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Medical Necessity: A Higher Hurdle for Marginalized Taxpayers?

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Medical Necessity: A Higher Hurdle for Marginalized Taxpayers?

Cover Page Footnote

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MEDICAL NECESSITY: A HIGHER HURDLE FOR MARGINALIZED TAXPAYERS?

*Julie Furr Youngman & Courtney D. Hauck**

Civil rights protection for transgender people—and in particular access to affordable health care—is currently the subject of intense political scrutiny, with a hostile administration chipping away at legal protections. Among other setbacks, a federal district court enjoined regulatory guidelines that were issued in 2016 to clarify that the federal prohibition on sex discrimination in health insurance applies to discrimination on the basis of gender identity and transgender status, and the promulgating agency itself is now reconsidering the guidelines. Without explicit federal protections against discrimination by health insurers and in the face of uneven state law protections, the ability to deduct costs associated with gender transition-related health care that are not covered by insurance on one’s personal income taxes has taken on new significance for the transgender population. This article takes a new look at the 2010 decision of the United States Tax Court in O’Donnabhain v. Commissioner of Internal Revenue, in which the Court held that a transgender taxpayer could deduct certain transition-related medical expenses on her federal income tax return, but not others. This article argues that, while the O’Donnabhain decision may legitimize transition-related treatments as medically appropriate in the insurance context, the Court overreached by considering whether the costs at issue were “medically necessary” and “widely accepted” in the medical community, requirements that the federal tax code does not impose. In so doing, the decision risks

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imposing an unwarranted burden of proof on transgender people and potentially on other marginalized populations. This article explores the implications of the O'Donnabhain decision for transgender health care in the current political and legal climate, and explores strategies to protect health care rights for transgender people and other marginalized communities, with a focus on the medical deduction for individual federal income taxes.

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INTRODUCTION

The topic of civil rights protection for transgender people is currently the subject of intense scrutiny from all sides, from politics to academia to the nation's courts. In particular, the cost of transgender health care, as well as the availability and scope of insurance coverage to pay for it, has become a topic of greater focus at both the federal and state level. The most recent developments, however, aim to make the process of obtaining and affording health care more burdensome for transgender individuals rather than less so.

In December 2017, the Trump administration banned the Center for Disease Control and Prevention from using the term “transgender” in its 2018 budget documents.¹ Prior to that, in the summer of 2017, President Trump cited the allegedly high cost of transgender health care as a reason for banning transgender people from serving in the U.S. military; in the same order, he banned “the use of [Department of Defense] and [Department of Homeland Security] resources to fund sex-reassignment surgical procedures for military personnel.”² In March 2017, the U.S. Census Bureau reversed plans to collect data on transgender individuals in the upcoming 2020 Census, which would have provided important information on such matters as uninsured rates and lack of access to health care among transgender populations.³ And, with the farthest reaching effects of all, Obama-era guidelines published by the U.S. Department of Health and Human Services (“HHS”) in May 2016, which clarified that a federal prohibition on sex discrimination in health insurance includes discrimination on the basis of gender identity and transgender status, were undermined by two events: in December 2016, in litigation challenging the guidelines on religious grounds, a federal court enjoined their implementation, and then in July 2017 HHS itself secured a stay of the litigation while it reassesses the guidelines and considers amending them.⁴ The

1. Juliet Eilperin & Lena H. Sun, *CDC Gets List of Forbidden Words: Fetus, Transgender, Diversity*, WASH. POST (Dec. 15, 2017), https://www.washingtonpost.com/national/health-science/cdc-gets-list-of-forbidden-words-fetus-transgender-diversity/2017/12/15/f503837a-e1cf-11e7-89e8-edec16379010_story.html?utm_term=.45a3636767ea (other banned terms include: “science-based,” “evidence-based,” “diversity,” and “vulnerable”).

2. See Presidential Memorandum for the Secretary of Defense and the Secretary of Homeland Security, 82 Fed. Reg. 41319 (Aug. 25, 2017) (banning transgender participation in the U.S. armed forces); see also Julie Hirschfeld Davis, *Trump Surprises Military with a Transgender Ban*, N.Y. TIMES, July 27, 2017, at A1.

3. See *infra* notes 50–55 and accompanying text.

4. See *infra* Section II(A).

prevalence of an antagonistic attitude in the current administration, as evidenced by these events, coupled with the lack of explicit enforceable statutory protections for transgender health care at both the state and federal levels of government, poses challenges for transgender people seeking affordable health care.

Typically, many Americans can look to their health insurance (whether provided by Medicare or Medicaid programs, or by private health insurers) to pay for the medical care they need, and many can deduct any remaining health care costs that are not covered by insurance from their income on their individual federal income tax returns using the medical deduction as a means of offsetting some of the burden of those out-of-pocket expenses. Likewise, transgender people may seek both insurance coverage and income tax deductions for the cost of their transition-related care, which may include psychotherapy, hormone therapy, gender conformity surgery,⁵ and other surgeries. The availability of the former (insurance coverage) may be limited to those treatments that are deemed “medically necessary,” depending upon the governing laws in the patient’s home state and on the terms of his or her insurance policy. The Internal Revenue Code, however, does not apply a “medical necessity” requirement to the latter (the income tax deduction for medical care) so long as a deducted expense meets the Code’s definition of medical care, discussed in more detail below.⁶ The Internal Revenue Service and the Tax Court has not generally questioned whether particular medical treatments, even non-traditional and non-mainstream treatments, are “medically necessary” or even widely accepted before allowing deductions, so long as the taxpayer and his or her health care provider believe the treatment would aid in diagnosing, curing, alleviating, or treating a disease or medical condition.⁷ Yet a recent decision of the United States Tax Court appears to import a “medical necessity” threshold for transgender people seeking to use the medical deduction for transition-related medical expenses, unjustifiably and disproportionately disadvantaging this already marginalized group.

5. Gender conformity surgery is also sometimes called Gender Affirmation Surgery, Gender Confirmation Surgery, Sex Reassignment Surgery (SRS), or Gender Reassignment Surgery (GRS). Glossary of Gender and Transgender Terms, THE FENWAY INST., http://fenwayhealth.org/documents/the-fenway-institute/handouts/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms_.fi.pdf (last updated Apr. 8, 2018).

6. I.R.C. § 213(d) (2017).

7. See *infra* text accompanying notes 262–63.

Admittedly, the United States Tax Court's 2010 decision in *O'Donnabhain v. Commissioner of Internal Revenue*⁸ creates precedent allowing transgender people to deduct certain transition-related medical expenses such as hormone therapy and gender conformity surgery on their federal income tax returns, representing a significant but preliminary step on the way to legitimizing such expenses as deductible, medically appropriate, and insurable in other contexts. Yet the *O'Donnabhain* Court may have gone too far by unnecessarily addressing whether the treatments were "widely accepted" and whether the costs at issue were "medically necessary," requirements that the federal tax code does not impose, instead of simply answering the question actually mandated by applicable tax regulations: whether the treatments at issue met the definition of deductible "medical care" without being ruled out by the exception for "cosmetic surgery."⁹ The holding may be helpful to transgender people seeking coverage of transition-related treatments in the insurance context. But by applying the higher—and unfounded—standard of "medical necessity" in the tax context, the Court unnecessarily inserted itself into the political debate over the appropriateness of various treatments for transgender patients. It thereby imposed a gratuitous hurdle that, if taken as more authoritative than the dicta that it is, may be used to harm taxpayers—both those who are transgender and those who are not—in the future by preventing them from deducting the cost of legitimate but uninsured medical care from their taxes simply because the decision-maker—whether an Internal Revenue agent or future Tax Court panel—finds the treatment to be experimental or non-traditional, or is otherwise not persuaded of its absolute necessity and wide acceptance. In light of the recent events described above, a fresh look at the *O'Donnabhain* decision is in order.

This Article describes the current climate for transgender health care and coverage and explores strategies to protect health care rights for transgender people and other marginalized communities, with a focus on the medical deduction for individual federal income taxes. Part I describes the widely-accepted best practices for transgender health care and identifies challenges to obtaining that care in the

8. 134 T.C. 34 (2010).

9. I.R.C. § 213(d) (2017).

United States. Part II analyzes current federal and state regulations governing transgender health care and their implications for transgender people living in different states. Part III explains the federal tax deduction for medical expenses and its application to gender transition-related care. Part IV discusses the Tax Court's decision in *O'Donnabhain v. Commissioner* as it relates to these issues and questions some of its reasoning and conclusions. Finally, Part V explores the implications of the ruling for transgender health care in the context of current federal and state legislation and guidance, including considerations for legal, political, and medical professionals seeking to protect the interests of transgender people and other marginalized populations.

I. TRANSGENDER MEDICAL NEEDS AND CHALLENGES

A. Transgender People Face High Rates of Illness and Poverty

Studies show that transgender populations experience a wide range of minority stressors at higher rates than the population at large. Before delving into the specifics, clarification of the current understanding of the term “transgender” may be useful. According to the American Psychological Association (“APA”), the term “transgender” refers to the state of “having a gender identity that differs from one’s sex assigned at birth,”¹⁰ while the American Psychiatric Association defines it as “the broad spectrum of individuals who transiently or persistently identify with a gender different from their gender at birth.”¹¹ Notably, being transgender does not necessarily mean that one wishes to transition (change one’s gender role)¹² or undergo gender conformity surgery; rather, “transgender” is “an umbrella term for persons whose gender identity, gender expression [such as dress] or behavior does not conform to that typically associated with the sex to which they were assigned at birth.”¹³ This includes individuals “who identify with binary gender

10. *The Psychology of Transgender: Eight Questions for Transgender Expert Walter Bockting*, PhD, AM. PSYCHOL. ASS’N (Nov. 19, 2015), <http://www.apa.org/news/press/releases/2015/11/psychology-transgender.aspx>.

11. *What is Gender Dysphoria?*, AM. PSYCHIATRIC ASS’N, <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> (last visited Feb. 18, 2018).

12. *The Psychology of Transgender: Eight Questions for Transgender Expert Walter Bockting*, PhD, *supra* note 10.

13. *Transgender People, Gender Identity and Gender Expression*, AM. PSYCHOL. ASS’N, <http://www.apa.org/topics/lgbt/transgender.aspx> (last visited Feb. 18, 2018).

identities (e.g., trans men, trans women) and/or nonbinary gender identities (e.g., gender-queer, gender-bender, gender-fluid, agender, bigender).”¹⁴ An estimated 1.4 million transgender people live in the United States today.¹⁵ Those individuals face numerous challenges, not the least of which is that they are statistically more likely than the adult population at large to experience poverty, as well as a wide range of mental and physical health issues, and to encounter obstacles in obtaining treatment for those issues.

According to transgender psychology expert Dr. Walter Bockting, “[h]ealth disparities in the area of mental health are well documented among this population. Transgender people are more vulnerable to symptoms of depression and anxiety, which is at least in part attributable to the social stress they experience as members of a gender minority population.”¹⁶ Even in the population in general, studies show that stigma and discrimination subject an individual to feelings of loneliness, isolation, hopelessness, and depression, all of which are factors associated with suicide; thus, the stigma and discrimination associated with being transgender can magnify suicide rates among transgender populations in particular.¹⁷ According to one study, among transgender people surveyed, “41% of respondents reported attempting suicide compared to 1.6% of the general population;”¹⁸ another source estimates that “[54%] of transgender youth have attempted suicide and 21% resort to self-mutilation.”¹⁹

14. Elliot A. Tebbe & Bonnie Moradi, *Suicide Risk in Trans Populations: An Application of Minority Stress Theory*, 63 J. COUNSELING PSYCHOL. 520, 520 (2016).

15. Jan Hoffman, *Estimate of U.S. Transgender Population Doubles to 1.4 Million Adults*, N.Y. TIMES (June 30, 2016), https://www.nytimes.com/2016/07/01/health/transgender-population.html?_r=0. This estimate came from a survey asking people whether they considered themselves to be transgender, with interviewers being instructed to define the term transgender as someone who “experience[s] a different gender identity from their sex at birth.” Andrew R. Flores et al., *How Many Adults Identify as Transgender in the United States?*, THE WILLIAMS INST. 3, 7 (June 2016), <http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf>.

16. *The Psychology of Transgender: Eight Questions for Transgender Expert Walter Bockting*, PhD, *supra* note 10.

17. Tebbe & Moradi, *supra* note 14, at 520–33.

18. See Jaime M. Grant et al., *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, NAT’L GAY AND LESBIAN TASK FORCE 72 (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf; see also Tebbe & Moradi, *supra* note 14, at 520 (“Estimated lifetime prevalence of suicide attempts in trans populations ranges from 26% to 45% . . .”).

19. AM. COLL. OF OBSTETRICS AND GYNECOLOGY, COMMITTEE OPINION NO. 512: HEALTH CARE FOR TRANSGENDER INDIVIDUALS 118 (2011) (hereinafter “ACOG Policy”).

A study of transgender people in the San Francisco area illustrates the incidence and effects of stigma and discrimination on that population: Among the sample, “59% of participants reported experiencing rape, 36% reported physical victimization . . . , 83% reported verbal discrimination . . . , and 62% reported other forms of discrimination (e.g., being fired, evicted or denied housing, denied access to health care services) as a result of gender identity.”²⁰ Significantly, the study noted that “participants’ experiences of rape and each of the forms of gender identity-based discrimination were associated positively with attempted suicide.”²¹ In addition, transgender people experience high rates of depression and substance abuse, two general risk factors for suicide in the general population. The lifetime prevalence of depression in transgender populations is estimated to exceed 50%, compared to 16% in the general population.²² Further, “approximately 17% of trans women and 33% of trans men reported past alcohol problems” compared to World Health Organization estimates of “1.9% for women and 5.5% for men . . . in the United States.”²³ Both minority stressors and increased rates of depression and substance abuse result in “individual differences in depression and suicide risk in transgender populations.”²⁴

Additionally, the stigma associated with the transgender population often makes it difficult for transgender people to access resources such as education, health care, employment, and housing.²⁵ These issues are compounded by, and potentially contribute to, high rates of poverty among transgender Americans. Transgender Americans are between three and four times more likely to have a household income under \$10,000 per year than the population as a whole, and 34% of African American transgender people reported incomes at this level compared to 9% of all African Americans.²⁶

20. Tebbe & Moradi, *supra* note 14, at 521.

21. *Id.*

22. *Id.* at 521-22.

23. *Id.* at 522.

24. *Id.* at 530.

25. *HIV Among Transgender People*, CENTERS FOR DISEASE AND CONTROL PREVENTION, <https://www.cdc.gov/hiv/group/gender/transgender/index.html> (last updated Aug. 3, 2017) (hereinafter “CDC HIV Among Transgender Webpage”).

26. *Paying an Unfair Price: The Financial Penalty for Being Transgender in America*, MOVEMENT ADVANCEMENT PROJECT (2015), <http://www.lgbtmap.org/file/paying-an-unfair-price-transgender.pdf>.

Finally, transgender people face additional challenges due to heightened rates of physical illnesses such as HIV and AIDS. According to the Center for Disease Control:

Multiple factors have put transgender people at risk for HIV infection and transmission, including multiple sexual partners, anal or vaginal sex without condoms or medicines to prevent HIV, injecting hormones or drugs with shared syringes and other drug paraphernalia, commercial sex work, mental health issues, incarceration, homelessness, unemployment, and high levels of substance misuse compared to the general population, as well as violence and lack of family support.²⁷

This heightened incidence of HIV/AIDS in the transgender community is compounded by race: while the transgender population experiences HIV/AIDS at four times the rate of the general U.S. population,²⁸ about “half of transgender people diagnosed with HIV are black/African American.”²⁹ Accordingly, increased access to compassionate and comprehensive mental and physical health care is necessary to prevent, detect, and treat these and other health care issues afflicting a disproportionate percentage of the transgender community.³⁰

B. Transition-Related Care as Treatment for Gender Dysphoria

A subset of transgender people suffers from a related diagnosable emotional disorder that involves significant psychological distress and discomfort with one’s assigned sex. This condition was known as gender identity disorder (“GID”) under the fourth edition of the authoritative Diagnostic and Statistical Manual of Mental Disorders (“DSM-IV”) and is now called gender dysphoria in the recently-published fifth edition (hereinafter “DSM-5”). The DSM-5 renamed the condition to acknowledge that, while transgender status is not itself a psychological disorder, the significant and pervasive psychological distress and discomfort that sometimes accompany one’s assigned sex

27. *HIV Among Transgender People*, *supra* note 25.

