

TRANSGENDER YOUTH, THE NON-MEDICAID REIMBURSABLE POLICY, AND WHY THE NEW YORK CITY FOSTER CARE SYSTEM NEEDS TO CHANGE

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I. INTRODUCTION

*“[My mother told me,] ‘You’re a sick aberration of an aberration. As far as I’m concerned you’re dead, and I don’t ever want to see you again.’”*¹

Working with foster children in New York City, I was struck by the discrimination against transgender foster youth in all aspects of their lives. Sentiments such as the above are unfortunately common. At a time in their growth when young people most need the support of others as they explore their identities,² transgender youth often are told that they cannot be who they are. Families of transgender youth frequently force these young people into “conversion therapy” or throw them out of their homes either onto the streets or into the foster care system.³ Transgender youth tend to suffer considerable psychological stress because not only do they suffer rejection and harassment in the home and at school, they also must deal with the primary issue of simply being uncomfortable in their own bodies. These factors, among others, account for the disproportionate instances of anxiety, depression, and suicidal ideation among this population.⁴

Familial rejection of transgender youth leads to their high rates of entry into the foster care system. Unfortunately, once in the foster system, transgender youth tend to see little improvement in their situations. Often transgender youth in foster care are bullied by their peers and discriminated against by the adults charged with ensuring their safety.⁵ This Comment will address discrimination against transgender foster youth in terms of a specific policy that infringes upon their rights to health care. The New York City Administration for Children’s Services (“ACS”) is required to provide “necessary medical or surgical care” for all children in the foster care system.⁶ Because the New York State Medicaid laws specifically exclude coverage for hormone therapy and sex-reassignment surgery, however, ACS historically has refused to provide medical treatment for

1. Alexis Belinda Dinno, *From the Perspective of a Young Transsexual*, in *TRANSGENER CARE* 203, 204 (Gianna E. Israel & Donald E. Tarver, eds., 1997). As discussed in Part II(A), “transsexual” is included in the umbrella term “transgender.”

2. See, e.g., LEGAL AID SOCIETY JUVENILE RIGHTS DIVISION, *INTERVIEWING CHILDREN DEVELOPMENTAL CONSIDERATIONS* (2005) (explaining that adolescents need to be supported rather than judged).

3. See, e.g., JODY MARKSAMER, DEAN SPADE, & GABRIEL ARKLES, NAT’L CENTER FOR LESBIAN RIGHTS & SYLVIA RIVERA LAW PROJECT, *A PLACE OF RESPECT: A GUIDE FOR GROUP CARE FACILITIES SERVING TRANSGENDER AND GENDER NON-CONFORMING YOUTH* 6 (2011), available at http://www.nclrights.org/site/DocServer/A_Place_Of_Respect.pdf?docID=8301; Judith S. Stern & Claire V. Merkin, *Brian L. v. Administration for Children’s Services: Ambivalence Toward Gender Identity Disorder as a Medical Condition*, 30 *WOMEN’S RTS. L. REP.* 566, 575–76 (Spring 2009).

4. See, e.g., AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, TEXT REVISION, DSM-IV-TR* 578 (4th ed. 2000) [hereinafter *DSM-IV-TR*].

5. E.g., TERESA DECRESZENZO & GERALD P. MALLON, *CHILD WELFARE LEAGUE OF AMERICA, SERVING TRANSGENDER YOUTH: THE ROLE OF CHILD WELFARE SYSTEMS*, *PROCEEDINGS OF A COLLOQUIUM SEPTEMBER 2000*, 10 (2002); see also GERALD P. MALLON, *WE DON’T EXACTLY GET THE WELCOME WAGON: THE EXPERIENCES OF GAY AND LESBIAN ADOLESCENTS IN CHILD WELFARE SYSTEMS* 65 (1998); James W. Gilliam, Jr., *Toward Providing a Welcoming Home for All: Enacting a New Approach to Address the Longstanding Problems Lesbian, Gay, Bisexual, and Transgender Youth Face in the Foster Care System*, 37 *LOY. L.A. L. REV.* 1037, 1038 (2004) (“LGBT teens, or those who are perceived as such, often experience more severe problems in the foster care system ‘because of prejudice against their sexual orientation or their nonconformity to gender stereotypes.’” (quoting COLLEEN A. SULLIVAN, SUSAN SOMMER & JASON MOFF, *LAMBDA LEGAL DEFENSE & EDUC. FUND, YOUTH IN THE MARGINS: A REPORT ON THE UNMET NEEDS OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER ADOLESCENTS IN FOSTER CARE*, 11 (2001), available at <http://www.jimcaseyouth.org/filedownload/266.>)).

6. N.Y. SOC. SERV. LAW § 398(6)(c) (McKinney 2011).

gender identity disorder (“GID”).⁷ As discussed later in this Comment, GID is a psychological condition with which some transgender youths are diagnosed due to the severe dissociation between their gender identities and physical sexes; physicians frequently deem treatment for GID (such as hormone therapy and sex-reassignment surgery) medically necessary for these young people.⁸

In 2008, the Legal Aid Society attempted to secure sex-reassignment surgery for a transgender girl in foster care.⁹ The subject child, Mariah L.,¹⁰ had received counseling from multiple psychologists, psychiatrists, and physicians, all of whom concluded that sex-reassignment surgery was medically necessary in her case.¹¹ The Appellate Division of the New York Supreme Court, however, concluded that the Family Court cannot order ACS to provide a specific medical treatment; ACS has ultimate discretion over the provision of medical care, and the only available remedy is an appeal to ACS itself.¹² *Mariah L.* thus left advocates fighting an uphill battle to secure appropriate medical care for transgender foster youth.¹³

On June 7, 2010, ACS instituted a new policy (the Non-Medicaid Reimbursable Policy, or “the Policy”) that ostensibly rectifies the unfortunate consequences of *Mariah L.*¹⁴ The Policy states in pertinent part that ACS may authorize payments for medically necessary treatment not covered by Medicaid.¹⁵ Any foster youth may inform their¹⁶ caseworker of the desired treatment, and the caseworker may file a request to ACS, which may provide treatment for which Medicaid will not pay.¹⁷ This policy at first appeared to be a victory for transgender rights: ACS no longer could simply deny care due to Medicaid’s failure to cover the costs of treatment. Nonetheless, the Policy requires the Deputy Commissioner of Children’s Services to approve any request for care, and grants the Deputy Commissioner absolute and unchecked power to veto any claim presented.¹⁸

7. N.Y. COMP. CODES R. & REGS. tit. 18 § 505.2(1) (2011) (“Payment is not available for care, services, drugs, or supplies rendered for the purpose of gender reassignment . . . or any care, services, drugs, or supplies intended to promote such treatment.”).

8. See, e.g., GIANNA E. ISRAEL & DONALD E. TARVER, *Transgender Youth*, in *TRANSGENER CARE* 132, 139 (1997).

9. Brian L. (*Mariah L.*) v. Admin. for Children’s Servs., 859 N.Y.S.2d 8 (App. Div. 2008) (holding that the regulation requiring ACS to provide medically necessary treatment does not demand ACS to provide sex-reassignment surgery) [hereinafter *Mariah L.*].

10. Most sources refer to the case as Brian L. and to the youth as Brian. Because the youth in question is a transgender girl, however, I will refer to her using her preferred name and pronoun throughout this Comment.

11. *Mariah L.*, 859 N.Y.S.2d at 12–13.

12. *Id.* at 19–20. Because a foster youth petitioner cannot appeal to the Family Court to receive medical care, the only available option is an Article 78 appeal to an agency decision (in this case, the Commissioner for Children’s Services). See N.Y. C.P.L.R. § 7801 (McKINNEY 2011).

13. See, e.g., Stern & Merkin, *supra* note 3. *Mariah L.* remains the leading case in this area. I use the term “transition-related care” to refer to hormone treatments, sex-reassignment surgery, and other medical treatments generally associated with the treatment of GID, especially as it relates to the physical transition from one sex to the other.

14. CITY OF NEW YORK ADMINISTRATION FOR CHILDREN’S SERVICES, POLICY NO. 2010/04: PROVISION OF NON-MEDICAID REIMBURSABLE TREATMENT OR SERVICES FOR YOUTH IN FOSTER CARE 1 (2010) [hereinafter *POLICY No. 2010/04*].

15. *Id.* (“This policy is intended to support the health and well-being of children and youth in foster care by establishing a clear and consistent mechanism for responding to requests for medical and mental health treatment or services that are not Medicaid reimbursable.”).

16. In this Comment, I will use gender-neutral plural pronouns in order to avoid assigning a gender to any real or hypothetical person.

17. *POLICY No. 2010/04*, *supra* note 14, at 2–3.

18. *Id.* at 6 (“Decisions regarding Children’s Services’ support for non-Medicaid reimbursable treatment or services will be made by the Deputy Commissioner of the Children’s Services Division under

In this Comment, I argue that the veto provision of the Policy rests on questionable legal grounds and must be amended in order to protect the rights of transgender youth in foster care. By focusing on a specific, local policy, I will explore possible legal remedies for a more general problem: the failure to provide sex-reassignment surgery and other medical treatments to transgender foster youth. Part II offers a brief explanation of terminology and describes the challenges facing transgender youth, with a focus on transgender youth in foster care. Part III examines *Mariah L. v. Administration for Children's Services* and its implications, and Part IV describes the Policy in detail. Part V argues that the veto clause itself is highly questionable under the Due Process Clause of the Federal Constitution. Finally, Part VI argues that a discriminatory application of the veto clause would violate the Equal Protection Clause of the Constitution.

II. TRANSGENDER YOUTH IN FOSTER CARE

A. TERMINOLOGY

“Transgender” is an umbrella term used to describe a person who expresses gender in a way that does not conform to prevailing societal expectations.¹⁹ Someone who is transgender may be gender non-conforming, genderqueer, a cross-dresser, a pre-operative or post-operative transsexual, or may express themselves in any number of non-stereotypical manners.²⁰ While American society generally operates under the assumption that sex and gender are binary – that there are only males and females, men and women – gender in fact encompasses a wide spectrum of possibilities and permutations.²¹ The term “gender expression” refers to a person’s gender-related appearances and behaviors.²² Gender expression may be fluid, and some people prefer not to confine themselves to one of two genders.²³ For other people, including many transgender people, gender expression is a more concrete personal characteristic that is not subject to many changes throughout the person’s life.

which case planning responsibility falls . . .”).

19. HUMAN RIGHTS CAMPAIGN FOUNDATION, *TRANSGENDER VISIBILITY: A GUIDE TO BEING YOU* 4 (2009), available at http://www.hrc.org/files/assets/resources/transgender_visibility_guide.pdf; *Answers to Your Questions About Transgender People, Gender Identity, and Gender Expression*, AMERICAN PSYCHOLOGICAL ASSOCIATION (2012), <http://www.apa.org/topics/sexuality/transgender.aspx>.

20. NAT’L CTR. FOR TRANSGENDER EQUALITY, *TRANSGENDER TERMINOLOGY 1* (May 2009), available at http://transequality.org/Resources/NCTE_TransTerminology.pdf. Some people include “intersex” within the umbrella definition of transgender. See NAT’L CTR. FOR TRANSGENDER EQUALITY, *supra*. Others, however, specifically reject including “intersex” within the term “transgender.” See Emi Koyama, *Is Gender Identity Disorder an Intersex Condition?*, INTERSEX INITIATIVE, <http://ipdx.org/articles/gid.html> (last visited Apr. 21, 2012). In my definition of “transgender” I therefore omit the term “intersex,” leaving it to reader discretion whether to include it in their own definition.

21. See, e.g., HUMAN RIGHTS CAMPAIGN FOUNDATION, *supra* note 19, at 2; Emi Koyama, *Suggestions to Improve “Queering Occupy Wall Street: Radical Language Road Guide,”* EMINISM.ORG (Nov. 6, 2011), <http://eminism.org/blog/entry/date/2011/11>.

22. See MARKSAMER ET AL., *supra* note 3, at 10.

23. *Id.*

There are different ways to frame what it means to be transgender. Some people find it helpful to distinguish between a person's sex and that person's gender. Sex refers to a person's physiological self, whereas gender, gender identity, or core gender refer to a deeply rooted sense of being either masculine or feminine – and as gender itself is a social construct, a gender-non-conforming person simply does not abide by society's expectations of a certain physical sex.²⁴ Under this definition, a cisgender person's gender identity conforms to the social expectations of their physical sex,²⁵ while, by contrast, a transgender person experiences discordance between their gender identity and the social expectations of their physical sex.²⁶ Other people do not find it helpful to distinguish between "sex" and "gender"; rather, these people would articulate "transgender" to mean that a transgender person does not conform to the gender role assigned to them at birth.²⁷

Some transgender people feel more strongly than others that they do not identify with their assigned sex. A deeply felt sense of being in the wrong body may be diagnosed as gender identity disorder.²⁸ A transgender person, especially with GID, may wish to "transition" physically to the gender they identify with; within this subset, a transgender girl, or male-to-female (MTF) person, is a person whose gender identity is female but whose physical sex is male, while a transgender boy (female-to-male, or FTM) is a person whose gender identity is male but whose physical sex is female.²⁹ Not everyone who is transgender has GID, but, as discussed *infra*, those who do have GID should receive proper and necessary treatment.

B. A HISTORY OF DISCRIMINATION AGAINST TRANSGENDER YOUTH

Studies estimate that transgender persons comprise 1% or less of the American population.³⁰ According to some scholars, the low proportion of transgender persons in the general population accounts for at least some of the prejudice against them because most people simply find it difficult to

24. MARKSAMER ET AL., *supra* note 3, at 10; HUMAN RIGHTS CAMPAIGN FOUNDATION *supra* note 19; Gender Equity Resource Center, *LGBT Resources – Definition of Terms*, http://geneq.berkeley.edu/lgbt_resources_definition_of_terms#transgender (last visited Mar. 14, 2012).

25. See, e.g., *Cisgender (adj.)*, QUEERDICTIONARY.COM (Aug. 20, 2011, 10:22 pm), <http://queerdictionary.tumblr.com/post/9264228131/cisgender-adj>.

26. See, e.g., MARKSAMER ET AL., *supra* note 3, at 10; Gender Equity Resource Center, *supra* note 24.

27. See Asher, *Not Your Mom's Trans 101*, TRANARCHISM (Nov. 26, 2010), <http://tranarchism.com/2010/11/26/not-your-moms-trans-101/>; Jodi Marksamer & Dylan Vade, *TRANS 101*, SYLVIA RIVERA LAW PROJECT, <http://srlp.org/trans-101> (last visited Apr. 21, 2012).

28. DSM-IV-TR, *supra* note 4, at 576. When I describe certain transgender persons as having GID, it is not a statement that transgender persons necessarily suffer from some psychological problem because they do not identify with their physical sex. I utilize the medical term of GID merely because the diagnosis allows the transgender community to assert arguments in favor of receiving transition-related care. This is not a statement on the controversy over whether or not GID should continue to be included in the DSM-IV-TR; it is a utilization of the current state of the law and of medicine to assert legal arguments.

