

Sex Reassignment Surgery: Required for Transgendered Prisoners but Forbidden for Medicaid, Medicare, and CHAMPUS Beneficiaries

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SEX REASSIGNMENT SURGERY: REQUIRED FOR
TRANSGENDERED PRISONERS BUT FORBIDDEN FOR
MEDICAID, MEDICARE, AND CHAMPUS BENEFICIARIES

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INTRODUCTION

The Eighth Amendment of the United States Constitution provides prisoners protection from “cruel and unusual punishments.”¹ Cruel and unusual punishment, a broad term, encompasses a variety of actions taken by prison officials concerning inmates. In particular, the “deliberate indifference to serious medical needs of prisoners” has been established as a violation of the Eighth Amendment.² In September of 2012, the U.S. District Court for the District of Massachusetts decided a case of first impression concerning the denial of necessary medical treatment to an inmate.³ In this case, the prisoner requested sex reassignment surgery (SRS) to treat his⁴ gender identity disorder (GID).⁵ For the first time, the court determined that

1. U.S. CONST. amend. VIII.

2. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

3. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 196 (D. Mass. 2012).

4. In accordance with the decision made by most courts, this Note will use pronouns matching parties’ biological gender, not the gender of identity.

5. *Kosilek*, 889 F. Supp. 2d at 196.

the denial of SRS by prison officials violated the Eighth Amendment protection against cruel and unusual punishment.⁶

If upheld, this decision creates a dichotomy in the distribution of medically necessary health care in the United States. Specifically, those that rely on the government for their health care plans cannot obtain SRS despite medical necessity due to the prohibitive cost of the procedure absent insurance.⁷ These government funded health care programs, including Medicaid, Medicare, and CHAMPUS (the health care program for veterans, active duty service members, and their families) explicitly prohibit, or have been held to prohibit SRS, even in cases of medical necessity.⁸

Without legislative action, on both the state and federal levels, however, this discrepancy will continue to exist. Unfortunately, current precedent concerning the right of individuals to receive medically necessary treatment would result in a failure of both due process and equal protection claims brought by patients requiring SRS. The resulting regime provides SRS for criminals serving prison sentences, and yet it leaves those reliant on public forms of health care to suffer with GID without the medically necessary treatment.

First, Part I of this Note will define Gender Identity Disorder, and describe how the medical community recommends it be treated. It also will discuss the costs related to GID treatment, including SRS. Part II will outline Eighth Amendment precedent concerning the provision of medical care in order to establish the standard that was utilized in *Kosilek II*. Part III will outline the precedent concerning Eighth Amendment challenges brought by inmates suffering from GID and requesting specific treatments. Part IV will explain the decision in *Kosilek II* and demonstrate why, in some cases, prison medical services must provide SRS for inmates. Part V will outline the limits states have placed on beneficiaries of state health care programs with regards to obtaining SRS. Part VI will analyze the dichotomy and moral dilemma that result from the provision of SRS to prisoners, but not beneficiaries of government health care programs. Additionally, Part VI will analyze how constitutional challenges on equal protection and due process grounds will not alleviate this discrepancy. Rather, Congress and state legislatures must act to provide SRS in their health care plans to alleviate this moral dilemma.

6. *Id.* at 198.

7. Mary Ann Horton, *The Cost of Transgender Health Benefits 2* (paper presented at Out and Equal Workplace Summit, Sept. 12, 2008), available at <http://www.tgender.net/taw/thb/THBCost-OE2008.pdf>.

8. *See, e.g.*, *Smith v. Rasmussen*, 249 F.3d 755,760 (8th Cir. 2001); *Casillas v. Daines*, 580 F. Supp. 2d 235, 243 (S.D.N.Y. 2008); *DeMare v. Dep't Human Servs.*, No. A06-803, 2006 WL 2533922, at *2 (Minn. Ct. App. Sept. 5, 2006).

I. GENDER IDENTITY DISORDER AND TREATMENTS

GID is a psychiatric condition recognized by the mental health community that varies in terms of severity and required treatment.⁹ Mental health professionals identify GID by the presentation of four criteria: cross gender identification;¹⁰ persistent discomfort with one's sex or a sense of inappropriateness in the gender role that is associated with that sex;¹¹ disturbance is not concurrent with a physical intersex condition (sexual development disorder);¹² and impairment or distress as a result of the cross gender identification that results in a negative impact on their lives.¹³ To be considered a "mental disorder," the impairment or distress must rise to such a level that it causes "a significant adaptive disadvantage to the person or cause personal mental suffering."¹⁴

Treatment for those with GID differs based on severity of the symptoms and the desires of the patient and treating mental health professional.¹⁵ Not all patients want or need SRS.¹⁶ According to best estimates, 1 in 11,900 natal males and 1 in 30,400 natal females qualify as having gender identity disorder.¹⁷ In contrast, only 1 in 30,000 natal males and 1 in 100,000 natal females seek SRS.¹⁸ For this reason, treatment guidelines suggest a tiered scheme for treating patients with GID.¹⁹

The first tier of treatment consists of psychotherapy.²⁰ Psychotherapy provides an educational role along with various mechanisms for the patient to use as a way to cope with anxieties and distress that result from GID.²¹ The goal of psychotherapy is not to cure the disorder but to allow the patient to cope in a healthy manner.²² The

9. See HARRY BENJAMIN INT'L GENDER DYSPHORIA ASS'N, STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS 2 (6th ed. 2001) [hereinafter STANDARDS OF CARE]; Peggy T. Cohen-Kettenis & Friedemann Pfäfflin, *The DSM Diagnostic Criteria for Gender Identity Disorder in Adolescents and Adults*, 39 ARCHIVES OF SEXUAL BEHAVIOR 499, 499 (2010).

10. Cohen-Kettenis & Pfäfflin, *supra* note 9, at 510.

11. *Id.*

12. *Id.*

13. *Id.*

14. STANDARDS OF CARE, *supra* note 9, at 6.

15. *Id.* at 1–2.

16. *Id.* at 3.

17. *Id.* at 2.

18. William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 ARCHIVES SEXUAL BEHAV. 759, 760 n.1 (2012).

19. See STANDARDS OF CARE, *supra* note 9, at 2.

20. *Id.* at 11.

21. *Id.*

22. *Id.*

treatment guidelines stress that not all GID patients require psychotherapy.²³ In many instances psychotherapy should be utilized throughout the other stages of treatment to assist in the gender transition.²⁴

Another treatment requires the patient to live as the opposite gender.²⁵ This real-life experience has the patient adopt living as the opposite gender into all aspects of life.²⁶ This stage is not as simple as it sounds. Often the real-life experience has great social and personal consequences.²⁷

To assist with the real-life experience, hormone therapy is often used.²⁸ The treatment guidelines provide valuable insight into the effects of hormones on GID patients:

Hormones are often medically necessary for successful living in the new gender. They improve the quality of life and limit psychiatric co-morbidity, which often accompanies lack of treatment. When physicians administer androgens to biologic females and estrogens, progesterone, and testosterone-blocking agents to biologic males, patients feel and appear more like members of their preferred gender.²⁹

The use of hormone therapy also indicates whether SRS may be appropriate. Any ambivalence to the hormone treatment could be noted and indicate that SRS is improper.³⁰ In other cases, the hormone treatment provides sufficient change to the patient to ease the anxieties resulting from GID.³¹

The last method of treatment that health care professionals may use to treat GID is SRS.³² The treatment guidelines only recommend SRS for "severe" cases of GID.³³ They note that SRS is an effective method to treat GID when used alongside hormone treatment and real-life experience.³⁴ The guidelines also note that "[s]ex reassignment [surgery] is not 'experimental,' 'investigational,' 'elective,' 'cosmetic,' or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound

23. *Id.*

24. STANDARDS OF CARE, *supra* note 9, at 11.

25. *Id.* at 17.

26. *Id.*

27. *Id.*

28. *Id.* at 13.

29. STANDARDS OF CARE, *supra* note 9, at 13.

30. *Id.* at 16.

31. *Id.*

32. *Id.* at 18.

33. *Id.*

34. STANDARDS OF CARE, *supra* note 9, at 18.

GID.”³⁵ Simply because the surgery alters the physical appearance of the body does not mean it is inappropriate as a means of treatment for a mental disorder.³⁶

SRS includes both breast and genital surgeries.³⁷ Depending on the severity and needs of the patient, various forms of SRS are available.³⁸ These surgeries also vary significantly in cost. The most comprehensive study of the cost of SRS conducted in 2001 demonstrates that the range of procedures vary by up to \$55,000.³⁹ In many cases, the cost of SRS is prohibitively expensive. Absent health insurance, surgery can cost anywhere from \$30,000 to \$80,000.⁴⁰ The cost is great to the payer, whether it be the insurer or the individual.