28. JAIME M. GRANT ET AL., NATIONAL TRANSGENDER DISCRIMINATION SURVEY REPORT ON HEALTH AND HEALTH CARE 13 (National Gay and Lesbian Task Force 2010).

29. *HIV Among Transgender People*, *supra* note 25.

30. *Id.*

can be.³¹ The DSM-5 defines gender dysphoria as a diagnosis that involves “a difference between one’s experienced/expressed gender and assigned gender” together with “significant *distress* or problems functioning” related to that dissonance.³² The American Medical Association (“AMA”) and other medical care organizations have recognized GID as described in the DSM-IV (and now gender dysphoria, as described in the DSM-5) as a “serious medical condition.”³³ Left untreated, gender dysphoria can result in “clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death.”³⁴

The World Professional Association for Transgender Health (“WPATH”) is the leading professional organization devoted to the understanding and treatment of gender dysphoria.³⁵ WPATH’s internationally accepted Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (hereinafter “WPATH Standards of Care” or “Standards of Care”) provide guidance on step-by-step treatment for gender dysphoria.³⁶ These steps typically begin with psychotherapy and other mental health care provided by a licensed psychotherapist or other health care professional.³⁷ They continue with various types of support for “[c]hanges in gender expression and role,”³⁸ such as change of name, dress, hair, voice and communication style.³⁹ In some cases, next steps may include, when appropriate, “hormone therapy to feminize or masculinize the body”⁴⁰ and/or gender conformity surgery (that is,

31. Wayne Parry, *Gender Dysphoria: DSM-5 Reflects Shift in Perspective on Gender Identity*, THE HUFFINGTON POST (June 4, 2013), http://www.huffingtonpost.com/2013/06/04/gender-dysphoria-dsm-5_n_3385287.html.

32. *What is Gender Dysphoria?*, *supra* note 11 (emphasis added).

33. AM. MED. ASS’N HOUSE OF DELEGATES, RESOLUTION 122 (A-08) REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS (2008), http://www.tgender.net/taw/ama_resolutions.pdf.

34. *Id.*

35. *Id.*

36. WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 9–10, 21–63 (7th ed. 2011), [https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20\(2\)\(1\).pdf](https://s3.amazonaws.com/amo_hub_content/Association140/files/Standards%20of%20Care%20V7%20-%202011%20WPATH%20(2)(1).pdf).

37. *Id.* at 10, 21–33.

38. *Id.* at 9. These changes “may involve living part time or full time in another gender role, consistent with one’s identity”. *Id.* at 52–54.

39. *Id.* at 9.

40. *Id.*

“[s]urgery to change primary and/or secondary sex characteristics”).⁴¹ The Standards of Care require the recommendation of one or more licensed psychotherapists depending on the type of surgery (one psychotherapist’s recommendation for “breast/chest surgery” and two for “genital surgery,” for instance).⁴²

The Standards of Care and their underlying principles are now recognized by major medical associations such as the AMA, APA, and American College of Obstetrics and Gynecology (“ACOG”). Specifically, the AMA issued the following policy statement:

Our AMA (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.⁴³

Likewise, the APA issued a resolution in which it acknowledged the WPATH Standards of Care and stated both that it “supports the provision of adequate and necessary mental and medical health care treatment for transgender and gender variant individuals” and that it “recognizes the efficacy, benefit and medical necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments.”⁴⁴ In a third example of such policy language, the ACOG acknowledged the wide use of the WPATH Standards of Care, described the steps of the Standards of Care in detail, and stated, “[O]bstetrician-gynecologists should be prepared to assist or refer transgender individuals for routine treatment and screening as well as hormonal and surgical therapies.”⁴⁵ The ACOG went on to urge “public and private health insurance plans to cover the treatment of gender identity disorder.”⁴⁶

41. *Id.* at 10, 54–64.

42. *Id.* at 27, 59–60.

43. *Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927*, AM. MED. ASS’N, <https://policysearch.ama-assn.org/policyfinder/detail/gender%20dysphoria?uri=%2FAMADoc%2FHOD-185.927.xml> (last updated 2016) (hereinafter “AMA Policy”).

44. *Transgender, Gender Identity, & Gender Expression Non-Discrimination*, AM. PSYCHOL. ASS’N, <http://www.apa.org/about/policy/transgender.aspx> (last visited Feb. 18, 2018).

45. ACOG Policy, *supra* note 19, at 1455–56.

46. *Id.* at 1455.

In all three of the foregoing policies, prominent medical organizations have (a) recognized the medical propriety and necessity, in line with physician recommendations and generally accepted care practices, of treatments for gender dysphoria, and (b) advocated for federal, state, and local policies to ensure coverage of such health care under both public and private insurance. Notably, the AMA and ACOG language specifically points to surgery (i.e., gender conformity surgery) as an appropriate path to treatment, and the APA and ACOG specifically acknowledge the WPATH Standards of Care.⁴⁷ However, despite near-universal acceptance in the medical community of gender dysphoria as a formal diagnosis and of the WPATH Standards of Care as the appropriate treatment for gender dysphoria, transgender people often experience difficulty receiving appropriate medical care, obtaining the psychotherapy, hormone treatment, and surgery they need, and/or securing insurance coverage for the care they do receive.

C. Discrimination and Lack of Awareness as Obstacles to Accessing Adequate Medical Care

The difficulties that transgender people encounter accessing appropriate medical care stem from a number of factors. Transgender and gender-nonconforming survey participants report “very high levels of postponing medical care when they are sick or injured due to discrimination (28%) or inability to afford [care] (48%).”⁴⁸ Twenty-eight percent reported being subjected to harassment in medical settings,⁴⁹ and according to a 2015 survey, “[o]ne in four (25%) respondents experienced a problem in the past year with their insurance related to being transgender, such as being denied coverage for care related to gender transition or being denied coverage for routine care because they were transgender.”⁵⁰

Because the U.S. Census Bureau has never collected data regarding transgender status or other matters related to gender identity and has canceled preliminary plans to do so in the 2020 census, independent studies such as those cited in this paper are the primary

47. See AMA Policy, *supra* note 43; ACOG Policy, *supra* note 19; *Transgender, Gender Identity, & Gender Expression Non-Discrimination*, *supra* note 44.

48. Grant, *supra* note 28, at 1.

49. *Id.*

50. Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey*, NAT’L CTR. FOR TRANSGENDER EQUALITY (Dec. 2016), <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>.

sources of statistical information regarding transgender and gender nonconforming people.⁵¹ Despite the fact that “more than 75 members of Congress” and various federal agencies requested that data on “sexual orientation and gender identity” be collected, the then-director of the Census Bureau, John Thompson, wrote in March 2017 that the Bureau had “concluded there was no federal data need” for such information.⁵² Significantly, in its report entitled, “Subjects Planned for the 2020 Census and American Community Survey,” the Bureau revealed that, even as it rejected suggestions to collect information about gender identity, it planned to continue to seek information about gender.⁵³ It stated, “A question about the gender of each person is used to create statistics about males and females and to present other data, such as occupation, by gender,” and clarified that the only two choices for “gender” would be “male” or “female.”⁵⁴ It went on to explain the purpose of collecting male/female data:

Gender data are used in planning and funding government programs and in evaluating other government programs and policies to ensure they *fairly and equitably serve the needs of males and females*. These statistics are also used to enforce laws, regulations, and policies against discrimination in government programs and in society.

...

Knowing the gender of people in the community in combination with information about housing, voting,

51. See Hansi L. Wang, *Collecting LGBT Census Data is 'Essential' to Federal Agency, Document Shows*, NAT'L PUB. RADIO (June 20, 2017), <https://www.npr.org/2017/06/20/533542014/collecting-lgbt-census-data-is-essential-to-federal-agency-document-shows>; see also Stephen Dinan, *President Trump Cancels Sexual Orientation Questions on 2020 Census*, WASH. TIMES (Mar. 28, 2017), http://www.washingtontimes.com/news/2017/mar/28/trump-cancels-census-sexual-orientation-questions-/?utm_source=RSS_Feedutm_medium=RSS

(“The Trump administration canceled plans to probe Americans for their sexual orientation in the 2020 Census, nixing efforts by congressional Democrats who’d wanted a better picture of the country’s increasingly complex family and sexual dynamics.”).

52. John W. Thompson, *Director’s Blog: Planned Subjects for the 2020 Census and the American Community Survey*, U.S. CENSUS BUREAU: CENSUS BLOGS (Mar. 29, 2017), https://www.census.gov/newsroom/blogs/director/2017/03/planned_subjects_2020.html (defending decision to remove gender identity and sexual orientation from list of 2020 Census topics).

53. U.S. DEP’T OF COMMERCE, SUBJECTS PLANNED FOR THE 2020 CENSUS AND AMERICAN COMMUNITY SURVEY: FEDERAL LEGISLATIVE AND PROGRAM USES 9 (Mar. 2017), <https://www2.census.gov/library/publications/decennial/2020/operations/planned-subjects-2020-ac.pdf>.

54. *Id.*

language, employment, and education, *helps government and communities enforce laws, regulations, and policies against discrimination on the basis of gender.*

...

*Knowing whether people of different genders have the same opportunities in education, employment, voting, home ownership, and many other areas is of interest to researchers, advocacy groups, and policymakers. For example, . . . several agencies use gender data to investigate whether women, including women who are military veterans, have similar employment opportunities as men.*⁵⁵

The same report identified numerous other areas of inquiry, including “health insurance,” and explained the purpose of that line of inquiry:

Knowing the health insurance coverage status of people in a community helps planners identify gaps in community services, plan programs that address those gaps, and qualify for funding for those programs.

Knowing more about changes in health insurance coverage rates and the characteristics of people who have or do not have health insurance is also of interest to researchers, advocacy groups, and policymakers.⁵⁶

Gathering the same types of information about gender identity would serve the same commendable purposes for the transgender population, and it would provide similar valuable information about whether transgender individuals are being “fairly and equitably” treated—or discriminated against—in a variety of spheres, such as employment, health insurance, and access to medical care. Yet, as of March 2017, the U.S. Census Bureau had determined not to collect data on the American transgender population and its specific needs.⁵⁷

Although data on the difficulties experienced by the transgender population in accessing health care is limited, anecdotally, at least some cases of health care denial stem from a lack of training and awareness related to transgender medical care among the medical community, leaving many physicians unaware of, for instance, the need for pap smears, breast exams, mammograms, and prostate

55. *Id.* at 9 (emphasis added).

56. *Id.* at 33.

57. *Id.*; Thompson, *supra* note 52.

screenings in transgender women.⁵⁸ Specifically, half of transgender patients surveyed “reported having to teach their medical providers about transgender [health] care.”⁵⁹ Accordingly, anti-discrimination protections and adequate education regarding proper treatment of transgender patients would improve the availability and quality of transition- and wellness-related care for transgender people, as would financial safeguards.⁶⁰ As stated above, up to half of transgender people report inability to afford health care as a primary reason for postponing medical care.⁶¹ Thus, from a purely financial perspective, equity in both health care insurance coverage and tax deductibility for transgender health care costs would help ensure that adequate health care is also affordable for transgender patients.

II. FEDERAL AND STATE REGULATIONS GOVERNING TRANSGENDER HEALTH CARE

Health care affordability is a common obstacle to health care among transgender people. Specifically, in two different studies, thirty-three percent⁶² and forty-eight percent⁶³ of transgender patients reported delaying or foregoing medical treatment due to their inability to afford care. One major reason for this lack of affordability is high out-of-pocket costs that are not covered by insurance.⁶⁴ About twenty percent of all transgender people (and more than thirty percent of African American transgender people) do not have health insurance at all,⁶⁵ as compared to 8.8% in the population at large.⁶⁶ Figures 1, 2, and 3 show the respective percentages of transgender men, women, and African-Americans who are privately insured, publicly insured, and uninsured.

58. Abby Ellin, *Transgender Patients Face Challenges at the Hospital*, N.Y. TIMES (Feb. 16, 2016, 2:59 AM), <https://well.blogs.nytimes.com/2016/02/16/for-transgender-patients-challenges-at-the-hospital>.

59. Grant, *supra* note 28, at 1.

60. *Id.*; Ellin, *supra* note 58.

61. Grant, *supra* note 28, at 1.

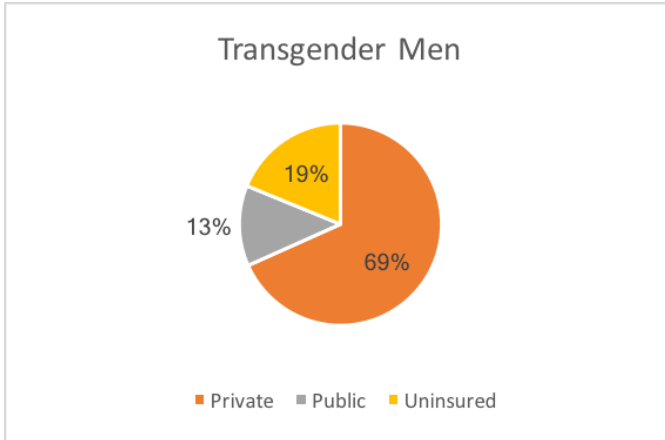
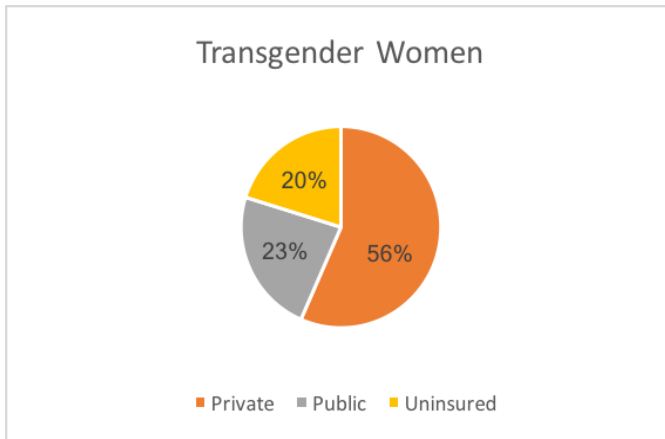
62. James, *supra* note 50, at 8.

63. Grant, *supra* note 28, at 1.

64. *Id.*

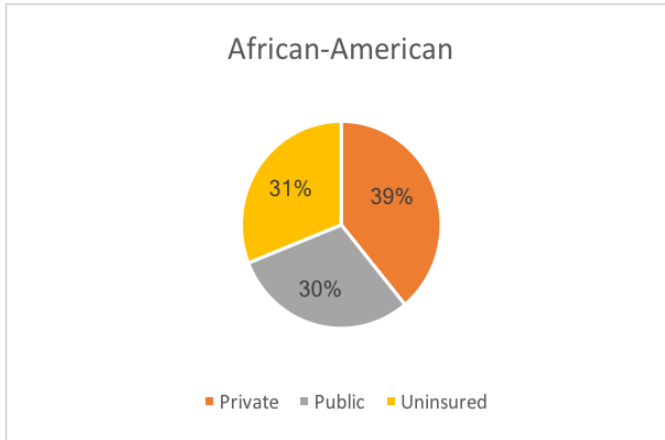
65. *Id.* at 8.