29. MARKSAMER ET AL., *supra* note 3, at 10.

30. See David Badash, *Study Shows How Many Americans Identify as Gay, Lesbian, Bisexual, Transgender*, THE NEW CIVIL RIGHTS MOVEMENT (Apr. 27, 2011), <http://thenewcivilrightsmovement.com/study-shows-how-many-americans-are-gay-lesbian-bisexual-transgender/news/2011/04/07/18551> (stating that a new study by The Williams Institute of UCLA estimates that 0.3% of Americans identify as transgender); NAT'L CTR FOR TRANSGENDER EQUALITY, UNDERSTANDING TRANSGENDER: FREQUENTLY ASKED QUESTIONS ABOUT TRANSGENDER PEOPLE 1 (2009), available at http://transequality.org/Resources/NCTE_UnderstandingTrans.pdf (estimating that between .25% and 1% of people in the United States are transsexual).

relate to transgender persons.³¹ Many parents of transgender children find it difficult to support their children, which researchers have attributed to a lack of understanding of how it is possible for a person's gender identity not to match their physical body.³² Parents generally expect their child to behave in a certain way; for instance, a child who was designated as a girl on her birth certificate should "act like a girl" throughout their entire life. When a child fails to conform to such expectations, many parents (and other family members) become upset and embarrassed³³:

[My mother] first tried to get me to agree to go to see a psychologist to see if I could change . . . Then she got really worried that I might tell other people, you know, the neighbors, other relatives. She said, 'If that's your lifestyle fine, but please don't go around and announce it to everybody.' . . . I wished that she had been able to be more supportive of me.³⁴

Parents often reject their transgender child, or even neglect or abuse their child: "[My father] started slapping me . . . He told me to get the hell out of his house and literally threw me out the front door."³⁵

Statistics on violence in the home against lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people, especially transgender people, are staggering. One study reported that 34% of lesbians and 33% of gay men suffered physical violence at the hands of family members because of their families' reactions to their sexual orientation.³⁶ According to another study, 62% of gay and transgender youth suffer intolerance and abandonment from their families, compared with 30% of heterosexual, cisgender youth.³⁷ Transgender youth endure a significant amount of rejection, neglect, and abuse at home, and even find themselves turned away from their homes entirely.

In New York City, when the Administration for Children's Services suspects that children or youth are neglected or abused, it may remove them from their homes and place them in the foster care system.³⁸ Because so many transgender

31. See Kenji Yoshino, *The New Equal Protection*, 124 HARV. L. REV. 747, 751 (2011) (attributing a great deal of discrimination in American society to pluralism anxiety stemming from "new" groups or "newly visible" groups). The low numbers of transgender persons, along with this inherent prejudice, also helps to explain the relative political powerlessness of transgender persons, which is discussed in Part VI(B), *infra*. It bears notice, however, that not all advocates agree that the pervasive discrimination against transgender people stems from these low numbers. Some scholars argue that the power structure (giving cisgender people more power than transgender people) in American society depends on a coercively enforced gender binary system. See JOEY L. MOGUL, ANDREA RITCHIE, & KAY WHITLOCK, INTRODUCTION TO QUEER (IN)JUSTICE: THE CRIMINALIZATION OF LGBT PEOPLE IN THE UNITED STATES xiii (2011).

32. DECRESCENZO & MALLON, *supra* note 5, at 10; MARKSAMER ET AL., *supra* note 3, at 18; SHANNON WILBER, CAITLIN RYAN, & JODY MARKSAMER, CHILD WELFARE LEAGUE OF AMERICA, CWLA BEST PRACTICE GUIDELINES (2006), available at <http://www.nclrights.org/site/DocServer/bestpracticeslgbtyouth.pdf?docID=1322>.

33. MARKSAMER ET AL., *supra* note 3, at 18.

34. MALLON, *supra* note 5, at 41 (quoting "Maurice").

35. *Id.* at 50 (quoting "José").

36. SULLIVAN ET AL., *supra* note 5, at 11.

37. *Gay and Transgender Youth Homelessness by the Numbers*, CTR. FOR AM. PROGRESS (June 21, 2010) http://www.americanprogress.org/issues/2010/06/homelessness_numbers.html.

38. ACS may file a petition to place into foster care a child who it suspects is neglected or abused. N.Y. FAM. CT. ACT §§ 1022–1024 (McKinney 2011) (giving ACS the power for emergency removals, temporary removals, and petitions for court orders); New York State Unified Court System, *New York Family Court: Abused or Neglected Children (Child Protective Proceeding)* (Feb. 10, 2012), http://www.nycourts.gov/courts/nyc/family/faqs_abusedchildren.shtml. Youth who are repeatedly absent from school may be petitioned into the foster care system as Persons in Need of Supervision (PINS). N.Y. FAM. CT. ACT § 732 (McKinney

youth suffer neglect and abuse at home, and/or become homeless due to family rejection, a disproportionate number of these young people are placed in foster care.³⁹ ACS is required to keep the youth safe until the situation at home is stable, until the youth is adopted, or until the youth reaches the age of maturity.⁴⁰ ACS assigns each youth a caseworker and/or foster care social worker who is responsible for ensuring that the foster child is placed in an appropriate home and receives proper care.⁴¹ A foster youth may be placed in a group home (a dormitory-style living situation) or with a foster family.⁴² Group homes are directed by independent agencies that contract their services with ACS, which technically remains the youth's legal guardian.⁴³

ACS repeatedly has failed in its duty to keep LGBTQ youth safe, and in fact has harassed and abused those under its guardianship. According to one survey, 100% of LGBTQ youth in New York City's group homes experienced harassment on the basis of sexual orientation and/or gender identity, and 70% of these youth reported physical violence on that basis.⁴⁴ Another study indicates that 78% of gay and transgender youth in New York City's foster care system were either removed or ran away from their placements due to conflicts and discrimination arising from their sexual orientation and/or gender identity.⁴⁵ As one transgender youth stated, "I came in to the detention center dressed as I always did, and they ripped the weave out of my hair, broke off my nails, wiped my makeup off, stripped me of my undergarments . . ." ⁴⁶ And when another transgender girl told her social worker that she was being physically beaten in her group home, the social worker replied, "It's your fault. Stop acting like a girl."⁴⁷

In 1996, ACS was sued by a class of LGBTQ children in foster care who alleged that they were victims of bias-related violence and harassment at the hands of other foster youth and of the New York City and State officials responsible

2010). A parent or guardian also may file a voluntary petition to place their child into the foster care system without needing ACS to file a neglect or abuse petition. N.Y. Soc. SERV. LAW § 384-a (McKinney 2011).

39. E.g., Rudy Estrada & Jody Marksamer, *Lesbian, Gay, Bisexual and Transgender Young People in State Custody: Making the Child Welfare and Juvenile Justice Systems Safe for All Youth Through Litigation, Advocacy, and Education*, 79 TEMP. L. REV. 415, 420 (2006); WILBER ET AL., *supra* note 32, at 3.

40. N.Y. FAM. CT. ACT § 1011 (McKinney 2011) ("This Article is designed to establish procedures to help protect children from injury or mistreatment and to help safeguard their physical, mental, and emotional well-being."); N.Y. Soc. SERV. LAW § 398(h) (McKinney 2011) (The commissioner of public welfare shall "[s]upervise children who have been cared for away from their families until such children become twenty-one years of age or until they are discharged to their own parents, relatives within the third degree or guardians, or adopted . . .").

41. See N.Y. CITY ADMIN. FOR CHILDREN'S SERVS., CHILDREN'S RIGHTS: QUESTIONS AND ANSWERS FOR YOUNG PEOPLE GOING INTO FOSTER CARE (August 2007), available at http://www.nyc.gov/html/acs/downloads/pdf/children_rights_english.pdf.

42. *Id.*

43. N.Y. Soc. SERV. LAW § 383-c (McKinney 2011); N.Y. CITY ADMIN. FOR CHILDREN'S SERVS. OFFICE OF COMMUNICATIONS, NYC ADMINISTRATION FOR CHILDREN'S SERVICES 8, 22 (Feb. 2006), available at http://www.nyc.gov/html/acs/downloads/pdf/pub_intro_acs_06.pdf (stating that ACS and its contract nonprofits provide foster care services and listing ACS's contract agencies).

44. NAT'L CTR. FOR LESBIAN RIGHTS, LGBTQ YOUTH IN THE CALIFORNIA FOSTER CARE SYSTEM: A QUESTION AND ANSWER GUIDE 1 (2006), available at http://www.allyaction.org/s/341/images/editor_documents/content/ResearchCheck%20back%20often%20for%20the%20latest%20research%20and%20facts%20o/lgbtqfostercare%20factsheetnclr.pdf.

45. CTR. FOR AM. PROGRESS, *supra* note 37.

46. MARKSAMER ET AL., *supra* note 3, at 7 (quoting Mariah, a transgender youth).

47. WILBER ET AL., *supra* note 32, at 7.

for them.⁴⁸ ACS settled the case, but did not change its policies significantly.⁴⁹ Despite its obligation to keep children safe, ACS has turned a blind eye to a great deal of harm befalling transgender youth in its care.⁵⁰ These instances of harm suffered by transgender youth illustrate that ACS has failed and continues to fail in its duty to protect transgender youth and thereby discriminates against them.

C. THE IMPORTANCE OF MEDICAL NECESSITY

Being constantly harassed and put down simply for being oneself is stressful for anyone, and is particularly so for people who already feel uncomfortable in their own bodies. Accordingly, transgender adolescents are likely to suffer from anxiety, depression, or suicidal ideation.⁵¹ Transgender youth also are at high risk for substance abuse, and it has been reported that 55% of students harassed on the basis of sexual orientation have experienced feelings of hopelessness to such an extent that they stopped participating in their usual activities for at least two weeks.⁵² Because transgender youth experience at least as much harassment as LGB students, it is likely that they experience similar feelings of distress.⁵³ The American Psychological Association's ("APA") Diagnostic and Statistical Manual ("DSM-IV") expressly notes that profound GID⁵⁴ can result in such distress that it interferes with daily functioning.⁵⁵ It is common for transgender youth, especially those going through puberty, to attempt self-harm: transgender boys have been known physically to pound in their developing

48. *Marisol A. v. Giuliani*, 929 F. Supp. 662, 669–70 (S.D.N.Y. 1996), *aff'd* 126 F.3d 372 (2d Cir. 1997) ("The factual allegations of the complaint portray a child welfare program in crisis and collectively suggest systemic deficiencies of gross proportions. The eleven children who seek to represent the proposed class have endured a wide range of abuses and all reflect the dire situation facing children in the system.").

49. *See Stern & Merkin*, *supra* note 3, at 577.

50. *See, e.g., Doe v. Bell*, 754 N.Y.S.2d 846 (2003) (striking down group home policy post-Marisol preventing transgender girl from dressing according to her gender identity); Lawyers for Children, *Special Project on Behalf of Lesbian, Gay, Bisexual, Transgender & Questioning Youth in Foster Care*, <http://www.lawyersforchildren.org/sitecontent.cfm?page=whatwedo-gaylesbian> (last visited Mar. 14, 2012) (describing how one transgender youth, post-Marisol, was harassed by her group home staff and prevented from contacting her lawyer); Sylvia Rivera Law Project, *Landmark Foster Care Case: Jean Doe vs. Bell*, <http://srjp.org/doebell> (last visited Mar. 14, 2012) ("The petitioner in this case is not alone in her experience as a transgender youth living in unsafe conditions. SLRP sees many transgender youth who are put in a place where they can't survive, where they are abused by residents and staff and where the system ignores and condones their abuse.").

51. *See, e.g., DSM-IV-TR*, *supra* note 4, at 578 (stating that children presenting with GID may manifest separation anxiety disorder, generalized anxiety disorder, and symptoms of depression; that adolescents are at risk for depression and suicide; and that personality disorders are relatively common among young people with GID); Brian J. Flynn, *LGBT Communities and Health Care*, in GERALD P. MALLON, SOCIAL WORK PRACTICE WITH LESBIAN, GAY, BISEXUAL AND TRANSGENDER PEOPLE 331 (Gerald P. Mallon, ed., 2d ed. 2008).

52. MOLLY O'SHAUGHNESSY ET AL., CAL. SAFE SCH. COAL. & 4-H CTR. FOR YOUTH DEV., UNIV. OF CAL., DAVIS 8 (2004), available at <http://www.CASafeSchools.org/SafePlacetoLearnLow.pdf>; *see also* MARKSAMER ET AL., *supra* note 3, at 20.

53. *See, e.g., BRIAN JUCHEMS, GAY-STRAIGHT ALLIANCE FOR SAFE SCHOOLS, MAKE IT BETTER: PROMOTING SAFETY FOR TARGETS OF ANTI-LGBT BULLYING*, available at <http://dpi.wi.gov/sspw/ppt/s3makeitbetter.ppt>.

54. "Profound GID" is a clinical term used to describe transsexualism, or GID that is so severe it should be treated with sex-reassignment surgery. *See, e.g., WALTER MEYER III, ET AL., THE HARRY BENJAMIN INT'L GENDER DYSPHORIA ASS'N, STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS* (6th ed. 2001), available at http://www.transgendercare.com/guidance/resources/hbigda01/hbigda01_10.htm ("In persons diagnosed with transsexualism or profound GID, sex-reassignment surgery . . . is a treatment proven to be effective.").

55. *DSM-IV-TR*, *supra* note 4, at 577.

breasts, and transgender girls have reported attempting self castration.⁵⁶ The psychological effects of GID, and of being transgender in a cisnormative world more generally, are not to be taken lightly.

The harrowing circumstances that transgender youth, especially transgender youth in foster care, face every day contribute to their need for transition-related medical treatment.⁵⁷ For a person with profound GID, treatment addresses both the primary need to feel comfortable in their own skin and the secondary need to mitigate the anxiety, depression, and suicidal ideation that result from living in a hostile environment. Because of the seriousness of these needs, nearly all reputable medical associations recognize GID as a genuine disorder, and recommend a system of hormone therapy and sexual reassignment surgery to treat the disorder and its accompanying effects.⁵⁸ As one study states, “SRS [sexual reassignment surgery] and hormonal treatments are an effective way to alleviate the chronic embodied distress that transsexuals experience. Indeed, it is often disastrous should their somatic incongruency not be addressed by the health care system.”⁵⁹ Hormone therapy and sex-reassignment surgery are also considered the most appropriate treatment for GID in youth; guidelines for treating transgender youth often recommend hormone therapy to delay the onset of puberty, and in some cases also recommend sex-reassignment surgery.⁶⁰ In a recent case, *Re Alex*, an Australian court allowed a transgender boy in foster care to receive sex-reassignment surgery because of the severity of his psychological distress and because of the importance of receiving the treatment while he was young.⁶¹

Unfortunately, New York State’s Medicaid laws specifically exclude transition-related treatment from coverage.⁶² This exclusion at the state level not only

56. DECRESCENZO & MALLON, *supra* note 5, at 7; *MSNBC Documentaries: Born in the Wrong Body*, MSNB (May 3, 2007), http://www.msnbc.msn.com/id/18250458/ns/msnbc_tv-documentaries/t/born-wrong-body/ (last visited Sept. 19, 2011).