II. EIGHTH AMENDMENT PROVISION OF MEDICALLY NECESSARY TREATMENT

Over the past century, the Supreme Court has greatly broadened the scope of the Eighth Amendment beyond “torture[s] and other barbar[ous]” punishments.⁴¹ In 1910, the Supreme Court proscribed any punishment that was “incompatible with ‘the evolving standards of decency that mark the progress of a maturing society.’”⁴² The Court also eliminated any punishment that “involve[s] the unnecessary and wanton infliction of pain.”⁴³

These holdings allowed for further expansion of the Eighth Amendment in 1976 to require the government to provide adequate medical care for the imprisoned, as established in *Estelle v. Gamble*.⁴⁴

An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical “torture or a lingering death,” . . . [t]he evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction

35. *Id.*

36. *Id.*

37. *Id.* at 19–20.

38. *Id.* at 19–22; see also Horton, *supra* note 7, at 3.

39. Horton, *supra* note 7, at 2.

40. Pauline Kim, *Massachusetts Judge Rules for Inmate’s Sex-Change Surgery*, CNN (Sept. 6, 2012, 8:58 AM), <http://www.cnn.com/2012/09/04/health/massachusetts-sex-change-surgery-inmate>.

41. See U.S. CONST. amend. VIII; *Estelle v. Gamble*, 429 U.S. 97, 102 (1976).

42. *Estelle*, 429 U.S. at 102 (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1910)).

43. *Gregg v. Georgia*, 428 U.S. 153, 173 (1976).

44. *Estelle*, 429 U.S. at 103.

of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common-law view that “[i]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.”⁴⁵

Inmates do not have access to adequate medical care, except through the prison authorities; thus, the denial by prison authorities to provide such treatment violates common standards of decency.⁴⁶ The Court, therefore, established the deliberate indifference standard for determining Eighth Amendment violations concerning the denial or inefficient provision of medical care.⁴⁷

The Supreme Court, however, did not define “deliberate indifference” until eighteen years after deciding *Gamble*.⁴⁸ In *Farmer v. Brennan*, the Court defined the deliberate indifference standard by using a two-prong, objective and subjective test.⁴⁹ A prison official is deliberately indifferent “if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it.”⁵⁰ Not only must the inmate face an objectively substantial risk of harm, but the prison authorities also must be aware of this risk, and yet not act on it, in order to establish an Eighth Amendment violation.⁵¹

The burden on officials to provide treatment when they have knowledge of a serious medical need, however, is not absolute.⁵² The Court left prison officials with a level of discretion within their “deliberate indifference” analysis.⁵³ To establish an unnecessary and wanton infliction of pain, prison officials could have no “legitimate purpose” to limit treatment.⁵⁴ If the prison officials can establish a valid, good faith basis for limiting treatment, there would be no violation.⁵⁵

To establish an Eighth Amendment violation by denial of medical treatment, the prisoner must demonstrate: the prisoner had a serious medical need,⁵⁶ the prisoner received no adequate treatment for this serious medical need,⁵⁷ prison officials knew of the prisoner’s

45. *Id.* at 103–04 (citations omitted) (quoting *In re Kemmler*, 136 U.S. 436, 447 (1890)).

46. *Id.* at 103–04.

47. *Id.* at 105.

48. *Farmer v. Brennan*, 511 U.S. 825, 835 (1994).

49. *Id.* at 845–46.

50. *Id.* at 847.

51. *Id.* at 846 n.9.

52. *Whitley v. Albers*, 475 U.S. 312, 321–22 (1986).

53. *Id.* at 320.

54. *Id.* at 322.

55. *Id.*

56. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

57. *See Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

serious medical need,⁵⁸ and prison officials made the decision to withhold treatment due to “bad faith and for no legitimate purpose.”⁵⁹

III. JURISPRUDENCE CONCERNING PRISONERS WITH GENDER IDENTITY DISORDER

Jurisprudence regarding transgender inmates has evolved greatly over the past twenty-five years. In general, courts have become more willing to provide treatment for prisoners with GID. In 1986, the U.S. District Court for the District of Kansas granted summary judgment against the plaintiff, a transgender prisoner.⁶⁰ Plaintiff requested that he be transferred to a women’s correctional facility, provided cosmetics and female clothing, and that he receive hormone therapy treatment in preparation for SRS.⁶¹ The court dismissed the request for transfer by stating that though the prisoner’s comfort may be relieved, the comfort of the women at the all female facility would outweigh plaintiff’s interest in comfort and result in a rational interest in segregating prisoners by sex.⁶² The court then set aside the request for female clothes and cosmetics as being at the discretion of the prison officials.⁶³ The court failed to recognize the potential for these actions in and of themselves to satisfy the “real-life experience” treatment.⁶⁴

The court also expressed doubt that plaintiff was even a transsexual.⁶⁵ The court challenged plaintiff’s medical documentation confirming his diagnosis by stating that plaintiff was a nonconformist that “receive[d] an ‘apparent delight in defying conventions, rules and regulations’”⁶⁶ The language of the opinion gave little credence to the validity of an Eighth Amendment claim for denial of real-life experience treatment for transsexual prisoners.⁶⁷ The *Lamb* court exemplified the hostility to GID treatment requests by courts when these issues first emerged in the mid 1980s.

58. *See id.*

59. *Whitley v. Albers*, 475 U.S. 312, 322 (1986).

60. *Lamb v. Maschner*, 633 F. Supp. 351, 354 (D. Kan. 1986).

61. *Id.* at 352.

62. *Id.* at 353.

63. *Id.*

64. *See STANDARDS OF CARE*, *supra* note 9, at 17.

65. *Lamb*, 633 F. Supp. at 353–54.

66. *Id.* at 354.

67. *Id.* at 353–54. Reference to transsexualism prior to the year 1994 is synonymous with the gender identity disorder diagnosis. *See STANDARDS OF CARE*, *supra* note 9, at 4. The DSM-IV committee (the committee that revised the *American Psychiatric Association Diagnostic and Statistical Manual*) changed the diagnosis from transsexualism to gender identity disorder to avoid confusion due to the gradual expansion of the use of the term “transsexual.” *Id.*

A few months after the district court of Kansas decided *Lamb, Supre v. Ricketts* echoed the belief that as long as the prison officials provided some sort of treatment, the court would defer to the medical judgment of the prison physicians and psychiatrists.⁶⁸ In this instance, the prisoner-plaintiff made multiple attempts to castrate himself, resulting in surgical removal of his testicles due to the severe damage.⁶⁹ Rather than provide the plaintiff with the estrogen therapy he requested, the prison medical staff determined that testosterone replacement therapy and mental health treatment would be the proper course of treatment.⁷⁰ The denial of the specifically requested treatment, the court concluded, did not establish a deliberate indifference to a serious medical need.⁷¹ The court indicated that the plaintiff had to demonstrate a “situation where there was a total failure to give medical attention” to establish a claim.⁷² The light standard allowed the court to hold that the prison officials did not violate plaintiff’s Eighth Amendment right.⁷³

The first instance of a court recognizing a need for the treatment of gender identity disorder occurred in *Meriwether v. Faulkner*.⁷⁴ The court in that case established for the first time that gender identity disorder was a “serious medical need” worthy of Eighth Amendment protection.⁷⁵ “There is no reason to treat transsexualism differently than any other psychiatric disorder.”⁷⁶ Additionally, the court reiterated the requirement of prison officials to provide some therapy.⁷⁷ The court found that the prison officials had knowledge of this serious medical need through multiple complaints made by the petitioners.⁷⁸ The prison officials ignored these complaints and took no action to treat the prisoner’s gender identity disorder, so their actions reached a level of deliberate indifference to the prisoner’s need.⁷⁹ The court reiterated, however, that the prisoner had no constitutional right to estrogen therapy, only that he had a constitutional right to some medical treatment.⁸⁰ The court indicated

68. *Supre v. Ricketts*, 792 F.2d 958, 963 (10th Cir. 1986).

69. *Id.* at 960.

70. *Id.*

71. *Id.* at 963.

72. *Id.*

73. *Id.*

74. *Meriwether v. Faulkner*, 821 F.2d 408, 412–13 (7th Cir. 1987).

75. *Id.* at 413.

