

Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals

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Note: [*#] denotes the page number on which the article originally appeared in the journal. Thus [*88] indicates the beginning of page 88 in the original publication.

[*88] Health insurance has an enormous impact on determining who receives medical care. If a policy does not cover a particular treatment, an individual in need of care either pays for the medical procedure from her own resources or foregoes treatment altogether. When a person's income, rather than her established medical need, determines the quantity and quality of care she receives, society is confronted with troubling ethical questions of what type of medical delivery system it provides for its citizens.¹ Although this is an important inquiry, I begin this article by focusing on another disquieting aspect of health care access: How does the legal system respond to private insurers that do not cover treatments [*89] because of their dislike of a patient or their hostility toward a patient's condition?²

To date, the federal government has initiated two sweeping measures to protect patients who are denied health care for improper reasons. In 1965 Congress enacted the Medicaid Act to provide minimal medical care to lower-income individuals.³ One of its most important components prevents state legislatures from refusing treatment or reducing payment for a targeted or singled-out medically necessary condition.⁴ When a Medicaid recipient believes she is being unfairly denied medical treatment, she can turn to the federal courts to ensure that a state legislature's coverage of health conditions is based on proper medical and fiscal criteria.

The government's second major intervention occurred in 1990 when Congress passed the Americans with Disabilities Act (ADA).⁵ The ADA protects privately insured individuals by prohibiting private employers, insurers, and health care providers from targeting a particular medical condition for discriminatory treatment.⁶ The ADA does not directly influence the content of health insurance policies, however, which is why consumer advocates are calling for a Patients' Bill of Rights that, among other things, would mandate private insurers provide minimum standards of coverage in health care plans.⁷ Currently there is an Equal [*90] Employment Opportunity Commission order interpreting the ADA that indirectly regulates insurance policies, prohibiting a private employer from withholding employee coverage in a discriminatory manner.⁸ An employer's obligations in turn place economic pressure on insurance companies to standardize policy offerings. Further, the ADA provides individuals with a cause of action to ensure their employer's insurance company complies with the ADA's anti-discrimination provisions. Since the vast majority of Americans receive their health care from private employers, the ADA's dual-regulatory scheme and court-enforced remedies have been effective in providing many people with non-discriminatory access to health care.⁹

Against this backdrop, I examine the discrete issues of whether transsexual individuals are improperly denied health care and whether legal remedies are available to them. A transsexual is a person whose "gender identity (internal sense of being a man or woman) conflicts with [his or her] anatomical sex at birth."¹⁰ A transsexual person is not necessarily a gay man or lesbian (person emotionally and sexually attracted to the same sex), hermaphrodite/intersexed person (person born with female and male genitals), transvestite (person who cross-dresses as a form of self-expression); or transgendered person ("transgender" is often used as an umbrella term to "include everyone who challenges the boundaries of sex and gender," which includes, but is not limited to, effeminate men, masculine women, intersexed people, and transsexual individuals).¹¹ Confusion arises when people conflate these identities or believe they are mutually exclusive of each other. The exact number of transsexuals is [*91]

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unknown, but estimates range from one to three percent of the population.¹² Statistics generally report biologically-born men transition (take steps to change their anatomical sex) more frequently than biologically-born women, but the reported gender discrepancy reflects researchers' male bias rather than the actual occurrence.¹³

In the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),¹⁴ the American Psychiatric Association defines a subset of transsexuals as suffering from gender dysphoria or gender identity disorder.¹⁵ Although of unknown origin, the medical community defines gender dysphoria as extreme discomfort with one's anatomical body and a persistent desire to be accepted as a member of one's self-identified or "psychological" sex.¹⁶ Due to advances in medical science over the past eighty years, more and more transsexuals undergo sex-reassignment surgery¹⁷ and take hormone treatments to align their biological sex with their gender identity. The national and international medical community overwhelmingly endorses sex-reassignment surgery and hormones as the only known medical treatment for transsexuals.¹⁸ Not all [*92] transsexuals are diagnosed with gender dysphoria nor do all transsexuals desire surgical alignment.¹⁹ However, for many who do, denial of medical surgery can lead to depression and even trigger suicidal tendencies.²⁰

Despite the DSM-IV diagnosis, the medical community's internationally endorsed treatment, and the documented side effects of leaving gender dysphoria untreated, most public and private insurers explicitly exclude coverage for sex-reassignment surgery.²¹ n21 Many members of the general public are probably unconcerned upon learning this fact, believing that an insurer's refusal to cover "sex change operations" is a reasonable one. For many, the thought of a medical insurer paying for a sex change is what seems unusual.

However, closer examination of this issue is warranted. Sex-reassignment surgery (SRS) exclusion clauses are motivated by non-medical and non-fiscal criteria. Like all forms of discrimination, an unlawful action belies a much more dangerous and powerful intent to manifest further harm. In the health care setting, doctors and nurses who dismiss transsexuals' health needs provide transsexuals with sub-standard medical care.²² n22 Most disturbing, many insurers liberally apply the SRS exclusion clauses to deny transsexuals coverage for non-transition related, medically necessary conditions such as back pain, intestinal cysts, and even cancer, under the rationale that any medical care a transsexual needs is an excludable transsexual-related condition.²³

Since invidious bias permeates the entirety of health care administration, Congress designed the ADA to protect patients with stigmatized medical conditions from employers who whimsically deny medical insurance coverage and from doctors and nurses who treat patients with disrespect and humiliation rather than with medicine. The previously described examples of injury are precisely the nature of the harm intended to be remedied by the ADA. However, transsexuals who encounter this harm cannot turn to the ADA, because the ADA contains an explicit [*93] exclusion clause denying protection for conditions related to gender dysphoria.²⁴

In Part I of this article, I describe the social problem of how private insurers and practitioners rely upon the SRS exclusion clause to discriminate against people with, or believed to have, gender dysphoria, and I explore the legal problem of the ADA exclusion clause. Over the past thirty years, transsexuals have appeared before state and federal courts requesting protection against discriminatory treatment in their jobs, public health care programs, and

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prisons. Courts have equivocated over whether a transsexual individual should be protected on the basis of her sex, status as a sexual minority, transsexual identity, or not at all. The vast spectrum of legal response--from confused hostility to empathetic protection--calls for inquiry and examination.

In searching for a remedy to the ADA exclusion, Part II looks at cases involving other forms of discrimination against transsexuals and courts' responses to other situations in which a new identity has failed to fit neatly into the then-currently defined categories. For instance, by examining how courts grappled with whether "race" extends to white Hispanics, whether "sex" includes pregnancy, women of color, or even men, history demonstrates that courts have often erred when responding to complex identities. Rather than seizing opportunities to reexamine old assumptions about how discrimination operates and harms its victims, courts too often have wrung the novelty from the emerging categories to make them fit past understandings of how the world is ordered. After eschewing competing categories of constitutional protection for transsexuals, I propose a framework through which courts can more fully understand the nuances of transsexual identity and best respond to the various forms of discrimination transsexuals face. Using this framework, Part III explores how the ADA exclusion clause probably violates the Equal Protection Clause²⁵ and should therefore be reconsidered, and ultimately [*94] repealed. Only when the ADA is fully enforced will all citizens be able to receive the health care they need and deserve, free from categorical exclusion.

I. FORMS OF PRIVATE HEALTH CARE DISCRIMINATION

As described in more detail in Part I.C and III, the ADA was explicitly amended to exclude from coverage: "homosexuality, bisexuality, transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual disorders; compulsive gambling, kleptomania, or pyromania; or current psychoactive substance use disorders resulting from current illegal use of drugs."²⁶ To understand how transsexuals are disadvantaged by the ADA exclusion clause, I began by searching for relevant legal cases and literature. Examining court cases to glean such information was fruitless. There is no "paper trail" of alleged denials because privately insured transsexuals are precluded from seeking remedies from the courts. I then surveyed other academic and scientific literature, but there are no studies documenting why and under what circumstances transsexual individuals are denied care or the extent of the problem.

Frustrated by the lack of information, I contacted attorney Shannon Minter,²⁷ who described several encounters with individuals who had experiences with insurance companies that refused to cover expenses for non-transition related conditions for transsexual individuals, and with doctors who refused to treat transsexuals in need of medical care. Minter's response indicated that health care discrimination was occurring, but ironically, the extent and nature of the problem would remain unknown until its solution--a legal remedy against private insurers and providers--was in place. The possibility of ongoing discrimination prompted me to locate and interview individuals from around the country who have first hand knowledge of how transsexuals are treated when they seek medical care.²⁸ Forty of the respondents were transsexual individuals and two were medical providers.

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[*95] I recognize the limitations inherent in conducting such interviews, primarily that the number of transsexuals located is a small sample and there is no means by which to determine how representative the population interviewed is of the larger transsexual population. However, this initial effort is an important starting point. Even as a preliminary investigation, the findings provide valuable information about health care discrimination that is otherwise unavailable in currently published reports, studies, or legal cases. Other academic fields have long recognized the value of information gleaned from interviews, and in legal scholarship there are a growing number of scholars who assert that even though individual stories are neither typical nor validated objectively they constitute a legitimate epistemology.²⁹

When I asked the interviewees about their experiences with medical insurers and providers, a large number reported discrimination by doctors, which often resulted in the transsexuals not receiving health care. In addition, the interviews confirmed that insurance companies use the SRS exclusion clause to deny any medical treatment to transsexuals on the grounds that any health care need required by a transsexual is an excludable transsexual-related condition. To my surprise, a number of individuals described having had positive experiences. The interviewees reported having doctors or employers who served as successful advocates against insurers' denials of health coverage, and even more importantly, a quarter of those interviewed had insurance companies that offered complete coverage for all medical conditions, including SRS surgery.³⁰ This initial, informal investigation raises two important points needing further attention. [*96] First, given that many employers and insurance companies will cover SRS procedures, on what basis can other insurance providers justify their refusal to cover SRS procedures?³¹ Second, given the dire consequences of health care providers' refusal to treat patients, the current failure of the government to provide transsexuals with legal means by which to redress discriminatory treatment calls for reconsideration.