57. I use the term “transition-related care” to refer to medical care such as hormone therapy and sex-reassignment surgery designed to assist a transgender person with GID in transitioning to the appropriate physical sex.

58. *E.g.*, MEYER ET AL., *supra* note 54 at 9–11; Linda J. Vorvick, Michelle Bengner Merrill, & David Zieve, *Gender Identity Disorder: Transsexualism*, in A.D.A.M. MEDICAL ENCYCLOPEDIA 2010 (U.S. NATIONAL LIBRARY OF MEDICINE, PUBMED HEALTH 2012), available at <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002495/>; Barry S. Anton, *Proceedings of the American Psychological Association for the Legislative Year 2008: Minutes of the Annual Meeting of the Council of Representatives, Feb. 22–24, 2008, Washington, D.C., & Aug. 13 and 17, 2008, Boston, MA. & Minutes of the Feb., Jun., Aug., & Dec. 2008 Meetings*, 64 AM. PSYCHOLOGIST 372 (2008) [hereinafter APA Proceedings], available at <http://www.apa.org/about/governance/council/policy/transgender.aspx>; AMERICAN MEDICAL ASSOCIATION, Res. 122, A–08, available at <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbst-advisory-committee/ama-policy-regarding-sexual-orientation.page> (“Our AMA supports public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient’s physician.”).

59. CHRISTOPHER A. SHELLEY, *TRANSPeOPLE: REPUDIATION, TRAUMA, HEALING* (2008) (citing Anne Lawrence, *Transsexual Surgery: Its Pros and Cons* (2000) (Comprehensive Exam essay, Institute for Advanced Study of Human Sexuality), available at http://www.starbacks.ca/WestHollywood/1497/htmlpostings/transsexual_surgery_its_pros_and_cons.htm).

60. ISRAEL & TARVER, *supra* note 8, at 139–40.

61. *Re Alex* (2004) 180 Fam LR 89, ¶ 169 (Austl.), available at http://www.austlii.edu.au/au/cases/cth/family_ct/2004/297.html (allowing female-to-male transgender teenager to undergo hormone treatment because of the emotional discomfort and social adjustment problems the child experienced when forced to live as a girl).

62. N.Y. COMP. CODES R. & REGS. tit. 18 § 505.2(1) (2011) (“Payment [of Medicaid funds] is not available for care, services, drugs, or supplies rendered for the purpose of gender reassignment . . . or any care, services, drugs, or supplies intended to promote such treatment.”). Advocates have been working to change this regulation, although thus far the exclusion still stands. *See, e.g.*, DR. JO REES & DR. REBECCA RIVERA-MAESTRE, SYLVIA RIVERA LAW PROJECT, TRANS FOCUS GROUP RESEARCH (2009–2010) (Nov. 2010), available at <http://srlp.org/files/Medicaid%20Focus%20Group%20Report%202009-2010.pdf>; Pooja

illustrates a deeply embedded antipathy towards transgender people, but also has allowed ACS to justify discriminating against transgender youth in terms of health care access.⁶³ At the same time, the New York State Social Services Law requires ACS to provide “necessary medical or surgical care” to all youth in its custody, either through its own funds or through Medicaid.⁶⁴ Because of the significant benefits hormone therapy and sex-reassignment surgery offer transgender youth with GID, transition-related care is, or ought to be, considered medically necessary within the meaning of the Social Services Law.

First, transition-related treatment should be considered “medically necessary” under the language of the statute. The state’s Medicaid laws define “medically necessary” to mean “necessary to prevent, diagnose, correct or cure a condition” in order to “restore the recipient to his or her best possible functional level; or improve the recipient’s capacity for normal activity.”⁶⁵ Hormone therapy and sex-reassignment surgery are the best means proven to correct the feeling of disconnect between gender identity and physical body for transgender people with profound GID.⁶⁶ Intuitively, rectifying this disconnect is the best way to restore a transgender person’s ability to complete their daily activities, like attending school or work, at a normal level of functioning. Under a plain reading of the statute, then, transition-related care should qualify as “medically necessary” within the meaning of the Medicaid law, supporting the proposition that it should also qualify as necessary under the Social Services Law.

Case law also indicates that transition-related care is, or should be, considered “medically necessary” under the New York State Social Services Law, which regulates – among other public assistance services – the child welfare system. Courts have implemented two tests for the determination of medical necessity that would include transition-related care. First, a procedure is sometimes deemed “medically necessary” if the treating physician determines so. For instance, in *Donovan v. Cuomo*, the Appellate Division of the New York Supreme Court declared that “the judgment as to whether an abortion is medically necessary is for the attending physician to make.”⁶⁷ The court thereby concluded that the physician’s statement of medical necessity regarding an abortion is prima facie evidence that the abortion is medically necessary for purposes of Medicaid coverage.⁶⁸ The Eighth Circuit Court of Appeals similarly has held that denial

Gehi & Lauren Jones, *In Defense of Basic Health Care for Transgender New Yorkers*, HOUSINGWORKS (Oct. 18, 2011), <http://www.housingworks.org/advocate/detail/in-defense-of-basic-health-care-for-transgender-new-yorkers>.

63. See *Mariah L. v. Admin. for Children’s Servs.*, 859 N.Y.S.2d 8, 13 (App. Div. 2008) (“ACS opposed the motion [to provide sex-reassignment surgery] on the ground that it was only permitted to pay for medical treatments approved by Medicaid law and that Medicaid law prohibited payment for sex reassignment surgery.”).

64. N.Y. SOC. SERV. LAW § 398(6)(c) (McKinney 2011) (ACS has a duty to “provide necessary medical or surgical care . . . and pay for such care from public funds, if necessary.”).

65. N.Y. COMP. CODES R. & REGS. tit. 18 § 513.1(c) (2011).

66. *E.g.*, SHELLEY, *supra* note 59; see ISRAEL & TARVER, *supra* note 8. This is not to preclude other methods of treating GID; for some, hormone therapy and sex-reassignment surgery may not be helpful or necessary, and many people prefer not to receive complicated treatment. Today’s medical standards, however, are quite clear that the only scientifically proven way to relieve the distress caused by GID is through hormone treatment and surgery.

67. *Donovan v. Cuomo*, 513 N.Y.S.2d 878, 881 (App. Div. 1987) (citing *Doe v. Bolton*, 410 U.S. 179, 192 (1973)).

68. *Id.* at 882 (citing *City of New York v. Wyman*, 37 A.D.2d 700, 322 N.Y.S.2d 952 (App. Div. 1972), *rev’d*, 30 N.Y.2d 537, 330 N.Y.S.2d 385 (“An abortion is medically indicated [for Medicaid purposes] when the examining physician determines that it is an advisable procedure to preserve the life or health of the

of Medicaid coverage for sex-reassignment surgery violates the Medicaid non-discrimination clause because the determination of medical necessity should be made between the patient and the physician.⁶⁹ If the physicians of transgender foster youth determine that transition-related care is medically necessary,⁷⁰ then some jurisdictions would deem such care “medically necessary.”

Second, New York courts have determined that a service may qualify as “medically necessary” within the State Medicaid statute if the service would greatly assist the beneficiary and if there are no less costly alternatives.⁷¹ This definition has been sufficient to provide a quadriplegic Medicaid recipient with an EasyStand to aid in his walking.⁷² Another definition, used in the private sector as a necessary (but not sufficient) condition for meeting the definition of medical necessity, is that the services must be consistent with accepted medical and professional practice.⁷³ Since hormone therapy and sex-reassignment surgery are the best methods shown to improve the functioning of persons with profound GID, transition-related care is both the least costly alternative and the treatment agreed upon by the medical community.⁷⁴ Transition-related care for youth with profound GID thus should pass both of the above tests.

The New York County Supreme Court has specifically stated in at least one case that sex-reassignment surgery is “medically necessary” for a person with profound GID. In *Davidson v. Aetna Life & Casualty Insurance Company*, a transgender woman whose health insurance was administered by Aetna sought treatment for GID and asked Aetna to cover her sex-reassignment surgery.⁷⁵ Aetna claimed the surgery was “cosmetic” and therefore ineligible for coverage.⁷⁶ In reply, the court stated, “Cosmetic surgery is surgery which is deemed optional or elective. The papers submitted on behalf of the plaintiff indicate that in order for the plaintiff to live a normal life, sex-reassignment surgery is imperative and necessary.”⁷⁷ Although this analysis related to a specific private insurance policy, the court’s essential holding still implies that transition-related care for persons with profound GID should be considered medically necessary within the meaning of the Social Services Law.

expectant mother. It is not medically indicated when the pregnant woman undergoes it because she does not, for any other reason, desire to bear a child.”). *Donovan* is not a perfect analogy to the case at hand, since it refers to N.Y. Soc. SERV. LAW § 365-a (McKinney 2011) rather than § 398, and because abortion is a recognized fundamental right (which likely changes the analysis). However, the Medicaid laws are similar enough to draw a reasonable parallel.

69. *Pinnecke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980).

70. *See* *Mariah L. v. Admin. for Children’s Servs.*, 859 N.Y.S.2d 8, 12–15 (App. Div. 2008) (illustrating an instance where physicians of a transgender youth determined that transition-related care was medically necessary).

71. *Layer v. Novello*, 795 N.Y.S.2d 810, 811 (App. Div. 2005).

72. *Id.*

73. *CityWide Soc. Work & Psy. Serv., P.L.L.C. v. Travelers Indem. Co.*, 777 N.Y.S.2d 241, 243 (Civ. Ct. 2004).

74. *See generally* ISRAEL & TARVER, *supra* note 8, at 140; SHELLEY, *supra* note 59, at 64–65. By being the least costly alternative, transition-related care satisfies the *Layer* test, and by being the treatment agreed upon by the medical community it satisfies the *CityWide* test.

75. *Davidson v. Aetna Life & Cas. Ins. Co.*, 420 N.Y.S.2d 450, 451 (Sup. Ct. 1979).

76. *Id.* at 452.

77. *Id.* at 454.

III. MARIAH L. v. ADMINISTRATION FOR CHILDREN'S SERVICES

As discussed, under Social Services Law § 398(6)(c), ACS has a duty to provide medically necessary care to all foster youth.⁷⁸ Historically, however, transgender youth have been precluded from receiving transition-related care because of the Medicaid exclusion clause.⁷⁹ In 2004, a transgender young woman in foster care, Mariah L., attempted to secure sex-reassignment surgery as a medically necessary treatment for her GID and to have ACS provide it through its own funds as required by the Social Services Law.⁸⁰ ACS had Mariah evaluated by four experts in treatment and diagnosis of GID, and all four agreed that sex-reassignment surgery was medically necessary in her case.⁸¹ When Mariah requested that ACS arrange the surgery, ACS refused.⁸² The resulting case, *Mariah L. v. Administration for Children's Services*, reached the Appellate Division in 2008 and became the landmark case defining ACS's duties regarding the medical needs of transgender youth in foster care.

Mariah argued that ACS was required to pay for her surgery under Social Services Law § 398.⁸³ ACS responded that it is precluded from paying for sex-reassignment surgery because Medicaid will not cover it.⁸⁴ Furthermore, ACS stated that even if it could provide such care, it would not do so because Mariah had not satisfied certain eligibility requirements for the surgery⁸⁵ – namely, the Harry Benjamin standards promulgated by the World Professional Association for Transgender Health (“WPATH”), which require that a person be of a certain minimum age, have lived as the other sex for at least one year, and understand the nature of the surgery.⁸⁶ Mariah, though, in fact did meet the Harry Benjamin standards.⁸⁷ Mariah began living as a female around three years before requesting her surgery, fulfilling one of the Harry Benjamin requirements.⁸⁸ Furthermore, Mariah was a legal adult at the time she requested ACS to provide sex-reassignment surgery for her.⁸⁹ After being evaluated by qualified physicians and therapists, the experts determined that “Mariah [was] a fully prepared surgical candidate for sex-reassignment surgery . . . [S]he expresse[d] being clear about what the surgery can and cannot do for her.”⁹⁰ All four doctors who evaluated her in relation to her request for surgery stated that her insight into the surgery was satisfactory.⁹¹ Although several therapists noted that Mariah suffered from some psychological disorders and lacked complete insight, they

78. N.Y. SOC. SERV. LAW § 398(6)(c) (McKinney 2011) (ACS has a duty to “provide necessary medical or surgical care . . . and pay for such care through public funds, if necessary.”).

79. N.Y. COMP. CODES R. & REGS. tit. 18 § 505.2(1) (2011) (“Payment [of Medicaid funds] is not available for care, services, drugs, or supplies rendered for the purpose of gender reassignment . . . or any care, services, drugs, or supplies intended to promote such treatment.”).

80. Stern & Merkine, *supra* note 3, at 576–78.

81. *Id.*

82. *Id.* at 578.

83. N.Y. SOC. SERV. LAW § 398(6)(c); *Mariah L. v. Admin. for Children's Servs.*, 859 N.Y.S.2d 8, 14 (App. Div. 2008).

84. N.Y. COMP. CODES R. & REGS. tit. 18 § 505.2(1) (2011); *Mariah L.*, 859 N.Y.S.2d at 13.

85. *Mariah L.*, 859 N.Y.S.2d at 13.

86. MEYER ET AL., *supra* note 54, at 575.

87. Stern & Merkine, *supra* note 3, at 577–78.

88. *Id.* at 575; MEYER ET AL., *supra* note 54, at 575.

89. Stern & Merkine, *supra* note 3, at 577.

90. *Id.*

91. *Id.* at 577–78.

did not see these as reasons to deny surgery.⁹² In fact, as previously discussed, symptoms such as anxiety and depression in transgender youth are often due to the stress of the incongruity between their core gender and their physical sex, and such symptoms can be relieved through transition-related treatment.⁹³ Mariah satisfied the Harry Benjamin standards to the fullest extent possible. Nonetheless, the Assistant Commissioner of ACS claimed that Mariah

simply has not demonstrated the kind of serious, thoughtful, and committed approach that would, as a matter of basic logic, be expected of anyone appropriately planning for this type of fundamental and serious surgical process. Rather, she has behaved in a manner that is indecisive, unstable, and self-defeating, and has been all but impossible to engage in meaningful planning on this or any other vital issue. . . . [None of the psychologists' recommendations] indicate that [Mariah] has either knowledge of the costs, procedures, and complications of various surgical approaches to the surgery . . . or that she has given any thought or shown any awareness of different competent surgeons.⁹⁴

The court credited ACS's justification to refuse to provide sex-reassignment surgery to Mariah, despite the ACS-sponsored expert testimony indicating it was necessary for her. By accepting ACS's argument, the *Mariah L.* court illustrated its conformity to a common bias among legal authorities: that those who do not adhere to the gender binary must instead adhere to a specific transgender narrative.⁹⁵ The court may have been more easily persuaded by ACS's argument because Mariah did not entirely conform to the court's vision of what a transgender girl requesting surgery should be. The court's endorsement of ACS's argument also illustrates the vast power the court granted to ACS in *Mariah L.* As discussed below, the court read the Social Services Law as granting ACS the authority over the provision of medical care to foster youth.⁹⁶ Thus, ACS does not need to justify to any other authority its decisions whether to provide medical care. As Mariah's claim for sex-reassignment surgery was objectively quite strong, ACS essentially indicated that, given the authority to grant or deny transition-related care for foster youth, it would always choose to deny it.