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987).

that deference should be given to prison officials as to the type of treatment given to the transsexual prisoner.⁸¹

The first court holding requiring prison officials to provide estrogen therapy occurred in the 1990 case *Phillips v. Michigan Department of Corrections*.⁸² Once again the court reiterated that gender identity disorder is a “serious medical need” within the meaning of the Eighth Amendment.⁸³ The court ordered the prison officials to provide estrogen treatment due to three factors specific to the facts of this case.⁸⁴ First, prison officials did not provide any treatment to the prisoner for his serious medical need.⁸⁵ Second, the prisoner was “the subject of ridicule and offensive remarks.”⁸⁶ Finally, the denial of estrogen treatment “reversed the therapeutic effects of previous treatment.”⁸⁷ The court, therefore, granted a preliminary injunction to give the prisoner access to estrogen therapy.⁸⁸ The holding of this case turned on the fact that the prisoner had received significant treatment, including hormone therapy, prior to incarceration.⁸⁹ The court made sure to emphasize that prison officials could refuse to provide sex reassignment surgery, as the surgery would be treatment to improve the prisoner’s medical condition.⁹⁰

Almost ten years following the *Lamb* decision, denials of treatment to prisoners suffering from GID rarely provided protection, although the language of the opinions indicated a less dismissive approach to the claims. In *Long v. Nix*, the court denied treatment, contrary to expert testimony and generally accepted medical standards, because of a dual diagnosis of fetishism and the belief that the plaintiff could not engage in the “real-life experience” treatment due to the fact that he was incarcerated.⁹¹

The court acknowledged that transsexualism and gender identity disorder was a “serious psychiatric disorder” creating a constitutional right to “some type of medical treatment,” consistent with precedent cases, but it still denied the prisoner any protection in this instance.⁹² Despite the expert’s recommendation for treatment,

81. *Id.* at 414.

82. *Phillips v. Mich. Dep’t of Corrs.*, 731 F. Supp. 792, 800 (W.D. Mich. 1990).

83. *Id.* at 799.

84. *Id.* at 800.

85. *Id.*

86. *Id.*

87. *Phillips v. Mich. Dep’t of Corrs.*, 731 F. Supp. 792, 800 (W.D. Mich. 1990). Plaintiff received estrogen treatment prior to incarceration. *Id.* at 794.

88. *Id.* at 801.

89. *Id.* at 800–01.

90. *Id.* at 800.

91. *Long v. Nix*, 877 F. Supp. 1358, 1365–66 (S.D. Iowa 1995).

92. *Id.* at 1364–65.

the court determined that the prisoner's gender identity disorder in this case did not "constitute a serious medical need for which treatment is mandated."⁹³ Again the court granted deference to the prison's medical authorities to determine the course of treatment necessary for the inmate.⁹⁴

Twenty-first century jurisprudence regarding transsexuals tends to provide for a much more liberal view of the necessary treatment to be provided to prisoners with GID. In *Wolfe v. Horn*, the court reiterated that the refusal by prison officials to continue to provide hormone therapy to prisoners that had received hormone treatment prior to incarceration could be considered deliberate indifference to a serious medical need.⁹⁵ Though the court stressed that deference should be given to the medical decisions made by prison officials when some treatment was provided, it also stated that to abruptly withdraw hormone treatment and failure to treat withdrawal symptoms "could constitute 'deliberate indifference.'"⁹⁶

Following this case, the U.S. District Court for the District of Massachusetts followed the previous precedent but utilized dicta to institute some medical care for inmates struggling with GID.⁹⁷ In this case, plaintiff Kosilek was a prisoner suffering from severe GID.⁹⁸ In an effort to determine what kind of treatment to provide Kosilek, prison officials established a blanket administrative policy that prisoners with GID would receive the same treatment that they were provided prior to incarceration—the freeze-frame approach.⁹⁹ Prison officials considered providing for treatment to address Kosilek's stress, anxiety, and depression through therapy sessions and psychotropic medications.¹⁰⁰ The court determined that Kosilek suffered from a very severe case of GID and that the blanket freeze-frame policy did not allow Kosilek to receive adequate treatment.¹⁰¹ The treatment that Kosilek received was "so clearly inadequate as to amount to a refusal to provide essential care."¹⁰² Despite this, the

93. *Id.* at 1365.

94. *Id.* at 1366.

95. *Wolfe v. Horn*, 130 F. Supp. 2d 648, 652–53 (E.D. Penn. 2001).

96. *Id.* at 653.

97. *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 191 (D. Mass. 2002).

98. *Id.* at 184.

99. *Id.* at 171–73. Prisoners prescribed hormone therapy prior to incarceration were allowed to continue hormone therapy. *Id.* at 171. The policy prohibited prisoners suffering with GID that had not received hormone therapy prior to incarceration to receive this treatment once incarcerated. The policy provided for no exceptions. *Id.*

100. *Id.* at 174.

101. *Id.* at 186–87.

102. *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 185 (D. Mass. 2002) (quoting *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991)).

court did not find an Eighth Amendment violation because prison officials had not acted with deliberate indifference when determining the type of treatment to provide Kosilek.¹⁰³ The court also stressed that concerns about treatment being an inappropriate utilization of taxpayer money were improper.¹⁰⁴ If Maloney refused to provide adequate treatment for GID in the future because of concerns about appropriate taxpayer expenditures and public disapproval, his actions would constitute deliberate indifference and would violate the Eighth Amendment.¹⁰⁵

Though the court could not order an injunction to require prison officials to provide Kosilek with adequate treatment, the court's dicta in effect required prison officials to take this action anyway.¹⁰⁶ The court stressed that the conclusions of this trial placed Maloney on notice that Kosilek had a serious medical need and required adequate medical treatment.¹⁰⁷ The court then laid out what treatment would satisfy the adequacy requirement.

The evidence demonstrates that, at a minimum, Kosilek should receive genuine psychotherapy from, or under the direction of, someone qualified by training and experience to address a severe gender identity disorder.

. . . .

If psychotherapy, and possibly psychopharmacology, do not eliminate the significant risk of serious harm that now exists, consideration should be given to whether hormones should be prescribed to treat Kosilek.¹⁰⁸

The court also addressed the security concerns that could arise from prescribing the adequate treatment to eliminate Kosilek's suffering as a result from GID and dismissed them.¹⁰⁹ Though Maloney should take security concerns into consideration, the court cited evidence indicating that security issues could easily be dealt with or were not serious concerns.¹¹⁰ The court indicated that Maloney

103. *Id.* at 195. The court made this determination because Maloney, the official ultimately in charge of prison administration policies, was not a medical professional and he reasonably relied on the advice of attorneys that the Eighth Amendment only required some treatment, but not hormone therapy unless prescribed before incarceration. *Id.* at 190–91.

104. *Id.* at 192.

105. *Id.*

106. *Id.* at 193–95.

107. *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 193 (D. Mass. 2002).

108. *Id.* at 193–94. This dicta set the stage in many ways for *Kosilek II*.

109. *Id.* at 194.

110. Specifically, the court noted that prison officials were prepared to deal with security concerns that arose with inmates that had been on hormone therapy prior to

would likely not violate Kosilek's rights in the future.¹¹¹ The dicta of this opinion stressed the actions that Maloney and prison officials should take to avoid future violations and thus had the same practical effect as an injunction in favor of Kosilek.¹¹²

The court came close to requiring sex reassignment surgery in 2012, but fell just short of requiring the prison officials to provide it for a transgender prisoner.¹¹³ Similar to the *Kosilek* case, *Soneeya v. Spencer* concerned a department of corrections administrative policy.¹¹⁴ This policy prohibited laser hair removal, plastic surgery, and sex reassignment surgery as medically unnecessary to treat GID, contrary to the standards of care.¹¹⁵ His suit requested an injunction to provide laser hair removal and sex reassignment surgery.¹¹⁶

The court found that the plaintiff's multiple attempts at self-castration and suicide, in addition to his medical diagnosis, established that his GID created a serious medical need.¹¹⁷ The blanket policy prohibiting consideration of further feminization or sex reassignment surgery prevented the plaintiff from receiving "adequate medical treatment" to treat his GID.¹¹⁸ The court also established that the prison officials knew of the plaintiff's medical need yet created numerous obstacles and delays to granting his treatment, establishing deliberate indifference.¹¹⁹ Though the court granted the injunction to remove the blanket policy and allow for the plaintiff to be considered for sex reassignment surgery and other feminization procedures, the court did not order prison officials to grant sex reassignment surgery.¹²⁰ The court stopped just short of requiring SRS because of some conflicting evidence as to the necessity of sex reassignment surgery in this case.¹²¹

incarceration and would continue in prison. *Id.* Additionally, other courts have provided inmates with hormone therapy and placed these prisoners in the general population of prisons with little incident. *Id.* Finally, the court noted that Kosilek had been living, in many ways, as a woman within the general population already and had posed no security risk. *Id.*

111. *Id.* at 193.

112. *See* *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 193–95 (D. Mass. 2002).

113. *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 252 (D. Mass. 2012).

114. *Id.* at 240.

115. *Id.* The plaintiff, Soneeya, sought various forms of treatment for her GID over many years. *Id.* at 236. Specifically, "Ms. Soneeya waited nine years after her initial diagnosis to receive a treatment plan that applied community standards of care. She waited another four years to receive an evaluation by an expert in gender identity disorders." *Id.* at 248.

116. *Id.* at 238, 252.

117. *Id.* at 244–45.

118. *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 247 (D. Mass. 2012).

119. *Id.* at 248.

120. *Id.* at 252.