A. Discrimination by Private Insurers and Medical Providers

1. Examples of Private Insurance Discrimination against Transsexuals

Many private insurance companies exclude SRS and hormone treatments from their coverage.³² Insurance companies defend the exclusion clause denying coverage of SRS as a reasonable measure to contain costs and disallow superfluous procedures. However, the medical profession is in near consensus that SRS and hormone treatment are the desired treatments for transsexuals.³³ Further, interviewees report some insurance companies pay for hormone treatment,³⁴ surgeries such as orchidectomy (removal of the testes)³⁵ and vaginoplasty (construction of a vagina),³⁶ and even entire sex-reassignment surgeries.³⁷

The lack of rational medical or fiscal justifications suggests that the insurance policies' SRS exclusion clauses operate as a pretext for other purposes. The interviews confirmed that the most disturbing aspect of these exclusionary clauses is that they are being broadly applied to deny transsexuals medical care for non-transition related conditions they will or have acquired. For example, interviewees report being denied entire [*97] medical plans once the insurers learned they were transsexual.³⁸ The insurers defend their denials by stating that because every treatment will have the end result of surgery, the exclusion clause extends to cover all health conditions developed by transsexuals.³⁹ This justification is even used to deny coverage to "post-

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op" transsexuals who have already undergone surgery.⁴⁰

Insurers also rely upon the clauses to terminate coverage for existing non-transition treatments. The interviewees reported that any mention of requesting treatment for gender dysphoria resulted in insurance companies stopping coverage for unrelated treatments such as anti-depression medication⁴¹ and psychological care that had been on-going for ten years.⁴² In addition, a therapist reported that an insurance company denied her *non-transsexual* patient therapy coverage. Because the patient spoke about her spouse who was contemplating a sex-reassignment operation, the insurer reasoned that the exclusion clause extended to exclude from coverage the non-transsexual's therapy sessions.⁴³

In the most extreme example, an insurer denied a transsexual coverage for routine treatments: office visits, blood tests, physical exams, sinus medication, and two emergency visits, once for a cut on the hand and another for a deviated septum. The insurance company also refused to cover treatment for her upper intestinal disorders, kidney cysts, and neck damage due to a work related accident. When the woman appealed the [*98] denial of non-gender dysphoria related medical treatments, the insurer told her that her medical treatment was denied because of her "condition," a reference to her transsexuality.⁴⁴

2. Examples of Discrimination by Health Care Providers against Transsexuals

Most doctors would probably agree that failure to treat a patient is unconscionable and contrary to their ethical responsibilities. A medical resident explained that although some of her colleagues made jokes about transsexual patients behind their backs, her colleagues and the hospital where she worked never let such views interfere with their professional responsibilities to provide quality care.⁴⁵ Unfortunately, the interviews reveal that not all doctors adhere to these standards.

For instance, interviewees report incidents such as doctors who gape at their bodies⁴⁶ and refer to them by their non-requested pronoun.⁴⁷ Medical providers also turn away transsexual patients known to need medical treatment.⁴⁸ Doctors openly inform turned-away patients of their discomfort; in one instance, a hospital representative informed one patient that they did not treat her "kind."⁴⁹ In Washington, D.C., ambulance workers were tending to a woman who had been hit by a car. Once they realized the patient was transsexual, they cracked jokes, insulted her, and stopped administering care, resulting in her death (and a \$2.9 million wrongful death jury award).⁵⁰

Interviewed transsexuals also report that hospitals often prevent their own physicians from administering procedures to transsexual patients.⁵¹ Female-to-male transsexuals report doctors who will not [*99] administer gynecological care, even when patients have abnormal vaginal discharges.⁵² In an extreme case, when a transsexual was diagnosed with cancer, a psychiatrist tried to commit him, telling him that his contraction of cervical cancer should make him "deal with the fact that he is not a real man." Over the next ten months, over twenty gynecologists refused to treat him, often explaining that they could not help him as their other patients would be uncomfortable sitting next to him in the waiting room. Although the man finally found a doctor willing to treat him, he ultimately died from the cancer that had spread untreated for months.⁵³

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3. Transsexuals' Absence of Legal Recourse

If the incidents described in Part I.A had involved public funding or government hospitals, Medicaid provides protections and a cause of action that transsexuals have successfully used to challenge the SRS exclusion clauses.⁵⁴ However, any disputes between a patient and her *private* insurer are a matter of contract law. During the 1970s, when insurance companies began denying payment for SRS, a transsexual sought a declaratory judgment in state court stating that her insurer had a contractual obligation to pay for SRS under its agreement to cover "all medically necessary procedures."⁵⁵ The insurance company defended its refusal to pay for the [*100] surgery on the basis that it was cosmetic in nature. The court reviewed the available medical literature and court decisions involving Medicaid and determined that SRS was a medically necessary, and therefore covered, medical procedure. Although the plaintiff received her payment, many insurance companies avoided covering future sex-reassignment surgeries by creating policies with an explicit clause denying coverage to all conditions related to SRS. No longer a matter of contract interpretation, the narrowed clause became a bargained-for contractual term, precluding further private actions against an insurer. However, the notion that health care policies contain bargained-for terms is a legal fiction given that most patients are stuck with the insurance offered by their employer. Individual consumers simply do not have the power to force a multi-million dollar company to change any terms of the blanket policy it offers to thousands, if not millions, of customers.⁵⁶

In the past, insurance companies have also claimed that other treatments such as prenatal care,⁵⁷ post-mastectomy breast reconstruction,⁵⁸ and contraception⁵⁹ are either too costly or not medically necessary. In response, Congress and some state legislatures have mandated that private insurance companies cover these procedures.⁶⁰ This stop gap measure is currently an infeasible solution for transsexuals. Transsexuals lack the necessary political clout to pass such measures due to the enormous social hostility they face.⁶¹

[*101] If a non-transsexual had the problems described in Part 1.A--difficulty receiving health care due to doctors or private insurance companies that were biased against her--she could turn to the ADA for protection. The Americans with Disabilities Act⁶² has been heralded as the most sweeping civil rights legislation since the Civil Rights Act of 1964.⁶³ "The purpose of the ADA is to provide a clear and comprehensive national mandate to end discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life."⁶⁴ Prior to the enactment of the ADA, the Rehabilitation Act of 1973⁶⁵ was the primary form of federal protection available to persons with disabilities.⁶⁶ The Rehabilitation Act prohibited physicians and hospitals that received public funding from discriminating against disabled people. However, the Rehabilitation Act failed to prohibit discrimination by private employers, state and local agencies, transportation services, and places of public accommodation.⁶⁷ n67 Congress therefore designed the ADA to complement, not preempt, the Rehabilitation Act by extending its anti-discrimination mandate to all hospitals, schools, federal, state, and local agencies, and places of public accommodation.⁶⁸

If a person with HIV or a paraplegic encounters a doctor who refuses to treat her based on the doctor's intolerance of or hostility toward the medical condition, the ADA protects the patient by offering her a cause [*102] of action against discriminatory treatment of disabled

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individuals by private health care providers who work out of private offices.⁶⁹ If a person with alcoholism or schizophrenia is unable to receive health care insurance because her employer or her employer's insurance company thinks the condition does not merit treatment or is too costly, the patient can rely upon the ADA to ensure that her private employer provides coverage for its employees in a non-discriminatory manner.⁷⁰ This basic guarantee that private health care will be offered and administered in non-discriminatory ways is not available to transsexuals because the ADA contains an explicit exclusion against covering transsexualism and gender identity disorders.⁷¹

B. Why Transsexuals Should Qualify for Protection Under the ADA

1. Legal Understandings of Disability

Under both the ADA and the Rehabilitation Act, a disability is defined as: "(1) a physical or mental impairment that substantially limits one or more of the major life activities . . . ; (2) a record of such impairment; or (3) being regarded as having such an impairment."⁷² A pre-ADA case, *Doe v. U.S. Postal Serv.*⁷³ demonstrates why gender dysphoria is a legal disability. In *Doe*, a transsexual employee claimed that her employer violated the Rehabilitation Act when he fired her after she informed him of her plans to change her sex. The plaintiff claimed, in part, that she qualified under the statute due to "her medically and psychologically established need for gender reassignment surgery." In support of her claim, she referred to the DSM-II, today the DSM-IV, definition of gender dysphoria.

The question in *Doe* was whether the particular medical condition of gender dysphoria rose to the level of a physical or mental "impairment which substantially limits one or more of such person's major life activities." The court reasoned that because "impairment" can be "any mental or psychological disorder,"⁷⁴ the DSM diagnosis falls within this [*103] definition. Second, because "major life activity" includes "functions such as caring for one's self, . . . speaking, breathing, and working,"⁷⁵ the court concluded that being fired from one's job qualifies as a substantial limitation on a "major life activity." Finally, as the definition of a disabled person "extends to those who are merely regarded by others as having an impairment which substantially limits major life activities," the court reasoned that the plaintiff had a viable claim under the Rehabilitation Act. Accordingly, the court permitted the claim to proceed to trial.⁷⁶

Under *Doe*, pre-operative transsexuals diagnosed with gender dysphoria satisfy all three prongs of what constitutes a disability, and transsexuals imputed to be impaired, regardless of whether the transsexual has had SRS or never plans to undergo surgery, meet the third aspect of this legal definition. *Doe's* legal conclusion that gender dysphoria is a medical condition meriting medical treatment is one shared by many other courts. While no federal appellate court has examined whether gender dysphoria is a Rehabilitation Act or ADA defined disability, in the Medicaid context, federal and state courts have determined that sex-reassignment surgeries are a medically necessary procedure for transsexuals who are diagnosed with gender dysphoria.⁷⁷ Internationally, the United Kingdom High Court of Justice ruled that denial of sex-reassignment and hormones to transsexuals [*104] by the national health system was without medical support.⁷⁸ Even more to the point, in the congressional debate over the ADA, senators were in complete agreement that transsexuals facing discrimination meet the ADA's legal definition of

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disability and discrimination.⁷⁹ As explained in Part III, the senators opposed to protecting transsexuals introduced an amendment to deny protections precisely because the medical and legal authorities supported the Rehabilitation Act's protection of transsexuals.