Mariah also argued that §§ 255 and 1015-a of the Family Court Act empower the Family Court to order ACS to provide medically necessary transition-related care.⁹⁷ The *Mariah L.* court, however, held that a regulation cannot

92. *Id.*

93. See generally DSM-IV-TR, *supra* note 4, at 578.

94. *Mariah L.*, 859 N.Y.S. 2d at 14.

95. See, e.g., Dean Spade, *Resisting Medicine, Re/Modeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 19–21 (2003) (describing the narrative transgender people must tell in order to convince the medical authorities that they need treatment).

96. *Id.* at 19–20 (“As section 441.22(g) would be ‘out of harmony’ with Social Services Law § 398 (6) (c) to the extent the regulation purported to substitute the discretion of a foster child’s physician for the public officer charged with responsibility for ensuring that the child receives necessary medical and surgical care, the statute prevails”).

97. *Id.* at 16; see also N.Y. FAM. CT. ACT § 255 (McKinney 2008) (“It is hereby made the duty of, and the family court or a judge thereof may order, any state, county, municipal and school district officer and employee to render such assistance and cooperation as shall be within his legal authority, as may be required, to further the objects of this act”); N.Y. FAM. CT. ACT § 1015-a (McKinney 2009) (“In any proceeding under this Article, the court may order a social services official to provide or arrange for the provision of services or assistance to the child . . . to facilitate the protection of the child”). Section 1015-a also states, however, that an “order shall not include the provision of any service or assistance to the child and his or her family which is not authorized or required to be made available pursuant to the comprehensive annual services program” The *Mariah L.* court found the Section 1015 argument to

be interpreted to be “out of harmony” with a State statute⁹⁸ – here, the State Social Services statute granting ACS authority to provide medical care to foster youth.⁹⁹ Holding that the Family Court does not have the power to compel ACS to provide medical services that are not authorized under the annual services plan, the court denied Mariah’s motion to order ACS to provide her sex-reassignment surgery.¹⁰⁰

The *Mariah L.* decision grants ACS an immense amount of discretion to determine which medical procedures it will provide to foster youth. According to the court, Social Services Law § 398 requires ACS to provide medical care, but it also “confer[s] upon . . . the Commissioner of ACS . . . the authority and responsibility to provide necessary medical and surgical care to children in [its] care.”¹⁰¹ After *Mariah L.*, ACS has the ultimate authority to decide what care to provide foster youth and the Family Court cannot order ACS to provide a specific medical treatment or procedure.¹⁰²

IV. THE NON-MEDICAID REIMBURSABLE POLICY

With vast discretion to deny care, and without any oversight by the Family Court, ACS’s argument in *Mariah L.* ominously predicts the application of the Policy. ACS has complete discretion over the provision of transition-related care, and any external check on its use (or abuse) of such power is extremely limited.¹⁰³ Thus, even if a transgender foster youth fulfills the criteria in the Policy, ACS still may deny the provision of care.

Having filed a complex amicus brief in *Mariah L.*, local and national youth advocacy groups and LGBT organizations viewed the case’s outcome as a devastating blow to transgender rights.¹⁰⁴ In light of the barriers to health care erected by *Mariah L.*, direct services and advocacy organizations emphasized to ACS the importance of medical care for transgender youth, clarified that they would fight to secure appropriate medical care for transgender foster youth, and stated in no uncertain terms that the unequal treatment of transgender youth is a form of unlawful discrimination.¹⁰⁵ Two years after the *Mariah L.* decision,

be fairly weak because the provision of transition-related care is not covered by Medicaid and therefore falls within this exception. *Mariah L.*, 859 N.Y.S.2d at 19–20.

98. *Mariah L.*, 859 N.Y.S.2d at 19.

99. *Id.* at 17–19. Social Services Law § 398, according to the *Mariah L.* court, grants ACS discretion to provide medical care and requires ACS to provide all necessary medical treatment, whereas N.Y. FAM. CT. ACT §§ 255 and 1015-a state that the family court may order ACS to render assistance to any child under the Court’s jurisdiction. In essence, the Court in this section states that the state Social Services law trumps the Family Court Act through principles of federalism.

100. *Mariah L.*, 859 N.Y.S.2d. at 20.

101. *Id.*

102. *Id.* Notably, the court did *not* grant ACS the ability to determine what is “medically necessary” under Social Services Law § 398. The court merely stated that, though ACS has a duty to provide care, ACS also has the authority to decide what care it will provide.

103. If the Family Court cannot check ACS’s use of power, then a foster youth denied care may have recourse under Article 78 of the New York Civil Practice Law and Rules. *See* N.Y. C.P.L.R. § 7801 (McKINNEY 2011).

104. Brief for the Children’s Law Center for Los Angeles, et al. as Amici Curiae Supporting Petitioner, *Mariah L. v. Admin. for Children’s Servs.*, 859 N.Y.S.2d 8 (App. Div. 2008) (No. K-1154/96).

105. *See, e.g.*, SYLVIA RIVERA LAW PROJECT, TRANSGENER YOUTH IN FOSTER CARE, available at <http://srp.org/files/kyr%20foster%20care%20eng-.pdf> (stating that transgender youth have the right to receive transition-related health care and that a youth who is denied appropriate medical care should call his/her attorney, or the Sylvia Rivera Law Project); Kristin Kimmel, LGBTQ Training for Lawyers for Children

ACS instituted the Non-Medicaid Reimbursable Policy, purportedly to conform to the statutory mandate to provide medical care and to rectify the injustice to transgender youth that *Mariah L.* sanctioned: “Informed by comments we received from provider agencies and advocates, Children’s Services is releasing the final policy on Provision of Non-Medicaid Reimbursable Treatment”¹⁰⁶ The Policy creates a method by which caseworkers can request that ACS pay for health care that is excluded from Medicaid coverage; it specifically lists “gender affirming healthcare associated with Gender Identity Disorder” as one of the conditions for which the Policy may be utilized.¹⁰⁷

The Policy, however, actually ratifies ACS’s ability to discriminate against transgender youth. It consists of a facially neutral process by which foster youth may petition for medical care. The foster care agency assesses whether a foster youth may need medical care not covered by Medicaid.¹⁰⁸ If such treatment is professionally recommended or appears desirable, the agency first must seek out private or other public funds to pay for it.¹⁰⁹ If no other funds are available, the case planner may submit a request to ACS for funds.¹¹⁰ ACS then sends a Child Protective Specialist to evaluate the situation, and if the specialist also believes that such treatment is “required,” then the case planner must provide price quotes and referral forms to the Deputy Commissioner of Children’s Services.¹¹¹ The Deputy Commissioner then evaluates whether five enumerated criteria have been met, and whether ACS will pay for the treatment.¹¹² In many cases, hormone therapy and sex-reassignment surgery would meet the five criteria enumerated in the Policy. Before ACS will pay for it, the treatment must: (1) be supported by the statement of a qualified medical professional, (2) be expected to relieve “substantial psychological and/or physical distress,” (3) be demonstrated to be effective based on current medical standards, and (4) offer a significant benefit to the child.¹¹³ In addition, there must (5) be documentation that there is “no appropriate, alternative treatment option covered by Medicaid.”¹¹⁴ As discussed in Part III, hormone therapy and sex-reassignment surgery are recommended as the most effective treatments for profound GID by all the leading medical associations.¹¹⁵ Such treatment will relieve the extreme amounts of stress that lead to anxiety, self-harm, and suicide

Interns (Jun. 15, 2011), (referring to ACS’s treatment of transgender youth in terms of placement and access to medical care: “It’s state sponsored discrimination”); New York City Administration for Children’s Services, Testimony to the New York City Council Committees on Juvenile Justice, General Welfare, Youth Services and Civil Rights (Feb. 10, 2011) *available at* <http://www.nyc.gov/html/acs/downloads/pdf/Testimony-on-ACS-LGBTQ-Policies-feb2011.pdf> (highlighting the Non-Medicaid Reimbursable Policy as an accomplishment, indicating that the need for proper medical care in light of *Mariah L.* has been reiterated to ACS).

106. POLICY No. 2010/04, *supra* note 14, at 1.

107. *Id.* at 2.

108. *Id.* at 3.

109. *Id.*

110. *Id.*

111. *Id.* at 3–4. The Policy does not include a specific definition of “required,” but it appears to be related to treatment that is “medically necessary.” Different methods of judging medical necessity are discussed above in Part I(C), and all methods appear to include transition-related care for persons with profound GID.

112. *Id.* at 5–6.

113. *Id.*

114. *Id.* at 6.

115. MEYER ET AL., *supra* note 54; Vorvick et al., *supra* note 58; APA Proceedings, *supra* note 58; AMERICAN MEDICAL ASSOCIATION, *supra* note 58.

among transgender youth, which is certainly a significant benefit to the youth's health.¹¹⁶ Finally, the treatment in many, if not most, cases is supported by the statement of a medical professional (often, multiple medical professionals).¹¹⁷ Once a request for treatment is deemed to meet the five criteria, in certain instances (such as off-label uses of medications and surgical procedures) the Deputy Commissioner must consult a Health Review Committee before making a final determination whether to provide the service.¹¹⁸ Once the Deputy Commissioner makes a final determination, they will provide notice to the foster care agency.¹¹⁹ Although transition-related care often would meet all five criteria, ACS may nevertheless deny transgender young people this necessary treatment because of the veto clause, which gives the Deputy Commissioner arbitrary power to deny any claim.¹²⁰ Although the Policy lists standards that must be met before care will be provided, it does not state that care must be provided if these standards are met. ACS still is not *required* to provide medically necessary care that is not covered by Medicaid.

This process harms transgender youth seeking transition-related care. As discussed below, both the veto clause and its discriminatory application against qualified transgender foster youth pose significant problems under the Federal Constitution.¹²¹

V. A FACIAL DUE PROCESS CHALLENGE TO THE POLICY'S VETO CLAUSE

The mere existence of the Policy's veto clause presents problems under the Fourteenth Amendment doctrine of substantive due process.¹²² While the United States Supreme Court has not recognized anything so specific as a right to receive transition-related care, it has recognized specific entitlements under the Due Process Clause to abortion, contraception, family structure, and intimacy.¹²³ Underlying these specific entitlements is the right to privacy, encompassing rights to medical decision-making, bodily integrity, and personal

116. ISRAEL & TARVER, *supra* note 8, at 133, 139–40; *see also* SHELLEY, *supra* note 59, at 64–65.

117. *See, e.g.*, Mariah L. v. Admin. for Children's Servs., 859 N.Y.S.2d 8, 13 (App. Div. 2008) (necessity of sex-reassignment surgery was supported by the written statements of a psychologist, a psychotherapist, and two licensed physicians).

118. POLICY No. 2010/04, *supra* note 14, at 6.

119. *Id.* ("Decisions regarding Children's Services' support for non-Medicaid reimbursable treatment or services will be made by the Deputy Commissioner of the Children's Services division under which case planning responsibility falls . . .").

120. *Id.*

121. I use the term "qualified transgender youth" to refer to youth who meet the five criteria enumerated in the Policy as well as the Harry Benjamin Standards. I recognize that in many instances, there are real concerns regarding the safety and propriety of providing a serious medical procedure to a young person. I therefore will limit my analysis only to those youths for whom this treatment is both appropriate and necessary; that is, *inter alia*, they have been evaluated by medical professionals and are over the age of 18.

122. Because part of the problem surrounding the veto clause involves a use of arbitrary decision-making, a procedural due process claim could also be a potential argument. This Comment, however, will focus on substantive arguments and leave an arbitrary and capricious claim to another author.

123. *E.g.*, Lawrence v. Texas, 539 U.S. 558 (2003) (right to intimacy between two consenting adults in the home); Planned Parenthood of Central Mo. v. Danforth, 428 U.S. 52 (1976); Roe v. Wade, 410 U.S. 113 (1973) (right to an abortion); Eisenstadt v. Baird, 405 U.S. 438 (1972) (right to contraception between unmarried partners); Griswold v. Connecticut, 381 U.S. 479 (1965); Pierce v. Soc'y of Sisters, 268 U.S. 510 (1925) (right to educate child according to individual family values).

autonomy.¹²⁴ In this section I will argue that transition-related care is one of the aspects of the due process right to privacy and that the arbitrary veto clause itself is an undue burden on that right.

A. THE STATE'S DUTY TO YOUTH IN FOSTER CARE

The State has affirmative due process obligations to persons in state custody.¹²⁵ The Supreme Court has indicated that foster youth in particular have a protected liberty interest in medical care.¹²⁶ Similarly, foster youth also have a protected liberty right to be free from physical and emotional harm.¹²⁷ Foster youth have these affirmative rights because they are not within the State's custody of their own volition.¹²⁸ When the State deprives a person of liberty, it has an affirmative obligation to provide certain minimum standards of care.¹²⁹ Thus, the due process analysis below does not apply to transgender youth who are not actually under the guardianship of ACS.¹³⁰ Courts tend to assume that if a youth is not in state custody, they will be able to care for themselves or their parents will be able to care for them.¹³¹ While this may not be true for a transgender youth who requires transition-related medical care, for the purposes of this Comment it is significant only that ACS has a constitutional duty to provide care to the foster youth in its guardianship.

B. THE RIGHT TO PRIVACY

ACS's special duties to youth in foster care affect the constitutionality of the Policy's veto clause. In this Section I discuss how the ability to receive transition-related care may be construed as part of the right to privacy. Because ACS has an affirmative duty to provide care for foster youth, failure to provide such care is no mere denial of a benefit; it is an "undue burden" on the youths' exercise

124. *E.g.*, *Lawrence*, 539 U.S. at 560 ("Petitioners' right to liberty under the Due Process Clause gives them the full right to engage in private conduct without government intervention."); *Roe*, 410 U.S. at 153 ("This right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.").

125. *See* *Youngberg v. Romeo*, 457 U.S. 307 (1982).