121. *Id.*

IV. *KOSILEK II* AND THE COURT ORDER FOR SEX REASSIGNMENT SURGERY

Recall that though the court in *Kosilek I* did not issue an injunction requiring action on the part of the Department of Corrections (DOC) to provide for hormone treatment for Kosilek's GID, the court utilized dicta to put the DOC on notice of Kosilek's need for care.¹²² In response to *Kosilek I*, the DOC changed the "freeze-frame" policy to one that allowed for hormone therapy for those who had received it by prescription prior to incarceration.¹²³ The change also allowed for increases or decreases in this treatment if deemed medically necessary, and had the approval of the Director of Health Services Division and the Commissioner of the DOC.¹²⁴ In 2003, the DOC's gender identity disorder specialist evaluated Kosilek and recommended estrogen therapy, electrolysis, access to female clothing, and makeup.¹²⁵ Additionally, he notified the DOC that Kosilek should be reevaluated after a year of recommended treatment to determine if SRS was necessary.¹²⁶ During Kosilek's reevaluation, the DOC's contracted GID specialists determined in multiple reports that Kosilek had a medical need for SRS.¹²⁷ Without SRS, reports indicated that Kosilek would continue to be "quite distressed" and that he would likely attempt suicide due to loss of hope and suffering caused by his GID.¹²⁸

At the same time, the DOC Commissioner, Kathleen Dennehy, and her predecessor, Michael Maloney, took various efforts to "delay, and ultimately deny, the medical care that was being prescribed for Kosilek."¹²⁹ They replaced many GID experts that recommended SRS, with GID experts that categorically opposed SRS for inmates.¹³⁰ Maloney terminated GID expert Dr. David Seil following his evaluation that SRS was a possible medically necessary treatment of Kosilek.¹³¹ Dennehy attempted to persuade representatives of the University of Massachusetts (UMass) (the contracted DOC medical provider) not to retain doctors from Fenway Community Health Center of Massachusetts (Fenway) to treat inmates with GID.¹³² Dennehy

122. *See supra* Part III.

123. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 218 (D. Mass. 2012).

124. *Id.*

125. *Id.*

126. *Id.*

127. *Id.* at 220–22.

128. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 221, 226 (D. Mass. 2012).

129. *Id.* at 220.

130. *Id.* at 220–21.

131. *Id.* at 218–19.

132. *Id.* at 220 (stating that Fenway was the "foremost referral center in New England for individuals with gender identity disorders. However, in view of the Fenway Clinic's

also instructed UMass to retain Licensed Social Worker Cynthia Osborne due to her history of opposition to SRS for inmates.¹³³ Dennehy testified that she did not understand the determination by Fenway's GID specialists that the requested SRS for Kosilek resulted from medical necessity.¹³⁴ Yet she gave multiple interviews to media outlets that indicated the contrary.¹³⁵ Additionally, Dennehy's testimony indicated her strong opposition to becoming the first corrections official to allow an inmate to receive SRS using taxpayer money.¹³⁶

The DOC attempted to justify its delays and denials by arguing that providing SRS would create insurmountable security concerns, both concerning Kosilek's potential escape and assaults resulting from his living in general population of either a male or female corrections facility.¹³⁷ These concerns as expressed by two expert witnesses were insufficient for the court.¹³⁸

When Kosilek once again sued the DOC for violating his rights under the Eighth Amendment, the District Court of Massachusetts became the first court to issue an injunction that required that an inmate receive sex reassignment surgery.¹³⁹ The court followed the proper Eighth Amendment analysis to come to this conclusion.¹⁴⁰

Kosilek must prove that: (1) he has a serious medical need; (2) sex reassignment surgery is the only adequate treatment for it; (3) the defendant knows that Kosilek is at high risk of serious harm if he does not receive sex reassignment surgery; (4) the defendant has not denied that treatment because of good faith, reasonable security concerns or for any other legitimate penological purpose;

reputation, it was foreseeable that Fenway doctors might recommend laser hair removal and sex reassignment surgery for Kosilek [UMass] had no other options [but to retain Fenway]").

133. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 220, 221 (D. Mass. 2012). Osborne worked for well-known sex reassignment surgery opponent and psychiatrist, Dr. Paul McHugh at Johns Hopkins School of Medicine. *Id.* at 221. Additionally, she held the belief that inmates could never satisfy the "real-life experience" requirement of the Standards of Care and, therefore, could never qualify for SRS. *Id.* In practice with the Virginia Department of Corrections and Wisconsin Department of Corrections, her denials of SRS ended in two inmate self castrations. *Id.*

134. *Id.* at 202.

135. *Id.* at 201–03.

136. *Id.* at 223.

137. *Id.* at 224.

138. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 239–40 (D. Mass. 2012). Security expert Beeler "formed his opinion [about the security risks] before visiting any DOC facility or learning anything specific to Kosilek." *Id.* at 225. The other expert, Dumond, did not "consider Kosilek's history of living safely as a woman" at his present correctional facility. *Id.*

139. *Id.* at 250–51.

140. *See supra* text accompanying notes 56–59.

and (5) the defendant's unconstitutional conduct will continue in the future.¹⁴¹

In establishing that Kosilek still had a serious medical need despite having received hormone therapy, Kosilek's illness was determined to still pose a "substantial risk . . . [of] serious harm."¹⁴² Kosilek's past behavior of attempted suicide and castration indicated that if SRS were denied, he posed a substantial risk of serious harm to himself.¹⁴³ Additionally, a serious medical need may be defined by a "diagnos[is] by a physician . . . mandating treatment."¹⁴⁴ Kosilek also satisfies this definition of a serious medical need.¹⁴⁵ The mental health experts that examined Kosilek, with the exception of Osborne, all determined that sex reassignment surgery was "medically necessary."¹⁴⁶ Additionally, seven U.S. Courts of Appeals determined that severe GID constitutes a serious medical need.¹⁴⁷

Yet the court recognized that an inmate does not have the ability to choose his care, rather, the requested treatment must be considered the only adequate treatment to treat the serious medical need.¹⁴⁸ The treatment must be "reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards."¹⁴⁹ When dealing with GID, modern medical standards are those outlined in the STANDARDS OF CARE.¹⁵⁰ Physicians must also base treatment on an individualized assessment of the patient's needs.¹⁵¹ When evaluated by mental health professionals specializing in GID that followed the STANDARDS OF CARE, all but Schmidt determined that Kosilek required the sex reassignment surgery as treatment for GID.¹⁵² The court also determined that the suggestion of psychotherapy, suicide watch, and antidepressants as treatment of the severe emotional distress instead of SRS was insufficient.¹⁵³ This treatment, as it treats only the symptoms of the disorder,

141. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 212 (D. Mass. 2012).

142. *Id.* at 229 (citing *Farmer v. Brennan*, 511 U.S. 825, 828, 835–47 (1994)).

143. *Id.*

144. *Id.*

145. *Id.* (citing *Farmer*, 511 U.S. at 828, 835–47; *McGuckin v. Smith* 974 F.2d. 1050, 1059 (9th Cir. 1992)).

146. *See Kosilek v. Spencer*, 889 F. Supp. 2d 190, 233 (D. Mass. 2012).

147. *Id.* at 230.

148. *Id.* at 236.

149. *Id.* at 207 (citing *United States v. DeCologero*, 821 F.2d 39, 42 (1st Cir. 1987)).

150. *Id.* (citing *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 158–59 (D. Mass. 2002)).

151. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 207–08 (D. Mass. 2012) (citing *Roe v. Elyea*, 631 F.3d 843, 862–63 (7th Cir. 2011), *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 242, 249–50 (D. Mass. 2012); *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 193 (D. Mass. 2002)).

152. *See Kosilek*, 889 F. Supp. 2d at 233.