66. JESSICA C. BARNETT & EDWARD R. BERCHICK, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2016 3 (U.S. Census Bureau 2017), <https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf> (reporting that “[i]n 2016, 8.8 percent of people . . . were uninsured for the entire calendar year,” while “[t]he uninsured rates for Blacks” was 10.5 percent).

FIGURE 1: TRANSGENDER MEN INSURANCE COVERAGE⁶⁷FIGURE 2: TRANSGENDER WOMEN INSURANCE COVERAGE⁶⁸

67. Grant, *supra* note 28, at 8.

68. *Id.*

FIGURE 3: TRANSGENDER AFRICAN-AMERICAN INSURANCE COVERAGE⁶⁹

High unemployment and poverty rates among the transgender population, as well as lesser likelihoods of obtaining health insurance through their employer, all contribute to this disparity.⁷⁰ Among uninsured transgender people, reported rates of “delaying care due to inability to afford it” are especially high: eighty-six percent for overall health care, and eighty-eight percent for preventative health care.⁷¹ As discussed in more detail below, even among those who are insured, the availability of coverage for medical care associated with gender conformity surgery, hormone therapy, and other care recommended by the WPATH Standards of Care varies depending both on the type of health insurance a person has—Medicare, Medicaid, private insurance, or otherwise—as well as on the varying laws governing insurance in the person’s state or geographical region.

A. *Uncertainty of Federal Protections under Section 1557 of the Affordable Care Act*

Medicare is a federal health insurance program that provides health insurance for older Americans and people with disabilities.⁷² Medicare is administered by the federal government and coverage

69. *Id.*

70. Barnett, *supra* note 66, at 3.

71. Grant, *supra* note 28, at 7.

72. *What is the difference between Medicare and Medicaid?*, U.S. DEP’T OF HEALTH AND HUMAN SERVS., <https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-difference-between-medicare-medicaid/index.html> (last visited April 4, 2018).

does not change from state to state. Meanwhile, each of the fifty states administer their own system for Medicaid, which provides health insurance to low-income Americans and can vary greatly between states.⁷³ Private health insurance coverage can also differ depending on the requirements of a combination of broad federal guidelines and specific state laws. This section addresses the role of federal legislation in protecting transgender health care insurance coverage under these three types of insurance plans.

Medicare, a purely federal program, is administered by the federal Department of Health and Human Services (“HHS”).⁷⁴ From 1989 to May 2014, HHS prohibited Medicare from covering gender conformity surgery,⁷⁵ and many states did (and still do) prohibit such coverage under their Medicaid programs.⁷⁶ In 2014, however, the federal policy changed; an HHS Departmental Appeals Board eliminated this categorical exclusion for coverage of transgender surgery under Medicare, explaining that the classification of—and resulting prohibition of coverage for—all transition-related treatment as “cosmetic” or “experimental” is “outdated and not based on current standards of care.”⁷⁷ However, because Medicaid is administered by the states, the HHS Appeals Board Decision directly controlled only Medicare coverage and did not effect a universal policy change to protect transgender people under state Medicaid systems.

Then, in May 2016, pursuant to its authority under the Affordable Care Act (“ACA”), HHS promulgated a final rule that clarified that the ACA’s prohibition on sex discrimination extends to prohibit discrimination on the basis of transgender status (among other prohibited grounds) by all “health insurers receiving Federal financial assistance [including state Medicaid programs], hospitals, clinics and

73. *Id.*

74. *How is Medicare funded?* MEDICARE.GOV, <https://www.medicare.gov/about-us/how-medicare-is-funded/medicare-funding.html> (last visited April 4, 2018).

75. Medicare Program: National Coverage Decisions, 54 Fed. Reg. 34,555, 34,572 (Aug. 21, 1989) (deeming “transsexual surgery for sex reassignment” to be “controversial,” unsupported by “well controlled, long-term studies of the safety and effectiveness,” “experimental,” and plagued by “a high rate of serious complications,” and deciding therefore that “transsexual surgery is not covered” by Medicare); *Know Your Rights | Medicare*, NAT’L CTR. FOR TRANSGENDER EQUALITY (2018), <http://www.transequality.org/know-your-rights/medicare>.

76. *See infra*, text accompanying note 111.

77. *NCD 140.3 Transsexual Surgery*, DEP’T OF HEALTH & HUMAN SERVS., DEPARTMENTAL APPEALS BD., APP. DIV. 1, 12, 21-24 (May 30, 2014), <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf> (last visited Feb. 18, 2018); *see Know Your Rights | Medicare*, *supra* note 75.

other health facilities, HHS health programs [such as Medicare] and activities”⁷⁸ The final rule is codified in the Code of Federal Regulations at 42 C.F.R. part 92 and is entitled, “Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and Health Programs or Activities Administered by the Department of Health and Human Services or Entities Established under Title I of the Patient Protection and Affordable Care Act.”⁷⁹ The regulation is based on HHS’s interpretation of section 1557 of the ACA, which states that “an individual shall 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, including . . . contracts of insurance . . .” on numerous grounds, including any “ground prohibited under . . . title IX of the Education Amendments of 1972 . . . ,”⁸⁰ which in turn prohibits discrimination on the basis of “sex.”⁸¹ Subject to certain exceptions, the rule became effective July 18, 2016.⁸²

With the May 2016 rule, HHS clarified that Section 1557’s prohibition of *sex* discrimination in health insurance by any insurer that receives funding from HHS or that is otherwise subject to Section 1557 of the ACA includes discrimination on the basis of *gender identity and transgender status*. The rule amended the definition of discrimination “on the basis of sex” to include “discrimination on the basis of . . . gender identity,” which it in turn defined to include

78. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31375,31376, 31375,31454-55 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92). The rule specifically excludes Medicare Part B but includes “[s]tate Medicaid agencies receiving Federal financial assistance.” *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. at 31,445.

79. 45 C.F.R. § 92.207(b) (2016).

80. 42 U.S.C. § 18116(a) (2012). Section 1557’s prohibition on “discrimination on the basis of race, color, national origin, *sex*, age, or disability” applies to “[a]ny health program or activity,” including state Medicaid programs and private health insurers, “any part of which received funding from HHS” or “that HHS itself administers,” as well as “Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.” Office for Civil Rights, *Section 1557 of the Patient Protection and Affordable Care Act*, U.S. DEP’T OF HEALTH & HUMAN SERVS. (July 30, 2017), <https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>.

81. 20 U.S.C. § 1681(a).

82. See *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. 31375,31376, 31375,31473 (May 18, 2016) (to be codified at 45 C.F.R. § 92.4) (“to the extent that provisions of this rule require[d] changes to health insurance or group health plan benefit design,” the rule became effective for plan years “beginning on or after January 1, 2017.”); see also 42 U.S.C. § 18116(a) (2012).

“transgender individual[s].”⁸³ In short, HHS clarified that state Medicaid programs and private insurers may not discriminate against transgender individuals. In support of its rulemaking, HHS referenced the Supreme Court’s opinion in *Price Waterhouse v. Hopkins*,⁸⁴ in which the Court held that discrimination on the basis of “stereotypical notions of appropriate behavior, appearance or mannerisms for each gender constitutes sex discrimination.”⁸⁵ As HHS pointed out, “in prohibiting sex discrimination, Congress intended to strike at the entire spectrum of discrimination against men and women resulting from sex stereotypes.”⁸⁶ Numerous lower federal courts have applied the same reasoning to hold that discrimination against a person based on his or her transgender status amounts to unlawful sex discrimination. For instance, the U.S. Court of Appeals for the Eleventh Circuit in *Glenn v. Brumby*⁸⁷ considered the claim of a transgender individual who was diagnosed with GID and who was terminated from his employment shortly after beginning the process of gender transition.⁸⁸ The court unequivocally held that “discrimination against a transgender individual because of her gender-nonconformity is sex discrimination, whether it’s described as being on the basis of sex or gender.”⁸⁹ While the *Price Waterhouse* Court, the *Glenn* court, and many other federal courts were interpreting the sex discrimination prohibition under Title VII, as HHS pointed out, “courts frequently look to case law interpreting other civil rights provisions, including Title VII, for guidance in interpreting Title IX,”⁹⁰ and, accordingly, those cases all support HHS’s decision to extend Title IX’s—and the ACA’s—prohibition on sex discrimination

83. See 45 C.F.R. § 92.4 (2017); see also Office for Civil Rights, *Nondiscrimination in Health Programs and Activities Proposed Rule: Section 1557 of the Affordable Care Act*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <https://www.hhs.gov/civil-rights/for-individuals/section-1557/nondiscrimination-health-programs-and-activities-proposed-rule/index.html> (last updated Sept. 3, 2015).

84. 490 U.S. 228 (1989).

85. *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. 31375,31376, 31375,31387-88 (citing *Price Waterhouse*, 490 U.S. at 250–51).

86. *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. at 31375,31389.

87. 663 F.3d 1312 (11th Cir. 2011).

88. *Id.* at 1314.

89. *Id.* at 1317 (citing *Schwenk v. Hartford*, 204 F.3d 1187, 1198–1203 (9th Cir. 2000); *Rosa v. Park W. Bank & Trust Co.*, 214 F.3d 213, 215–16 (1st Cir. 2000); *Smith v. City of Salem*, 378 F.3d 566, 569 (6th Cir. 2004); *Barnes v. City of Cincinnati*, 401 F.3d 729, 732 (6th Cir. 2005); *Kastl v. Maricopa Cty. Cmty. Coll. Dist.*, 325 F.App’x. 492, 493 (9th Cir. 2009)).

90. *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. at 31375,31376, 31375,31389.

to encompass and prohibit discrimination against transgender individuals as well.

Despite ample statutory and case law support for the HHS regulation, in August 2016, a group of states and religiously-affiliated health care organizations filed a lawsuit in the United States District Court for the Northern District of Texas against HHS and the Secretary of HHS, challenging the HHS regulation's prohibition on discrimination by health care providers and insurers on the basis of transgender status, as well as another amendment prohibiting discrimination on the basis of termination of pregnancy.⁹¹ The plaintiffs in *Franciscan Alliance, Inc.* argued that the amended regulation "pressures doctors to deliver healthcare in a manner that violates their religious freedom and thwarts their independent medical judgment."⁹² HHS defended its interpretation of section 1557 by explaining that the regulatory amendment "does not mandate any particular procedure" but rather "requires only that covered entities provide nondiscriminatory health services and health insurance in a nondiscriminatory manner."⁹³ Specifically, the "discriminatory actions" that HHS intended to prevent included "[h]av[ing] or implement[ing] a categorical coverage exclusion or limitation for all health services related to gender transition."⁹⁴ In other words, covered entities would be prohibited from denying coverage for transition-related treatment solely on the basis that such treatment is transition-related.

On December 31, 2016, the District Court issued its opinion in *Franciscan Alliance, Inc. v. Burwell* and held that HHS's interpretation of "sex discrimination" was arbitrary and capricious insofar as it failed to include an exemption for religious organizations that are opposed to abortion and gender transition.⁹⁵ The court

91. *Franciscan Alliance, Inc. v. Burwell (Burwell I)*, 227 F. Supp. 3d 660 (N.D. Tex. 2016). The lawsuit also challenged a related amendment to the same regulation that clarified that the prohibition on discrimination on the basis of sex includes discrimination on the basis of termination of a pregnancy. See *id.* The original plaintiffs included Nebraska, Kentucky, Kansas, Texas, and Wisconsin. See Complaint at 1, *Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016) (ECF No. 1). In October 2016, Louisiana, Arizona, and Mississippi joined as plaintiffs. See First Amended Complaint at 1, *Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016) (ECF No. 21).

92. *Franciscan Alliance, Inc.*, 227 F. Supp. 3d at 671–72.

93. *Id.* at 672.

94. *Id.* (quoting 45 C.F.R. § 92.207(b) (2016)).

95. *Id.* at 692.

imposed a nationwide injunction barring the enforcement of HHS's regulation prohibiting discrimination on the basis of gender identity and termination of pregnancy.⁹⁶ Seeking to support the implementation of HHS's regulation, the American Civil Liberties Union and the River City Gender Alliance (collectively, the "ACLU") filed a motion to intervene in the case on HHS's behalf on September 16, 2016, and another motion to stay the injunction on January 9, 2017.⁹⁷ While not allowing the ACLU to formally intervene, the court allowed the ACLU to participate as amici curiae.⁹⁸ The court denied the ACLU's motion to stay the injunction on January 24, 2017, leaving the injunction in place.⁹⁹ Next, on May 2, 2017, HHS moved the court to stay the litigation and remand the matter to HHS to give it the opportunity to reassess its regulation and potentially conduct a new rulemaking proceeding.¹⁰⁰ In its motion, made under the new presidential administration, HHS represented a willingness to reconsider the regulation, stating that:

[n]ew leadership at HHS has now had time to scrutinize the two aspects of the Rule at issue in this case and has concerns as to the need for, reasonableness, and burden imposed by those parts of the Rule. HHS takes the concerns of the Court seriously and should be given the opportunity to initiate rulemaking proceedings to reconsider the Rule.¹⁰¹

96. *Id.* at 695.

97. Memorandum of Law in Support of Motion to Intervene of River City Gender Alliance and ACLU of Texas, *Franciscan Alliance, Inc. v. Burwell*, No. 7:16-CV-00108-O (N.D. Tex. Sep. 16, 2016), ECF No. 8; Proposed Intervenors' Motion for Ruling on Intervention and Stay of Preliminary Injunction Pending Appeal, *Franciscan Alliance, Inc. v. Price*, No. 7:16-CV-00108-O (N.D. Tex. Jan 9, 2017), ECF No. 63; see Matthew Loughran, *ACLU to Appeal Court's Block of Transgender Nondiscrimination Rule*, BLOOMBERG NEWS (Jan. 12, 2017), <https://www.bna.com/aclu-appeal-courts-n73014449745>.

98. The motion to intervene has had a somewhat convoluted history. Technically, the ACLU moved both for intervention as of right and for permissive intervention. The court denied the ACLU's motion to intervention as of right, and delayed ruling on permissive intervention pending briefing by the other parties. In the meantime, the ACLU appealed the former ruling to the Fifth Circuit, and the district court determined that it should not consider the latter in light of the appeal. See *Franciscan Alliance, Inc. v. Price*, No. 7:16-cv-00108-O, 2017 WL 3616652, at *1-3, *nn. 4-7 (N.D. Tex. July 10, 2017).

99. *Franciscan Alliance, Inc. v. Burwell (Burwell II)*, No. 7:16-CV-00108-O, 2017 WL 2964088, at *7 (N.D. Tex. Jan. 24, 2017).

100. Defendant's Motion for Voluntary Remand and Stay at 1, *Franciscan Alliance, Inc. v. Price*, No. 7:16-CV-00108-O (N.D. Tex. May 2, 2017), ECF No. 92.

101. *Id.* at 3

The court granted HHS's motion on July 10, 2017, and entered an order staying the case indefinitely while leaving the injunction in effect and the court has been requiring HHS to file periodic status reports on the progress of HHS's rulemaking in the meantime.¹⁰² For nine months, HHS reported the same news in multiple status reports, namely that, under the new presidential administration, "[a] draft of a proposed rule is going through the clearance process within the Executive Branch," and that the proposed rule will then go through "an inter-agency clearance process managed by the Office of Management and Budget (OMB)" and the usual "rulemaking proceedings" with public "notice and comment" opportunities,¹⁰³ all of which could take several years and may well ultimately result in an agency repeal of the explicit prohibition on transgender discrimination. Finally, in its April 2018 status report to the court, HHS revealed that it had submitted its proposed revised rule to OMB for "inter-agency clearance as required by Executive Order 12,866," and that the proposed rule "will not be publicly available until after the E.O. 12,866 process is complete," but it did not reveal any of the content of the proposed revision or hint about the nature of the revisions.¹⁰⁴

The district court's refusal to date to enforce the prohibition on discrimination on the basis of transgender status (and HHS's willingness to reconsider that prohibition) contradicts the line of federal court cases arising from *Price Waterhouse v. Hopkins* discussed above, as well as an administrative decision, *Macy v. Holder*,¹⁰⁵ in which the U.S. Equal Employment Opportunity Commission concluded that, in the employment context, "discrimination against a transgender individual because that person is transgender is, by definition, discrimination 'based on . . . sex,'"

102. *Franciscan Alliance, Inc. v. Price*, No. 7:16-cv-00108-O, 2017 WL 3616652, at *5 (N.D. Tex. July 10, 2017).