126. *See* *Deshaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 199–201 (1989) (holding that the state has no affirmative duty to protect youth not in foster care but indicating that the state would have such duty for youth in foster care because such youth would be in state custody due to state's affirmative act); *see also* *Youngberg*, 457 U.S. at 315 (stating that persons in state custody have an affirmative right to reasonable safety).

127. *See* *Marisol A. v. Giuliani*, 929 F. Supp. 662 (S.D.N.Y. 1996), *aff'd* 126 F.3d 372 (2d Cir. 1997).

128. *See* *Deshaney*, 489 U.S. at 200 ("The affirmative duty to protect arises not from the State's knowledge of the individual's predicament or from its expressions of intent to help him, but from the limitation which it has imposed on his freedom to act on his own behalf.").

129. *See id.* The analysis of when the State has an affirmative duty to protect is certainly made more complicated when discussing the rights of minor children rather than adults, since minor children do not have a right to liberty in the same way as an adult. *See, e.g.*, *Troxel v. Granville*, 530 U.S. 57, 67 (2000) (protecting the parents' right to care, custody, and control of their children); *Vernonia Sch. Dist. 47J v. Acton*, 515 U.S. 646, 656 (1995) (stating that children do not have the freedom to come and go as they please but rather are subject to the care and control of their parents). Thus, for purposes of this Comment, when I refer to "qualified transgender youth," I am only referring to those who meet the Harry Benjamin standards – that is, youth who are over the age of eighteen but still remain in foster care. For a more complex argument detailing why minor children should also have a right to transition-related treatment while in foster care see Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 N.Y.U. REV. L. SOC. CHANGE 361 (2007).

130. *See* *Deshaney*, 489 U.S. at 204.

131. *See id.* at 201.

of a constitutional right.¹³² Furthermore, the veto clause infringes on the rights of transgender foster youth, *even if* ACS never actually uses it to deny them transition-related care.

i. The Right's Scope

Courts have recognized two kinds of privacy rights: the right to confidentiality in personal matters, and the right to autonomy and independence in personal decision-making.¹³³ In this section I will illustrate, first, how a right to transition-related care is implicated in the confidentiality prong of the privacy right, and, second, how the bodily integrity and personal autonomy prong entails a right to transition-related care.

a. Informational Privacy

The confidentiality protection encompasses the body itself, as well as information about sexual preference and medical conditions.¹³⁴ According to at least one lower court, and at least in the context of informational privacy, the Due Process Clause appears to encompass the physical body of a transgender person.¹³⁵ In *Kastl v. Maricopa County Community College District*, the District Court of Arizona found the privacy right implicated when a transgender woman's employer required her to provide proof of sex-reassignment surgery before she could use the women's restroom.¹³⁶ Professor Jillian Weiss argues that, because of the right to informational privacy, and due to the extensive amount of government record-keeping regarding a person's sex, the informational privacy right implicates a right to "gender autonomy."¹³⁷ "Gender autonomy" describes the right to self-determination and self-identification in a person's gender identity.¹³⁸ Weiss argues that because personal information is protected, and because persons must identify their sex on nearly all government documents, the right to informational privacy encompasses the right to self-identify as any particular gender.¹³⁹ Though the possibility of a right to gender autonomy remains unexplored in case law, the work of scholars such as Weiss indicates

132. *E.g.*, *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977) (holding that the government is not obligated to pay for abortions for indigent women, so long as the state does not actually infringe upon the abortion right).

133. *See, e.g.*, *Doe v. City of N.Y.*, 15 F.3d 264, 268 (2d Cir. 1994).

134. *See Powell v. Shriver*, 175 F.3d 107, 111 (2d Cir. 1999) (holding that the Due Process Clause protects confidentiality in the information of an individual's transsexualism); *Kastl v. Maricopa Cnty. Cmty. College Dist.*, No. Civ.02-1531PHX-SRB, 2004 WL 2008954, at *5 (D. Ariz. June 3, 2004) (*citing* *Granger v. Klein*, 197 F. Supp. 2d 851 (E.D. Mich. 2002) (privacy right includes the genital region); *Hirschfield v. Stone*, 193 F.R.D. 175 (S.D.N.Y. 2000) (privacy right includes information about sexual preference and orientation); *Yin v. California*, 95 F.3d 864 (9th Cir. 1996) (privacy right protects information about medical conditions); *York v. Story*, 324 F.2d 450 (9th Cir. 1963) (privacy right protects the body itself)).

135. Of course, many other lower courts unequivocally find no fundamental right at stake when trans people make due process arguments regarding privacy and bodily integrity. *See, e.g.*, *Qz'etax v. Ortiz*, No. 05-1316, 2006 WL 515612 (10th Cir. 2006) (finding no fundamental right at stake when a prisoner claimed a due process violation for the denial of treatment for GID).

136. *Kastl*, 2004 WL 2008954, at *6-8.

137. Jillian Todd Weiss, *The Gender Caste System: Identity, Privacy, and Heteronormativity*, 10 LAW & SEXUALITY 123, 168-69 (2001) [hereinafter *Gender Caste*].

138. Jillian Todd Weiss, *Gender Autonomy, Transgender Identity, and Substantive Due Process: Finding a Rational Basis for Lawrence v. Texas*, 5 TOURO J. RACE, GENDER & ETHNICITY, 2, 6-7, (2010) available at <http://www.tourolaw.edu/JournalRGE/?pageid=470> [hereinafter *Gender Autonomy*].

139. *Id.* at 7.

that the right to confidentiality may protect the right to transition-related care as a form of self-identification.

b. Bodily Integrity and Personal Autonomy

The bodily integrity and personal autonomy prong of the privacy right may include a right to transition-related care under two different formulations: protection of autonomy in medical treatment and protection of sexual autonomy.

The Supreme Court's privacy rights jurisprudence embraces a right to personal autonomy and bodily integrity in relation to medical decision-making.¹⁴⁰ Its specific medical care cases deem the right to refuse medical treatment fundamental,¹⁴¹ indicating that the right to privacy encompasses some form of a right to decision-making authority over the type of medical treatment a person receives. The Court has also recognized the significance of medical autonomy in its reproductive rights cases. For instance, the Court in *Roe v. Wade* supported the right to abortion through the right to medical decision-making:

This right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy. The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. . . . Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by childcare. . . . All these are factors the woman and her responsible physician necessarily will consider in consultation.¹⁴²

Although *Roe* has been severely restricted by its progeny, its holding rooted in the right to privacy has not been overruled.¹⁴³ Indeed, in upholding *Roe*'s central holding, the Court in *Planned Parenthood v. Casey* stated that the right to an abortion is rooted in the privacy right's concept of personal decision-making; the Court indicated that this right includes autonomy in medical decisions.¹⁴⁴

Two considerations seem important to defining the outer limits of the privacy right. First, the right is influenced by the physical and psychological harm that can come from denying the right. Second, the right of physicians to make decisions with their patients is also implicated in the privacy right. Like abortion, transition-related care entails physical and psychological harm if it is denied and implicates the rights of physicians to make decisions with their

140. See *Cruzan by Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (holding that a competent person has a privacy right to refuse medical treatment); *Washington v. Harper*, 494 U.S. 210, 221–22 (1990) (holding that the forcible injection of medication into a person violates that person's fundamental right to bodily integrity); *Vitek v. Jones*, 445 U.S. 480, 494 (1980) (stating that mandatory behavior modifications infringe on privacy rights); *Parham v. J.R.*, 442 U.S. 584, 600 (1979) (“[A] child . . . has a substantial liberty interest in not being confined unnecessarily for medical treatment.”). *But see* *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997) (holding that there is no right to assisted suicide).

141. See *Cruzan*, 497 U.S. at 278; *Harper*, 494 U.S. at 221–22.

142. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

143. *E.g.*, *Gonzales v. Carhart*, 550 U.S. 124 (2007) (upholding the Partial Birth Abortion Act and indicating in dicta that there is a compelling government interest in ensuring that women have no regrets in their abortion decisions, but still upholding the fundamental right to abortion); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (erasing the trimester system and establishing an “undue burden” standard of review, but upholding the central holding of *Roe*).

144. See *Casey*, 505 U.S. at 857–58.

patients.¹⁴⁵ Thus, the right to transition-related care is already included in the privacy right as a facet of bodily integrity in terms of medical treatment.

Transition-related care also fits into the privacy right's protection of sexual autonomy. First, such care may be included in the sexual autonomy prong of the privacy right as it relates specifically to reproduction. The earliest of the bodily integrity and personal autonomy cases also indicated that privacy includes the right to be free from interference in the realm of procreation, contraception, and family relationships.¹⁴⁶ Indeed, some scholars argue that the binding principle of the privacy right is its relation to sexuality and bodily decisions.¹⁴⁷ Transition-related care influences the procreative ability of its recipients; a lack of transition-related care for a person who needs it can negatively affect that person's reproductive capacity.¹⁴⁸ In its strictest sense, therefore, constitutional protection of sexual autonomy as it relates to reproductive decision-making includes transition-related care. In *Eisenstadt v. Baird*, furthermore, the Supreme Court held that the privacy right goes beyond contraception and pregnancy; it reaches not just "the decision whether to bear or beget a child," but "matters so fundamentally affecting a person as the decision whether to bear or beget a child."¹⁴⁹ The Court's language indicates that the privacy right is quite broad. By protecting an individual's autonomy over family planning, the Due Process Clause also protects an individual's bodily autonomy as it relates to reproduction. Thus, transition-related care should be protected by the Due Process Clause.

Second, transition-related care may be protected under substantive due process because of the broad construction of the sexual autonomy right. The privacy right's protection of sexual autonomy goes beyond sexual acts and reproduction as such. Weiss argues that the privacy right as formulated by *Lawrence v. Texas* creates a fundamental right to gender autonomy in terms of personal autonomy and decision-making.¹⁵⁰ *Lawrence* embodies the right to privacy as one that broadly protects the right of autonomous individuals to make personal choices:

The case . . . involve[s] two adults who, with full and mutual consent from each other, engaged in sexual practices common to a homosexual lifestyle. The petitioners are entitled to respect for their private lives.

145. For a more detailed description of the psychological harm and relationship to physicians' rights, see Part II(C), *supra*.

146. See *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944); *Skinner v. Oklahoma*, 316 U.S. 535, 541–42 (1942).

147. See David Cruz, "The Sexual Freedom Cases"? *Contraception, Abortion, Abstinence, and the Constitution*, 36 HARV. C.R.-C.L. L. REV. 299 (2009), available at http://weblaw.usc.edu/assets/docs/Sexual_Freedom.pdf (arguing that the binding principle of the rights to bodily integrity, autonomy, and privacy identified in *Roe*, *Griswold*, and *Lawrence* is a right to sex – that is, "a right to engage in consensual activities for purposes other than procreation").

148. Gabriel Arkles, Remarks from Sylvia Rivera Law Project on Panel at CR10, Prisons as a Tool for Reproductive Oppression: Cross-Movement Strategies for Gender Justice (Sept. 27, 2008), available at <http://srlp.org/prisons/reproductiveoppression> ("Many trans people in prison are refused even hormone therapy, the most common and least expensive form of treatment that trans people can need. These denials are not only profoundly damaging the physical and mental health of trans people in prisons and robbing them of the ability to make intimate decisions about their own bodies and to self-determine their own gender, but they can also lead to loss of reproductive capacity in another way. Some trans women who are denied hormones or any form of other gender treatment end up trying to perform self-surgery—in other words, some try to treat themselves by amputating their own testicles or penis.").

149. *Eisenstadt*, 405 U.S. at 453 (emphasis added).

150. *Gender Autonomy*, *supra* note 138, at 16–17 (citing *Lawrence v. Texas*, 539 U.S. 558 (2003)); Laura K. Langley, *Self-Determination in a Gender Fundamentalist State: Toward Legal Liberation of Transgender Identities*, 12 TEX. J. ON C.L. & C.R. 101 (2007).

The State cannot demean their existence or control their destiny by making their private sexual conduct a crime. Their right to liberty under the Due Process Clause gives them the full right to engage in their conduct without intervention of the government.¹⁵¹

While the facts of *Lawrence* only related to autonomy in sexual relations, the case supports a broad interpretation of the privacy right. The Court notes that the framers could not have anticipated the “manifold possibilities” of the Fifth Amendment, and implies that many forms of liberty are protected by substantive due process.¹⁵² The Court stated, “As the Constitution endures, every generation can invoke its principles in their own search for greater freedoms.”¹⁵³ A growing body of scholarship indicates that the right to autonomy supports a right to self-determination in gender identity.¹⁵⁴ Much of the new scholarship focuses on how transition-related care categorically falls within the privacy right laid out in *Roe* and *Lawrence*.¹⁵⁵ Professor Chai Feldblum characterizes the core privacy right as a right to define oneself, which certainly includes the right to articulate one’s own gender.¹⁵⁶ The right to transition-related care, thus, is arguably already included within a broad interpretation of the sexual and reproductive autonomy protected in *Lawrence* and *Roe*.

Indeed, the sweeping language used in *Lawrence* and *Planned Parenthood v. Casey* creates a syllogism by which a court could include transition-related care within substantive due process protections. In *Lawrence*, the Court wrote, “Freedom extends beyond spatial bounds. Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and intimate conduct.”¹⁵⁷ According to the Court in *Casey*, “At the heart of liberty is the right to define one’s own concept of existence, of the universe, and of the mystery of human life.”¹⁵⁸ As Professor Feldblum states, “A person’s sexual anatomy, and hence that person’s sense of sexual self, is core to an individual’s self-definition. Similarly, one’s sense of gender is core to one’s sense of self.”¹⁵⁹ If protected rights are centered on one’s own concept of the universe, and if being in the proper body expresses one’s conception of the universe, then the right to obtain the proper body should be protected.

Transition-related care also is so closely related to expressly recognized sexual autonomy rights that denying such care would be an undue burden on the exercise of these rights. Though transition-related care arguably is not fundamental to our nation’s history and traditions, marriage and procreation

151. *Lawrence*, 539 U.S. at 578. As *Lawrence* deals only with adults, it is worth noting that when I argue for a right to transition-related care, I am referring specifically to qualified transgender youth – that is, young persons aged eighteen or older.

152. *Id.* at 578

153. *Id.* at 580.

154. E.g., Chai R. Feldblum, *The Right to Define One’s Own Concept of Existence: What Lawrence Can Mean for Intersex and Transgender People*, 7 GEO. J. GENDER & L. 115 (2006); Jennifer Rellis, “Please Write ‘E’ in this Box” *Toward Self-Identification and Recognition of a Third Gender: Approaches in the United States and India*, 14 MICH. J. GENDER & L. 223 (2008); Franklin Romeo, *Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law*, 36 COLUM. HUM. RTS. L. REV. 713 (2005).

155. See Feldblum, *supra* note 154, at 126–27; Rellis, *supra* note 154; Romeo, *supra* note 154; *Gender Caste*, *supra* note 137; see also *Lawrence*, 539 U.S. 558; *Roe v. Wade*, 410 U.S. 113 (1973).