153. *Id.* at 235–36.

not the disorder itself, is inadequate for an Eighth Amendment objection absent penological concerns.¹⁵⁴ The court determined that Kosilek's serious medical need required SRS as the only adequate treatment for GID, satisfying the objective prong of the deliberate indifference test.¹⁵⁵

In order to determine whether the subjective prong of the deliberate indifference test was satisfied, the court had to determine that the relevant decision maker knew of and disregarded "excessive risk to inmate health or safety, . . . facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."¹⁵⁶ The relevant decision maker in the DOC did know of Kosilek's serious medical need and that lack of treatment created a substantial risk of serious harm to him, particularly through suicide, due to the multiple clinical reports and recommendations by Fenway doctors to the DOC commissioner.¹⁵⁷ Additionally, the DOC was put on notice of the severity of Kosilek's GID and potential consequences of denying medically necessary treatment by the *Kosilek I* decision.¹⁵⁸ These established actual knowledge and disregard of Kosilek's serious medical need and lack of adequate treatment on the part of the DOC.¹⁵⁹

Despite the knowledge of DOC decision makers, the court determined that if adequate security or penological concerns were established, the DOC would not have violated the Eighth Amendment.¹⁶⁰ Yet, the court found that DOC simply used security concerns as a pretext to deny Kosilek's medically necessary treatment.¹⁶¹ First, upon becoming acting Commissioner of DOC, Dennehy immediately halted any further provision of treatment to Kosilek, despite her lack of knowledge and expertise in medical treatment of GID.¹⁶² Additionally, Dennehy hired SRS opponents in order to counter the

154. *Id.* at 208 (citing *Fields v. Smith*, 653 F.3d 550, 556 (7th Cir. 2011); *Wolfe v. Horn*, 130 F. Supp. 2d 648, 653 (E. D. Penn. 2001) (stating that although transexual inmate was prescribed Prozac for depression, there was a fact question precluding summary judgment as to whether inmate received any treatment for transsexualism); *West v. Keve*, 571 F.2d 158, 162 (3rd Cir. 1978) (providing aspirin rather than recommended post-operative treatment may not constitute adequate medical care); *Sulton v. Wright*, 265 F. Supp. 2d, 292, 300 (S.D.N.Y. 2003) (explaining that treatment of symptoms rather than the underlying condition is presumptively inadequate treatment)).

155. *Id.* at 236.

156. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 208–09 (D. Mass. 2012) (quoting *Farmer v. Brennan*, 511 U.S. 825, 837 (1994)).

157. *Id.* at 222.

158. *Id.* at 217.

159. *Id.* at 237–38.

160. *Id.* at 199.

161. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 198 (D. Mass. 2012).

162. *Id.* at 202.

recommendations by Fenway's doctors.¹⁶³ Dennehy also falsely stated that she did not understand the recommendation for SRS.¹⁶⁴ Finally, Dennehy's interviews to media outlets about the DOC's denial of SRS due to safety and security concerns were given prior to any report on the actual impact of safety and security SRS would have.¹⁶⁵ The actual testimony about security additionally did not consider the particular facts of Kosilek's confinement.¹⁶⁶ All alternative plans for Kosilek's confinement were not considered in determining security risks resulting from his SRS.¹⁶⁷ In conjunction with these facts, Dennehy also stated that she would be motivated to deny SRS for political reasons, which is an invalid reason to deny medically necessary treatment to an inmate.¹⁶⁸ Collectively these facts indicated bad faith on the part of DOC's denial of SRS to Kosilek.¹⁶⁹ The denial of SRS to Kosilek, the court concluded, resulted in the "unnecessary and wanton infliction of pain" prohibited by the Eighth Amendment.¹⁷⁰

The court proceeded to grant an injunction for the DOC to make reasonable efforts to provide Kosilek with SRS.¹⁷¹ The court determined that despite its favor for judicial restraint, past actions by the DOC indicated that absent an injunction, the denial of proper treatment for Kosilek would continue.¹⁷² This conclusion is the result of three factors: (1) the DOC has spent the greater part of the past decade denying Kosilek treatment for GID in some way;¹⁷³ (2) the attempts to deny treatment persisted through trial and after the resignation of Commissioner Dennehy;¹⁷⁴ (3) transsexual inmates have suffered a pattern of unconstitutional denial of treatment.¹⁷⁵ These factors allowed the court to enact an unprecedented injunction.¹⁷⁶ When an inmate suffers from severe GID such that SRS is a medically necessary procedure and is denied such treatment as a result of deliberate indifference, the Department of Corrections must

163. *Id.*

164. *Id.* Evidence indicated that Dennehy wrote to the Director of Bureau of Prisons concerning the recommendation for SRS. *Id.*

165. *Id.* at 203.

166. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 224–25 (D. Mass. 2012).

167. *Id.* at 243–45.

168. *Id.* at 203.

169. *Id.* at 247.

170. *Id.* at 217 (quoting *Hope v. Pelzer*, 536 U.S. 730, 737 (2002)).

171. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 251 (D. Mass. 2012).

172. *Id.* at 250.

173. *Id.* at 248.

174. *Id.* at 249.

175. *Id.* at 249–50 (citing *Battista v. Clarke*, 645 F.3d 449, 455 (1st Cir. 2011); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 251 (D. Mass. 2012); *Brugliera v. Comm'r of Mass. Dep't of Corrs.*, No. 07-40323-JLT, 2009 U.S. Dist. Lexis 131002, at *26 (D. Mass. Dec. 16, 2009)).

176. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 250 (D. Mass. 2012).

take “all of the steps reasonably necessary to provide [the inmate] that treatment as promptly as possible.”¹⁷⁷

V. LACK OF COVERAGE FOR SEX REASSIGNMENT SURGERY UNDER MEDICAID, MEDICARE, AND CHAMPUS

Though SRS may be required for inmates in situations similar to *Kosilek*, many less culpable people suffering from GID do not have the ability to obtain sex reassignment surgery. As a result of *Kosilek II*, the only transgendered people who rely on the federal government for health care and can receive SRS are incarcerated criminals.¹⁷⁸ Those that rely on the federal government for health care insurance, through Medicaid, Medicare, and military health insurance programs, have virtually no access to SRS even if it is from a clinical perspective “medically necessary,” because SRS is prohibitively expensive.¹⁷⁹

A. Medicaid

State regulations and statutes concerning Medicaid in many cases are hostile to providing beneficiaries access to SRS. Many states, including Iowa, Minnesota, and New York, specifically prohibit the use of funds for sex reassignment surgery, even if surgery is medically necessary.¹⁸⁰ In addition, federal courts denied coverage of “medically necessary” SRS in instances when states fail to address whether SRS is covered or not.¹⁸¹ Only in California has a court held that SRS is required under Medicaid and that ruling remains good law.¹⁸²

Iowa specifically excluded SRS in its Medicaid coverage and survived a challenge as improper under the federal Medicaid statute.¹⁸³ The regulation states:

177. *Id.* at 204–05.

178. *Id.* at 250.

179. *See, e.g.,* *Smith v. Rasmussen*, 249 F.3d 755,760 (8th Cir. 2001); *Casillas v. Daines*, 580 F. Supp. 2d 235, 243 (S.D.N.Y. 2008); *DeMare v. Dep’t Human Servs.*, No. A06-803, 2006 WL 2533922, at *2 (Minn. Ct. App. Sept. 5, 2006).

180. *See* IOWA ADMIN. CODE r. 441-78.1(4) (2013); MINN. STAT. ANN. § 256B.0625(3a) (West 2013); N.Y. COMP. CODES R. & REGS. tit. 18 §505.2(1) (2013).

181. *See* *Rush v. Parham*, 625 F.2d 1150, 1152 (5th Cir. 1980); *Rush v. Johnson*, 565 F. Supp. 856, 857–58 (N.D. Ga. 1983).

182. *G.B. v. Lackner*, 145 Cal. Rptr. 555, 559 (Cal. Ct. App. 1978). The Minnesota Supreme Court held that SRS must be covered by Medicaid on a statutory basis. *Doe v. Minn. Dep’t of Pub. Welfare*, 257 N.W.2d 816, 821 (Minn. 1977). The legislature invalidated this holding by explicitly prohibiting coverage of SRS through legislation. MINN. STAT. ANN. § 256B.0625(3a) (West 2013).

183. *Smith v. Rasmussen*, 249 F.3d 755, 759–62 (8th Cir. 2001).

For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions Surgeries for the purposes of sex reassignment are not considered as restoring bodily function and are excluded from coverage.¹⁸⁴

The inapplicability of Medicaid coverage for SRS procedures is also reiterated in the statute two more times.¹⁸⁵ First, “[c]osmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are: (2) Procedures related to transsexualism . . . [or] gender identity disorders”¹⁸⁶ Finally, the statute states that the “[f]ollowing is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program (15) Sex reassignment.”¹⁸⁷ Iowa clearly eliminated any leeway in statutory interpretation through this legislation.¹⁸⁸

Additionally, legislation prohibiting coverage of SRS is valid under the federal Medicaid regulation. *Smith v. Rasmussen* challenged the regulation on the grounds that the state could not place such a limitation on medically necessary services and that the state should give deference to physician and patient decisions.¹⁸⁹ The court held that limitations on medically necessary services were valid as long as they were not “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.”¹⁹⁰ The prohibition of coverage for SRS was not considered arbitrary or capricious, and, therefore, valid, because the Iowa Department of Human Services allowed for review of regulations by the medical community for appropriateness.¹⁹¹

Similar to the Iowa statute, Minnesota explicitly prohibited Medicaid coverage of SRS.¹⁹² Legislators reacted to an initial holding of the Minnesota Supreme Court in 1977, that the blanket prohibition of SRS coverage, as outlined in the Medical Assistance Program

184. IOWA ADMIN. CODE r. 441-78.1(4) (2013).

185. IOWA ADMIN. CODE r. 441-78.1(4)(b),(d)(15) (2013).

186. IOWA ADMIN. CODE r. 441-78.1(4)(b) (2013).

187. IOWA ADMIN. CODE r. 441-78.1(4)(d)(15) (2013).

188. IOWA ADMIN. CODE r. 441-78.1(4)(b),(d)(15) (2013).

189. *Smith v. Rasmussen*, 249 F.3d 755, 759 (8th Cir. 2001).