2. Controversy over the DSM's Classification of Gender Dysphoria as a Disability

In 1973, out of pressure from gay activists and a growing societal tolerance of gay individuals, the American Psychological Association stopped classifying homosexuality as a medical condition. However, in the subsequent version of the DSM, DSM-III (1980), "gender identity disorder" (later interchangeable with "gender dysphoria") was listed as a cognizable psychological condition for the first time. Some transsexual and gay activists are critical of inclusion of gender dysphoria in the DSM for two main reasons. First, although most medical professionals only administer treatment of gender identity disorder to adults, non-mainstream doctors still rely upon the diagnosis to prevent a child from growing up gay or transsexual. Parents and professionals have administered aversion therapy and behavior modification to effeminate boys and masculine girls for the purpose of keeping girls feminine and boys masculine. Activists are concerned that in practice, the removal of homosexuality from the DSM is disingenuous since a newly found disorder will be used to cure children of "gender non-conformity" through the same discredited techniques that were used to cure gay adults of their "sexual orientation."⁸⁰

[*105] Activists are rightfully concerned about the flagrant abuse of children--that is, forcing them to conform to traditional gender roles through emotional and physical abuse--and subsequently call for the end of diagnoses of gender identity disorder in children. However, I argue that the *existence* of gender identity disorder as a medical disability is not the reason that non-mainstream doctors abuse children under this heading. Doctors that continue to subject children to such harms are most likely motivated by the desire to prevent adult homosexuality and transsexuality.⁸¹ In such [*106] circumstances, gender dysphoria is turned into a tool to realize means and ends contrary to the medical profession's endorsement. Ending the diagnosis of *childhood* gender identity disorder is appropriate, ending the diagnosis of *adult* gender identity disorder is not. The treatment of transsexual adults, unlike the children who are subjected to these procedures, is voluntary, cautiously administered, and internationally endorsed as the proper medical treatment for a mental condition. Removing adult gender identity disorder from the DSM deprives adult patients any means of receiving needed medical treatment. The repeal of gender dysphoria should therefore be limited to childhood applications.

Second, some activists are concerned about the implications of having their identities classified as a mental disability. Before homosexuality was dropped from the DSM, lawmakers justified denying gay men and lesbians civil rights because homosexuality was deemed a medical disorder.⁸² Transsexual activists in turn cite concerns that DSM definition of gender dysphoria will be used against them to prevent them from entering mainstream society as healthy, and therefore equal, human beings. I argue, however, that the medicalization of the transsexual identity may actually be the means by which transsexuality is no longer stigmatized. Unlike the medical classification of homosexuality that was designed to impair gay people's advancements in society, the classification of gender dysphoria, and ADA's definition of legal disability, protects transsexuals from discrimination.

For instance, not all transsexuals are categorized as having gender dysphoria, it is only a

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subset requiring medical treatment who receive this diagnosis. I find this case-by-case diagnosis significant. Unlike the blanket conclusion that all gay people are deficient, gender dysphoria is diagnosed only for an individual who is in actual need of treatment. Moreover, the medical treatment for transsexuals is an internationally endorsed process that allows transsexuals to realize their identities, in sharp contrast to the aversion therapy applied to gay people that was intended to deny them their core identities. Additionally, "disability" as legally defined by the ADA and the Rehabilitation Act does not necessarily require a showing of pathology or permanent condition. For instance, some transsexuals only need medical care while they transition. Administering treatment to someone for a specific window of time parallels treatment of women who suffer from the disability of pregnancy receive medical care only for the prenatal and birthing period. Likewise, some transsexuals need hormone treatment for an indefinite period, akin to the long-term care diabetes or asthma patients receive. As shown in the interviews with transsexual patients in Part I, without the medical understanding of "gender dysphoria," people would not have access to SRS and hormone treatment to assist them in aligning their gender identities with their anatomies.

[*107] The stigma of having gender dysphoria, then, does not arise from the actual medical condition or disability, but from societal discrimination toward it. Pragmatically speaking, the ADA definition of "disability" is the only means by which people can receive protection from discrimination. Denying someone medical treatment out of fear that others will pathologize her condition only takes away needed medical benefits and does not assuage any underlying societal prejudice against transsexuals. Protecting gender dysphoria as a medical condition and a legal disability is essential in guaranteeing that the woman who leaves work--either to have a child or to have sex-reassignment surgery--can return to the same job without discrimination in pay, advancement, or medical benefits. Calls to remove adult gender dysphoria from the DSM are simply without medical support, and worse, analogizing the treatment to the now discredited homosexuality classification obscures the needed legal protections to which those with gender dysphoria, like pregnant women before them, are entitled.

C. How the ADA Fails to Protect Transsexuals from Discrimination

In September 1989 as the ADA was nearing its final vote, Senators Armstrong and Helms took the floor and objected to the ADA's coverage of certain psychological conditions. Due to the Senators' efforts, the ADA was explicitly amended to exclude from coverage "homosexuality, bisexuality and transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual disorders; compulsive gambling, kleptomania, or pyromania; or current psychoactive substance use disorders resulting from current illegal use of drugs."⁸³ Under this bill, the Rehabilitation Act was also amended to exclude coverage of these conditions.⁸⁴ Transsexuals need coverage under the ADA to protect themselves against private insurers and medical providers who harbor hostility toward them. As much as Congress has the right to withhold benefits or favor some groups over others, I argue in Part III that the categorical exclusion of transsexuals from the ADA is a constitutionally impermissible congressional action. In formulating appropriate legal remedies, I begin Part II by examining competing jurisprudential conceptions of transsexual identity.

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II. COMPETING LEGAL CLASSIFICATIONS OF TRANSSEXUAL IDENTITY

A. Traditional Legal Categorization of Transsexuals

Transsexuals have been before the courts for over thirty years, yet there is no consensus on whether transsexuals should be protected on the basis of sex, transsexual identity, or not at all. In an early seminal case, *Holloway v. Arthur Anderson & Co.*,⁸⁵ a transsexual plaintiff brought a Title VII and equal protection action against her employer for firing her after she announced her intention to transition. The Ninth Circuit dismissed the Title VII claim because "sex" does not extend to transsexuals and dismissed the equal protection claim because transsexuals do not constitute a suspect class.⁸⁶ In reaching this conclusion, the court reasoned that "the complexities involved merely in defining the term 'transsexual' would prohibit a determination of suspect classification for transsexuals."⁸⁷ In further explanation, the court cited to an early footnote expressing implicit anxiety that anyone could have gender dysphoria because the origins of transsexuality are unknown.⁸⁸ Presumably then, because the origins of transsexuality are indeterminate and the transition from one gender to another is a fluid process, a transsexual, by definition, can never belong to a "discrete and insular" minority, and therefore is ineligible for constitutional protection.

For the next twenty-three years, other circuits consistently relied upon the reasoning in *Holloway* when denying transsexuals protection based on Title VII and equal protection claims.⁸⁹ The courts often cited *Holloway* as an unquestioned conclusion that transsexuals have no claim to legal protection because they do not fall into a traditional suspect class.⁹⁰ [*109] For example, in *Kirkpatrick v. Seligman & Latz, Inc.* a district court also denied a male-to-female transsexual's claims to Title VII and constitutional protection. Since biological men do not form a suspect class, the court concluded that neither do non-biological men.⁹¹ In *Voyles v. Ralph K. Davies Medical Center* a district court denied a Title VII action because the transsexual was akin to "homosexuals and bi-sexuals" who were not intended to be protected under Title VII as evidenced by the failed amendments to include "affectional or sexual preference" under Title VII protection.⁹²

Holloway's emphasis on suspect classes is a product of equal protection jurisprudence. According to the Supreme Court, the Equal Protection Clause demands that when a law implicates a fundamental right or classifies people based on particular characteristics, it must undergo a heightened form of review.⁹³ Analysts and courts cite "prejudice," "insularity," "discreteness," and political or numerical "minority" as typical indicators of a "suspect class."⁹⁴ Race⁹⁵ and gender,⁹⁶ for example, are two suspect classes that the government generally may not use to distribute benefits and responsibilities among citizens. A racial classification may be permissible if the government can demonstrate a categorization narrowly tailored to satisfy a compelling state interest.⁹⁷ Gender classification is subject to less stringent review, instead the government must show that the classification is substantially related to an important government objective.⁹⁸

However, as cautioned by commentators, determining and justifying who comprises a suspect class under the Equal Protection Clause can be a misleading endeavor. The promise of

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equal protection of the laws is intended to curtail the government's hostility toward a group absent a persuasive government interest. The gravity of the need to check arbitrary uses of government power should not depend upon the identity of the targeted group. For this reason, the Holloway emphasis on suspect class is [*110] mistaken. Under this traditional approach, courts questioned whether transsexuals are like women, the only category the court assumed was protected by notions of "sex" under anti-sex discrimination measures such as Title VII, various state laws, and the Fourteenth Amendment. However, by concluding the transsexuals were more like men, homosexuals, or beyond an analogy, the courts failed to address whether the discrimination faced by transsexuals was the type of discrimination meant to be checked by statutory and constitutional prohibitions. The traditional approach is inadequate because the question to answer in equal protection analysis is not whether the class is suspect, but whether the government's classification is unjustified.⁹⁹

B. Burgeoning Legal Protections for Transsexuals

In *Schwenk v. Hartford*,¹⁰⁰ the plaintiff, a male-to-female prisoner housed in a men's prison, brought a 1983 and Gender Motivated Violence Act (GMVA) claims against her prison guard for his alleged rape attempt. The prison guard claimed that Schwenk did not have a valid claim because, among other reasons, Schwenk is man, and thus outside the GMVA protections intended for women. The guard also contended that since Schwenk is a transsexual, he is precluded from advancing any gender-based cause of action because gender dysphoria is a "psychiatric illness," not a gender-based identity.¹⁰¹ The guard's defense is consistent with the reasoning of *Holloway* that transsexuals cannot be protected because they fail to be like women or constitute a suspect class. However, the Ninth Circuit soundly rejected this reasoning, and in dictum, overturned *Holloway*.¹⁰²

The Ninth Circuit referred to *Price Waterhouse*¹⁰³ in which the Supreme Court interpreted Title VII to prohibit discrimination against the plaintiff because she was a woman and failed to "act like a woman." Applying this analysis to the facts in *Schwenk*, transsexuals fall under the rubric of protection because they fail to fulfill the prescribed notion that women do not transition from one sex to another, or that all women are born women. Significantly, the court concluded that under Title VII and the GMVA, "gender," defined as the "socially-constructed" expectations of [*111] how men and women are supposed to act,¹⁰⁴ and "sex," defined as the "biological differences between men and women,"¹⁰⁵ have "become interchangeable."¹⁰⁶

The *Schwenk* decision makes a point of rejecting the object of discrimination as being a stumbling block to redressing wrongs. The court rejects the traditional *Holloway* reasoning by declaring, "the gender of the rapist or the victim does not make the assault in question any more acceptable under the Eighth Amendment,"¹⁰⁷ and "the Supreme Court recently held [that Title VII] has long protected men from sex discrimination and harassment regardless of the gender of the supervisor perpetrating the discrimination."¹⁰⁸ The significance of the court's emphasis away from the object of discrimination allows for the court to conclude that in this particular instance, *Schwenk* was discriminated against because of her failure to conform to societal expectations of gender.