103. Defendant's Status Report at 1–2, *Franciscan Alliance, Inc. v. Price*, No. 7:16-CV-00108-O (N.D. Tex. Aug. 4, 2017), ECF No. 106; Defendant's Status Report at 1–2, *Franciscan Alliance, Inc. v. Price*, No. 7:16-CV-00108-O (N.D. Tex. Oct. 16, 2017), ECF No. 109; Defendant's Status Report at 1–2, *Franciscan Alliance, Inc. v. Price*, No. 7:16-CV-00108-O (N.D. Tex. Dec. 15, 2017), ECF No. 110; Defendant's Status Report at 1–2, *Franciscan Alliance, Inc. v. Azar*, No. 7:16-CV-00108-O (N.D. Tex. Feb. 13, 2018), ECF No. 111.

104. See Defendant's Status Report at 1, *Franciscan Alliance, Inc. v. Azar*, No. 7:16-CV-00108-O (N.D. Tex. Apr. 16, 2018), ECF No. 113.

105. No. 0120120821, 2012 WL 1435995 (EEOC Apr. 20, 2012).

and hence prohibited under Title VII.¹⁰⁶ Yet the *Franciscan Alliance, Inc.* decision will stand unless and until an appellate court reverses or stays the injunction, or until HHS promulgates a revised regulation and thereby inspires the district court to lift its injunction. For now, the injunction prevents the enforcement against state Medicaid programs and private insurers of HHS regulations that prohibit discrimination in the context of health insurance against transgender and gender nonconforming people.¹⁰⁷ Although the injunction may limit HHS's ability to investigate and respond to discrimination against transgender patients the injunction does *not* affect HHS's decision to cover gender conformity surgery and hormone therapy under Medicare for elderly Americans and Americans with disabilities. Nor does it affect coverage in the numerous states where *state* law explicitly requires that Medicaid and/or private insurers must cover these procedures, as discussed in more detail in the next section.¹⁰⁸ However, the injunction might affect the rate at which remaining states adopt explicit coverage protections.¹⁰⁹

B. State Law Protections Governing Private Insurance and Medicaid

State insurance law governs what health insurance providers must cover under state Medicaid programs and private health insurance plans.¹¹⁰ A growing number of state legislatures have adopted some form of insurance safeguards for transgender people. As of January 22, 2018, the insurance laws of nineteen states and the District of Columbia prohibit private insurers from excluding transgender health care coverage; those states are: California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maryland, Massachusetts, Michigan,

106. *Id.* at *11.

107. *See Burwell I*, 227 F. Supp. 3d at 695; *see also* George B. Breen & Jonathan K. Hoerner, *Court Issues Nationwide Injunction Prohibiting Enforcement of Section 1557 Provisions Relating to Gender Identity and Termination of Pregnancy—But Other Provisions Still Can Be Enforced*, HEALTH L. ADVISOR (Jan. 9, 2017), <https://www.healthlawadvisor.com/2017/01/09/court-issues-nationwide-injunction-prohibiting-enforcement-of-section-1557-provisions-relating-to-gender-identity-and-termination-of-pregnancy-but-other-provisions-still-can-be-enforced/>.

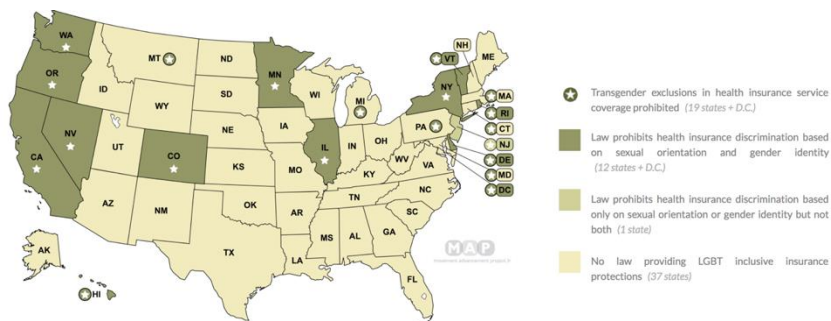
108. Georgia Burke, *Injunction Puts Focus on Need to Keep 1557 Protections*, JUST. IN AGING (Jan. 9, 2017), <http://www.justiceinaging.org/injunction-limits-health-care-protections-transgender-individuals>.

109. *Id.*

110. *Alexander v. Choate*, 469 U.S. 287, 303 (1985) (citing 42 U.S.C. § 1396a(a)(19)). State insurance law also governs requirements for state employee health care insurance coverage. However, this paper focuses on insurance coverage requirements for non-state employees.

Minnesota, Montana, Nevada, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington.¹¹¹ Twelve of those nineteen states and the District of Columbia also more generally prohibit private health insurance discrimination based on sexual orientation and gender identity; New Jersey prohibits health insurance discrimination based only on sexual orientation, not gender identity.¹¹² Figure 4 illustrates the distribution of these legal protections among the various states.

FIGURE 4: HEALTHCARE LAWS AND POLICIES: PRIVATE INSURANCE¹¹³



Notably, some of the nineteen states that require private insurers to cover transgender health care do not explicitly provide this same coverage under their Medicaid programs.¹¹⁴ Yet Medicaid patients in the District of Columbia and the following eighteen states are explicitly protected under state policy to receive coverage for transgender health care: California, Colorado, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington.¹¹⁵ The list of states that have

111. *Healthcare Laws and Policies: Table Format*, MOVEMENT ADVANCEMENT PROJECT, http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies (last updated Apr. 13, 2018).

112. *Id.*

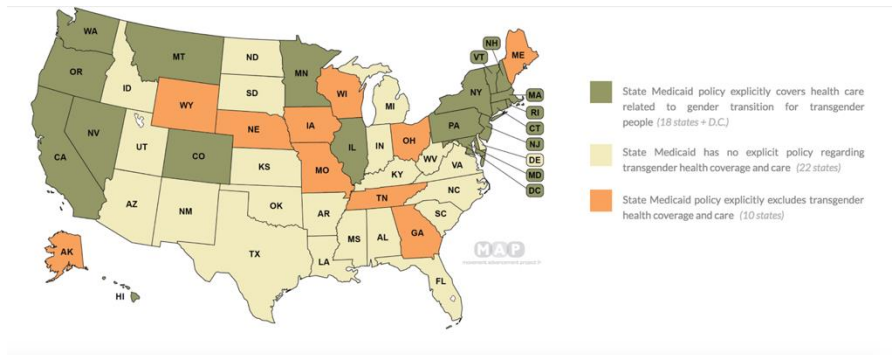
113. *Healthcare Laws and Policies: Private Insurance*, MOVEMENT ADVANCEMENT PROJECT, http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies (last updated Apr. 13, 2018).

114. *Id.* Specifically, Delaware and Michigan have explicit transgender non-discrimination protections under private insurance plans, but both states are silent on whether transgender non-discrimination rules apply under Medicaid.

115. *Id.*

adopted laws to protect transgender access to healthcare has continued to change and grow; please visit the Movement Advancement Project website for the most recent updated list.¹¹⁶ Figure 5 illustrates these differences in Medicaid coverage in the various states.

FIGURE 5: HEALTHCARE LAWS AND POLICIES: MEDICAID¹¹⁷



The state laws providing explicit protections for transgender patients under private insurance and/or Medicaid have a common theme: the threshold that the covered treatments are “medically necessary.” For instance, California’s insurance statutes and regulations generally require health insurance providers to cover medically necessary basic health care services and pharmaceuticals¹¹⁸ and permit them to deny coverage on the basis that a procedure is not “medically necessary.”¹¹⁹ Section 2561.2 of Title 10 of the California Code of Regulations prohibits transgender discrimination by insurers as follows:

An admitted insurer shall not, in connection with health insurance as defined in subdivision (b) of Insurance Code section 106, discriminate on the basis of an insured’s or prospective insured’s actual or perceived gender identity, or

116. *Id.*

117. *Healthcare Laws and Policies: Medicaid*, MOVEMENT ADVANCEMENT PROJECT http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies (last updated Apr. 13, 2018).

118. CAL. HEALTH & SAFETY CODE § 1367.005 (West 2017); CAL. CODE REGS. tit. 28, §§ 1300.67.24, 1300.71.4 (2018); CAL. INS. CODE § 10123.193(c) (West 2018).

119. *See, e.g.*, CAL. INS. CODE §§ 10112.27, 10123.7, 10123.135, 10123.201 (West 2018); CAL. BUS. & PROF. CODE § 511 (West 1997); CAL. CODE REGS. tit. 10, §§ 2562.2, 2699.300, 2699.301, 2699.6203 (West 2017).

on the basis that the insured or prospective insured is a transgender person.¹²⁰

The statute goes on to list a number of prohibited forms of discrimination, including “[d]enying, cancelling, [or] limiting” health insurance coverage “on the basis of an insured’s or prospective insured’s actual or perceived gender identity or” their status as a “transgender person” and “[d]enying or limiting coverage” for transition-related and non-transition-related health care services on the basis of gender identity.¹²¹ Section 2561.2 concludes by stating: “This Section . . . shall have no bearing on the question of whether or not a particular health care service is *medically necessary* in any individual case.”¹²² Accordingly, although insurers may not discriminate on the basis of transgender status in providing health insurance coverage, they may attempt to deny coverage for gender conformity surgery and other transition-related care on the basis of medical necessity and follow the procedures set up by California law for challenging medical necessity.¹²³ In addition, the guidance for Medi-Cal benefits (California’s version of Medicaid) specifically states that “[t]reatment for Gender Identity Disorder (GID) is a covered Medi-Cal benefit *when medical necessity has been demonstrated*.”¹²⁴

Likewise, Oregon’s regulations—which are modeled after California Code of Regulations Title 10 § 2561—include similar language creating the same ban on transgender discrimination bundled with the same “medically necessary” caveat when describing the requirements for private insurers to cover treatments for gender dysphoria.¹²⁵ The relevant Oregon statute states:

An individual may not, on the basis of actual or perceived . . . gender identity . . . be excluded from participation in, be denied the benefits of or otherwise be subjected to discrimination by any health benefit plan issued or delivered in this state, in the receipt of medical assistance . . . or in the

120. CAL. CODE REGS. tit. 10, § 2561.2 (2017).

121. *Id.* §§ 2561.2(a)(1), 2561.2(a)(4).

122. *Id.* (emphasis added).

123. CAL. CODE REGS. tit. 28, § 1300.68 (West 2018).

124. *Medi-Cal Update*, MEDI-CAL (Mar. 2013), <http://files.medi-cal.ca.gov/pubsdoco/bulletin/s/artfull/gm201303.asp#a21> (last visited Feb. 18, 2018) (emphasis added).

125. KATE BROWN, OREGON DIVISION OF FINANCIAL REGULATION BULLETIN DFR 2016-1 (2012), <https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2016-01.pdf>.

coverage of or payment for the services, drugs, devices, products and procedures¹²⁶

Elsewhere in the Oregon statutes however, as in California, insurers are given the authority to deny coverage on the basis of “medical necessity;” presumably, then transgender services may be denied on the basis of lack of medical necessity.¹²⁷ Finally, as in California, Oregon’s version of Medicaid, the Oregon Health Plan, covers treatment for gender dysphoria, including hormone therapy and sex reassignment surgery.¹²⁸

Consequently, in California, Oregon, and other states that have adopted prohibitions on discrimination on the basis of transgender status in the context of insurance, the meaning and interpretation of the term “medical necessity” are crucial to whether insured patients actually receive coverage for their treatment. Yet there is no federal statutory language—and, often, no state statutory language—to define “medical necessity.”¹²⁹ Medical necessity, as defined by Medicare.gov, describes “*Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.*”¹³⁰ Explicit definitions (where they exist) typically incorporate, at minimum, the two-pronged requirement that “medically necessary” health care must involve services or supplies that (1) evaluate or treat an illness or other condition, as well as (2) align with applicable medical standards.¹³¹ However, the determination whether specific treatments are

126. OR. REV. STAT. § 659.875 (2017).

127. See, e.g., OR. REV. STAT. §§ 743B.001, 743B.225, 743B.252, 743B.256, 743B.281, 743B.282, 743B.420, 743B.422, 743B.423 (2017).

128. *Prioritized List: Guideline for Gender Dysphoria: Frequently Asked Questions*, OR. HEALTH AUTHORITY (Oct. 2015), <http://www.oregon.gov/OHA/HPA/CSI-HERC/FactSheets/Gen-der-dysphoria.pdf>.

129. See, e.g., *Thie v. Davis*, 688 N.E.2d 182, 188 (Ind. Ct. App. 1997) (noting “the absence of a definition of medical necessity”).

130. *Glossary—M*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicare.gov/glossary/m.html> (last visited Mar. 20, 2018) (emphasis added).

131. See *Policy 8: Definition and Application of Medical Necessity*, AM. COLL. OF MED. QUALITY, <http://www.acmq.org/policies/policy8.pdf> (last visited Feb. 18, 2018) (“Medical necessity is defined as *accepted health care services and supplies* provided by health care entities, appropriate to the *evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.*”) (emphasis added); see also, *Medical Necessity Definitions*, CIGNA, <https://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions> (last visited Feb. 18, 2018) (“‘Medically Necessary’ . . . shall mean health care services . . . for the purpose of *evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are . . . in accordance with the generally accepted standards* of medical practice”) (emphasis added).

“medically necessary,” if not explicitly addressed via state statute, can remain unclear.¹³²

Some argue that gender conformity surgery and other transition-related procedures are “medically necessary” and must therefore be covered under all state Medicaid plans, in accordance with guidelines for “general medical necessity” (which is determined by state legislature and relies on the consensus of the medical community) and “specific medical necessity” (which relies on the judgment of the specific patient’s physician).¹³³ Indeed, the U.S. Supreme Court, in its opinion in *Beal v. Doe*,¹³⁴ wrote that “serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage.”¹³⁵ However, the “Federal Medicaid Act does not explicitly require states to cover all medically necessary treatment.”¹³⁶ Therefore, the argument that transition-related procedures are “medically necessary” merely opens state Medicaid statutes up for debate.

In addition to disparities in coverage under Medicaid, coverage, even for “medically necessary” treatments, can vary greatly depending on the patient’s specific health insurance plan.¹³⁷ Although the widely-accepted WPATH Standards of Care recognize gender conformity surgery, hormone therapy, and other transition-related treatments as medically necessary,¹³⁸ this language leaves room for ambiguity that may cause additional obstacles to coverage and therefore treatment, which this paper addresses in Section IV.

Because federal regulations that prohibit discrimination by health insurers against transgender people are currently unenforceable due to

132. See, e.g., *Choose the Right Plan*, CAL. DEP’T OF MANAGED HEALTH CARE, <https://www.dmhc.ca.gov/HealthCareinCalifornia/ChoosetheRightPlan.aspx#.Wg4ti7Q-et8> (last visited Feb. 18, 2018) (“A definition of what is medically necessary can be found in your health plan contract . . .”).

133. Nicole M. True, *Removing the Constraints to Coverage of Gender-Conforming Healthcare by State Medicaid Programs*, 97 IOWA L. REV. 1329, 1343–44 (2012) (explaining general and specific necessities).