190. *Id.* at 760.

191. *Id.* A previous case, *Pinneke v. Preisser*, challenged the same regulation successfully prior to review by a committee made up of representatives of the medical community. The case was distinguished from *Rasmussen* on this basis. *Pinneke v. Preisser*, 623 F.2d 546, 547 (8th Cir. 1980).

192. MINN. STAT. ANN. § 256B.0625(3a) (West 2013).

Physician's Handbook without force of law, void.¹⁹³ In response to the fact that the holding limited only non-statutory guidelines, the Minnesota legislature amended the statutory provision of covered services to eliminate SRS in 2005.¹⁹⁴ The new law stated, "[s]ex re-assignment surgery is not covered."¹⁹⁵ Though dicta in *Doe v. Minnesota Department of Public Welfare* indicated that it was improper to make any blanket determination concerning medically necessary treatment,¹⁹⁶ the only challenge to the 2005 amended statute failed, without considering the language of *Doe*.¹⁹⁷

In New York, "[p]ayment is not available for care, services, drugs, or supplies rendered for the purpose of gender reassignment (also known as transsexual surgery) or any care, services, drugs, or supplies intended to promote such treatment."¹⁹⁸ In 2008, a patient challenged the statutory limitations on SRS and other proscribed GID treatments for Medicaid coverage.¹⁹⁹ The plaintiff challenged that the proscription violated both the federal regulations for states receiving federal Medicaid funding, and the Fourteenth Amendment's equal protection clause.²⁰⁰ The court dismissed the suit for failure to state a claim, because New York's proscription of SRS coverage was an "appropriate limit" under federal Medicaid legislation²⁰¹ and the legislature had a rational basis in enacting the prohibition.²⁰²

Three years later, politicians in New York considered removing the total prohibition of Medicaid funding for medically necessary SRS.²⁰³ A Medicaid redesign task force recommended eliminating

193. *Doe v. Minn. Dep't Pub. Welfare*, 257 N.W.2d 816, 820 (Minn. 1977).

194. Omnibus Healthcare Services Bill, 2005 Minn. Sess. Law Serv. 2520 (West).

195. MINN. STAT. ANN. § 256B.0625(3a) (West 2013).

196. *Doe v. Minn. Dep't Pub. Welfare*, 257 N.W.2d 816, 820 (Minn. 1977). The court stated, "[t]he total exclusion of transsexual surgery from eligibility for [medical assistance] benefits is directly related to the type of treatment involved and, therefore, is in direct contravention of [45 C.F.R. § 249.10]." *Id.* at 820.

197. *DeMare v. Minn. Dept. of Human Servs.*, No. A06-803, 2006 WL 2533922, at *1 (Minn. Ct. App. Sept. 5, 2006).

198. N.Y. COMP. CODES R. & REGS. tit. 18 § 505.2(1) (2013).

199. *Casillas v. Daines*, 580 F. Supp. 2d 235, 237 (S.D.N.Y. 2008); *see also* *Denise R. v. Lavine*, 39 N.Y.2d 279, 284 (1979) (upholding decision of Commissioner of the New York State Department of Social Services to deny authorization for sex reassignment surgery).

200. *Casillas*, 580 F. Supp. 2d at 243.

201. *Id.* at 242–43.

202. *Id.* at 247. "The state agency's assessment of public comment on the proposed regulation explained succinctly the reasons for denying reimbursement of gender reassignment surgeries and associated treatments. It cited 'serious complications' from the surgeries . . . 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." *Id.*

203. *NY Administration Rejects Medicaid Sex Changes*, WALL ST. J. (Sept. 30, 2011, 4:39 PM), <http://online.wsj.com/article/APc7636fc64eab462ca1644ef0ca1ad325.html>.

the prohibition on Medicaid coverage of GID treatment including SRS.²⁰⁴ Despite this recommendation, the Cuomo administration quickly rejected the recommendation.²⁰⁵

In states that do not outright prohibit Medicaid coverage of SRS, courts have shown no willingness to require the coverage of these procedures. The Fifth Circuit, for example, denied the extension of coverage because it considered SRS experimental treatment.²⁰⁶ The court reasoned that states had the ability to “define medical necessity in a way tailored to the requirements of its own Medicaid program.”²⁰⁷ Essentially, the state can reject coverage of a procedure that is medically unnecessary because the state defines it as medically unnecessary.²⁰⁸ Though the attending physician has the “primary responsibility of determining what treatment should be made available to his patients,”²⁰⁹ the physician must “operate within such reasonable limitations as the state may impose.”²¹⁰ The court reasoned that the Georgia limitation on experimental procedures was reasonable.²¹¹ It held that because SRS was experimental, the Georgia Medicaid program may deny coverage of SRS.²¹²

Currently, the only state that guarantees SRS under its Medicaid program as when medically necessary is California.²¹³ *G.B. v. Lackner* set forth the precedent requiring Medi-Cal to fund SRS when medically necessary.²¹⁴ Much of this result rests on California’s Medi-Cal regulations and the requirements therein.²¹⁵ The California Administrative Code required that Medi-Cal provide coverage for “health care services which are reasonable and necessary for the prevention, diagnosis and treatment of disease, illness or injury. . . .”²¹⁶ The court also categorized SRS as more than mere cosmetic surgery,

204. *Id.*

205. *Id.*

206. *Rush v. Parham*, 625 F.2d 1150, 1155 (5th Cir. 1980). The court dodged the question as to whether the state of Georgia was required to provide coverage of all medically necessary procedures for Medicaid recipients. *Id.*

207. *Id.*

208. *Id.* (“The Supreme Court has interpreted this language as conferring broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be ‘reasonable’ and ‘consistent with the objectives’ of the Act.” (quoting *Beal v. Doe*, 432 U.S. 438, 444 (1977) (internal quotations omitted))).

209. *Id.* at 1156.

210. *Id.*

211. *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980).

212. *Id.* at 1155.

213. *G.B. v. Lackner*, 145 Cal. Rptr. 555, 559 (Cal. Ct. App. 1978).

214. *Id.*

215. *Id.* at 558.

216. *Id.*

which would be prohibited under Medi-Cal regulations.²¹⁷ Rather, Medi-Cal must cover medically necessary SRS procedures and cannot arbitrarily define SRS as a cosmetic surgery to avoid such coverage.²¹⁸ California, however, is the exception to the rule. All other federal court analyses do not require states to provide SRS to those suffering from GID with physician recommendation and approval for the procedure.²¹⁹

B. Medicare

Though the federal and state governments provide health care for the needy through Medicaid programs that in practice prohibit funding for SRS, Medicare also provides health care insurance coverage for the elderly and disabled of the United States.²²⁰ In 2011, forty-eight million people utilized Medicare for health insurance.²²¹ Yet SRS remains excluded from Medicare coverage.²²²

The National Coverage Determinations (NCDs) outline the particular services covered under the Medicare program.²²³ Manual Section 140.3 of the NCDs prohibits Medicare reimbursement for SRS due to its controversy.²²⁴ It classifies the surgery as high risk and experimental.²²⁵ Similar to the Medicaid coverage, Medicare regulations establish a blanket prohibition on SRS coverage regardless of medical necessity.²²⁶

217. *Id.* at 559.

218. *G.B. v. Lackner*, 145 Cal. Rptr. 555, 559 (Cal. Ct. App. 1978).

219. *See, e.g., Smith v. Rasmussen*, 249 F.3d 755, 756 (8th Cir. 2011); *Rush v. Parham*, 625 F.2d 1150, 1154–55 (5th Cir. 1980); *Ravenwood v. Daines*, 06-CV-6355-CJS, 2009 WL 2163105, at *6 (W.D.N.Y. July 17, 2009).

220. *Pulling It Together: Medicare, Medicaid, and the Multiplier Effect*, THE KAISER FAMILY FOUND. (June 9, 2011), <http://www.kff.org/health-reform/perspective/pulling-it-together-medicare-medicaid-and-the/>.

221. *Id.*

222. NAT'L CTR. FOR TRANSGENDER EQUAL., *Medicare Benefits and Transgender People* (Aug. 2011), http://transequality.org/Resources/MedicareBenefitsAndTransPeople_Aug2011_FINAL.pdf.

223. 42 C.F.R. § 405.1060(a)(1) (2013).

224. *National Coverage Determination (NCD) for Transsexual Surgery (140.3)*, CTR. FOR MEDICARE AND MEDICAID SERVS. (Feb. 24, 2013), <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=83&ncdver=1&bc=AgAAQAAAAAAAA&> (“Transsexual surgery for sex reassignment of transsexuals is controversial. Because 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. Moreover, there is a high rate of serious complications for these surgical procedures. For these reasons, transsexual surgery is not covered.”).