Schwenk is notable for rejecting reliance on traditional suspect classifications--race and

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gender--as stopping points for a determination of discrimination. The Ninth Circuit instead used the theoretical underpinnings of "sex" found in *Price Waterhouse*. No longer confined to women alone, sex discrimination is more aptly understood to be discrimination against a person who fails to conform to societal expectations of her gender, which includes everything from women who do not wear make-up to men who do. By eschewing the Holloway inquiry of whether transsexuals are women, sexual minorities, or compose a suspect class, the Ninth Circuit demonstrates how anti-discrimination law can be more responsive to actual harm faced by individuals. As discussed in the next section, other courts agree with Schwenk's protection of transsexuals under the Title VII sex discrimination provision and, by examining these cases more thoroughly, I argue that the same reasoning can be applied to Fourteenth Amendment jurisprudence.

1. Protecting Transsexuals under Anti-Sex Discrimination Measures

Some courts recognize that discrimination against transsexuals is a form of sex discrimination. In *Ulane v. Eastern Airlines, Inc.*,¹⁰⁹ a district court reasoned that firing a transsexual employee for her sex-reassignment [*112] operation was a form of sex discrimination under Title VII.¹¹⁰ The court began its analysis of the definition of "sex" by citing *Carrillo v. Illinois Bell Telephone Co.*,¹¹¹ which held that white Hispanics, like non-white Hispanics, are protected on the basis of race.¹¹² The court stated that the applicability of *Carrillo* is that

it is illustrative of the fact that the things we think we know we do not necessarily know and that people sometimes react to other people according to stereotypes, misperceptions, and other motivations which are arguably discriminatory and are arguably redressable under statutes which might not be thought ordinarily to apply to those situations.¹¹³

The court continued that because the scientific community rejects sex as "a cut-and-dried matter of chromosomes," the definition of sex under Title VII should not be interpreted in a limited manner.¹¹⁴ Although the Seventh Circuit reversed, eschewing this reasoning for a limited definition of sex based on congressional intent,¹¹⁵ the district court's expansive understanding of sex discrimination to protect transsexuals is endorsed by other courts. Recently the European Court of Justice emphatically argued that firing a transsexual for undergoing a sex change is obviously motivated by sex discrimination.¹¹⁶ Likewise, in *Miles v. New York Univ.*,¹¹⁷ a district court held that Title IX protections against sex discrimination extend to a male-to-female transsexual. In *Maffei v. Kolaeton Ind., Inc.*,¹¹⁸ n118 a state court extended the definition of sex under local law to protect a transsexual who was fired from his job.

[*113] The courts' dispute is over the meaning of "sex," whether it is limited to women or is intended to include transsexuals. In support of the more expansive view, over the past thirty years the Supreme Court's definition of sex discrimination has continued to evolve. In 1971, the Court announced in *Reed v. Reed*¹¹⁹ that arbitrary preference for one sex over another violates the Equal Protection Clause. In *Weinberger v. Wiesenfeld*,¹²⁰ the Court expanded this definition to include "gender-based generalizations." In *Mississippi Univ. for Women v. Hogan*,¹²¹ the Court struck down a nursing school exclusion of men because "if the statutory objective is to

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exclude or 'protect' members of one gender because they are presumed to suffer from an inherent handicap or to be innately inferior," the objective, and therefore statute, is "illegitimate."

In *Geduldig v. Aiello*¹²² and *General Elec. Co. v. Gilbert*¹²³ the Court temporarily halted this expansion by refusing to recognize denial of pregnancy coverage as a form of sex discrimination. The Court observed in *Geduldig*, "The California insurance program does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition--pregnancy--from the list of compensable disabilities."¹²⁴ After Congress overturned this holding under the Pregnancy Discrimination Act (PDA), the Supreme Court subsequently endorsed denial of pregnancy benefits as a form of sex discrimination in *California Fed. S. & L. Ass'n v. Guerra*.¹²⁵ To clarify its new position, the majority reiterated Justice Brennan's dissent that Congress adopted in the PDA:

Discrimination is a social phenomenon encased in social context and, therefore, unavoidably takes its meaning from the desired end products of the relevant legislative enactment . . . that may demand due consideration of the uniqueness of the "disadvantaged" individuals. A realistic understanding of conditions found in today's labor environment warrants taking pregnancy into account in fashioning disability policies.¹²⁶

[*114] Along this march of recognizing "sex" as a socially determined meaning, the inclusion of transsexuals under sex-based discrimination is the next logical progression. As pointed out by commentators, if a Muslim were fired from her job for converting to Christianity, the courts would easily conclude that the plaintiff lost her job because of religious discrimination.¹²⁷ Investigating the authenticity of her conversion or whether the first religion is more innate to her than her chosen one are questions that the court would not ask in coming to this conclusion. In comparison, in past transsexual cases, courts have been less inclined to protect the plaintiff from discrimination unless the court concludes whether the biological or chosen gender is the "real" one and whether a transition from one gender to another bars protection based on sex.

2. Introducing the Overlapping Identities Framework

Understanding discrimination as a complicated process is important in devising appropriate legal remedies for an actor's illegal actions. When black women brought forward claims of discrimination under Title VII, courts initially denied them protection, stumbling over the intersection of race and sex.¹²⁸ The courts reasoned that a group of black women was not entitled to protection under Title VII unless they could prove that animus was directed also at white women¹²⁹ or all black men.¹²⁹ The courts would not entertain the possibility that black women were singled out for discrimination.^{130 131}

Professor Crenshaw critiques the courts' traditional approach as "an uncritical and disturbing acceptance of dominant ways of thinking about [*115] discrimination."¹³² The problem with the traditional reasoning is that only a privileged subgroup defines the norm, and the most vulnerable members of a group are left without protection unless their experience mirrors that of the privileged members. "The point is that black women can experience

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discrimination in any number of ways and that the contradiction arises from our assumptions that their claims of exclusion must be unidirectional."¹³³ For instance, when gender discrimination is understood based on the experience of white women, the law eludes how sexism is manifest for other women. Equal protection analysis must not replicate the process of erasure by failing to extend protections to subgroups who, because they do not fit traditional definitions, often times need the protection most. Different actors harbor bias toward non-white people, women of all ethnicities, and at times, specifically against women of color. On some occasions, a person will be discriminated against based on one form of discrimination; at other moments, a combination of biases may converge.¹³⁴

In *Lam v. University of Hawaii*,¹³⁵ the Ninth Circuit adopted the overlapping identities framework articulated by Professor Crenshaw. In *Lam*, a female Asian law professor claimed that the university did not offer her a position in violation of the Title VII prohibitions against discriminating based on race, her Vietnamese national origin, and gender. The district court denied *Lam's* allegations of discrimination because the university's initial offering of the position to a Chinese-American man indicated a lack of racism, and the university's subsequent offer of employment to a white woman exonerated charges of sexism.¹³⁶ The Ninth Circuit rejected the district court's reasoning, explaining that race and sex cannot be separated because "bisecting a person's identity at the intersection of race and gender often distorts or ignores the particular nature of their experiences."¹³⁷ Accordingly, the court allowed *Lam's* claim of overlapping discrimination--bias based on gender, race, and national origin--to go to trial.

3. Applying the Overlapping Identities Framework to Transsexual Identity

The puzzle over how transsexuals should be protected is not effectively resolved by determining which box transsexuals fit into best. [*116] Similar to *Lam's* protection of women of color, legal doctrines need to be responsive to the nature and cause of real-world discrimination against transsexuals. When a transsexual was fired based on her employer's intolerance of her gender change, *Miles v. New York Univ.* rightfully extended protection to her under Title IX as a woman facing discrimination because of her gender.¹³⁸ When a transsexual was imputed to be a sexual minority and subjected to repeated abuse and persecution on the belief that he was a gay man, *Hernandez-Montiel v. INS* correctly extended the same level of protection other gay individuals would receive, which in the context of immigration law was asylum based on imputed sexual orientation and gender identity.¹³⁹ Most importantly, when an employer discriminated against an employee because of the person's transsexuality, *Maffei v. Kolaeton* reasoned well by claiming the employee should be able to sustain a claim of discrimination without having to show that the employer is also discriminating against either gay or female employees.¹⁴⁰ *Holloway's* flaw was in ignoring the fluidity of transsexual identity when deciding transsexuality was not like "sex." Although more and more courts are protecting transsexuals under sex-based protections, I argue that courts should also continue to recognize the evolving protections for transsexuals based on imputed sexual orientation and transsexual identity. These grounds are neither divergent nor conflicting, rather the multiple protections make sense in light of the complex nature of the discrimination a transsexual faces. Rather than seeking to solidify protections under one static category, the courts should protect a transsexual against the type of discrimination she faces, whether based on her sex, sexual orientation, or

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transsexual identity.