134. 432 U.S. 438 (1977).

135. *Id.* at 444.

136. True, *supra* note 133, at 1342.

137. See, e.g., *Definition and Application of Medical Necessity*, *supra* note 131 (“Preventive care may be Medically Necessary but *coverage for Medically Necessary preventive care is governed by terms of the applicable Plan Documents.*”) (emphasis added).

138. WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, *supra* note 36, at 5 (“Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are *medically necessary* for many people.”) (emphasis added).

the *Franciscan Alliance, Inc.* Court’s nationwide injunction, state-level legislation has become ever more important.¹³⁹ As illustrated in Figure 4, thirty-seven states lack laws providing transgender-inclusive private insurance protections, and thirty-two states either have no explicit Medicaid policy (twenty-two) or explicitly exclude transgender health coverage (ten) under Medicaid.¹⁴⁰ As indicated above, in those states without protective laws, transgender people who have insurance can find themselves denied coverage for transition-related procedures and even basic health care; often, this is due to the use of binary gender categories (male or female) as a proxy for determining which gender-specific services are covered,¹⁴¹ or due to a health care provider’s failure to sufficiently show that a given treatment is “necessary” for a given patient.¹⁴²

Due to these inequalities in access to transgender-inclusive medical care, many transgender people incur vast out-of-pocket expenses for both transgender health-related health care services including gender conformity surgery and hormone therapy, as well as potentially even basic medical procedures.¹⁴³ They may also be forced to travel long distances to find appropriate care providers, which can mean that even a patient who is insured might be denied coverage if the insurer considers a provider “out-of-network.”¹⁴⁴ For all of these patients—those living in states that prohibit insurers from discriminating against transgender people but whose care is deemed “not medically necessary” and those in states without such prohibitions—the possibility of deducting medical expenses from taxable income (known as the “medical deduction”) is the only remaining federal protection providing any hope for financial relief for transition-related health care costs. The following section

139. *Burwell I*, 227 F. Supp. 3d 660 (N.D. Tex. 2016).

140. *Healthcare Laws and Policies*, MOVEMENT ADVANCEMENT PROJECT (July 20, 2015), http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies.

141. Lisa Gillespie, *Transgender People Still Denied Health Services Despite Affordable Care Act*, PBS (July 23, 2015, 2:52 PM), <http://www.pbs.org/newshour/rundown/transgender-people-still-denied-health-services-despite-affordable-care-act>.

142. *Transgender Health Benefits in California*, TRANSGENDER L. CTR. 3 (Dec. 2, 2015), <http://transgenderlawcenter.org/wp-content/uploads/2015/12/2015-12-02-TLC-Health-Appeals-Guide.pdf>.

143. Liz Kowalczyk, *In Mass., Transgender Patients Decry Hostility Over Medical Care*, BOSTON GLOBE (Feb. 1, 2017), <https://www.bostonglobe.com/metro/2017/02/01/transgender-people-say-hostility-ignorance-common-doctors-offices-emergency-rooms/HYfNoCi2HAHw1QANBjNMJP/story.html>.

144. *Id.*

describes the medical deduction and its applications within the realm of transgender health care.

III. OVERVIEW OF THE MEDICAL DEDUCTION AS IT PERTAINS TO TRANSGENDER HEALTH CARE

A. *Introduction to the Medical Deduction*

Since the passage of the United States Revenue Act of 1942, Americans have been entitled to deduct medical expenses from their taxable income, so long as they met the applicable threshold.¹⁴⁵ That threshold was moved to 7.5% for tax year 1987, and then to 10% as of tax year 2013.¹⁴⁶ After passage of the Tax Cuts and Jobs Act on December 22, 2017, the federal medical deduction threshold will be reduced back to 7.5% of the taxpayer's Adjusted Gross Income ("AGI") for tax years 2017 and 2018; after tax year 2018, the threshold for medical deductions will increase back to 10% of AGI.¹⁴⁷

Currently, about 30% of U.S. taxpayers file itemized federal tax returns.¹⁴⁸ This number is expected to decrease starting in 2018, as the Tax Cuts and Jobs Act nearly doubles the standard deduction from \$6,350 to \$12,000 for single individuals and from \$12,700 to \$24,000 for married couples filing jointly.¹⁴⁹ Among these itemized returns, the medical and dental deduction accounted for \$82,811,803 of the \$1,206,705,085 (about 6.86%) estimated total itemized deductions claimed in 2014.¹⁵⁰ Only a small percentage of U.S. taxpayers claim this tax benefit; in 2015, only about 8.8 million Americans claimed the medical deduction on their tax returns.¹⁵¹ In general, taxpayers who itemize their tax deductions "tend to be middle to upper income

145. Revenue Act of 1942, Pub. L. No. 77-753, 56 Stat. 798.

146. Tax Reform Act of 1986, Pub. L. No. 99-514, 100 Stat. 2085; Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 868 (2010).

147. See Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11027, 131 Stat. 2044; see also Michelle Andrews, *Bonus Tucked into GOP Tax Bill for Those Aiming to Deduct Medical Expenses*, KAISER HEALTH NEWS (Dec. 22, 2017), <https://khn.org/news/bonus-tucked-into-gop-tax-bill-for-those-aiming-to-deduct-medical-expenses>.

148. *SOI Tax Stats – Tax Stats at a Glance*, IRS (2017), <https://www.irs.gov/uac/soi-tax-stats-tax-stats-at-a-glance>.

149. Sarah O'Brien, *GOP Tax Bill Expands Medical Expense Deduction for Two Years*, CNBC (Dec. 16, 2017, 10:24 AM), <https://www.cnn.com/2017/12/16/gop-tax-bill-expands-medical-expense-deduction-for-two-years.html>.

150. John A. Koskinen et al., *Individual Tax Returns Line Item Estimates, 2014*, IRS, <https://www.irs.gov/pub/irs-soi/14inlincount.pdf> (last updated Aug. 30, 2018).

151. Andrews, *supra* note 147.

taxpayers” in light of the level of expenditures necessary to exceed the standard deduction, and fewer of those taxpayers may incur unreimbursed medical expenses that exceed the threshold percentage, as compared to other deductions with no threshold such as taxes paid, mortgage interest, and charitable deductions.¹⁵²

Yet for those taxpayers who incur large out-of-pocket medical expenses that are not covered by health insurance, the medical deduction provides relief that is unavailable elsewhere. As described above, the transgender community continues to face immense out-of-pocket expenses for both transition-related and routine medical care, due to a combination of discrimination, lack of insurance protections, and lack of knowledge of transgender health needs within the medical industry, and the question whether those expenses qualify for the medical deduction is therefore an important one for the community.

Deductible costs can include many expenses associated with health care, including travel to and from medical appointments, prescription medications, and other out-of-pocket costs not covered by insurance or tax-preferred health savings accounts.¹⁵³ Yet the determination whether a particular expense is a deductible medical expense is not always clear: issues arise regarding whether a particular expense is truly medically necessary, and not, for instance, associated with cosmetic surgery.¹⁵⁴

B. Definition of “Medical Care” Under Internal Revenue Code § 213

Under section 213 of the Internal Revenue Code, the term “medical care” means amounts paid “for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.”¹⁵⁵ Accordingly, the Code recognizes two categories of medical care expenses that can qualify as deductible: first, medical expenditures for the “diagnosis, cure, mitigation, treatment, or prevention of disease” and, second,

152. Kelly Phillips Erb, *Deduct This: The History of the Medical Expenses Deduction*, FORBES (June 11, 2011, 8:25 AM), <https://www.forbes.com/sites/kellyphillipserb/2011/06/20/deduct-this-the-history-of-the-medical-expenses-deduction/#64be8311478c>.

153. I.R.C. § 213(d) (2017).

154. *See infra* Section II.B.

155. I.R.C. § 213(d)(1)(A) (2017).

medical expenditures that “affect[] any structure or function of the body.”¹⁵⁶

The legislative and case history surrounding this statutory definition has first expanded, then subsequently narrowed, the definition of what qualifies as “medical care.” In 1981, the U.S. Tax Court applied the second category and decided that it was “broad enough to include hair transplant surgery . . . [performed] solely for cosmetic reasons”¹⁵⁷ because such surgery “affected” a “structure” of the body insofar as it involved changing the structure of the scalp.¹⁵⁸ In response, in 1990, Congress amended the statute explicitly to exclude cosmetic surgery, defined below, in order to curtail the use of the medical deduction for elective cosmetic surgery.¹⁵⁹ The amended statute reads:

(213)(d)(9) Cosmetic surgery.

(A) In general. – The term “medical care” does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is *necessary* to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

(B) Cosmetic surgery defined. – For purposes of this paragraph, the term “cosmetic surgery” means any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.¹⁶⁰

Accordingly, in order for cosmetic surgery to qualify as medical care that qualifies for the medical deduction, it must satisfy one of the following conditions:

1. Be “necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal

156. *Id.*

157. Eric Smith & Ryan H. Pace, *Deductible Cosmetic Surgery and the Treatment of Transgenderism: An Analysis of the Medical Expense Deduction Post-O’Donnabhain*, AM. TAX’N ASS’N MIDYEAR MEETING: JLTR CONF. Feb. 2012, at 12, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2003902.

158. *Mattes v. Comm’r*, 77 T.C. 650, 653 (1981); Smith & Pace, *supra* note 157, at 12–13.

159. I.R.C. § 213(d)(9) (2017); Smith & Pace, *supra* note 157, at 14.

160. I.R.C. § 213(d)(9) (2017) (emphasis added).

injury resulting from an accident or trauma, or disfiguring disease,”¹⁶¹ or

2. “[M]eaningfully promote the proper function of the body,”¹⁶² or

3. “[P]revent or treat illness or disease.”¹⁶³

Within the context of transition-related care, as discussed in more detail below, litigants have focused on the third option (the treatment of the symptoms of an illness, namely gender dysphoria) to argue that gender conformity surgery is deductible medical care, rather than non-deductible cosmetic surgery.

The Internal Revenue Service (“IRS”) provides guidance on the interpretation and application of the various requirements of the Internal Revenue Code through numerous publications. One such publication, IRS Publication 502, provides guidance to taxpayers on the inclusion of certain expenses as medical expenses for the purposes of calculating their medical deduction.¹⁶⁴ The Publication begins by defining “medical expenses” with language mirroring the statute: “Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body.”¹⁶⁵ It goes on to list examples of deductible expenses: “payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners” and “the costs of equipment, supplies, and diagnostic devices needed for these purposes.”¹⁶⁶ The Publication then elaborates on these categories. Besides the obvious examples of medical care such as out-of-pocket payments to physicians for office visits and for surgeries to treat physical illnesses and injuries, the following categories might also be relevant to deductions for transition-related care:

1. Deductions for Prescribed Medication: Taxpayers may deduct amounts paid to obtain prescription medications obtained in the

161. I.R.C. § 213(d)(9)(A) (2017).

162. I.R.C. § 213(d)(9)(B) (2017).

163. *Id.*

164. *Pub. 502 (2017) Medical and Dental Expenses*, IRS (2017), <https://www.irs.gov/publications/p502/ar02.html>.

165. *Id.*

166. *Id.*

U.S.¹⁶⁷ A taxpayer generally cannot include amounts paid to obtain non-prescription medications other than insulin.¹⁶⁸

2. Deductions for Mental Health-Related Medical Expenses: The cost of psychiatric care, psychoanalysis, and therapy for medical treatment may all be included in deductible medical expenses.¹⁶⁹ A taxpayer may deduct legal fees paid that are “necessary to authorize treatment for mental illness.”¹⁷⁰ However, a taxpayer cannot deduct as medical expenses legal fees for “the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees” that are not directly necessary for medical care.¹⁷¹

3. Deductions for Cosmetic Purposes: Publication 502 repeats and elaborates on the statutory exception for “unnecessary cosmetic surgery.”¹⁷² Generally, a taxpayer cannot include in medical expenses the amount one pays for elective cosmetic surgery, such as “facelifts, hair transplant surgery, hair removal (electrolysis), and liposuction.”¹⁷³ The Publication states that a taxpayer, however, can deduct as medical expenses the amount paid for cosmetic surgery “if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.”¹⁷⁴ For instance, a taxpayer may deduct amounts paid for breast reconstruction surgery following a mastectomy to treat breast cancer.¹⁷⁵ Additionally, a taxpayer may deduct “the cost of a wig purchased upon the advice of a physician for the mental health of a patient who has lost all his or her hair from disease.”¹⁷⁶ The Publication thereby presents an important distinction: Although a wig is not deductible if it merely serves to protect the mental health of a patient suffering from genetic hair loss, a wig is deductible if it is (a) recommended by a physician and (b) protects the mental health of a patient who has suffered hair loss *from disease*. It follows that cosmetic medical expenses are only deductible if recommended by a physician as treatment for symptoms related to

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.*

171. *Id.*

172. *Id.*

173. *Id.*

174. *Id.*

175. *Id.*

176. *Id.*

a specific disease. Significantly, Publication 502 is silent on the issue whether gender conformity surgery is a deductible medical expense or a non-deductible cosmetic surgery, and it has not been revised to explicitly address the issue, even in the wake of the *O'Donnabhain* decision discussed below.

4. Other Deductions: According to Publication 502, a taxpayer can deduct “amounts paid for transportation primarily for, and essential to, medical care.”¹⁷⁷ This includes mileage reimbursement at a rate of 17 cents per mile and airfare to and from medical treatments.¹⁷⁸ Additionally, subject to certain restrictions outlined in the Publication, a taxpayer may also deduct out-of-pocket health insurance premiums and other costs for one’s own or a qualifying dependent’s health care services.¹⁷⁹ Significantly, neither the Internal Revenue Code, nor the IRS’s implementing regulations, nor Publication 502 address medical necessity beyond the Publication’s passing reference to “unnecessary cosmetic surgery,”¹⁸⁰ nor does the Publication identify medical necessity as a threshold requirement for deductibility.

IV. EFFECT OF *O'DONNABHAIN V. COMMISSIONER OF INTERNAL REVENUE* ON TRANSGENDER HEALTH CARE TREATMENT UNDER TAX LAW

A. Case Background

As discussed above, being transgender in the United States brings with it many financial, legal, and other challenges related to access to care beyond those typically faced by the population at large. In *O'Donnabhain v. Commissioner of Internal Revenue*,¹⁸¹ the United States Tax Court addressed the issue whether transition-related treatment costs qualify for the medical deduction, thereby offering a potential financial solution to transgender health care challenges.¹⁸² Yet by reaching the unnecessary question whether transition-related treatments were medically necessary, the court created a double-edged sword: it lent credibility to the idea that transition-related treatments,

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.*

181. 134 T.C. 34 (2010).

182. *Id.* at 35.

including those described by the WPATH Standards of Care, are medically necessary, which is surely helpful precedent for individuals contesting adverse insurance coverage determinations to the contrary. Yet it also potentially—and erroneously—creates precedent for imposing a heightened “medically necessary” threshold on medical tax deductions, making paying for transition-related treatments potentially harder to afford for an already marginalized population.

The case arose when petitioner Rhiannon G. O’Donnabhain sought to deduct medical expenses associated with her treatment for *GID* (as it was then known) from her federal income taxes.¹⁸³ In a controversial court decision, the United States Tax Court held that *GID* is a disease within the meaning of the tax code,¹⁸⁴ and that the cost of hormone replacement therapy and sex reassignment surgery to treat O’Donnabhain’s *GID* were therefore deductible medical care (and not cosmetic surgery),¹⁸⁵ but that her breast augmentation surgery was cosmetic in nature and therefore not deductible.¹⁸⁶ The controversial majority opinion, joined by eight of the 16 Tax Court judges who heard the case, was accompanied by numerous concurring and dissenting opinions that, as one judge aptly noted, put the court “squarely . . . in the middle of a serious fight within the relevant scientific community, and the larger battle among those who are deeply concerned with the proper response to transsexual persons’ desires for extensive and expensive surgeries.”¹⁸⁷

The court described the facts of the case as follows: O’Donnabhain “was born a genetic male with unambiguous male genitalia” and assigned that gender at birth but, since childhood, felt “uncomfortable in the male gender role.”¹⁸⁸ She began wearing “women’s clothing secretly around age ten.”¹⁸⁹ Throughout her adolescence and into her adulthood, “[h]er discomfort . . . intensified, and she continued to dress in women’s clothing secretly.”¹⁹⁰ In August

183. *Id.* at 42.