156. Feldblum, *supra* note 154, at 126.

157. *Lawrence*, 539 U.S. at 563.

158. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 852 (1992).

159. Feldblum, *supra* note 154, at 124.

certainly are.¹⁶⁰ A person's physical body clearly affects the intimate relations they have: it influences the sort of physical acts that are possible as well as with whom they are performed.¹⁶¹ The ability to be in a body that matches one's gender identity affects the right to marry. Depending on the state, the physical sex of a person will determine whether that person can marry the partner of their choice, and what body a person has may influence that person's decision to enter intimate relations – or the decision of that person's partner to enter relations with them.¹⁶² Furthermore, transition-related care is interconnected with the ability to structure a family.¹⁶³ A post-operative transsexual may wish to be "Mother" where previously they were "Father"; a person who chooses a more moderate form of hormone treatment and does not identify as male or female per se may structure their family in a gender-neutral and egalitarian manner. A person who has been denied transition-related care may be in such a state of discomfort that they do not even start a family where they may have done so otherwise. Finally, in a very basic sense, the ability to be the proper sex is certainly a "matter[] so fundamentally affecting a person as the decision whether to bear or beget a child."¹⁶⁴ Indeed, a person's sex will greatly influence whether they bear or beget a child – a person may want children in a male body where they would not in a female body. Denial of transition-related care may even lead to sterility.¹⁶⁵ A right to transition-related care therefore may be so intertwined with other explicitly recognized entitlements that denial of it would be to deny recognized rights, and thus would violate substantive due process.

Transition-related care thus may be included within the Due Process Clause as part of the right to self-definition inherent in informational privacy or as an aspect of personal autonomy in medical, sexual, and familial decisions.

ii. The Undue Burden Test

Because a transgender person's ability to obtain transition-related care puts constitutionally protected interests at stake, ACS may not lawfully have unrestricted veto power over a youth's exercise of that right. As discussed in Part V(A) above, ACS has special duties to provide for the youth in its care. While ACS is in many ways like a parent to foster youth, it does not have as much freedom in determining how to treat its dependent children as would a biological or adoptive parent.¹⁶⁶ Ordinarily the state merely has a duty not

160. See *Lawrence*, 539 U.S. at 569.

161. *Id.* (finding a fundamental right to intimate, consensual sexual conduct); *Griswold v. Connecticut*, 381 U.S. 479 (finding a privacy right in the marital bedroom). Some "straight" people likely would refuse to engage in intimate relations with someone not in the physical body of the opposite gender, just as some gays or lesbians likely would not engage in relations with a person not in the body of the same gender.

162. See *Loving v. Virginia*, 388 U.S. 1 (1967) (creating a fundamental right to marry); *Skinner v. Oklahoma*, 316 U.S. 535 (1942). As of June 2012, only six states and the District of Columbia grant marriage licenses to same-sex couples. National Conference of State Legislators, *Same Sex Marriage, Civil Unions and Domestic Partnerships*, NCSL.ORG, <http://www.ncsl.org/default.aspx?tabid=16430>. Different states address the issue of how to define a person's legal sex differently. Compare *Littleton v. Prange*, 9 S.W.3d 223 (Tex. App. 1999) (defining legal sex to be the sex on birth certificate) with *M.T. v. J.T.*, 140 N.J. Super. 77 (1976) (defining legal sex to be "medical sex" or "sex of presentation"). Thus, a trans person who has not had sex-reassignment surgery will not be able to marry a person of her own choosing in certain states.

163. The right to family structure is protected in the earliest of the Supreme Court's privacy cases. See *Prince v. Massachusetts*, 321 U.S. 158 (1944); *Skinner*, 316 U.S. 535.

164. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

165. See *Arkles*, *supra* note 148.

166. Compare *Troxel v. Granville*, 530 U.S. 120 (2000) (affirming that a parent has a fundamental right to raise her own child) with *Deshaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189 (1989)

to interfere with a citizens' exercise of the right of parental control, but the state has an affirmative duty not to deny certain types of care to persons in state custody.¹⁶⁷ Although *Mariah L.* granted ACS the ultimate authority over the provision of foster youth's medical care,¹⁶⁸ ACS cannot have unrestrained power to deny foster youth their fundamental rights.¹⁶⁹

The specific entitlement of foster youth to receive abortions offers a close analogy to the entitlement at issue here. The Supreme Court has ruled in a line of cases parallel to *Roe* that minor as well as adult women have a fundamental right to abortion.¹⁷⁰ The Court has therefore held it unconstitutional to grant parents complete veto power over a minor woman's decision to receive an abortion.¹⁷¹ In *Belotti v. Baird (Belotti I)*, the Court indicated that a statute requiring parental consent would not be acceptable if it amounted to a "parental veto," whereas parental guidance or approval would be acceptable.¹⁷² On remand in *Belotti II*, the Court upheld the statute requiring "parental notice and consent," seeing it as a recognition of a minor's less mature decision-making capacity and the parents' right to guide the child rather than a "parental veto."¹⁷³ Similarly, in *Parham v. J.R.*, the Supreme Court stated that parents may exercise medical decision-making power for their child, but also indicated that the parent would not have the right to exercise *absolute* power over the exercise of their child's constitutional right.¹⁷⁴ In *Lady Jane v. Maher*, the District Court of Connecticut confronted an analogous problem where minor women in foster care were required by statute to receive permission from the Commissioner of Children and Youth Services in order to receive an abortion.¹⁷⁵ Relying on the Supreme Court's decision in *Planned Parenthood of Central Missouri v. Danforth*, the court stated unequivocally that such a veto power unconstitutionally infringes on the child's fundamental privacy right.¹⁷⁶ As ACS is analogous to a foster youth's parent (though with significantly greater duties of care), these cases indicate that ACS may exercise some kind of decision-making authority over a foster youth's medical care, but cannot be vested with an unchecked veto over a youth's exercise of a fundamental right.

Because the right to transition-related care appears to lie within the realm of the fundamental right to privacy, ACS's veto power imposes an undue burden on the exercise of that right.¹⁷⁷ ACS, of course, can argue that it has legitimate

(indicating that social services has an affirmative duty to care for persons in its custody).

167. See *Deshaney*, 489 U.S. at 202–03.

168. *Mariah L. v. Admin. for Children's Servs.*, 859 N.Y.S.2d 8, 16 (App. Div. 2008) (stating that ACS must provide medically necessary care and pay for it as necessary, but that the Family Court cannot compel ACS to provide care).

169. U.S. CONST. art. VI, cl. 2 (establishing the U.S. Constitution as the "supreme law of the land.").

170. *E.g.*, *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 75 (1976) ("Constitutional rights do not mature and come into being magically only when one attains the state-defined age of eighteen.").

171. See *id.* (striking down state abortion law with a "parental veto" over the ultimate abortion decision).

172. *Belotti v. Baird (Belotti I)*, 428 U.S. 132, 145–47 (1976).

173. *Belotti v. Baird (Belotti II)*, 443 U.S. 622, 640–41 (1979). *Accord* *Planned Parent League v. Belotti*, 641 F.2d 1006, 1012–14 (1st Cir. 1981) (upholding a law requiring parental or court approval for a minor to receive an abortion because the legislature rationally could have thought that the abortion process is more dangerous than other medical procedures).

174. See *Parham v. J.R.*, 442 U.S. 584, 605 (1979).

175. See *Lady Jane v. Maher*, 420 F. Supp. 318 (D. Conn. 1976).

176. *Id.* at 321–22.

177. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992).

purposes in enacting the clause. Indeed, the Policy's veto clause theoretically could be construed as a form of "parental notice and consent that does *not* unduly burden the right to seek an abortion."¹⁷⁸ ACS could believe that sex-reassignment surgery is more dangerous than other medical procedures, and a court could find such a belief to be rational.¹⁷⁹ In the abortion context, the Supreme Court has recognized that a state's protection of such interests as the health of the mother, the life of the fetus post-viability, and potentially the mother's psychological well-being does not create an unconstitutional undue burden on a woman's exercise of the abortion right.¹⁸⁰ That is, in the abortion context the state may "create a structural mechanism . . . [to] express profound respect for the life of the unborn . . . if [the mechanisms] are not a substantial obstacle to the woman's exercise of the right to choose."¹⁸¹ Analogously, the Policy's veto clause could be viewed as a "structural mechanism" through which ACS protects the well-being of the children within its custody. ACS could claim that adolescents do not have the maturity to make permanent decisions about their bodies and that a hasty decision could be detrimental.¹⁸² Such an argument, however, makes little sense in the context of the Policy's structure and purpose. The five enumerated criteria already ensure that the youth requesting the treatment has not made a hasty decision.¹⁸³ Furthermore, if the object of the Policy is to create a means for youth to receive treatment that may involve permanent alterations of their bodies, it is purposeless to deny the treatment because it may permanently alter their bodies.¹⁸⁴

Even if ACS could make out an argument that the veto clause has a legitimate purpose, the clause still should fail as an undue burden in light of *Lady Jane* and similar cases. The statute that failed in *Lady Jane* stated: "An abortion may be performed on a patient only if medically necessary and after the legal consent to such procedure has been obtained . . . In the case of a committed child, a written consent form is secured from the Welfare Commissioner, as guardian."¹⁸⁵ By contrast, the statute upheld in *Belotti II* required the consent of both parents, but allowed a judge to grant consent for an abortion if it was in the child's best interests.¹⁸⁶ The Policy at issue here provides for no such judicial bypass and says nothing about the Deputy Commissioner's consideration of the youth's best interests.¹⁸⁷ The veto clause effectively gives the Deputy Commissioner the

178. *Belotti II*, 443 U.S. at 641 (emphasis added).

179. See *Planned Parent League v. Belotti*, 641 F.2d 1006 (1st Cir. 1981).

180. See *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007) (holding statute banning partial-birth abortion not an undue burden on exercise of abortion right); *Casey*, 505 U.S. at 846 (1992). *Carhart* also notes other legitimate state interests, such as maintaining the integrity of the medical profession. *Carhart*, 550 U.S. at 158. Since *Carhart*, the Supreme Court has not recognized any additional state interests that would lead an abortion restriction not to be an undue burden.

181. *Casey*, 505 U.S. at 877.

182. In fact, such an argument was found to be persuasive in *Belotti II*, where the Court decided that the parental consent regulation was not an undue burden because minors do not have sound enough judgment to make important decisions. 443 U.S. at 636.

183. See POLICY NO. 2010/04, *supra* note 14, at 5–6.

184. See *id.* at 2 (stating that the Policy may be used to provide "gender affirming healthcare associated with Gender Identity Disorder.").

185. *Lady Jane v. Maher*, 420 F. Supp. 318, 320 n.1 (D. Conn. 1976).

186. See *Belotti II*, 443 U.S. at 626 ("If the mother is less than eighteen years of age and has not married, the consent of both the mother and her parents [to an abortion to be performed on the mother] is required. If one or both of the mother's parents refuse such consent, consent may be obtained by order of a judge of the superior court for good cause shown, after such hearing as he deems necessary.") (citing MASS. GEN. LAWS ch. 112, § 12S (1979)).

187. See POLICY NO. 2010/04, *supra* note 14 at 5–8 (describing the procedures and re-consideration

same “absolute, and possibly arbitrary, veto” power criticized in *Danforth*.¹⁸⁸ An arbitrary veto power acts as a complete barrier to the exercise of a fundamental right; according to *Casey*, this would qualify as having the “purpose or effect of placing a substantial obstacle in the path” of a citizen exercising a fundamental right.¹⁸⁹ Thus, such a power is an “undue burden” on a youth’s exercise of a fundamental right, and therefore a violation of substantive due process.

VI. AN AS-APPLIED EQUAL PROTECTION CHALLENGE TO THE POLICY

When the government treats similarly situated persons differently, it violates the constitutional guarantee of equal protection under the law.¹⁹⁰ Thus, ACS would violate the Equal Protection Clause if, for example, it granted all men every one of their medically necessary health needs, except for one man because he is biologically female.¹⁹¹ In this section I will describe how an application of the Policy’s veto clause that denies qualified transgender youth in foster care their medically necessary treatment violates equal protection.¹⁹²

A. THE SEX DISCRIMINATION FRAMEWORK

Transgender people as such are not a protected class.¹⁹³ Some courts therefore will refuse to apply heightened scrutiny to transgender equal protection claims, and may even dismiss any equal protection claim made based on a transgender identity.¹⁹⁴ Plaintiffs in different courts have argued with some success, however, that discrimination against transgender people is unconstitutional sex discrimination.¹⁹⁵ Under this framework, a transgender foster youth could

processes without noting any form of judicial bypass available for a youth seeking treatment).

188. See *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 75 (1976).

189. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992).

190. U.S. CONST. amend. XIV § 1 (“No state shall . . . deny to any person within its jurisdiction the equal protection of the laws.”); see also NAN D. HUNTER, COURTNEY G. JOSLIN, & SHARON MCGOWAN, *AMERICAN CIVIL LIBERTIES UNION, THE RIGHTS OF LESBIANS, GAY MEN, BISEXUALS, AND TRANSGENDER PEOPLE: THE AUTHORITATIVE ACLU GUIDE TO LESBIAN, GAY, BISEXUAL, OR TRANSGENDER PERSON’S RIGHTS* 176 (2004).

191. See *generally Doe v. Yunits*, No. 001060A, 2000 WL 33162199, 7 (Mass. Super. Oct. 11, 2000) (explaining that “[s]ince plaintiff identifies with the female gender, the right question is whether a female student would be disciplined for wearing items of clothes plaintiff chooses to wear. If the answer to that question is no, plaintiff is being discriminated against on the basis of her sex, which is biologically male.”); HUNTER ET AL., *supra* note 191, at 220.

192. See U.S. CONST. amend. XIV.

193. *E.g.*, *Lopez v. City of New York*, No. 05 Civ. 10321 (NRB), 2009 WL 229956, *14 (S.D.N.Y. Jan. 30, 2009) (finding no court decision holding transgender people to be a protected class, and thereby analyzing an equal protection claim under rational basis review); *Stevens v. Williams*, 2008 WL 916991 (D. Or. Mar. 27, 2008); Kylar W. Broadus, *The Evolution of Employment Discrimination Protections for Transgender People*, in *TRANSGENDER RIGHTS* 93 (Paisley Currah, Richard M. Juan, & Shannon Price Minter, eds., 2000). *But see Rowe v. Corf. Med. Servs., Inc.*, No. 1:08-cv-827, 2010 WL 3779561 (W.D. Mich. Aug. 18, 2010) (interpreting a Sixth Circuit case, *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. 2005), to mean that transsexuals are a protected class).