By surveying past responses to Title VII and equal protection cases brought by women of color, pregnant workers, men in traditionally female workplaces, masculine women, and white Hispanic people, the various cases reveal two important points consistent with the adoption of the expansive understanding of transsexual identity. First, history shows that the courts were once reluctant to protect a variety of people who were perceived to have "complicated" identities that by definition fell outside the scope of discrimination law. Second, as the courts puzzled their way past the novelty, the cases demonstrate that anti-discrimination law is indeed capacious enough to encompass complexities. Building upon these [*117] insights, fashioning an expansive response to transsexual identity in antidiscrimination law is no longer a novel project, but rather a means by which anti-discrimination law can be more responsive to forms of discrimination that may affect us all.

III. CHALLENGE TO THE AMERICANS WITH DISABILITIES ACT

At first impression, a transsexual's equal protection challenge to the ADA exclusion clause may seem unlikely to prevail.¹⁴¹ Transsexuals are not currently a suspect class, and health care is not understood to be a fundamental right; therefore, the government need only show a rational basis for its exclusion clause. This argument is flawed, however, because it fails to recognize that the Supreme Court's evolving and capacious definition of sex discrimination can extend protections to transsexuals. Second, even without a pre-existing suspect class, the Supreme Court has a one hundred year history of guarding against invidious classifications that are based on social animus directed at a group of people perceived to be sexual and social outcasts. By applying the overlapping identity framework, which allows for multiple grounds of protection, two different, yet complementary, constitutional challenges to the ADA exclusion clause are advanced.

A. ADA Exclusion Clause as Sex Discrimination

Examining the legislative history helps to determine whether the ADA exclusion clause was motivated by sex discrimination. On September 5, 1989, Senator Armstrong began a two-day discussion by explaining that although he was willing to pass legislation that extended "help[] to people in wheelchairs or who have some kind of physical disability or handicap of some sort and who are trying to overcome it,"¹⁴² he was unwilling to support the bill if the ADA would protect those with "mental disorders."¹⁴³

Senator Harkin, the ADA sponsor, claimed he did not have enough information to answer his concerns. Senator Armstrong replied that his list of disorders "was drawn from court cases under [the Rehabilitation Act] which has similar definitions"¹⁴⁴ and that he "could not imagine the sponsors would want to provide a protected legal status to somebody who [*118] has such disorders . . . which in the opinion of some people have a moral content."¹⁴⁵ The next day, Senator Helms continued Senator Armstrong's challenge to the ADA. Senator Helms launched an inquiry of Senator Harkin asking whether the ADA would protect the following litany of

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conditions: "pedophiles," "schizophrenics," kleptomanics, "manic depressives," individuals with intelligence levels "far below standard average levels," people with "psychotic disorders," "homosexuals," "transvestites," and "people who are HIV positive."¹⁴⁶ This litany is significant as it is this grouping of conditions that ultimately formed the ADA exclusion clause.

In response, other senators selectively refuted the attacks of Senators Helms and Armstrong by proclaiming that President Lincoln suffered from manic depression, by introducing a report by the National Commission of AIDS to demonstrate the harm people with HIV face,¹⁴⁷ and by pointing to the fact that homosexuality is not a mental condition.¹⁴⁸ When Senator Helms first asked whether the ADA would cover a transvestite, Senator Harkin initially denied that a transvestite would be covered, but then corrected himself when an aide informed him otherwise. Senator Harkin stated that "one court at one time [Doe v. U.S. Postal Serv.] held that a transvestite was mentally impaired,"¹⁴⁹ but then quickly added that as Senator Helms had blocked protection to transvestites in the Fair Housing Act, Senator Helms could present a similar amendment "drafted the same way" to the ADA committee.¹⁵⁰

As Doe is a case protecting transsexuals and not transvestites, the Senators' conflation of the two reveals their ignorance about the medical complexities people with these conditions face. Transvestites are understood as individuals who cross-dress as a means of self-expression. Medical care, if any, only requires counseling to aid a person in accepting this form of actualization. A transsexual, on the other hand, requires counseling and surgical procedures to realign his or her biological and psychological sex. The Senators' ignorance is significant. It is no coincidence that all of the conditions defended by senators as legitimate medical conditions were dropped in the final bill, while all conditions not defended remained.

[*119] Bad or faulty information has historically led to bad and faulty medical policies. The medical community's history of ignoring the medical needs of non-male individuals, for example, is well-documented.¹⁵¹ For most of this past century, the medical community preferred to test medicine on male subjects because men lacked hormonal variances (the preference for male subjects was so entrenched that the birth control pill was tested on male subjects).¹⁵² When the National Institutes of Health launched the Women's Health Initiative in 1993, wide-spread medical research was conducted on women's health needs for the first time.¹⁵³ Not surprisingly, an entirely new field of knowledge is emerging as researchers discover that women react to treatments differently and are susceptible to different diseases.¹⁵⁴ The lack of concern for women's health, due to the preceding lack of knowledge, is the recognized reason that Congress has been slow to protect women's health needs, including pregnancy, post-mastectomy breast reconstruction operations, and female contraceptives.¹⁵⁵ The selection of the conditions in the ADA exclusion clause illustrates how prior knowledge, or lack of knowledge, about a particular medical condition can influence a legislator's interest in protecting that condition. Whether concerning women, transsexuals, or kleptomaniacs, Congress should not confer nor withhold legal entitlements based on ignorance of the medical condition affecting the group. Under the Constitution, Congress cannot rely upon "gender-based generalizations" to impute transsexuals to be "inferior" to biologically-born women and men, and therefore, less deserving of health care.¹⁵⁶ n156 The resulting disadvantage renders transsexuals less able to access comparable medical care than similarly-situated women and men who have medically classified disabilities.

[*120] The exclusion of transsexuality from an ADA covered disability is consistent with the Supreme Court's understanding of sex discrimination. Thirty years ago, the Supreme

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Court had difficulty grasping that an insurer's exclusion to cover pregnancy involves sex bias. Feminists explained that sex bias exists when an insurer will cover men's health needs because men need them (such as prostate conditions), but will not cover women's health needs because women need them (such as pregnancy).¹⁵⁷ Today, transsexuals are the ones wrongfully singled out for differential treatment. As reasoned by European and a growing number of U.S. courts,¹⁵⁸ denying medical treatment to an individual as she transitions from one sex to another is a form of sex discrimination. Therefore, the refusal to cover transsexual health needs because only one subgroup of a gender needs them is another manifestation of this particular form of discrimination based on sex.

In evaluating a sex discrimination claim, the government can subject an individual to "differential treatment" based on her gender if an "exceedingly persuasive" justification is "substantially related" to an "important governmental objective."¹⁵⁹ Under the *United States v. Virginia* standard, the court will not accept a rationalization or after-the-fact reason for an act. Rather, the court will evaluate the "genuine" reason why a particular piece of legislation was enacted.¹⁶⁰ Applying this standard to the ADA exclusion clause, the clause will not prevail because the articulated desired goal — allowing employers to discriminate against those they find to be immoral¹⁶¹ — is not a governmental objective substantial enough to justify such a classification. Although a transsexual should be able to sustain a sex-based discrimination claim, I will also explore the strength of a claim based on congressional animus against transsexuals if the court determines they are not members of a suspect class.

B. ADA Exclusion Clause as Government Animus Toward Members of a Non-Suspect Class

For over one hundred years, the Supreme Court has been guarding against legislation motivated by impermissible purposes. Beginning in 1886, the Court found that if a law "is applied and administered by public authority with an evil eye and an unequal hand, so as practically to make unjust and illegal discriminations between persons in similar circumstances . . . the denial of equal justice is still within the prohibition of the [*121] Constitution."¹⁶² In *Romer v. Evans*,¹⁶³ the Court struck down an invidiously motivated state referendum proposal designed to take legal protections away from gay men, lesbians, and bisexuals. Colorado municipalities had been enacting ordinances to protect its citizens from discrimination based on sexual orientation in transactions such as housing, employment, education, public accommodations, and health and welfare services. In 1992, Colorado voters approved a statewide proposal, known as "Amendment 2,"¹⁶⁴ that repealed all such protective ordinances and prohibited "all legislative, executive or judicial action at any level of state or local government designed to protect the named class [of gay men, bisexuals, and lesbian women]."¹⁶⁵ The Supreme Court struck down the proposal noting that it sought to repeal existing protections, but also introduced "sweeping" measures that have the effect of placing a special disability on gay individuals, making it harder for them to receive protections, arguably including general anti-discrimination measures. The Court noted that "these are protections taken for granted by most people either because they already have them or do not need them; these are protections against exclusion from an almost limitless number of transactions and endeavors that constitute ordinary civic life in a free society."¹⁶⁶ The Court concluded that the amendment failed because

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it "impose[s] a broad and undifferentiated disability on a single named group" and because "its sheer breadth is so discontinuous with the reasons offered for it that the amendment seems inexplicable by anything but animus toward the class it affects."¹⁶⁷

The breadth of the Romer holding is unknown. Some commentators speculate that like gender in *Reed v. Reed* thirty years ago, the Court is paving the way for the next case to extend gay individuals suspect class status. However, I find it notable that the Court focused on the principle that "[a] law declaring that in general it shall be more difficult for one group of citizens than for all others to seek aid from the government [*122] is itself a denial of equal protection of the law."¹⁶⁸ The fatal flaw of Amendment 2 was that out of a list of nearly a dozen state protected conditions--age, health, veteran status, religion, socio-economic class--the proposal designated gay men, lesbians, and bisexuals for disadvantage. Accordingly, a more conservative, and I argue, more faithful reading is that Romer proscribes government action that places a "special disability" upon a singled-out class that has the effect of excepting them from the general protections the rest of the population enjoys.