184. *Id.* at 59 (“we conclude that *GID* is a ‘disease’ within the meaning of section 213.”).

185. *Id.* at 70 (“We therefore conclude and hold that petitioner’s hormone therapy and sex reassignment surgery ‘treated . . . disease’ within the meaning of section 213(d)(9)(B) and accordingly are not ‘cosmetic surgery’ . . .”).

186. *Id.* at 73 (“[T]he breast augmentation surgery is ‘cosmetic surgery’ that is excluded from deductible ‘medical care.’”).

187. *Id.* at 92 (Holmes, J., concurring).

188. *Id.* at 35.

189. *Id.*

190. *Id.*

1996, O'Donnabhain began seeing Diane Ellaborn, a licensed psychotherapist.¹⁹¹ “After diagnosing severe GID in petitioner [O'Donnabhain] in early 1997, Ellaborn administered a course of treatment” in accordance with WPATH's Standards of Care.¹⁹² Pursuant to her prescribed treatment, O'Donnabhain began hormone therapy in September 1997, which she continued through the taxable year 2001.¹⁹³ O'Donnabhain began presenting herself publicly as female in March 2000.¹⁹⁴

Despite her positive response to hormone therapy and public transition to the female gender role, O'Donnabhain's “anxiety as a result of having male genitalia persisted,” and Ellaborn determined that, absent surgery, “petitioner's anxiety . . . would impair her ability to function normally in society.”¹⁹⁵ Ellaborn and a second licensed psychotherapist, Dr. Alex Coleman, provided the two required recommendations in favor of gender conformity surgery.¹⁹⁶ In 2001, at their referrals, O'Donnabhain underwent pre-surgery consultation and gender conformity surgery performed by Dr. Toby Meltzer, a “board-certified plastic and reconstructive surgeon, with over 10 years' experience specializing in” gender conformity surgery.¹⁹⁷ During 2001, O'Donnabhain incurred and paid the following expenditures, which she claimed as deductible medical expenses on her 2001 federal income tax return:¹⁹⁸

- (1) \$19,195 to Dr. Meltzer for surgical procedures, including \$14,495 for vaginoplasty and other procedures, \$4,500 for breast augmentation, and \$200 towards a portion of petitioner's postsurgical stay at Dr. Meltzer's facility;
- (2) \$60 for medical equipment;
- (3) \$1,544 in travel and lodging costs away from home for presurgical consultation and surgery;
- (4) \$300 to Ms. Ellaborn for therapy;
- (5) \$260 for the consultation for a second referral letter for surgery; and
- (6) \$382 for hormone therapy. These payments [which totaled

191. *Id.* at 36.

192. *Id.* at 39.

193. *Id.*

194. *Id.* at 39–40.

195. *Id.* at 40.

196. *Id.* at 41.

197. *Id.* at 40–41.

198. *Id.* at 42.

\$21,741] were not compensated for by insurance or otherwise.¹⁹⁹

During a subsequent audit, the Office of the Chief Counsel of the IRS expressed doubt that the expenses were incurred either “to promote the proper functioning of [O’Donnabhain’s] body” or “for treatment of a disfiguring condition” and thus concluded that the expenses did not qualify for the exception to the cosmetic surgery exclusion.²⁰⁰ It also cited the opinions of a Dr. Paul McHugh concerning the “controversial” nature of surgery and other treatments for gender dysphoria.²⁰¹ Subsequently, the IRS determined that none of those expenses qualified for the medical deduction, and it denied O’Donnabhain’s deductions and demanded a return of her tax refund.²⁰² O’Donnabhain then petitioned the U.S. Tax Court for a determination whether that denial was in error.

*B. Opposition to WPATH’s Standards of Care:
Historical Context of the IRS Response*

Ample evidence demonstrates that, at the time of its decision to deny O’Donnabhain’s deductions, the IRS was under a great deal of pressure not to allow medical deductions for transgender transition-related health care, which may have biased the IRS in favor of denying O’Donnabhain’s deduction. The IRS Office of Chief Counsel cited controversial research by Dr. Paul McHugh (then leader of President George W. Bush’s Council on Bioethics) in its advice to the Boston IRS Appeals Office, which office thereafter denied O’Donnabhain’s requested medical deductions.²⁰³ Dr. McHugh, who was and remains an outspoken opponent of WPATH’s Standards of Care, has stated that those who enable transgender people to undergo the transition

199. *Id.*

200. Memorandum Number 200603025, OFFICE OF CHIEF COUNS. I.R.S. 1, 5 (Oct. 14, 2005), <https://www.irs.gov/pub/irs-wd/0603025.pdf>.

201. *Id.* (“In light of the Congressional emphasis on denying a deduction for procedures relating to appearance in all but a few circumstances and the controversy surrounding whether GRS [gender reassignment surgery] is a treatment for an illness or disease, the materials submitted do not support a deduction.”).

202. *O’Donnabhain*, 134 T.C. at 42 (IRS “disallowed [the foregoing medical expenditures] in a notice of deficiency.”).

203. Katherine Pratt, *The Tax Definition of “Medical Care:” A Critique of the Startling IRS Arguments in O’Donnabhain v. Commissioner*, 23 MICH. J. GENDER & L. 313, 333–34, 344 (2016) (citing Memorandum Number 200603025, OFFICE OF CHIEF COUNS. I.R.S. 1, 5 (Oct. 14, 2005), <https://www.irs.gov/pub/irs-wd/0603025.pdf>).

process are “collaborating with madness.”²⁰⁴ In addition, around the same time, a conservative Christian advocacy group, the Traditional Values Coalition, sent Mark Everson, IRS Commissioner under President Bush, a letter “to demand that the IRS not allow a deduction for O’Donnabhain’s costs of medical transition,” citing views expressed by Dr. McHugh.²⁰⁵ The pressure was at least partially successful: the IRS (including its Office of Chief Counsel) frequently cited Dr. McHugh’s views in IRS advice and arguments throughout the subsequent tax litigation.²⁰⁶

In a widely read Op-Ed published in the Wall Street Journal, Dr. McHugh contends that transgender people suffer from the “disordered assumption” that one’s experienced gender differs from the gender he describes as “given in nature,” that is, the traditionally perceived binary gender (male or female), usually assigned based on one’s genitalia at birth (sometimes referred to as one’s “natal gender” within the medical community).²⁰⁷ He explains that typical “disordered assumptions” recognized by the psychiatric community include the disordered assumptions associated with anorexia and bulimia nervosa, wherein “the dangerously thin [believe] that they are overweight.”²⁰⁸ Applying this reasoning, Dr. McHugh advocates not for validation of transgender individuals’ perceived gender with gender conformity surgery and other gender-conforming procedures, but rather for treatment of their “disordered assumption” with psychotherapy and medication designed to realign the patient’s perceived gender with the patient’s natal sex.²⁰⁹

204. Michael W. Chapman, *Johns Hopkins Psychiatrist: Support of Transgenderism and Sex-Change Surgery is ‘Collaborating with Madness’*, CNS NEWS (June 2, 2016), <http://www.cnsnews.com/blog/michael-w-chapman/johns-hopkins-psychiatrist-support-transgenderism-and-sex-change-surgery>.

205. Pratt, *supra* note 203, at 317 (citing Katherine T. Phan, *TVC Asks IRS to Reverse Tax Deduction for Sex-Change Operation*, CHRISTIAN POST (Dec. 15, 2004), <https://www.christianpost.com/news/tvc-asks-irs-to-reverse-tax-deduction-for-sex-change-operation-20790>).

206. Pratt, *supra* note 203, at 348–52.

207. Paul McHugh, *Transgender Surgery Isn’t the Solution*, WALL STREET J. (June 12, 2014, 2:18 PM), <https://www.wsj.com/articles/paul-mchugh-transgender-surgery-isnt-the-solution-1402615120>; AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451 (5th ed. 2013).

208. McHugh, *Transgender Surgery*, *supra* note 207.

209. *Id.*; Paul R. McHugh, *Surgical Sex: Why We Stopped Doing Sex Change Operations*, FIRST THINGS (Nov. 2004), <https://www.firstthings.com/article/2004/11/surgical-sex> (further describing his views and reasons for ceasing gender reassignment surgery at Johns Hopkins Hospital).

To support his position, Dr. McHugh cites a 1970s Johns Hopkins University study — conducted while he was head of psychiatry at that university — that found little difference in psychological health when comparing the outcomes of transgender people who had undergone surgery with the outcomes of those who did not.²¹⁰ This study has been criticized in that it is unverified and was not published in a peer-reviewed medical journal, but rather in a religious publication.²¹¹ Further, Dr. McHugh’s reliance on the study ignores an obvious alternative explanation: that is, because *not all* transgender people suffer from gender dysphoria and desire to undergo hormone treatment and surgery, it would make sense that, in a group of transgender people, some of whom experienced gender dysphoria and chose to undergo gender conformity surgery, and some of whom chose to forego gender conformity surgery (either because they did not experience gender dysphoria or because their dysphoria was sufficiently treated by non-surgical methods alone), all would experience generally similar psychological outcomes and levels of satisfaction with their choices.²¹²

Dr. McHugh also cites a 2011 study that revealed that “beginning about 10 years after having the surgery, the transgendered [sic] [who had undergone gender conformity surgery] began to experience increasing mental difficulties. Most shockingly, their suicide mortality rose almost 20-fold above the comparable nontransgender population.”²¹³ Although the results of this study are certainly disturbing, the data may not actually be statistically significant, given the small sample size and the fact that transgender Americans experience more than 25-fold rates of attempted suicide compared to non-transgender Americans.²¹⁴ A 20-fold rate might actually represent a decline for post-gender conformity surgery individuals relative to the transgender population at large. True enough, after Dr. McHugh cited

210. McHugh, *Transgender Surgery*, *supra* note 207.

211. O’Donnabhain v. Comm’r, 134 T.C. 34, 67 n.47 (2010).

212. WORLD PROF’L ASS’N FOR TRANSGENDER HEALTH, *supra* note 36, at 6 (“... transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available.”).

213. McHugh, *Transgender Surgery*, *supra* note 207.

214. Ann P. Haas et al., *Suicide Attempts Among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey*, THE WILLIAMS INST. 1, 2 (Jan. 2014), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf>.

this study, Dr. Dan Karasic, a psychiatrist and WPATH board member, published a response that characterized Dr. McHugh's description of the study as a misrepresentation.²¹⁵ In his response, Dr. Karasic indicates that "the increased mortality [above the comparable non-transgender population] is in those who had surgery before 1989, and that mortality in trans people after 1989 is not statistically different from the general population."²¹⁶ Dr. Karasic also points to a more recent study by the same researcher, published in 2014, which indicates that regret rates have been declining significantly in recent decades:

The risk of regretting the procedure was higher if one had been granted a new legal gender before 1990 For the two last decades, the regret rate was 2.4% (1991–2000) and 0.3% (2001–2010), respectively. The decline in the regret rate for the whole period 1960–2010 was significant.²¹⁷

This recent study indicates that, since 1990, regret rates surrounding gender conformity surgery have decreased dramatically, perhaps due, in part, to advances in medical techniques. This information further undermines the conclusions Dr. McHugh draws from the older 2011 study, which took place between 1973 and 2003.²¹⁸

Finally, Dr. McHugh characterizes the treatment of transgender and gender nonconforming children as "close to child abuse," stating that puberty-delaying hormones "stunt . . . children's growth and risk causing sterility."²¹⁹ He further implies that these risks are unnecessary, as "close to 80% of such children would abandon their confusion and grow naturally into adult life if untreated."²²⁰ If these statements accurately depicted treatment of gender nonconforming

215. Dan Karasic, *Wall Street Journal Editorial Critiques Transgender Health*, WORLD PROF. ASS'N FOR TRANSGENDER HEALTH (July 2, 2014), http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1635&pk_association_webpage=4905 [https://web.archive.org/web/20170705102125/http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1635&pk_association_webpage=4905].

216. *Id.*

217. Cecilia Dhejne et al., *An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960–2010: Prevalence, Incidence, and Regrets*, 43 ARCHIVES OF SEXUAL BEHAV. 1535, 1543 (2014).

218. Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLOS ONE (Feb. 22, 2011), <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885>.

219. McHugh, *Transgender Surgery*, *supra* note 207; McHugh, *Surgical Sex*, *supra* note 209, at 36–37.

220. McHugh, *Transgender Surgery*, *supra* note 207.

children, then certainly this treatment would be problematic. However, Dr. Karasic's response states that this is a mischaracterization as well, writing:

As McHugh states, most gender nonconforming children do not identify as transgender in adulthood. However, those who receive puberty blocking drugs do not do so until puberty, when trans identity is likely to persist. These drugs allow adolescents and their parents to work with doctors to achieve the best outcome. This approach was demonstrated to be successful in research in the Netherlands before being adopted widely in the U.S.²²¹

Dr. Karasic concludes his response by stating that “[t]he American Psychiatric Association and [WPATH] no longer view transgender identity as inherently pathological. Dr. McHugh’s views are stuck in the past.”²²² The modern medical community’s thorough acceptance of the WPATH Standards of Care implies that Dr. McHugh’s pressure on the IRS Commissioner in 2004 was guided by his strongly-held bias and was unsupported by verifiable studies. Further, the IRS response in this situation indicates a potential tendency for IRS rulings on contentious tax issues to differ depending on the current administration’s views, rather than be guided by an impartial reading of the tax code.

C. Overview of the Tax Court: Implications for Future Petitioners

It is worth mentioning that O’Donnabhain could have chosen to sue the Commissioner of Revenue in either a federal district court or in the U.S. Tax Court; her choice to sue in the U.S. Tax Court is significant for two reasons.²²³ First, the Tax Court is an entity that is independent from the IRS, the 19 members of which are presidentially appointed.²²⁴ The Tax Court is “a court of record established by Congress under Article I of the U.S. Constitution.”²²⁵ The Supreme Court, in a five-four decision in 1991, explained that, in its current incarnation, although it is not an Article III court, it is an “Article I

221. Karasic, *supra* note 215.

222. *Id.*

223. *Suits Against the United States and Claims for Damages under IRC § 7433*, IRS (Jan. 13, 2017), https://www.irs.gov/irm/part25/irm_25-003-003.html.

224. *About the Court*, U.S. TAX COURT (Aug. 2016), <https://www.ustaxcourt.gov/about.htm> (hereinafter “U.S. Tax Court, *About the Court*”).

225. *Id.*

legislative court” and “exercises a portion of the *judicial* power of the United States.”²²⁶ Accordingly, Tax Court holdings apply to all American taxpayers, and the IRS has specifically confirmed that it will follow the decision in *O’Donnabhain*.²²⁷ However, most Tax Court opinions — specifically, those denominated “memo” and “summary” opinions — historically have “lack[ed] precedential value” even in later Tax Court cases, and they are not binding on federal appellate courts in any event.²²⁸ Full-court opinions like the *O’Donnabhain* decision, sometimes referred to as “reviewed opinions,” do have precedential value insofar as later Tax Court panels must follow them.²²⁹ Yet, following traditional rules of *stare decisis*, neither federal district courts nor federal courts of appeals are bound to treat any Tax Court decision as precedent²³⁰ or even deserving of deference.²³¹ Hence, the Tax Court’s *O’Donnabhain* decision, despite its potentially pivotal role in determining the outcomes for future tax issues, cannot direct the decisions of federal appellate courts concerning whether gender dysphoria constitutes a disease and, by extension, whether gender conformity surgery and other gender conforming treatments that alter the appearance constitute deductible “medical care” or non-deductible “cosmetic surgery” when used to treat a mental illness. For future taxpayers seeking to bring similar challenges in a court bound to follow the *O’Donnabhain* ruling, then, the Tax Court is their obvious choice.

