thomas Kaplan, *Senate Rejects Slimmed-Down Obamacare Repeal as McCain Votes No*, N.Y. TIMES (July 27, 2017), <https://www.nytimes.com/2017/07/27/us/politics/obamacare-partial-repeal-senate-republicans-revolt.html>.

trans identity has a connection to higher rates of suicide attempts, and “[c]omparably high, or higher, prevalence of suicide attempts were found among respondents who said that they someday wanted FTM genital surgery, hysterectomy, or phalloplasty, suggesting that desiring transition-related health care services and procedures but not yet having them may exacerbate respondents’ distress at the incongruence between their gender identity and physical appearance.”¹⁸⁴ We are facing a health crisis regarding the high suicide rates of trans people, and this crisis requires swift and concrete action, not ideological battles. While concerns about further stigmatization regarding the medicalization of trans identities are legitimate, we must first address the immediate needs of trans Americans who feel great distress, and whose needs could be met through greater access to gender-confirmation surgery. To the extent that trans identities are stigmatized by medicalization, American society must address and change its attitudes toward mental illness. In the meantime, America must protect its communities from immediate harm, and provide paths to the affirmation and inclusion of all identities.

Although the immediate needs of trans people should take precedence in our understanding of the law, we should also be aware of the presentation and evolution of legal discourse regarding trans identities. Law is emphasized as “a site of cultural production.”¹⁸⁵ It does not merely mirror social and cultural discourse; law creates and cements it. In the case of access to gender-confirmation surgery, law both informs and reflects our understanding of trans identities. The medicalization of trans identities is both a cause and a result of Obama Administration-era law regarding gender-confirmation surgery. Therefore, outside of addressing immediate needs, we should also remain concerned about stigmatization of trans identities through medicalization. However, given the urgency of the health crisis and the importance of treatment for people with gender dysphoria, medicalization arguments should be utilized to increase or maintain access to gender-confirmation surgery.

The American federal administrative state has the responsibility to protect and care for all Americans. One of President Obama’s greatest successes was greater healthcare accessibility. This is exemplified by the Obama administration’s actions to make gender-confirmation surgery more accessible to those interacting with the federal bureaucracy—from federal employees to active military service members. It is important that federal

¹⁸⁴ Haas, Rodgers & Herman, *supra* note 148, at 14.

¹⁸⁵ ANDREW N. SHARPE, *TRANSGENDER JURISPRUDENCE: DYSPHORIC BODIES OF LAW* 5 (1st ed. 2002).

and state governments continue this trend to make gender-confirmation surgery widely available. This greater access can and must be improved upon, for example in the VA. If the Trump administration moves to reverse some of the progress made by the Obama administration, trans rights activists should look to arguments made during the Obama administration to defend access to gender-confirmation surgery, including arguments regarding the safety and efficacy of gender-confirmation surgery, as well as the recent, more nuanced understanding of trans identities by the medical community.