The ADA exclusion clause, which denies protection to people with transsexuality, homosexuality, bisexuality, and ten other conditions,¹⁶⁹ is another example of a law that excludes a small group of people from the ADA protections that the rest of the population enjoys. The DSM-IV (in 1990, the DSM-IIIr) is the indisputable authority on psychological conditions in the medical community, which is why statutes and courts regularly defer to it in defining mental conditions and disabilities.¹⁷⁰ The ADA exclusion clause defied this uncontested deference on the enumerated conditions. It did not dispute the medical authority of DSM-IV, or rely on an alternative authority. As stated by Senator Armstrong when he introduced his measure to exclude the conditions from the ADA, "I do not know if [DSM-IIIr] is a good reference. I do not know if it is the best source of information."¹⁷¹ Rather, Senator Armstrong defers to the DSM authority because "it is the source of information which the courts use."¹⁷²

Senator Armstrong explained: "Courts have looked to [the DSM-IIIr] to define what constitutes a mental impairment under statutory language."¹⁷³ As "voyeurism is in unless we take it out . . . I am going to have an amendment that will take voyeurism and some other things out."¹⁷⁴ n174 [*123] Senator Armstrong introduced the exclusion clause with the sole purpose of isolating particular conditions from medical authority. As the ADA unequivocally endorses the general application of DSM-IV in defining disabilities, understanding why a dozen conditions were removed becomes an important task.

In a heated exchange with Senator Harkin, Senator Helms tried to eliminate protections for HIV positive individuals. While Senator Harkin insisted that "fear and prejudice and unfounded fears [sic]" not preclude people from opportunities,¹⁷⁵ Senator Helms questioned:

If this were a bill involving people in a wheelchair or those who have been injured in the war, that is one thing. But how [in] the world did you get to the place that you did not even include transvestites? How did you get into this business of classifying people who are HIV positive, most of whom are drug addicts or homosexuals or bisexuals, as disabled?¹⁷⁶

Unpersuaded by Senator Harkin's response, Senator Helms exclaimed that "one of the problems he finds with this bill...[is that] here comes the U.S. Government telling the employer that he cannot set up any moral standards for his business by asking someone if he is HIV positive, even

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though eighty-five percent of those people are engaged in activities that most Americans find abhorrent."¹⁷⁷ The thrust of the exclusion clause is now clear: according to Senator Helms, the government should not curtail an employer's ability to be hostile toward people who have medical conditions that he does not understand.

Of course, it is precisely this problem--individual employers and health care provider's ignorance--that the ADA attempts to redress. Furthermore, Senator Helms' bifurcation of disability into "good" (wheelchairs) and "bad" (transvestitism) categories echoes a disturbing misuse of medicine. In the United States, most notably during the progressive era's endorsement of eugenics, state and federal legislatures have periodically enacted legislation to pathologize individuals as deviant in order to separate them from society.¹⁷⁸ One hundred years ago, a targeted group consisted of recent Chinese immigrants and citizens of Chinese descent who were believed to carry syphilis.¹⁷⁹ When these laws [*124] were understood as racist attempts to exclude a group of people from integrating into society, they were discredited and abandoned. The significance of using the ADA as a similar moral mandate of who deserves of medical treatment¹⁸⁰ n180 is disturbing for two reasons. As a practical matter, individuals are being denied protection for political, rather than medical reasons. Implicating deeper questions of the moral nature of our society, Congress has failed to learn from history that medicine should not be used to create a social caste of lepers and prostitutes.

Like Romer's constitutionally impermissible Amendment 2, the ADA exclusion clause isolated a specific group of individuals for unconstitutional disadvantage. Denying these select few conditions, out of nine hundred conditions covered under the ADA, makes it more difficult for people with these enumerated conditions to "seek aid from the government" in the form of protection against health care discrimination. The denial of government protection in these circumstances is "a denial of equal protection."

The lack of suspect class status does not preclude a court from extending protection to individuals with these conditions.¹⁸¹ Under rational review, a "classification [must] bear a rational relationship to an independent and legitimate legislative end."¹⁸² The government needs to justify why Congress selected these ten particular medical conditions for disadvantage.

The ADA exclusion clause denies perceived social and sexual outsiders protection under the ADA.¹⁸³ As was made clear in Romer, the government may not classify individuals out of a desire to harm them.¹⁸⁴ Furthermore, under the ADA exclusion clause, insurers, and health care [*125] providers are free to insult, mistreat, and provide substandard or no medical care to individuals with these conditions.¹⁸⁵ Even if a legitimate justification for the ADA exclusion clause was found, a law that "inflicts...immediate, continuing, and real injuries that outrun and belie any legitimate justification" is a denial of equal protection.¹⁸⁶ As stated in *Harris v. McRae*,¹⁸⁷ the Fourteenth Amendment guarantees to all citizens "the right to be free from invidious discrimination in statutory classifications and other governmental activity."¹⁸⁸ Even under rational review, the entire ADA exclusion clause fails because it disadvantages a particular group of individuals and it is neither a rational means nor a legitimate end of government action.

Under equal protection analysis, the ADA exclusion clause cannot withstand intermediate or even "rational basis with teeth" scrutiny that can be accorded to transsexuals based on their gender and as disadvantaged members of non-suspect classes. Once the clause is eliminated, transsexuals can, and should, be able to rely on the ADA to protect them from impermissible

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discrimination by private insurers and health care providers.

V. CONCLUSION

No one has a fundamental right to receive adequate health care in the United States. However, over the past thirty-five years, the federal government has mandated that state and private providers will not deny medically necessary care out of malice toward a particular health condition. Insurance clauses and health care providers that deny treatment for transsexual health needs and the ADA exclusion clause that precludes protection to transsexuals are contrary to this minimal protection that American citizens enjoy. In the past, the fluidity of transsexual identity has precluded courts from offering protection based on sex, sexual orientation, or transsexual identity. More and more courts are abandoning the significance of the contours of transsexual identity, and are instead investigating the nature or extent of discrimination targeted against the individual. Although a growing number of courts recognize discrimination against transsexuals as a form of sex discrimination, I argue that a court should retain the fluidity of transsexual identity, and when appropriate, provide remedies to discrimination based on imputed sexual orientation, transsexual identity, and sex. When the ADA is examined more closely within this framework, the exclusion clause operates precisely to deprive [*126] transsexuals of the right to be protected from unfair or discriminatory denial of health care. Such action is a form of sex discrimination and a type of government animus seeking to disadvantage a particular group. In this article, I proposed a creative solution to a problem that has not received much attention in mainstream society. Despite how novel the problem and remedy may seem, I do not want to obscure the nature and the type of harm described by the interviewees who were denied health care treatment because their doctors, insurers, and senators failed to understand, and were hostile to, their medical condition. The expectation that a person will not be discriminated against by her doctor or insurer is a reasonable one. The assumption that Congress will rely upon science and medical authority in formulating health care policy is probably universal. The knowledge that a court will stop wrongful actions that rise to the level of discrimination is fundamental. Transsexual individuals, however, have not received this minimal standard of care. In this context, it is understandable how logical and sound protections against "exclusion"--the discrimination resulting from the exception of particular people from general protections of the law--is a denial of equal protection. Until transsexuals receive the protections the rest of the population enjoys, they remain estranged from the Constitution, and our unresponsiveness remains contrary to common sense, medical authority, and the law.

Notes

¹ Unequal wealth distribution skews access to health care in two ways. First, lack of wealth serves to prevent some individuals from accessing treatments. *See* Frustration and Fury are Keeping Pace with Escalating Health Insurance Premiums, N.Y. Times, Sept. 18, 2000, at A1 (reporting that due to the costs of health insurance, more than forty million Americans are not insured); Martin F. Shapiro et al., Variations in the Care of HIV-Infected Adults in the United States: Results from the HIV Cost and Services Utilization Study, 281 *JAMA* 2305, 2314 (1999) (reporting findings that private insurance offers better care than Medicaid and that the poor, ethnic minorities, and women received worse quality and less quantity of care than white males received in the same period). *See also* Marianne Means, Equity for Women's Health Care Still Elusive, Fort Worth Star-Telegram, Oct. 24, 1998, at 15 (citing a 1994 Alan Guttmacher Institute study reporting that "in general women pay about 68 percent more in out-of-pocket health expenses than men, partly because many insurers don't cover basic reproductive health services" despite their coverage of "male-only needs" such as prostate conditions). Second, the inequitable distribution of wealth precludes consumer demand from being an accurate indicator of value. *See* Duncan Kennedy, Distributive and Paternalist Motives in Contract and Tort Law, with Special Reference to Compulsory Terms and Unequal Bargaining Power, 41 *Md. L. Rev.* 563, 608 (1982) ("Consumers are *too poor*, given the other things they want to do or have to do with their money, to induce sellers to provide something that, under the free contract model, sellers don't have to provide unless the price is right.").

² Private and public insurers have not covered conditions affecting women such as contraception, because of a sexist bias. *See, e.g.*, Insurance Companies Should Provide Birth Control Coverage, Daily Collegian, Feb. 3, 1999, at A28 (reporting on a Pennsylvania bill to mandate insurance coverage for prescribed birth control. The purpose is "to end discrimination against women by health insurance companies [as women's health needs] have been sometimes ignored."). Further, insurers have provided inequitable coverage of a particular illness or disease due to hostility toward that disease, that is usually based on moral judgments. *See, e.g.*, Federal Judge Says HIV Cap Is Illegal under Americans of [sic] Disabilities Act, Mealey's Ins. L. Wkly., Dec. 7, 1998, at 10 (reporting that the Mutual Insurance company set "a lifetime ceiling" on non-AIDS related conditions at \$ 1 million, but set "a lifetime ceiling on HIV-related benefits" on two policies at \$ 100,000 and \$ 25,000. "Mutual conceded in court that there was no justification for its caps.").

³ 42 *U.S.C. §* 1396 (1994). The Medicaid Act is a cooperative scheme by which states administer medical treatment to needy individuals residing within their borders and the federal government reimburses participating states for incurred costs. *See Wilder v. Virginia Hosp. Ass'n*, 496 *U.S.* 498, 502 (1990).

⁴ Under the Medicaid Act, a participating state must cover "medically necessary" conditions by providing sufficient duration, scope, and services to abate a person's injury, illness, or condition. *See* 42 *U.S.C. §* 440.230(b) (1994). For more information, see *infra* note 37.

⁵ 42 *U.S.C. §* 12101 (1994).