226. *Freytag v. Comm’r*, 501 U.S. 868, 891–92 (1991) (emphasis added).

227. Thomas D. Moffitt, Action on Decision, IRB No. 2011-47, IRS (Nov. 21, 2011) available at <https://www.irs.gov/pub/irs-aod/aod201103.pdf>.

228. Amandeep S. Grewal, *The Un-Precedented Tax Court*, 101 IOWA L. REV. 2065, 2066–67 (2016).

229. *Id.* at 2065 n.7; *Battat v. Comm’r*, No. 17784-12, 2017 WL 449951, at *9 (T.C. Feb. 2, 2017) (“Tax Court opinions are subject to *stare decisis*.”); *Smith v. Comm’r*, 926 F.2d 1470, 1479 (6th Cir. 1991) (noting that the Tax Court is bound by *stare decisis*, but that the full court can overrule a prior Tax Court decision, and explaining how it “know[s] of no authority which prevents a court, sitting *en banc*, from overruling one of its prior decisions when it has determined that the rule is outdated and an impediment to legal process”).

230. *Carroll v. United States*, 198 F. Supp. 2d 328, 357 (E.D.N.Y. 2001), *vacated on other grounds*, 339 F.3d 61 (2d Cir. 2003) (“[T]he decision of the Tax Court . . . would not be entitled to *stare decisis* effect in this [federal district court] any more than the decision of a federal district court sitting in Illinois would be entitled to *stare decisis* effect in the United States Court of Appeals for the Second Circuit.”).

231. *Maier v. Comm’r*, 360 F.3d 361, 365 (2d Cir. 2004) (quoting *Madison Recycling Assocs. v. Comm’r*, 295 F.3d 280, 285–86 (2d Cir. 2002) for the proposition that “[w]e owe no deference to the Tax Court’s statutory interpretations, its relationship to us being that of a district court to a court of appeals, not that of an administrative agency to a court of appeals”).

For such taxpayers, a second factor weighing in favor of the Tax Court is cost. The relatively low costs of the Tax Court might be beneficial to transgender taxpayers who, as discussed above, experience disproportionate levels of poverty. Other than a \$60 filing fee when filing the petition, there are no other court costs associated with litigating a case before the Tax Court.²³² Meanwhile, fees to bring a case before U.S. District Courts tend to be much higher and vary by state. For example, the U.S. District Court of Massachusetts, O'Donnabhain's home state, charges \$195 to file a Civil Complaint or Petition, and there may be other fees involved depending on the filings of the petitioner.²³³ Perhaps more significantly for a litigant of modest means, "[o]nce the petition is filed [in Tax Court], payment of the underlying tax ordinarily is postponed until the case has been decided."²³⁴ The same is not true in federal district court, where the taxpayer would be required to pay the tax balance before suing for a refund. Prior to the trial date, interest continues to accrue upon the petitioner's unpaid tax balance, however, the petitioner can "stop the interest accrual before going to tax court by making a payment and labeling it as a deposit."²³⁵

D. The U.S. Tax Court's Decision in O'Donnabhain

For better or worse, given the foregoing considerations, O'Donnabhain brought her case in the Tax Court and not federal district court. The Tax Court, in an 11-5 decision, ruled in favor of allowing deductions as "medical care" for certain of O'Donnabhain's treatments — her hormone therapy, gender conformity surgery, and transportation — but disallowed deduction of the cost of her breast augmentation surgery, ruling that the latter was excluded by the cosmetic surgery exception to the definition of deductible medical care. The majority opinion addressed the following issues:

232. U.S. Tax Court, *About the Court*, *supra* note 224. There are of course litigation costs, such as attorney fees, expert witness fees, etc., but those would presumably be the same whether the taxpayer chose the Tax Court or a federal district court.

233. *Boston Municipal Court and District Court Filing Fees*, MASS.GOV, <http://www.mass.gov/courts/court-info/filing-fees/dc-fees-gen.html> (last visited Feb. 18, 2018).

234. U.S. Tax Court, *About the Court*, *supra* note 224.

235. Mark P. Cussen, *Tax Court: Your Last Resort*, INVESTOPEDIA, <http://www.investopedia.com/articles/tax/09/tax-court-last-resort.asp> (last visited Feb. 18, 2018).

1. Whether gender identity disorder, or *GID*, constituted a “disease” for purposes of section 213 of the Internal Revenue Code,²³⁶
2. If so, whether O’Donnabhain suffered from *GID*,²³⁷ and
3. If so, whether O’Donnabhain’s hormone therapy, gender conformity surgery, and breast augmentation constitute “treatment” of her *GID*, and were thus deductible medical care expenses for purposes of section 213.²³⁸

As a threshold matter, the Court held that *GID* does constitute a “disease” for purposes of section 213.²³⁹ As rationale, the Court cited *GID*’s classification as a mental disorder in *DSM-IV*,²⁴⁰ “widespread recognition of the condition in medical literature,”²⁴¹ and *GID*’s nature as “a serious, psychologically debilitating condition” that “poses a serious medical need,” as recognized by “every U.S. Court of Appeals that has ruled on the question.”²⁴²

The Court next turned to the issue whether the petitioner suffered from the “disease” *GID*. It rejected the IRS’s argument that O’Donnabhain was not correctly diagnosed with *GID*, holding that O’Donnabhain’s *GID* diagnosis was “substantially supported by the record.”²⁴³ Specifically, the Court cited the qualifications and opinions of O’Donnabhain’s treating psychotherapist: Ellaborn was licensed to diagnose *GID*, she had ample experience treating transgender patients, she did, in fact, make such a diagnosis, and she gave “persuasive” testimony regarding the methodology behind her diagnosis and the ruling out of other conditions.²⁴⁴ The Court noted that Dr. Coleman, the second licensed professional who examined O’Donnabhain, concurred in the diagnosis and in the appropriateness of treatment through gender conformity surgery.²⁴⁵ Finally, the Court cited the concurrence of O’Donnabhain’s expert witness, Dr. George Brown,

236. O’Donnabhain v. Comm’r, 134 T.C. 34, 55 (2010).

237. *Id.* at 63.

238. *Id.* at 64.

239. *Id.* at 59.

240. *Id.* at 60.

241. *Id.*

242. *Id.* at 61–62 (referring to opinions from seven of the U.S. Courts of Appeals that “have concluded that severe *GID* or transsexualism constitutes a ‘serious medical need’ for the purposes of the Eighth Amendment” and noting that “[n]o U.S. Court of Appeals has held otherwise”).

243. *Id.* at 63.

244. *Id.*

245. *Id.*

whom it acknowledged as “a recognized authority in the field.”²⁴⁶ The Court ruled that the testimony of these three witnesses, all of whom had examined O’Donnabhain, was entitled to greater weight than the testimony of the IRS’s two expert witnesses, who had not.²⁴⁷

Having concluded that GID is a “disease” within the meaning of the Internal Revenue Code’s definition of “medical care” and that O’Donnabhain did indeed suffer from it, the Court then turned to the issue whether the various costs that O’Donnabhain sought to deduct qualified as payments for “treatment” or other “medical care” for GID and were thus eligible for the medical deduction, and did not instead fall into the exception for non-deductible “cosmetic surgery,” as the IRS maintained. The Court held that, although O’Donnabhain’s gender conformity surgery and hormone therapy “treated” her GID for purposes of section 213,²⁴⁸ on the facts of this case, her breast augmentation did not.²⁴⁹ Concerning its holding that the gender conformity surgery and hormone therapy were deductible, the Court cited case law and standard dictionary definitions of “treatment,” and found that hormone therapy and gender conformity surgery were treatments of GID under both of these definitions insofar as they both relieved or cured its symptoms.²⁵⁰

The Court decided, however, that O’Donnabhain’s breast augmentation surgery fell into the “cosmetic surgery” exception and was not therefore a deductible medical treatment because she provided insufficient documentation of any breast-related anxiety that would be treated and ameliorated by augmentation.²⁵¹ As the basis of its reasoning, the majority of the Court applied the relevant statutory language that describes the cosmetic surgery exception (that surgery designed to “improve the patient’s appearance” is non-deductible “cosmetic surgery” unless it meets one of three conditions, namely that it (1) is “necessary to ameliorate a deformity arising from . . . a congenital abnormality,” (2) “promote[s] the proper function of the body” or (3) “prevent[s] or treat[s] illness or disease”).²⁵² The court ruled out the first condition on the grounds that “Petitioner has not

246. *Id.*

247. *Id.*

248. *Id.* at 70.

249. *Id.*

250. *Id.*

251. *Id.* at 72–73.

252. *See supra* section III(B) (describing I.R.C. § 213(d)(9)).

argued, or adduced evidence, that the breast augmentation surgery ameliorated a deformity within the meaning of section 213(d)(9)(A).”²⁵³ It then ruled out the second condition, noting that “the parties [had] stipulated that petitioner’s breast augmentation ‘did not promote the proper function of her breasts.’”²⁵⁴

To evaluate whether the third condition applied, the Court reviewed Dr. Meltzer’s presurgical notes and testimony, which indicated that O’Donnabhain had developed B-cup breasts of a “very nice shape” due to hormone therapy treatments and from which the Court concluded that no deformity was present.²⁵⁵ It noted that O’Donnabhain had produced no evidence of breast-related anxiety or distress that the augmentation could have been justified as treating, as required by the WPATH Standards of Care.²⁵⁶ The majority therefore concluded that the third condition did not apply and that, because O’Donnabhain’s “breast augmentation surgery meets the definition of ‘cosmetic surgery’ in section 213(d)(9)(B), it is not ‘medical care’ that is deductible pursuant to section 213(a).”²⁵⁷ Several judges issued concurring opinions, noting that they agreed with the result but not the majority’s reasoning. In one such concurrence, Judge Halpern stated that he generally agreed with the majority opinion, but disapproved of the majority’s reference to the “apparent normalcy” of O’Donnabhain’s breasts as a “superfluous and potentially misleading” reason to deny the deduction for O’Donnabhain’s breast-augmentation surgery.²⁵⁸ Rather, Judge Halpern agreed with the decision to deny the deduction solely because of O’Donnabhain’s failure to show that her doctors documented her “breast-engendered anxiety” in accordance with WPATH’s Standards of Care.²⁵⁹ Implicitly, had O’Donnabhain adequately documented such “breast-engendered anxiety”²⁶⁰ related to her GID, then the breast augmentation would have been considered a medical treatment to treat the illness of GID, and the deduction for that surgery would have been allowed as well.

253. *O’Donnabhain*, 134 T.C. at 72.

254. *Id.* at 73.

255. *Id.* at 72–73.

256. *Id.* at 73. The *O’Donnabhain* Court refers to the WPATH Standards of Care as the Benjamin standards, in reference to the previous name of the organization.

257. *Id.* at 72.

258. *Id.* at 77–78.

259. *Id.* at 77.

260. *Id.* at 73.

Before ending its inquiry, however, the majority opinion overreached in two ways, seemingly applying two tests that do not find their source in the Internal Revenue Code. First, the Court discussed at length the degree to which the WPATH Standards of Care are accepted “in the psychiatric profession” and, more generally, in the medical community at large, considering whether that acceptance is “limited,” “broad,” “widespread,” or “substantial.”²⁶¹ These qualifiers and the requirement for any specific degree of “acceptance” are not prescribed by section 213 of the Code, or any other section for that matter. In fact, numerous opinions of the Tax Court have allowed deductions for treatments that were surely less widely accepted by the medical community than the WPATH Standards of Care. For instance, as the *O’Donnabhain* majority itself pointed out, the Tax Court has previously approved medical deductions for such non-mainstream treatments as naturopathic and holistic cancer treatments, Navajo healing ceremonies or “sings,” acupuncture, and Christian Science practitioner services²⁶² — “treatments that are highly unlikely to survive rigorous scientific review.”²⁶³ As the Court in those matters understood, the “deductibility of medical care payments under section 213 is not strictly limited to traditional medical procedures” but rather “allows medical expense deductions for ‘nontraditional’ medical care.”²⁶⁴ The relevant inquiry is not whether a treatment is universally — or even widely — accepted as the best and most appropriate treatment by the majority of traditional medical doctors. Instead, the inquiry is simply whether the treatment fits the definition of medical care under section 213 and is one that the taxpayer and his medical care provider believe will aid in diagnosing, curing, mitigating, treating or preventing a disease by, for instance, relieving the taxpayer’s symptoms. By its lengthy examination of the degree of acceptance of the WPATH Standards of Care, the Tax Court applied an unnecessary and unfounded test to transgender care that it has not applied to other treatments and forms of care; in so doing, it may have created precedent that will help future patients obtain insurance coverage for transition-related care. Yet the inquiry was unnecessary

261. *Id.* at 65–68.

262. *Id.* at 69 (citing *Dickie v. Comm’r*, 77 T.C.M. (CCH) 1916 (T.C. 1999); *Crain v. Comm’r*, 51 T.C.M. (CCH) 806 (1986); *Tso v. Comm’r*, 401 T.C.M. (CCH) 1277 (1980); Rev. Rul. 72–593, 1972–2 C.B. 180; Rev. Rul. 55–261, 1955–1 C.B. 307).

263. *Id.* at 91.

264. *See, e.g.*, *Dickie v. Comm’r*, 77 T.C.M. (CCH) 1918.

for the determination before the Court and should not be seen to create an extra hurdle for a single class of taxpayers.

In another concurrence, Judge Holmes noted the danger of politicizing the courts and inserting judges into medical debates, and expressed concerns with the majority's search for consensus surrounding the Standards of Care as a means to establishing their legitimacy as accepted medical procedures. Judge Holmes explained, "The consensus of WPATH is not necessarily the consensus of the entire medical community."²⁶⁵ Although there is, indeed, wide consensus surrounding WPATH's Standards of Care, Judge Holmes was right to point out that excess emphasis on consensus may come at a cost to future taxpayers. Ultimately, the Court explained that regardless of the controversy surrounding the efficacy of gender conformity surgery and hormone therapy, case law under section 213 indicated that "complete consensus on the advisability or efficacy of a procedure is not necessary for a deduction"²⁶⁶ However, the decision to wade into the topic sets the Court on a path down a slippery slope of questioning the treatment choices of taxpayers; those patients with lesser-understood conditions, those who seek treatments that have not yet achieved consensus among all health care providers, and other marginalized patients may be unjustifiably denied a deduction.

Further, the Court applied a second, unnecessary, and unfounded test when it considered whether the two procedures, gender conformity surgery and hormone treatment, were medically necessary, despite the fact that the section 213 does not require such a finding as a precondition to deductibility. The IRS argued that "medical necessity" was a "requirement intended by Congress to apply to procedures directed at improving appearance."²⁶⁷ The majority opinion implicitly acknowledged that a "medical necessity" requirement is not expressly prescribed by the Code; it stated that it need not decide whether to infer such a requirement "notwithstanding the absence of the phrase in the statute."²⁶⁸ It explained that the requirement "would not bar the deductions at issue, inasmuch as . . .

265. *O'Donnabhain*, 134 T.C. at 88 (Holmes, J., concurring).

266. *Id.* at 69.

267. *Id.* at 74.