194. See, *e.g.*, *Holloway v. Arthur Anderson & Co.*, 566 F.2d 659, 663 (9th Cir. 1977) (holding that transgender people are not a suspect class for equal protection purposes and any claim by a trans person will only receive rational basis scrutiny); *Gomez v. Maass*, 918 F.2d 181 (Table), 2 (9th Cir. 1990) (rejecting a transgender person’s equal protection claim because “transsexuals are not a suspect class”).

195. See, *e.g.*, *Glenn v. Brumby*, 724 F. Supp. 2d 1284 (N.D. Ga. 2010), *aff’d* 663 F.3d 1312 (11th Cir. 2011) (finding discrimination based on gender non-conformity to be sex-based discrimination in violation of the Equal Protection Clause).

claim that ACS treats transgender foster youth differently than other foster youth of the same gender identity: it provides all medically necessary care to every women except for transgender women.¹⁹⁶ This discriminates against a transgender female foster youth because of her sex, which is biologically male.¹⁹⁷

Discrimination against a transgender person may be understood as sex discrimination in three ways.¹⁹⁸ First, some courts have stated that discrimination against a transgender person is *per se* sex discrimination.¹⁹⁹ Second, discrimination against transgender people may be analogized to religious discrimination. In *Schroer v. Billington*, the District Court for the District of Columbia stated that discrimination against a person for transitioning to a different sex is like discriminating against a person for converting to a different religion.²⁰⁰ Since we consider the latter to be discrimination based on religion, we should consider the former to be discrimination based on sex.²⁰¹

Finally, discrimination against a transgender person may be understood as a form of sex stereotyping, a practice condemned by the Supreme Court's equal protection jurisprudence.²⁰² For instance, in *United States v. Virginia*, the Supreme Court rejected Virginia Institute of Technology's claim that any individual woman could be excluded from the institution because women in general would not thrive in an "adversative" environment.²⁰³ Discrimination against transgender people may be said to rest on similarly overbroad generalizations: the State treats transgender people differently on the impermissible ground that all people who are biologically male (or female) should dress and act in a certain way. Put another way, treating people differently because they do not embody assumptions about how persons of a certain gender are supposed to look or behave is a form of sex discrimination within the meaning of the Equal Protection Clause.

Advocates have utilized this sex-stereotyping framework with some success in constitutional cases.²⁰⁴ For instance, in *Smith v. City of Salem*, the Sixth Circuit Court of Appeals held that a firefighter discharged for her intent to transition

196. For instance, ACS would not deny a female foster child treatment for cervical or ovarian cancer just because it is related to her gender.

197. See, e.g., *Doe v. Yunits*, No. 001060A, 2000 WL 33162199 (Mass. Super. Oct. 11, 2000).

198. See generally Jason Lee, *Lost in Transition: The Challenges of Remedying Transgender Employment Discrimination Under Title VII*, 35 HARV. J. L. & GENDER 423, 427, 435–36 (2012) (describing the Gender Nonconformity, Per Se, and Constructionist approaches to Title VII claims by transgender individuals).

199. See *Ulane v. Eastern Airlines (Ulane I)*, 581 F. Supp. 821, 825 (N.D. Ill. 1983) ("I find by the greater weight of the evidence that sex is not a cut-and-dried matter of chromosomes, and that while there may be some argument about the matter in the medical community, the evidence in this record satisfies me that the term, "sex," as used in any scientific sense and as used in the statute can be and should be reasonably interpreted to include among its denotations the question of sexual identity and that, therefore, transsexuals are protected by Title VII."), *rev'd*, 742 F.2d 1081 (7th Cir. 1984); see Glenn, 724 F. Supp. 2d at 1300 ("While transsexuals are not members of a protected class based on sex, those who do not conform to gender stereotypes are members of a protected class based on sex.").

200. See *Schroer v. Billington*, 577 F. Supp. 2d 293, 306–07 (D.D.C. 2008).

201. See *id.*

202. See *United States v. Virginia*, 518 U.S. 515, 541–42 (1996).

203. *Id.* at 145–46.

204. See, e.g., *Kastl v. Maricopa Cnty. Cmty. Coll. Dist.*, No. 06-16907, 2009 WL 990760, at *2 (9th Cir. 2009) ("[I]t is unlawful to discriminate against a transgender (or any other) person because he or she does not behave in accordance with an employer's expectations for men or women . . . Thus, [plaintiff] states a prima facie case of gender discrimination . . ."); *Smith v. City of Salem, Ohio* 378 F.3d 566, 577–78 (6th Cir. 2004) (holding that a transgender firefighter had an equal protection claim of gender discrimination on a sex-stereotyping theory); *Rosa v. Park W. Bank & Trust*, 214 F.3d 213 (1st Cir. 2000) (stating that a cross-dresser would have a claim under the Equal Credit Opportunity Act because a bank treated a man who dresses like a man differently than a man who dresses like a woman).

from the male sex to the female sex stated a valid equal protection claim:

[E]mployers who discriminate against men because they *do* wear dresses and makeup, or otherwise act femininely, are . . . engaging in sex discrimination, because the discrimination would not occur but for the victim's sex. . . . [D]iscrimination against a plaintiff who is a transsexual – and therefore fails to act and/or identify with his or her gender – is no different from the discrimination directed against Ann Hopkins in *Price Waterhouse*, who, in sex-stereotypical terms, did not act like a woman.²⁰⁵

Likewise, in *Glenn v. Brumby*, a federal court awarded judgment for a male-to-female transsexual who had been fired from the Office of Legislative Counsel.²⁰⁶ Finding that the employer's expectations of "appropriate" dress reflected impermissible sex stereotypes, the court expressly held that transgender people may assert sex discrimination claims under the Equal Protection Clause.²⁰⁷

B. DISCRIMINATORY INTENT

The Non-Medicaid Reimbursable Policy is facially neutral; it draws no explicitly sex-based distinctions itself. But the Policy may be discriminatory in its application.²⁰⁸ In this Section, I discuss how vetoing transition-related care to qualified transgender youth constitutes sex-stereotyping, and is therefore a form of intentional, invidious discrimination.²⁰⁹

First, invidious discrimination can be inferred by examining the effects of a law, the history of discrimination against a group, and the sequence of events leading up to the challenged decision.²¹⁰ In the event that ACS vetoes a qualified transgender youth's request for care, an examination of these factors indicates that the denial would likely have been motivated by discriminatory stereotypes. ACS and its contract agencies have a history of discrimination against transgender youth by engaging in sex-stereotyping. As discussed more thoroughly in Parts I and II, *supra*, it is common for caseworkers and group home directors to state that transgender youth are simply going through a phase of wanting to be the "wrong" gender.²¹¹ Such statements indicate that these authority figures believe that someone who is biologically a male should present himself in a particular way, and any other behavior is somehow improper. Case

205. *Smith v. City of Salem, Ohio*, 378 F.3d 566, 568, 575–76, 578 (2004) (holding that plaintiff has stated a valid equal protection claim based on the facts supporting the Title VII sex-stereotyping claim).

206. *Glenn v. Brumby*, 724 F. Supp. 2d 1284, 1290–91 (N.D. Ga. 2010).

207. *Id.* at 1305.

208. *See Pers. Admin'r of Mass. v. Feeney*, 442 U.S. 256 (1979) ("When a statute gender-neutral on its face is challenged . . . a twofold inquiry is thus appropriate. The first question is whether the classification is indeed neutral in the sense that it is not gender-based. If the classification itself, covert of [*sic*] overt, is not based on gender, the second question is whether the adverse effect reflects invidious gender-based discrimination."). I use the hypothetical "may be discriminatory in its application" because as of the writing of this Comment, no claim has actually made it to the Deputy Commissioner for review. Therefore, any as-applied challenge is based on a hypothetical situation where the Deputy Commissioner denies a qualified transgender youth's request for transition-related care under the Policy.

209. At this point it is also clear, but important, to note that as a government agency, ACS meets the requirement for state action in order to make a valid equal protection claim.

210. *See Village of Arlington Heights v. Metro. Housing Dev. Corp.*, 429 U.S. 252 (1977).

211. *See, e.g., MARKSAMER ET AL., supra* note 3, at 6; Hazel Beh & Milton Diamond, *Ethical Concerns Related to Treating Gender Nonconformity in Childhood and Adolescence: Lessons from the Family Court of Australia*, 15 HEALTH MATRIX 239, 251–52 (2005) (giving the example of Alex's caseworker who is "still not totally convinced" that Alex is transgender boy rather than just a lesbian).

planners frequently place transgender girls in boys' homes and vice versa, and tell the youth that when things go poorly in the home it is the youth's fault for not conforming to others' gendered expectations.²¹² Though not in a health care context, acts such as these indicate a history of intentional discrimination against transgender youth. These actions are manifestations of stereotypical views of gender norms: a person with male body parts cannot be anything but a "boy." Because of the unfortunate frequency with which such actions occur, these stories and others indicate that ACS systematically engages in routine sex stereotyping of transgender youth.²¹³

Next, if the Policy were applied to deny qualified transgender youth their medically necessary transition-related care, the denial would reflect motives rooted in sex-stereotyping.²¹⁴ Such a veto would deny medically necessary health care to one specific group of foster youth, where ACS does not deny medically necessary care to other groups.²¹⁵ Child welfare agencies cannot refuse other foster youth gender-related, medically necessary health care – such as treatment for gender-related cancers or medically necessary abortions.²¹⁶ ACS therefore provides *all* medically necessary care to foster youth whose gender expressions match their biological sex, but does not provide all such care to foster youth whose gender expressions do not match their biological sex. Such refusal reflects ACS's assumption that a person who is biologically a male will only have those significant medical needs that "normal" males have.²¹⁷ Because such an assumption is a form of sex-stereotyping, if ACS were to use the veto clause to deny care to qualified transgender youth, the evidence indicates that such denial would be motivated by invidious discrimination.

Of course, ACS may argue that it would not be denying care to transgender youth where it gives the same or similar care to cisgender youth; it would be denying one type of treatment to every foster youth. From this view, ACS is simply making a calculated decision of what types of care will best serve the children in its charge, rather than purposefully denying some youth the medical

212. *Doe v. Bell*, 754 N.Y.S.2d 846, 849 (Sup. Ct. N.Y. Co. 2003) (describing a case where a group home would not allow a trans girl to dress according to her gender); MARKSAMER ET AL., *supra* note 3, at 6 (documenting one trans boy's recollection that during his time in a group home "[t]he staff would tell me I wasn't 'talking like a lady' or that I was being 'too gentlemanly'").

213. See *Arlington Heights*, 429 U.S. 252, 266 (stating that the history and pattern of discrimination against a group is a way of gleaning evidence of invidious discrimination). Exact statistics on how many trans youth are placed in the incorrect ward of a group home are difficult to come by; however, one statistic indicates that 74% of LGBT youth experienced prejudice in the foster care system based on their sexual orientation or gender identity. MIMI LAVER & ANDREA KHOURY, *OPENING DOORS FOR LGBTQ YOUTH IN FOSTER CARE: A GUIDE FOR LAWYERS AND JUDGES* 15, available at <http://www.scribd.com/doc/57364408/Opening-Doors-for-LGBTQ-Youth-in-Foster-Care-Guide-for-Lawyers-and-Judges>. Such high proportions of discriminatory incidents indicate the pervasiveness of anti-trans actions in the foster care system.

214. See *Arlington Heights*, 429 U.S. at 266 (stating that the effects of a law may indicate invidious discrimination).

215. See *Shield*, *supra* note 129, 414 (highlighting the injustice in the fact that others do not need to go through similar bureaucratic procedures such as proving attendance of therapy to receive health care).

216. N.Y. Soc. SERV. LAW § 398(6)(c) (McKinney 2011); *Belotti v. Baird*, 443 U.S. 622 (1979); see *Lady Jane v. Maher*, 420 F. Supp. 318 (D. Conn. 1976) (holding that minor women in the care of the Commissioner of Children's Services have just as strong a right to abortion as do adult women, and therefore the Commissioner may not veto the choice to have an abortion. It is important to note that abortion is considered a fundamental right whereas sex-reassignment surgery is not. Such a difference would likely influence a court's decision, but for the purposes of this discussion it is significant merely that ACS must provide some forms of gender-specific health care).

217. See generally *Kastl v. Maricopa Cnty. Comm. Coll. Dist.*, No. Civ.02-1531PHX-SRB, 2004 WL 2008954, at *3 (D. Ariz. 2004) (illustrating that the assumption that "the presence or absence of anatomy typically associated with a particular sex" means one must conform with that sex's biological and social expectations is a form of sex discrimination); 1 EMP. DISCRIM. COORD. OF FED. L. § 3:13 (Nov. 2011).

care that they need. This argument, though, runs into a problem analogous to *In re Marriage Cases* and *Perry v. Brown*.²¹⁸ On its face, denying sex-reassignment surgery certainly treats all genders equally by denying them the exact same treatment.²¹⁹ The veto clause of the Policy, however, affects only youth who actually request the care. A discriminatory application of the veto clause does not limit the medical care of all foster youth; it denies one form of medically necessary care to transgender youth because they are transgender, and at the same time allows cisgender youth to receive all of their medically necessary care. A disparate impact such as this indicates that vetoing transition-related claims for qualified transgender youth is a form of invidious discrimination.²²⁰

To summarize, ACS has a history and ongoing practice of discriminating against transgender youth for not conforming to traditional gender roles. The application of the Non-Medicaid Reimbursable Policy to deny qualified transgender youth medically necessary transition-related care would adversely affect transgender youth because of their gender identity. This application of the veto clause therefore would be motivated by a discriminatory intent based on sex-stereotyping.

C. HEIGHTENED SCRUTINY

Having established state action and discriminatory intent in a facially neutral policy, the next step of constitutional analysis is to apply heightened scrutiny. In equal protection cases involving gender discrimination, this means that the challenged policy or action must be “substantially related” to an “important” or “exceedingly persuasive” government interest.²²¹ In this Section I argue that ACS’s differential treatment of transgender youth would not pass heightened scrutiny.

ACS could set forth several interests justifying its refusal of transition-related treatment to qualified transgender youth. First, ACS could argue that the veto clause protects youth from harmful medical procedures and irreversible, spontaneous choices.²²² As ACS does have a duty to protect the youth in its

218. *In re Marriage Cases*, 43 Cal.4th 757, 783–84 (2008) (reviewing statute banning same-sex marriage under strict scrutiny because even though statute bans practice for all persons, ban only affects homosexuals), *superseded by constitutional amendment*, Cal. Const. art. I, § 7.5 (“Only marriage between a man and a woman is recognized in California.”), *invalidated by* *Perry v. Schwarzenegger*, 704 F. Supp. 2d 921 (N.D. Cal. 2010), *stay granted*, 2010 WL 3212786, No. 10-16696 (9th Cir., Aug 16, 2010); *see also* *Loving v. Virginia*, 388 U.S. 1 (1967) (striking down an antimiscegenation law on equal protection grounds).