⁶ *See id.*

⁷ For a discussion of Patients' Bill of Rights, see Robert Pear, Patients- Rights Bill Revised in Bid for Passage in Senate, N.Y. Times, Sep. 12, 2000, at A20 (describing the collapse of the negotiation efforts to reconcile differing House and Senate bills, that vary on the nature and type of remedies and causes of action provided to private individuals against HMOs); Robert Pear, New Insurance Rules for Patients Ease Way for Faster Decisions and Appeals, N.Y. Times, Nov. 21, 2000, at A14 (commenting on President Clinton's regulations requiring most private employer-sponsored health plans to change their procedures on January 1, 2002 to facilitate an appeals process that is more prompt and fair than the current system. The article notes that, absent Congressional endorsement, the regulations fall short of providing patients with a right to sue their HMOs).

⁸ *See* EEOC Interim Guidance on Application of ADA to Health Insurance, 109 BNA Disability L. Rep. E-1 (June 9, 1993) *cited in* Laura F. Rothstein, Disabilities and the Law, 496 (2d ed. 1997); *see also* EEOC Order 205.001, *cited in* Rothstein, *supra*, at 496 n.37; *Henderson v. Bodine Aluminum, Inc.*, 70 F.3d 958 (8th Cir. 1995) (finding that employee health plan and its insurers violated ADA by denying insurance coverage for high-dose chemotherapy treatment for a covered employee's breast cancer if employee proves that such treatment is a medically sound treatment for breast cancer).

⁹ For a more in depth discussion of the ADA, see *infra* Part I.C and III.

¹⁰ Taylor Flynn, Transforming the Debate: Why We Need to Include Transgender Rights in the Struggles for Sex and Sexual Orientation Equality, 101 *Colum. L. Rev.* 392, 420 n.4 (2001) (citations omitted); *see also* Julie A. Greenberg, Defining Male and Female: Intersexuality and the Collision between Law and Biology, 41 *Ariz. L. Rev.* 265 (1999).

¹¹ *See* Leslie Feinberg, *Transgender Warriors*, at x-xi (1996).

¹² *See* San Francisco Human Rights Commission, *Investigation Into Discrimination against Transgendered People* 8 (1994).

¹³ *See* Marjorie Garber, *Vested Interests* 101-04 (1993) (noting that the statistics reporting that more biological men than women transition is probably due to the fact, among others, that male researchers began the investigations and for years clinics only accepted male-to-female patients). Garber also wryly observes that, due to sexism, known male-to-female transsexuals include Christine Jorgenson and Renee Richards, but well-known female-to-male transsexuals are discovered, and become famous, only upon their death. *Id.* at 110.

¹⁴ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. 1994) [hereinafter DSM-IV]. Commonly referred to as the DSM-IV, this authoritative manual enumerates all known and treatable psychological conditions and details recommended treatment.

¹⁵ *Id.* at 532-38.

¹⁶ *Id.*

¹⁷ Sex-reassignment surgery [hereinafter SRS] and hormone treatment is the process by which a

person's anatomy is aligned with her identified sex. SRS is only administered to transsexuals diagnosed with gender dysphoria. "Depending on the physicality and the overall health of the patient," surgery may include for male to female transsexuals: vaginoplasty, penectomy, orchidectomy, clitorplasty, breast augmentation, rhinoplasty, facial remodeling, thyroid chondroplasty and crico-thyroid approximation. For female to male transsexuals procedures may include: hysterectomy, oophorectomy, bilateral mastectomy, and phalloplasty. *See* Russell Reid et al., *Transsexualism: The Current Medical Viewpoint* § 4.2 (2d ed. 1996). *See also* David Brez Carlisle, *Human Sex Change and Sex Reversal* 374-82 (1998) (providing cross-cultural description of the nature, procedures, and costs of SRS).

¹⁸ *See* Gerald Mallon, *Practice with Transgendered Children*, in *Social Services with Transgendered Youth* 49, 55-58 (Gerald Mallon ed., 1999). Note that "the generally accepted view among the medical and psychological professions is that efforts to alter a person's core gender identity are futile and unethical." Flynn, *supra* note 10, at 394 n.10.

¹⁹ *See* Kate Bornstein, *Gender Outlaw* 119 (1994). Throughout history, many transsexuals passed as the other gender without technological aids. *See* Feinberg, *supra* note 11, at 83-89 (listing known transsexuals in the 18th, 19th, and 20th centuries). In addition, many contemporary transsexual activists are opposed to surgery as it medicalizes or pathologizes their identity. *See* Pat Califia, *Sex Changes* 265-68 (1997); *see also infra* Part I.B (for more information about the history of and controversy over the DSM classification of gender dysphoria).

²⁰ *See, e.g.*, *R v. North West Lancashire Health Authority*, (Q.B. 1998) (finding that the international and English medical community overwhelmingly endorsed SRS, the surgery's cost was minimal, and that transsexuals diagnosed with gender dysphoria who were denied the procedure suffered devastating consequences).

²¹ *See infra* Part I.

²² *Id.*

²³ *Id.*

²⁴ As described in more detail in Parts I.C and III, due to the efforts of a small number of Senators, the ADA was explicitly amended to exclude from coverage: "homosexuality, bisexuality, transvestitism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual disorders; compulsive gambling, kleptomania, or pyromania; or current psychoactive substance use disorders resulting from current illegal use of drugs." *See* 42 U.S.C. § 11211 (1994).

²⁵ The Fourteenth Amendment applies to actions by a state. It does not apply to relations between the individual and the federal government. Instead the Fifth Amendment applies to the federal government and also contains an equal protection component. *Bolling v. Sharpe*, 347 U.S. 497, 499 (1954). "This Court's approach to Fifth Amendment equal protection claims has...been precisely the same as to equal protection claims under the Fourteenth Amendment." *Weinberger v. Wiesenfeld*, 420 U.S. 636, 638 n.2 (1975). *See* *Buckley v. Valeo*, 424 U.S. 1 (1976) (per curiam). For the sake of simplicity, I refer to Fourteenth Amendment jurisprudence throughout the article because it is this case law that a federal court would apply to the ADA via the Fifth Amendment.

²⁶ 42 U.S.C. § 11211 (1994).

²⁷ Shannon Minter is Senior Attorney at the National Center for Lesbian Rights in San Francisco, California.

²⁸ Between August and September 1999, I sent letters and emails, and posted inquiries on internet sites of a handful of organizations that provide support to or political advocacy for transsexual individuals. I asked for people's experiences with medical insurers and professionals. The original recipients of my letter in turn forwarded my solicitation to membership lists or posted my solicitation on more internet websites. To counter skepticism about the interviews' reliability, I conducted extensive follow-up interviews and requested supporting documentation where possible to reduce inaccuracies and exaggerations. *See generally* David A. Hyman, Lies, Damned Lies, and Narrative, 73 *Ind. L.J.* 797 (1998) (positing that many "horror story" anecdotes are deceptively incomplete); Daniel Farber & Suzanna Sherry, Telling Stories Out of School: An Essay on Legal Narratives, 45 *Stan. L. Rev.* 807 (1993). For details of interview responses see *infra* Part I.A.

²⁹ For an excellent discussion of the debate and articulation of the value individual anecdotes can bring to the law, see Ariela Gross, Beyond Black and White: Cultural Approaches to Race and Slavery, 101 *Colum. L. Rev.* 640 (2001); *see also* Kathryn Abrams, Hearing the Call of Stories, 79 *Cal. L. Rev.* 971, 1028 (1991); Symposium, Legal Storytelling, 87 *Mich. L. Rev.* 2073 (1989); William Eskridge, Gaylegal Narratives, 46 *Stan. L. Rev.* 607 (1994); Carol Gilligan, In a Different Voice (1982); Alex M. Johnson, The New Voice of Color, 100 *Yale L.J.* 2007 (1991). All sources cited in Gross, *supra*, at nn.9 & 23. For criticism of this view, see Farber & Sherry, *supra* note 28.

³⁰ When I asked the interviewees about their experiences with medical insurers and providers, fourteen reported problems with doctor and provider bias; twelve reported denials of SRS or hormones; and eighteen reported denials of non-transition related conditions. Despite the frequency of problems, interestingly enough, twenty reported having SRS and hormones covered; and ten reported no problems with current doctors or insurers (the numbers do not add up to forty-two as people responded to more than one category and typically had both positive and negative experiences). Notably, of those people who had no problems, seven explicitly informed their insurer that they are transsexuals and three were passing as biologically born women or men. In addition, one non-transsexual respondent reported being denied treatment for a congenital hormone imbalance by a state Medicaid program based on the mistaken belief that she was a transsexual.

³¹ For example, the City of San Francisco adopted a measure to extend health insurance to all municipal employees. The insurance covers SRS and hormone treatment. *E.g.*, San Francisco Workers Get Sex-Change Coverage, *N.Y. Times*, Feb. 18, 2001, at A20; Tackling Bias in Health Care, *The Advocate*, May 23, 2000, at 18. I argue that evidence of such coverage sheds doubt on the rationale provided by insurers that claim providing such coverage is too costly.

³² *See supra* note 17 for a description of sex-reassignment surgery (SRS) and hormone treatment. SRS is only administered to transsexuals diagnosed with gender dysphoria.

³³ *See, e.g.*, Reid et al., *supra* note 17; Mallon, *supra* note 18.

³⁴ See e-mail from David (Sept. 10, 1999); e-mail from Vicky Steele (Sept. 12, 1999); e-mail from Shane (Sept. 8, 1999); e-mail from Andrea James (Sept. 8, 1999). All e-mails cited in this article are on file with the author.

³⁵ See e-mail from Nancy Zeitlin (Sept. 24, 1999).

³⁶ See e-mail from Amanda Fournier (Oct. 10, 1999).

³⁷ See e-mail from Vicky Steele, *supra* note 34; e-mail from Anne Ogborn (Oct. 23, 1999).

³⁸ See e-mail from Name Withheld (Sept. 10, 1999) (Michigan plan withdrew offer to cover her); e-mail from Christine Howey (Sept. 7, 1999) (insurance broker explained to the post-op transsexual she was excluded from all medical plans); e-mail from Anne Ogborn, *supra* note 37 (an employer's insurer refused to cover a post-op transsexual employee on the basis its clause extended to all of her medical conditions. After the employer threatened to sue, the insurer backed down from its denial, and agreed to fully cover the transsexual employee).

³⁹ See e-mail from Name Withheld, *supra* note 38.