268. *Id.*

petitioner has shown that her sex reassignment surgery was medically necessary.”²⁶⁹ The majority explained:

Given Dr. Brown’s expert testimony, the judgment of the professional treating petitioner, the agreement of all three experts [O’Donnabhain’s one expert and both of the IRS’s] that untreated GID can result in self-mutilation and suicide, and . . . the views of a significant segment of knowledgeable professionals that sex reassignment surgery is medically necessary for severe GID, the Court is persuaded that petitioner’s sex reassignment surgery was *medically necessary*.²⁷⁰

In his concurring opinion, Judge Holmes weighed in to criticize the majority for unnecessarily considering whether O’Donnabhain’s various treatments were “medically necessary,” when that requirement is not found in the tax code.²⁷¹ Judge Holmes aptly explained that it “is not essential to the holding and drafts our Court into culture wars in which tax lawyers have heretofore claimed noncombatant status.”²⁷²

Just as the Court’s inquiry into the degree of acceptance of the WPATH Standards of Care was irrelevant, so too was the Court’s inquiry into medical necessity. Not only is the requirement not found in the Internal Revenue Code, the phrase “medical necessity” has been used only very rarely in prior decisions regarding the medical deduction, in cases where the expenditure was for items barely related to medical treatment at all. For instance, the petitioners in *Garcia v. Commissioner*²⁷³ tried to deduct the cost of heating and cooling their home and the cost of a lawn care service, and in questioning the “medical necessity” of those expenditures, the Tax Court questioned whether the treatments were even medical in nature, not whether those treatments were preferred or required by the medical community for a particular disease or condition.²⁷⁴ Moreover, there is no universally-

269. *Id.*

270. *Id.* at 76 (emphasis added).

271. *Id.* at 90–97 (Holmes, J., concurring). Other judges filed concurring and dissenting opinions on related issues, but this Article does not address them.

272. *Id.* at 85.

273. 111 T.C.M. (CCH) 1 (T.C. 2016).

274. *Id.* at 17; *see also* Lenn v. Comm’r, 75 T.C.M. (CCH) 1892 (T.C. 1998) (disallowing legal fees that were not necessary to obtain medical care or a legitimate a method of treatment, but rather incurred during an effort to obtain reimbursement for private school tuition for taxpayer’s son from a public school district).

recognized definition of medical necessity, and even the IRS's expert acknowledged that "the definition of medical necessity 'varies according to the defining party.'"²⁷⁵ Significantly, the U.S. Tax Court has found that section 213 allows deductions for medical care even without a physician referral,²⁷⁶ one of the two essential prongs in typical definitions of medical necessity in the insurance context, as discussed above. By delving into an evaluation of medical necessity, without first reaching a clear decision regarding the definition of medical necessity or whether the inquiry was even appropriate, the majority not only inserted itself into an unnecessary debate outside the expertise of most tax judges, but it also set an example that may introduce unintended barriers to controversial medical care in future cases and cast the courts as ill-equipped decision-makers in the medical arena. Depending on the defining party, medical necessity's definition may change — and, due to the overreach of the Court in this case, that definition may have significant bearing over whether a future taxpayer's chosen medical treatment is deductible. Significantly, this may bring additional challenges to future taxpayers who might, as a result of this opinion, be asked to satisfy more onerous burdens of proof to show that their chosen treatment was medically necessary in their case, even though medical necessity is not required by statute.

Although the Court properly held that hormone therapy and gender conformity surgery are treatments for GID for purposes of deduction under section 213, its inquiry should have ended there. In sum, its decision even to entertain the respondent's arguments surrounding "medical necessity" and "wide acceptance" is problematic for future decisions regarding the deductibility of other controversial medical care since "medical necessity" and "wide acceptance" are not thresholds that are imposed by the applicable laws, and the decision potentially creates a hurdle for marginalized populations not imposed on other taxpayers.²⁷⁷ Because medical consensus regarding the merits and acceptance of a treatment and determinations of medical necessity have not historically been

275. *O'Donnabhain*, 134 T.C. at 75.

276. *See Dickie v. Comm'r 77 T.C.M. (CCH) 1916, 1918–19 (T.C. 1999)* ("More importantly, section 213 does not preclude deduction of amounts expended for medical care even though such care was not prescribed by a medical doctor.").

277. *O'Donnabhain*, 134 T.C. at 70.

necessary to qualify those treatments as medical care, to impose requirements of medical necessity and consensus in this case contradicts precedent, is unjustly burdensome, and unfairly limits patient choice in seeking affordable medical care. Those portions of the majority opinion should instead be treated as the dicta that they are.

V. RECOMMENDATIONS AND CONCLUSIONS

Following the Tax Court's decision in 2010, many lauded *O'Donnabhain* as the first of many policy-based changes in favor of transgender rights.²⁷⁸ However, more recent actions, such as the federal court injunction of HHS's regulation prohibiting discrimination on the basis of transgender status by insurers and health providers, the commitment by HHS to reassess that regulation, the prohibition on the CDC's use of the term transgender, and the Trump administration's determination to ban military service by transgender individuals and to ban the use of federal funds for transition-related care for military members, putatively based at least in part on the cost of transgender care,²⁷⁹ prove that the future of transgender health care is far from certain.

Moving forward, at the next opportunity presented by an appropriate case, the Tax Court should clarify that its inquiry into "medical necessity" and "wide acceptance" in the *O'Donnabhain* case was merely dicta and not intended to create new requirements out of whole cloth. As discussed above, the meaning of "medically necessary" for the purposes of health care insurance coverage can vary between states and between insurance providers, and sometimes even lacks an explicit definition. Notably, the Tax Court did not define this term in its opinion, and therefore it is reasonable to assume that the Tax Court uses the plain language definition of "necessary" for the purposes of its analysis. Due to ambiguities in the definition of "medical necessity", the fact that the Internal Revenue Code does not use the term "medical necessity", and the general overreach of the Court in its analysis thereof, the Court should clarify its position to

278. *O'Donnabhain v. Commissioner of Internal Revenue*, GLAD, <https://www.glad.org/cases/in-re-rhiannon-odonnabhain/> (last visited Apr. 10, 2018).

279. *Presidential Memorandum for the Secretary of Defense and the Secretary of Homeland Security*, 82 Fed. Reg. 41319 (Aug. 25, 2017) (banning transgender participation in the U.S. armed forces).

prevent the imposition of an unnecessary — and unfounded — hurdle on future taxpayers. Advocates and other interested parties may want to identify an appropriate case to bring the issue to the forefront, or to request a revenue ruling from the IRS.

At a more fundamental level, so long as insurance coverage for transition-related care is not universally protected from discriminatory exclusions under state and federal law, attorneys and policy experts must continue to support the longevity of the medical deduction within Internal Revenue Code. In all, O'Donnabhain's deductions, in 2017 dollars, equate to \$23,715.19 (or \$29,904.98 if including breast augmentation surgery), which given the average American's effective tax rate of 29.8%²⁸⁰ would amount to a one-time savings of approximately \$7,067.13 in avoided taxes (\$8,911.68 if including breast augmentation).²⁸¹ Yet the initial U.S. House of Representatives draft of the Tax Cuts and Jobs Act had proposed to repeal the medical deduction entirely, while increasing the standard deduction to \$24,400 for married couples filing jointly.²⁸² If O'Donnabhain were to pursue the same treatments today, assuming that she provided adequate documentation of distress and anxiety to deduct her breast augmentation costs, and if Congress had, in fact, eliminated the medical deduction, O'Donnabhain would lose out on a deduction of almost \$18,000 (the \$29,905 cost minus the standard \$12,000 deduction, for a loss of approximately \$5,364 in tax savings at a tax rate of 29.8%²⁸³), *ceteris paribus*. Even without allowing a deduction for breast augmentation surgery, O'Donnabhain's itemized medical deductions would still exceed the new standard deduction by almost \$12,000. While the medical deduction was not ultimately eliminated by the 2017 tax legislation,²⁸⁴ the issue is sure to arise again in future legislation. Interested parties will need to be vigilant in monitoring proposed legislation and advocating for retaining it in the face of future legislative threats.

280. Matthew Frankel, *What's the Average American's Tax Rate?*, MOTLEY FOOL (Mar. 4, 2017, 7:31 AM), <https://www.fool.com/retirement/2017/03/04/whats-the-average-americans-tax-rate.aspx>.

281. *CPI Inflation Calculator*, BUREAU OF LAB. STAT., <https://data.bls.gov/cgi-bin/cpicalc.pl> (last visited Feb. 18, 2018).

282. Tax Cuts and Jobs Act, H.R. 1, 115th Cong. §§ 1308, 1002 (2017) (discussing proposed repeal of the medical expense deduction and enhancement of the standard deduction).

283. Frankel, *supra* note 280 (showing that the average American's effective tax rate, including state/local, Federal, Social Security, and Medicare taxes, is about 29.8%).

284. Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11027, 131 Stat. 2044.

Transgender people are only one demographic who could face negative externalities if future attempts to repeal the medical deduction come to fruition. As just one example, people with disabilities currently can use this deduction to deduct expenses associated with specialized care, household accommodations, and travel to and from specialist appointments. Likewise, the elderly often use the deduction to offset costs associated with dental, eye, and long-term nursing home care not covered by Medicare. Both groups would lose the ability to deduct such expenses, which often exceed the proposed standard deduction. By preserving the medical deduction now and in the future, as well as ensuring that the precedent set by *O'Donnabhain* is upheld within the IRS, transgender people who seek medical care—transition-related or otherwise—will be able to deduct the out-of-pocket expenses associated with medical procedures that are often denied coverage under state Medicaid services and private health insurers.

With regard to protecting the rights of transgender people and other members of the Lesbian, Gay, Bisexual, and Transgender (“LGBT”) community, there are three additional important considerations that professionals in the legal, political, and medical arenas must explore further. First, in order to ensure that policy-makers understand fully the experiences and needs of transgender Americans, political influencers must first ensure that policy-makers have access to reliable data that reaches populations across the United States. As indicated above, due to current lack of Census data related to gender identity and transgender status, most existing data on transgender populations relies on surveys that are often conducted by LGBT-focused non-profit organizations.²⁸⁵ As described above, in March 2017, the U.S. Census Bureau determined that there was “no federal data need” for questions about “sexual orientation and gender identity” on the 2020 Census,²⁸⁶ despite requests for the collection of such data by “at least four federal agencies, including the Justice Department,”²⁸⁷ which wrote a letter to the Census Bureau in November 2016 to demonstrate “the legal authority supporting the

285. Wang, *supra* note 51.

286. Thompson, *supra* note 52.

287. Hansi L. Wang, *Census Bureau Found No Need for LGBT Data Despite 4 Agencies Requesting it*, WGBH NEWS (July 18, 2017), <https://news.wgbh.org/2017/07/18/census-bureau-found-no-need-lgbt-data-despite-4-agencies-requesting-it>.

necessity for the collection of [LGBT-related] information.”²⁸⁸ Until transgender and gender-nonconforming people are recognized in the Census and other data collection surveys, the U.S. government will not produce large-scale, reliable data concerning the health and other outcomes of transgender people in the United States. Continuing to exclude such topics and questions on the 2020 Census will eliminate opportunities to gather data on a large scale that the government and other entities can use to implement effective policies that address transgender and gender-nonconforming health care needs.²⁸⁹

Second, psychiatric groups must consider the implications of gender dysphoria’s classification as a mental illness. Some transgender rights advocates have voiced criticism that continued classification of gender dysphoria as a “disease” or “mental illness” will only perpetuate stigma surrounding the transgender and gender nonconforming community.²⁹⁰ This rationale is also why the DSM-5 workgroup on gender dysphoria made the conscious decision to remove the word “disorder” when renaming GID.²⁹¹ As a parallel example, some point to the removal of homosexuality from the DSM as an important step in the de-stigmatization of homosexuality.²⁹² Issues of stigmatization aside, treating gender dysphoria as a medical disorder poses the risk of creating a “homogenous, medicalized model of the ‘ideal’ transgender body” that inhibits access to appropriate medical treatment for transgender people who do not fit this mold.²⁹³ As such, it is arguably problematic to continue to provide deductions for gender conformity surgery and other treatments for gender dysphoria as a “disease” under section 213.

Yet removing gender dysphoria from the DSM might make it even more difficult for transgender people suffering from gender dysphoria to obtain approval to deduct transition-related medical care.

288. *Letter from Arthur E. Gary, General Counsel, U.S. Dep’t of Justice, to John H. Thompson, Director, Economics and Statistics Administration, U.S. CENSUS BUREAU* (Nov. 4, 2016), apps.npr.org/documents/document.html?id=3892167-DOJ-to-Census-Bureau-2016-11-04-Edit.

289. Dinan, *supra* note 51.

290. Katy Steinmetz, *Being Transgender is Not a Mental Disorder: Study*, TIME HEALTH (July 26, 2016), <http://time.com/4424589/being-transgender-is-not-a-mental-disord>.

291. Jack Drescher, *New Diagnostic Codes Lessen Stigma for Transgender People*, MEDSCAPE (Sept. 11, 2007), <https://www.medscape.com/viewarticle/885141>.

292. *The History of Psychiatry and Homosexuality*, LGBT MENTAL HEALTH SYLLABUS, http://www.aglp.org/gap/1_history (last visited Feb. 18, 2018).

293. Alesdair H. Ittelson, *Trapped in the Wrong Phraseology: O’Donnabhain v. Commissioner*, 26 BERKELEY J. GENDER L. & JUST. 356, 356 (Oct. 26, 2011).

One potential solution that protects access to care while reducing stigma might involve efforts to educate the public about the true nature of gender dysphoria as distress associated with, but distinct from, transgender identity. This is a question for policy-makers and medical professionals to weigh in the years ahead. This consideration goes hand-in-hand with the need for improved training and education of health care professionals surrounding the needs of transgender health care, so that transgender patients everywhere can have access to adequate and compassionate health care.

Third, and most important, policy experts interested in protecting transgender rights must advocate for state- and federal-level antidiscrimination protections to prohibit discrimination on the basis of sexual orientation and gender identity by health care providers and insurers. As discussed above, state-level legislation that both explicitly protects private insurer and Medicaid coverage of transition-related medical care, in accordance with WPATH's Standards of Care, as well as prohibits health care and other forms of discrimination on the basis of gender identity is necessary to ensure that transgender people are not denied essential health care on the basis of gender identity. At the federal level, protecting transgender health care will require keeping and enforcing guidance such as 42 C.F.R. part 92 which, as discussed above, has been enjoined indefinitely, despite better-reasoned prior case law that indicates that transgender discrimination is a form of sex discrimination. Given the current presidential administration's lack of support for transgender protections thus far, it is not likely that federal-level protections will effectively protect transgender patients in the near future. Therefore, state-level protections are increasingly critical to protecting transgender health care access; fortunately, the states are also where demonstrable growth has occurred throughout the past several years.²⁹⁴ States wishing to prevent discriminatory health care practices will want to consider adopting their own versions of 42 C.F.R. part 92, with the religious exceptions identified by the *Franciscan Alliance, Inc.* court as appropriate.

294. See *Healthcare Laws and Policies*, supra note 140; *Healthcare Laws and Policies*, MOVEMENT ADVANCEMENT PROJECT (Sept. 21, 2016), http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies [https://web.archive.org/web/20160921174545/http://www.lgbtmap.org:80/equality-maps/healthcare_laws_and_policies]; *Healthcare Laws and Policies*, MOVEMENT ADVANCEMENT PROJECT (Oct. 7, 2017), http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies [http://web.archive.org/web/20171004060034/http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies].

Overall, except for the “widely accepted” and “medically necessary” dicta discussed above, *O’Donnabhain v. Commissioner* represents a tremendous success for transgender health care rights and offers opportunities for increasing affordable access to transition-related care. States and, ultimately, federal policymakers must take the next steps to promulgate its principles into insurance regulations and elsewhere to realize the potential of the decision.