225. *Id.*

226. *See* NAT'L CTR. FOR TRANSGENDER EQUAL., *supra* note 222.

C. Civilian Health and Medical Program for Uniformed Services (CHAMPUS)

The last form of health insurance provided by the federal government provides coverage for those in the armed forces, veterans, and their families. The Civilian Health and Medical Program for Uniformed Services (CHAMPUS) “is a program of medical benefits” and is delivered through the TRICARE managed health care program.²²⁷ CHAMPUS services cover active duty members, dependents of active duty members, survivors of active duty members, and retired members of the armed services.²²⁸ Beneficiaries covered under CHAMPUS have three plans from which they may choose to enroll: TRICARE Prime, TRICARE Extra, and TRICARE Standard (CHAMPUS).²²⁹ Yet, the programs contain explicit and implicit exclusions of SRS coverage, despite medical necessity.²³⁰

Transsexualism or such other conditions as gender dysphoria. All services and supplies directly or indirectly related to transsexualism or such other conditions as gender dysphoria are excluded under CHAMPUS. This exclusion includes, but it not limited to psychotherapy, prescription drugs, and intersex surgery that may be provided in connection with transsexualism or such other conditions as gender dysphoria. There is only one very limited exception to this general exclusion, that is, notwithstanding the definition of congenital anomaly, CHAMPUS benefits may be extended for surgery and related medically necessary services performed to correct sex gender confusion (that is, ambiguous genitalia) which has been documented to be present at birth.²³¹

The regulation further excludes coverage of any “[c]osmetic, reconstructive, or plastic surgical procedures that are justified primarily

227. 32 C.F.R. §§ 199.1(d), (r) (2013).

228. 32 C.F.R. § 199.17(c) (2013).

229. 32 C.F.R. §§ 199.17 (d)–(f) (2013). TRICARE Prime acts like an health maintenance organization (HMO). 32 C.F.R. § 199.17(a)(6)(ii)(A) (2013). Beneficiaries may receive care at military treatment facilities and designated civilian network providers. 32 C.F.R. § 199.17(a)(6)(iii) (2013). TRICARE Extra beneficiaries subscribe to a system that acts like a preferred provider organization (PPO), in that beneficiaries may utilize the providers outlined in TRICARE Prime coverage, or out of network providers at a reduced out of pocket rate. 32 C.F.R. § 199.17(a)(6)(ii)(B) (2013). TRICARE Standard allows access to any civilian facility for covered medically necessary treatment. 32 C.F.R. § 199.17(a)(6)(ii)(C) (2013).

230. 32 C.F.R. § 199.17 (2013).

231. 32 C.F.R. § 199.4(e)(5)(ii)(7) (2013).

on the basis of a psychological or psychiatric need.”²³² CHAMPUS regulations prohibit any treatment for GID including SRS despite any determination of medical necessity.²³³

The statutes and regulations controlling federal entitlement programs have in some way or another limited the medically necessary benefits for which a transgendered person may receive compensation.²³⁴ Medicaid coverage of SRS is essentially prohibited by state statute and regulations,²³⁵ the only exception being California.²³⁶ Medicare prohibits any funding for SRS for elderly or disabled beneficiaries.²³⁷ CHAMPUS, the health care program for the military, veterans and their families, also prohibits SRS repeatedly within its regulations.²³⁸ In conjunction with the recent ruling in the Kosilek case, a dichotomy emerges. The government must provide medically necessary SRS for convicted inmates with GID, and yet those with GID who are reliant upon the government for medical care funding outside the prison system cannot receive SRS despite acting in a law-abiding manner.

VI. CONSTITUTIONAL CHALLENGES TO THE DISCREPANCY CREATED BY *KOSILEK* DECISION

The great leeway federal statutes have granted in regulating what is and is not covered under federal health care programs²³⁹ has led to a situation in which the discrepancy that has resulted from

232. 32 C.F.R. § 199.4(e)(8)(iv)(B) (2013). *See also* 32 C.F.R. §§ 199.4(8)(iv)(P)–(R) (2013) (prohibiting procedures with specific reference to gender dysphoria), 32 C.F.R. § 199.4(g)(29) (2012) (excluding services and supplies related to transsexualism or gender dysphoria).

233. 32 C.F.R. §§ 199.4(a)(7)–(8) (2013).

234. *See supra* Part V.C.

235. *See supra* Part V.A.

236. *See supra* text accompanying notes 213–19.

237. *See* National Center for Transgender Equality, *supra* note 222.

238. *See supra* Part V.C.

239. *See* 42 U.S.C. § 1396a(a)(17) (2013) (requiring regulations to establish “reasonable standards” in determining “the extent of medical assistance under the plan which . . . are consistent with the objectives of [Medicaid] . . .”); 5 U.S.C.A. § 301 (2013) (“The head of an Executive department or military department may prescribe regulations for the government of his department, the conduct of its employees, the distribution and performance of its business, and the custody, use, and preservation of its records, papers, and property. This section does not authorize withholding information from the public or limiting the availability of records to the public.”); 42 U.S.C.A. § 405 (2013) (“The Commissioner of Social Security shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder.”).

the *Kosilek* case can only be resolved through a constitutional challenge of the denial of SRS or legislative action explicitly providing for coverage of SRS.

Unfortunately, current constitutional jurisprudence provides no avenue with which to bring a successful challenge to the SRS denial. Neither equal protection challenge nor substantive due process claim could support covering SRS under these health care programs.

A. *Equal Protection Challenge*

The Equal Protection Clause of the Fourteenth Amendment of the United States Constitution provides that, “[n]or shall any state . . . deny to any person within its jurisdiction the equal protection of the laws.”²⁴⁰ The Supreme Court has interpreted this to limit discrimination among similarly situated individuals.²⁴¹ If the classification made by the state actor is suspect, the analysis requires a heightened level of scrutiny.²⁴² Within these limits, the government may make benign classifications as long as the state can provide a reasonable basis for making such distinctions.²⁴³ The threshold for what is rational is very low and easily satisfied.²⁴⁴

In this instance, the Eighth Amendment requires SRS for prisoners that have a medical necessity for the treatment, whereas those with a medical need for SRS that rely on federal health insurance programs cannot get coverage for the treatment under their plans.²⁴⁵ A strained argument exists that prisoners with medical need for SRS and federal health insurance program beneficiaries with a medical need for SRS are similarly situated. Both groups rely upon the federal government to pay for their health care and treatment. Prisoners cannot obtain health care through means outside of the prison system.²⁴⁶ Similarly, payment for health care, including sex reassignment surgery, is prohibitively expensive without health insurance coverage. Without some sort of managed care insurance program, most Americans cannot afford the high cost. Though many have the ability to obtain reasonable health insurance through private insurance companies, those that turn to the government for coverage do so

240. U.S. CONST. amend. XIV, § 1. Equal protection has also been read into the Fifth Amendment. U.S. CONST. amend. V; *Bolling v. Sharpe*, 347 U.S. 497, 498–99 (1954).

241. *E.g.*, *McGowan v. Maryland*, 366 U.S. 420, 425 (1961).

242. *E.g.*, *Brown v. Bd. of Educ.*, 347 U.S. 483, 495 (1954).

243. *E.g.*, *McGowan*, 366 U.S. at 425–26.

244. *E.g.*, *Williamson v. Lee Optical of Okla.*, 348 U.S. 483, 486–90 (1955).

245. *Fields v. Smith*, 653 F.3d 550, 559 (7th Cir. 2011).

246. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

because, in many cases, they cannot afford the private insurance.²⁴⁷ This dependence upon the government for payment of medically necessary treatment establishes a similar situation in which the two groups can be compared in an equal protection analysis.

The classification made by the *Kosilek* case does not create a discrepancy based on a suspect class. In this case, the distinction between the two groups is that one group of those in need of SRS are in prison, the other group is not. The Supreme Court has never held that the non-imprisoned are a suspect class.²⁴⁸ Facing rational basis review, a rational reason for this distinction must exist.²⁴⁹ Here, the government can reduce costs by limiting surgical procedures covered by the statute. Prohibiting sex reassignment surgery has a rational relation to the goal of cost curbing and, therefore, survives this test.²⁵⁰

B. Fundamental Right

For either an equal protection challenge or a substantive due process challenge, if a fundamental right is at issue, courts apply heightened scrutiny to determine if the governmental action at issue is constitutional.²⁵¹ To demonstrate that a right is fundamental, the right must be “deeply rooted” in the history and tradition of the United States and “implicit in the concept of ordered liberty.”²⁵² The

247. To qualify for Medicaid coverage, one must be medically or financially needy such that private insurance is unaffordable. *Medicaid by Population*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/By-Population.html> (last visited Mar. 30, 2014). Under private insurance, beneficiaries of Medicaid would face extremely high premiums due to the high cost of care for the disabled and elderly. *Policy Basics: Introduction to Medicaid*, CTR. ON BUDGET AND POLICY PRIORITIES (May 8, 2013), <http://www.cbpp.org/cms/index.cfm?fa=view&id=2223>. CHAMPUS provides insurance to its service member employees and their families. See discussion *supra* Part V.C. In many instances, the fact that the United States uses an employer provider service for health insurance provides a much more affordable option for armed service members to obtain health care than in the private market. See *supra* text accompanying note 218.