219. *See* *Geduldig v. Aiello*, 417 U.S. 484, 498 n. 20 (1974), *superseded by statute*, Pregnancy Discrimination Act of 1978, 42 U.S.C. § 2000e(k) (2006) (“The program divides potential recipients into two groups – pregnant women and nonpregnant persons. While the first group is exclusively female, the second includes members of both sexes.”). Though *Geduldig* has not been overruled, the case is recognized as an anomaly. *See* Priscilla J. Smith, *Give Justice Ginsburg What She Wants: Using Sex Equality Arguments to Demand Examination of the Legitimacy of State Interests in Abortion Regulation*, 34 HARV. J.L. & GENDER 377, 378 (2011).

220. *See* *Village of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252 (1977) (indicating that a disparate impact may be used to show discriminatory intent); *Loving*, 388 U.S. 1 (explaining that although the Virginia law theoretically affected all races equally, it truly impacted only a particular class of persons who sought to marry interracial, indicating that the law’s true purpose was to preserve white supremacy).

221. *United States v. Virginia*, 518 U.S. 515 (1996) (altering the standard of review from “important” interest to “exceedingly persuasive” interest); *Craig v. Boren*, 429 U.S. 190 (1976) (stating the standard that a law must be “substantially related to an important government interest”).

222. In *Mariah L.*, ACS argued that it would deny Mariah her surgery because she “simply has not demonstrated the kind of serious, thoughtful, and committed approach that would, as a matter of basic logic, be expected of anyone appropriately planning for this type of fundamental and serious surgical process.” 859 N.Y.S. 2d at 14.

care,²²³ this argument likely would carry the most weight of the interests I identify. This “safety” argument, though, should not be considered an important government interest. To begin, the criteria established in the Policy already provide protections for youth seeking treatment.²²⁴ ACS need only follow the Policy’s guidance in order to avoid harming youth. If a transgender youth meets the criteria, then the safety argument has no basis in fact. Indeed, for a qualified transgender youth, denying a claim for transition-related care appears to be based more on archaic stereotypes than on protection of youth: transgender youth do not actually want to be permanently changed into the other sex because they are just going through a phase, and therefore are incapable of making their own decisions. Such reasoning impermissibly hinders the autonomy of foster youth.²²⁵ In the case of transgender youth, the stereotype about the impulsiveness of youth also implies stereotypes about gender. Stating that transgender youth would eventually regret their decision to undergo sex-reassignment surgery or other transition-related treatment seems to be a statement that a transgender girl is not really a “girl,” but just a very confused boy (and vice versa). This argument is just another way of stating that people who are born biologically one sex are supposed to behave in a way consistent with certain societal expectations about that sex. Perpetuating stereotypes, as ACS would be doing through a discriminatory veto, is an impermissible justification for gender-based classifications.²²⁶ Thus, ACS’s counterarguments to a gender equal protection claim, under current Supreme Court jurisprudence, should fail under the “exceedingly persuasive” government interest prong.

Denying medically necessary care to qualified transgender youth also is certainly not substantially related to protecting youth. The “safety” argument cannot be based on broad generalities. In *Lantz by Lantz v. Ambach*, a school district argued that barring a female student from the boys’ football team was for her own safety, and therefore the school policy prohibiting girls from playing football was “substantially related” to an “exceedingly persuasive” interest.²²⁷ The Southern District Court of New York, however, saw the school’s blanket ban on letting girls join boys’ teams as a reflection of “averages and generalities”; the school simply assumed that all girls are weaker than boys, and that playing football is too dangerous for *any* girl.²²⁸

Vetoing a qualified transgender youth’s request for transition-related care

223. See N.Y. SOC. SERV. LAW § 398 (describing all the powers and responsibilities of child welfare agencies to children, such as investigating instances of abuse, providing shelter and mental health services, and providing care for children born out of wedlock).

224. See POLICY No. 2010/04, *supra* note 14, at 5–6 (listing specific criteria that must be met before treatment will be provided).

225. Under current informed consent doctrine, minors have the constitutional right to make choices about their own health care without parental consent in certain circumstances. For instance, states cannot bar minors from obtaining contraceptives, and minors may obtain treatment for sexually transmitted infections without parental consent. *Shield*, *supra* note 127, at 400–01 (citing *Carey v. Population Servs. Int’l*, 431 U.S. 678 (1977)). Thus, youth do have a constitutional right to a certain amount of autonomy over their health care decisions. ACS therefore cannot justify its denial of equal protection to trans youth by attempting to infringe upon another of the youths’ constitutional rights.

226. See *Frontiero v. Richardson*, 411 U.S. 677, 685 (1973) (“The Court therefore held that, even though the State’s interest in achieving administrative efficiency ‘is not without some legitimacy,’ ‘(t)o give a mandatory preference to members of either sex over members of the other, merely to accomplish the elimination of hearings on the merits, is to make the very kind of arbitrary legislative choice forbidden by the [Constitution]” (quoting *Reed v. Reed*, 404 U.S. 71, 76 (1971))).

227. *Lantz by Lantz v. Ambach*, 620 F. Supp. 663, 665–66 (S.D.N.Y. 1985) (striking down school policy prohibiting girls from playing football).

228. See *id.*

on the basis of safety similarly relies on overly broad generalizations. Certainly, sex-reassignment surgery and other treatments may be dangerous, but for some youths – ones who have met the Policy’s criteria, for instance – it may not be dangerous, and in fact would most likely be beneficial. ACS should not be able to decide that transition-related care is too dangerous for all youths just because it may be dangerous for some. As discussed above, the Policy’s criteria already serve to protect foster youth in terms of their medical decisions. If a young person has met the criteria listed in the Policy, then that youth has clearly made a well-thought-out, well-informed decision.²²⁹ Denying a transgender youth this treatment, when it is medically necessary and the youth understands the consequences, is in fact harmful to the youth.²³⁰ Without proper treatment, transgender foster youth will simply continue to be placed in improper group homes and harassed by peers and staff.²³¹ These youths will also continue to suffer from the primary harm of feeling distressed in their bodies.²³² Thus, ACS’s safety argument should fail heightened scrutiny.

Second, ACS may argue that by retaining the veto provision and using it to deny transition-related care to transgender youth, it is availing itself of the authority granted to it in Social Services Law § 398 as interpreted by *Mariah L.*²³³ This interest is also illegitimate. While the Social Services Law may indeed grant ACS authority, no law can give a local governmental agency the power to deny a particular group of people a constitutional right.²³⁴ This justification also does not appear to be “substantially related” to the means of denying transgender youth their care. By instituting the Policy in the first place, and creating its own criteria for determining when to provide non-Medicaid reimbursable care, ACS already preserved its authority and discretion. ACS thus can preserve its authority and utilize its discretion without treating transgender youth differently from cisgender youth – that is, it can accomplish this particular goal simply by following the Policy’s gender-neutral criteria. As the Supreme Court has noted that the availability of sex-neutral alternatives is a strong indication that a policy is not “substantially related” to an important government interest,²³⁵ this second interest also should fail heightened scrutiny.

Finally, ACS may view the denial of care as a simple expedient to conserve its financial resources. This argument likely is not “exceedingly persuasive,” as it is merely a variant of the “administrative convenience” argument declared unpersuasive in the Supreme Court’s gender equality jurisprudence.²³⁶ Should

229. See POLICY NO. 2010/04, *supra* note 14, at 5–6 (listing, inter alia, that a youth requesting non-Medicaid reimbursable treatment must have a physician recommending the treatment).

230. See, e.g., SHELLEY, *supra* note 59.

231. See, e.g., Estrada & Marksamer, *supra* note 39; MARKSAMER ET AL., *supra* note 3.

232. See DSM-IV-TR, *supra* note 4.

233. See N.Y. SOC. SERV. LAW § 398(6)(c) (McKinney 2011) (stating that ACS must provide medically necessary care to foster youth); *Mariah L. v. Admin. for Children’s Servs.*, 859 N.Y.S. 2d 8 (App. Div. 2008) (stating that Social Services Law § 398 gives ACS authority to provide medical care).

234. U.S. CONST. art. VI, cl. 2 (establishing the U.S. Constitution as the “supreme law of the land.”).

235. *E.g.*, *Nyugen v. Immigration and Naturalization Serv.*, 533 U.S. 53, 79 (2001) (“[T]he availability of sex-neutral alternatives is often highly probative of the validity of the classification.”); *Wengler v. Druggists Mut. Ins. Co.*, 446 U.S. 142, 152 (1980) (“But the question remains whether the statutory means employed – discrimination against women wage earners and surviving male spouses – itself substantially serves the statutory end.”).

236. See, e.g., *Reed v. Reed*, 404 U.S. 71 (1971) (declaring that outright preferences for one gender over another are impermissible if justified only by administrative convenience, and allowing administrative justifications only in rare situations). *But see* *Nguyen v. Immigration & Naturalization Serv.*, 533 U.S. 53 (2001) (upholding sex classification to preserve administrative convenience in determining whether

a court find this interest “exceedingly persuasive,” though, this argument is more likely to succeed on the “substantially related” prong than the other interests I have identified. Even so, it still should fail the heightened scrutiny test. Since only about 13% of foster youth are LGBTQ, and only some of them are transgender, and not all transgender foster youth desire sex-reassignment surgery, the instances where ACS would need to pay for an expensive procedure would be rare.²³⁷ ACS would, however, need to pay for some expensive hormones and surgeries. The cost of a male-to-female transition (including surgery and corresponding hormone treatment) has been estimated at around \$20,000,²³⁸ which is certainly not an insignificant amount. The low instances of having to pay for such a costly procedure, though, especially in light of the importance of the constitutional right at stake, should lead the financial interests argument to fail.

When presented with a similar issue in the context of the Department of Corrections’ (“DOC”) duty to provide transition-related care for inmates, the Eastern District Court of Wisconsin pointed out that the DOC is required to pay for procedures even more expensive than sex-reassignment surgery.²³⁹ That court therefore did not find the financial argument persuasive.²⁴⁰ Similarly, ACS must provide many expensive procedures if medically necessary.²⁴¹ ACS would have to pay for some transition-related procedures, though, and because some procedures here would require considerable expenses from ACS’s own funds, it is unclear whether this justification would succeed under the “substantially related” prong. It is significant, though, that this argument is at least highly questionable. ACS would not be able to depend on succeeding with the financial interest argument. Under heightened scrutiny, then, using the Policy’s veto clause to deny transition related care to qualified transgender youth appears to violate equal protection.

VII. CONCLUSION

“One time a [group home] staff member asked me, ‘Don’t you like men beating on you?’ Another staff even told me to kill myself . . . But I never really felt like I could change. I felt like I was who I was and that I couldn’t change that . . . When I got [to Green Chimneys Group Home], I finally felt content, and that I could be myself and unique at the same time.”²⁴²

– Mariah L.

prospective citizen has a close connection to the country).

237. MARKSAMER ET AL., *supra* note 3 (citing ANGELA IRVINE, CERES POLICY RESEARCH, THE INAPPROPRIATE USE OF SECURE DETENTION FOR LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER (LGBTQ) YOUTH (2009), presented at the Columbia University Gender on the Frontiers Symposium (April 10, 2009) (on file with MARKSAMER ET AL.)).

238. *Transgender Health Benefits*, TRANSGENDER AT WORK, <http://www.tgender.net/taw/tsins.html> (last visited Nov. 29, 2011).

239. *Fields v. Smith*, 712 F. Supp. 2d 830, 837 (E.D. Wis. 2010).

240. *Id.* at 863.

241. See N.Y. Soc. Serv. Law § 398 (6) (c) (McKinney 2011. Transition-related care may be distinguished from many other forms of medically necessary treatment because many other procedures are not excluded from Medicaid coverage, and so where ACS would have to provide transition-related care from its own funds it could use Medicaid funds for procedures such as emergency heart surgery. The statutes and regulations, however, indicate that there are instances where ACS must provide care from its own funds (e.g., certain forms of disability treatment not covered by Medicaid), and those other expensive procedures indicate that ACS should also provide transition-related treatment.

242. Mariah Lopez, *Trapped!*, YOUTHSUCCESSNYC.COM, <http://www.youthsuccessnyc.org/lgbtq/>

The world is unsympathetic toward transgender youth. These youth, particularly those in the foster care system, face many small and large instances of discrimination and harassment every day.²⁴³ Rejected by families, friends, and schools, transgender youth in foster care often are doomed to dreary existences. Too many of these youth face physical violence and emotional trauma in their everyday lives.²⁴⁴ Against these odds, many of these young people have shown amazing strength in resisting oppression, standing up for their rights, and rising above these hardships.²⁴⁵ Their efforts would be made easier, though, if society would recognize their plight and work with them in changing it. The Administration for Children's Services is duty-bound to ensure that each child in its care is safe.²⁴⁶ ACS is in a unique position to help transgender youth. Indeed, when placed into a group home where the staff respected her female name and allowed her to dress in female clothing, one transgender young woman stated, "I don't feel so alone here. Here I feel normal."²⁴⁷ The Non-Medicaid Reimbursable Policy could be a powerful tool to bring this kind of hope to more transgender foster youth. As it stands, however, the Policy is simply another instrument of oppression.

The veto clause in the Non-Medicaid Reimbursable Policy raises serious constitutional issues. The unbounded discretion it gives ACS over a youth's medical treatment runs afoul of the Due Process Clause, and a discriminatory application would violate equal protection. Because of these serious legal problems, it is necessary that ACS amend the Policy. Transgender youth already are denied their families, their education, and their peace of mind. ACS should not deny them their rights as well.

stories/Trapped-Lopez.html (last visited Mar. 16, 2012). This story was written when Mariah was fourteen, before *Mariah L.* entered the courtroom. Today, Mariah is an activist for transgender rights and one of the founders of FIERCE, an advocacy group for LGBTQ youth. See Lincoln Anderson, *Gay Bars and Neighbors Say, 'Anything Goes' Has Got to Go*, 79 THE VILLAGER 3 (2009), available at <http://thevillager.com/villager321/anythinggoes.html> (quoting Mariah L., "a transgender woman who was a founder of FIERCE").

243. See generally MARKSAMER ET AL., *supra* note 3.

244. For general background on the rejection and violence faced by transgender youth, see my discussion in Part II(B).

245. See generally JOEY L. MOGUL, ANDREA J. RITCHIE & KAY WHITLOCK, QUEER (IN)JUSTICE: THE CRIMINALIZATING OF LGBT PEOPLE IN THE UNITED STATES 147-49 (2011); FIERCE.ORG, <http://www.fiercenyc.org/index.php?s=1> (last visited Apr. 23, 2012).

246. See N.Y. City Admin. for Children's Servs., *Mission & Organization*, ACS.ORG, <http://www.nyc.gov/html/acs/html/about/mission.shtml> ("Every child we come into contact with will get the help (s) he needs to be healthy and achieve his/her full educational and developmental potential.") (last visited Nov. 19, 2011).

247. MARKSAMER ET AL., *supra* note 3, at 32 (quoting "Mimi").