248. Classes deserving of heightened scrutiny have been established as race, national origin, and alienage. See, e.g., *Bolling v. Sharpe*, 347 U.S. 497, 499 (1954) (recognizing race as a suspect class); *Graham v. Richardson*, 403 U.S. 365, 376 (1971) (recognizing national origin as a suspect class). Gender has also received intermediate scrutiny as a quasi-suspect class. See, e.g., *Craig v. Boren*, 429 U.S. 190, 198–200 (1976) (using heightened scrutiny for gender classifications).

249. *Williamson v. Lee Optical of Okla.*, 348 U.S. 483, 491 (1955).

250. See, e.g., *Armour v. City of Indianapolis*, 132 S.Ct. 2073, 2081 (2012) (finding that administrative considerations can provide a rational basis for tax related distinction); *Carmichael v. S. Coal & Coke Co.*, 301 U.S. 495, 511–12 (1937) (finding administrative convenience and expense to be a rational basis for a tax exemption).

251. *Harris v. McRae*, 448 U.S. 297, 312 (1980) (quoting *Mobile v. Bolden*, 446 U.S. 55, 76 (1980) (plurality opinion)).

252. *Washington v. Glucksberg*, 521 U.S. 702, 720–21 (1997).

interest must also be termed by a “careful description” of the right.²⁵³ How one defines the right, in many instances, can make the difference between a fundamental interest and a non-fundamental interest in the eyes of the court.²⁵⁴ Even a broad definition to establish a right to SRS coverage under federal health care programs would fail this test. Medically necessary SRS coverage would be included within a right to medically necessary health care.²⁵⁵ This is arguably a “careful description of the asserted fundamental liberty interest.”²⁵⁶ Yet, this broad definition would still fail a fundamental liberty test.

A right to medically necessary health care cannot be considered a fundamental right, because it is not a right “deeply rooted” in the history and tradition of the United States.²⁵⁷ Health insurance emerged in the 1920s with the development of Blue Cross.²⁵⁸ Patients would pay the hospital a low premium in exchange for medical treatment from the hospital.²⁵⁹ Following World War II, employers purchased insurance plans as a way to attract employees.²⁶⁰ This eventually developed into the employer-based insurance system that covers most of citizens of the United States.²⁶¹

The federal government did not get involved in the provision of health insurance for citizens until the 1960s.²⁶² In 1965 Congress passed an amendment to the Social Security Act that established Medicare to provide health care for the elderly.²⁶³ Congress enacted Medicaid to create a state-federal partnership in providing health insurance for the medically needy and indigent of the United States.²⁶⁴ Medicaid allowed for state discretion in determining what is and is not covered as long as the regulations were reasonable and consistent with the objectives of Medicaid.²⁶⁵ Medicare originally only provided coverage for inpatient hospital costs and specified outpatient services.²⁶⁶ In 1980, the Supreme Court upheld a Constitutional

253. *Id.* at 721.

254. *See id.* at 726–28.

255. *See, e.g.,* DentedBlue, *Why Sex Change Surgery Is Medically Necessary, Revisited*, DAILY KOS (Mar. 7, 2012, 10:42 AM), <http://www.dailykos.com/story/2012/03/07/1072072/-Why-Sex-Change-Surgery-is-Medically-Necessary-Revisited#>.

256. *Id.* at 721.

257. *See, e.g., id.* at 720–21.

258. Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. POL'Y 1, 7–8 (2005).

259. *See id.* at 8.

260. *Id.* at 10.

261. *Id.* at 5, 13.

262. *See id.* at 13.

263. Social Security Act Amendments, Pub. L. No. 89-97, 79 Stat. 286 (1965).

264. *Id.*

265. 42 U.S.C.A. § 1396a(a)(17) (West 2013). *See also* *Beal v. Doe*, 432 U.S. 438, 444 (1977).

266. Social Security Act Amendments, Pub. L. No. 89-97, 79 Stat. 286 (1965).

prohibition on federal funding of abortion.²⁶⁷ The history of the United States health care system points to a more limited coverage of specific and especially controversial procedures under federal health care programs.²⁶⁸

The federal government has also only covered specific groups of people under its health care programs.²⁶⁹ In 2010, the United States established a plan that expanded government coverage of health care beyond the specified groups to include those without employer-based insurance.²⁷⁰ Even then, these exchanges do not contain federal insurance programs. They simply provide federally approved private plans.²⁷¹ The government has never provided health care in such a way that a right to medically necessary treatment could be established as rooted in the history and traditions of the United States.²⁷²

Additionally, the Supreme Court stated that affirmative actions by the government are not protected as fundamental rights under the Due Process Clauses of the Fifth or Fourteenth Amendments.²⁷³ The Constitution only provides protection from “unwarranted governmental interference.”²⁷⁴ The Court has addressed an analogous situation in which a government-funded health insurance program refused funding for a controversial medical procedure despite its medical necessity.²⁷⁵ In *Harris v. McRae*, the Court addressed the Hyde Amendment to the appropriations bill for the Department of Health, Education and Welfare that prohibited federal funding for abortions “except where the life of the mother would be endangered if the fetus were carried to term.”²⁷⁶ Similar to the SRS restrictions, Medicaid would not fund medically necessary abortion procedures unless they threatened the life of the mother.²⁷⁷ The Court responded that the Constitution does not require the government to subsidize all medically necessary abortions.²⁷⁸ Congress chose to subsidize the

267. *Harris v. McRae*, 448 U.S. 297, 317–18 (1980).

268. *Id.* at 316–18.

269. These programs and groups include: Medicare coverage of the elderly and disabled; Medicaid coverage of the poor; and CHAMPUS coverage for members and veterans of the armed services and their families. See discussion *supra* Part V.

270. Patient Protection and Affordable Care Act, 26 U.S.C.A. § 5000A (West 2013).

271. *Id.*

272. See *supra* text accompanying notes 257–68.

273. See *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 196 (1989); *Harris v. McRae*, 448 U.S. 297, 317–18 (1980).

274. *Harris v. McRae*, 448 U.S. at 317.

275. *Id.* at 316.

276. *Id.* at 303. The amendment also provided an exception for medical procedures for rape and incest victims if the incident was reported to a law enforcement agency or public health service. *Id.* See also Pub. L. No. 96-123 § 109, 93 Stat. 926 (1979).

277. Pub. L. No. 96-123 § 109, 93 Stat. 926 (1979).

278. *Harris*, 448 U.S. at 317.

health care of certain medically necessary procedures, but has no positive constitutional obligation to subsidize the health care of all medically necessary procedures, even if the funds might be necessary to enjoy a constitutionally protected freedom.²⁷⁹ Unlike abortion, no fundamental right specifically exists to receive SRS.²⁸⁰ This means that the argument that Congress has an affirmative duty to provide funding for SRS is even weaker than the argument that the Supreme Court rejected in *Harris v. McRae*.²⁸¹

No fundamental right to medically necessary treatment exists, so any challenge to the prohibitions of funding for medically necessary SRS procedures would face rational basis review.²⁸² As stated above, cost control satisfied the rational basis test. Any substantive due process or equal protection challenge to the discrepancy established through the *Kosilek* decision would not solve the inequality.²⁸³

CONCLUSION

The *Kosilek* decision left a remarkable impact on the jurisprudence concerning transgendered inmates. If sex reassignment surgery is medically necessary for a transgendered prisoner, and the request for treatment is denied, the Eighth Amendment is likely violated.²⁸⁴ The impact of the *Kosilek* decision, however, brings to light an inequality in the United States health care system. Though prisoners with a medical need for SRS have a right to receive this treatment, those outside the prison system that rely on the government for health care cannot receive the same treatment. Unfortunately, neither due process, nor equal protection challenges to this inequality will correct the injustice. The political system remains as the only apparatus available to alleviate this inequality. Congress, state legislatures, and federal and state agencies must act to correct the inherent problem that has emerged from the *Kosilek* decision.

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279. *Id.*

280. *See* *Roe v. Wade*, 410 U.S. 113, 154 (1973).

281. *Harris v. McRae*, 448 U.S. 297, 317 (1980).

282. *See* discussion *supra* Part VI.

283. *See* discussion *supra* Part VI.

284. *See* discussion *supra* Part VI.A.

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