⁴⁰ See e-mail from Anne Ogborn, *supra* note 37; e-mail from Christine Howey, *supra* note 38.

⁴¹ See e-mail from Vicky Steele, *supra* note 37. When a transsexual requested treatment for gender dysphoria, a New York insurer stopped covering a patient's antidepressant prescription, despite the fact that it knew the patient had recently attempted suicide.

⁴² See e-mail from Respondent P (Sept. 8, 1999). A North Dakota insurance company abruptly ended paying for a woman's therapy after reading her therapist's case notes that the stated patient mentioned her sex-reassignment surgery. The woman had been diagnosed with depression twenty-five years prior and the company had paid for psychological care for ten years. This particular transsexual has coped with the overwhelming prejudice by withdrawing from doctors and health care, noting "it is better to risk poor health than to deal with prejudice and insurance problems. If I die years earlier than I should have, so be it--at least I've lived as I believe." See e-mail from Respondent P (Oct. 9, 1999).

⁴³ See e-mail from Arlene Istar Lev (Oct. 24, 1999).

⁴⁴ See e-mail from Candice (Sept. 9, 1999).

⁴⁵ See e-mail from Respondent A (Sept. 2, 1999).

⁴⁶ See e-mail from Chris Faust (July 10, 1999).

⁴⁷ See e-mail from Jes (Oct. 26, 1999).

⁴⁸ See e-mail from David King (Sept. 8, 1999).

⁴⁹ See e-mail from Sarah Fox (Sept. 8, 1999). A Seattle veterans hospital told a navy veteran who was exposed to radiation and chemical burns during his duty to go elsewhere, explaining that they do not treat her "kind." She received copies of her medical records, that referred to her as "gay" and a "faggot."

⁵⁰ See Maria Elena Fernandez, *Death Suit Costs City \$ 2.9 Million; Mother of Transgendered Man Wins Case*, Wash. Post, Dec. 12, 1998, at C1.

⁵¹ See e-mail from with Michele Taylor (Sept. 7, 1999); e-mail from Josh (Sept. 1, 1999). In one instance, a doctor performed a phalloplasty (construction of genitals) operation in his office, after being refused use of hospital facilities for the procedure. The patient subsequently developed an infection from having surgery in a non-hospital environment.

⁵² See e-mail from Mik (Aug. 31, 1999).

⁵³ See e-mail from Lola Cola (Sept. 6, 1999). A documentary was made about Robert and his partner Lola. See *Southern Comfort* (Q-Ball Productions 2001). For a review of the film, see Kelly McWilliam, BIFF: Review of *Southern Comfort*, M/C Reviews, Aug. 2, 2001, at <http://www.media-culture.org.au/reviews/screens/southerncomfort.html> (last visited Oct. 11, 2001).

⁵⁴ See, e.g., *Pinneke v. Preiser*, 623 F.2d 546 (8th Cir. 1980) (rejecting categorical exclusions as violation of the Medicaid Act guarantee of individualized assessments of medical necessity); *Smith v. Rasmussen*, 57 F. Supp 2d. 736, 771 (N.D. Iowa 1999) (dismissing Iowa's claim that SRS is not a medically necessary procedure); *G.B. v. Lackner*, 145 Cal. Rptr. 555 (Cal. Ct. App. 1978) (concluding that SRS is not a cosmetic procedure even though some cosmetic surgery is performed. The court stated that as reconstructive surgery is also required after an accident, SRS is medically necessary.); *Doe v. State, Pub. Dep't of Welfare*, 257 N.W.2d 816 (Minn. 1977) (finding Minnesota's blanket ban on SRS impermissibly broad). The State was unable to justify its ban in the face of uncontroverted medical evidence that some individual patients will be eligible for this treatment. The only decision that held to the contrary is *Rush v. Parham*, 625 F.2d 1150 (5th Cir. 1980) (finding SRS was not medically necessary), remanded to *Rush v. Parham*, 565 F.Supp. 856 (N.D. Ga. 1983). However, the court based its conclusions on medical opinions that are now completely outdated. As described in Mallon, *supra* note 18, medical providers used to "treat" gender identity disorder through aversion therapy. Today, however, there is consensus among members of the medical profession that any attempt to treat gender dysphoria through psychological care encouraging a person to ignore their self-identity and accept their biological gender as determinative is futile and even unethical. See Mallon, *supra* note 18.

⁵⁵ See *Davidson v. Aetna Life & Cas. Ins. Co.*, 420 N.Y.S.2d 450 (N.Y. Sup. Ct. 1979)

⁵⁶ Among other factors, the inequitable distribution of wealth precludes consumer demand from being an accurate indicator of value. See, e.g., Kennedy, *supra* note 1, at 608 ("Consumers are too poor, given the other things they want to do or have to do with their money, to induce sellers to provide something that, under the free contract model, sellers don't have to provide unless the price is right.").

⁵⁷ See Delia M. Rios, '78 Law Gave Pregnant Workers a New Future, Minneapolis Star Tribune, Sept. 27, 1998, at 9E (describing how the Health Insurance Association of America opposed the Pregnancy Disability Act, and the predicted "catastrophic" costs of the measure did not materialize).

⁵⁸ See Christine Nardi, Comment, When Health Insurers Deny Coverage for Breast Reconstructive Surgery: Gender Meets Disability, 1997 Wis. L. Rev. 777, 778, 780 n.13 (1997) (citing a survey that found over one hundred insurance companies denied breast reconstruction

surgery. Despite medical evidence to the contrary, insurers usually deny this procedure on the basis of its cost or "cosmetic" nature).

⁵⁹ See Means, *supra* note 1, at 15 (criticizing insurers' double-standard finding Viagra, a drug for male impotency, medically necessary, while deeming birth control preventative and therefore not necessary).

⁶⁰ See Rios, *supra* note 57, at 9E (Pregnancy Disability Act enacted to redress insurer's failure to cover pregnancy costs); Nardi, *supra* note 58, at 809 n.201 (listing state statutes mandating insurance coverage for post-mastectomy breast reconstruction); Daily Collegian, *supra* note 1 (reporting on a Pennsylvania bill to mandate insurance coverage for prescribed birth control).

⁶¹ See generally Mubarak Dahir, Whose Movement Is It? Transgender Activists Seek Allies Among Often Reluctant Lesbians and Gay Men, *The Advocate*, May 25, 1999, at 50 (noting that transsexuals are marginalized by the larger gay community); Elaine Herscher, S.F. Transgender Laws Called Ineffective, *S.F. Chron.*, Nov. 17, 1999, at A22 (noting widespread discrimination despite legal protections); Gregory Sokoloff, Transsexuals Strive against Odds for Acceptance in US, *Agence France Presse*, Oct. 25, 1999, at 1 (observing that "transsexuals still have a long way to go before they can enjoy the same degree of legal protection accorded to gays and lesbians").

⁶² 42 U.S.C. § 12101 (1994).

⁶³ 42 U.S.C. § 2000e (1994). The ADA is heralded as a "sweeping" civil rights act. See Rothstein, *supra* note 8, at 23. As such, comparisons to the Civil Rights Act are made as both statutes enable an enormous number of individuals to redress private acts of discrimination against them.

⁶⁴ S. Rep. No. 101-116, at 2 (1989).

⁶⁵ 29 U.S.C. §§ 701-96 (1994). The legislative history of the Rehabilitation Act is recorded in S. Rep. No. 93-318 (1972).

⁶⁶ In addition to the Rehabilitation Act, persons with disabilities receive piecemeal protection from statutes. See, e.g., Individuals with Disabilities Education Act, 20 U.S.C. §§ 1401-20 (1994) (applies to state special educational programs); Architectural Barriers Act of 1968, 42 U.S.C. §§ 4151-57 (1994) (applies to construction of buildings financed with federal funds); Fair Housing Act, 42 U.S.C. §§ 3601-19 (1994) (applies to housing); Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1002 (1994) (regulates employer-offered employee health plans). For an overview and listing of other statutes, see Rothstein, *supra* note 8, at § 1.16-.35.

⁶⁷ See S. Rep. No. 101-116, at 18-20 (1989).

⁶⁸ See 42 U.S.C. § 12131 (1994).

⁶⁹ Title III proscribes private health care providers from offering services to disabled people in a discriminatory manner. 42 U.S.C. §§ 12181-89 (1994).

⁷⁰ See *supra* note 8.

⁷¹ See 42 U.S.C. § 12211 (1994). The ADA excludes from coverage "homosexuality, bisexuality, transsexualism, transvestitism, pedophilia, exhibitionism, voyeurism, gender identity

disorders not resulting from physical impairments, other sexual behavior disorders, compulsive gambling, kleptomania, pyromania, and psychoactive substance use disorders resulting from current use of drugs."

⁷² 42 U.S.C. § 12102 (1994).

⁷³ 1985 WL 9446 (D.D.C. 1985). See also *Blackwell v. U.S. Dep't of Treasury*, 656 F. Supp. 713 (D.D.C. 1986) (citing *King v. Palmer* 778 F.2d 878 (extending protection to transvestites and homosexuals under the Rehabilitation Act)).

⁷⁴ *Doe*, 1985 WL 9446, at *2 (citing 45 C.F.R. 84.3(j)(2)(i)(B)).

⁷⁵ *Id.* at *3 (citing 45 C.F.R. 84.3(j)(2)(ii)).

⁷⁶ The case settled before being tried. See William N. Eskridge & Nan D. Hunter, *Sexuality, Gender, and the Law* 1111 (1st ed. 1997).

⁷⁷ The Medicaid Act is a cooperative scheme by which States administer medical treatment to needy individuals residing within their borders and the federal government reimburses a participating state for incurred costs. 42 U.S.C. § 1396 (1994); see *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). Under Medicaid, a participating state must cover "medically necessary" conditions by providing sufficient duration, scope and services to abate a person's injury, illness, or condition. 42 U.S.C. § 1396(a) (1994). What is "medically necessary" is defined as a service that is "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve functioning of a malformed body member." § 1395(y)(a)(1)(A). A procedure is not medically necessary if it is not cosmetic or experimental. § 440.230 (c)(d). Forty-two states have exclusions barring coverage for SRS and hormones. When these exclusions have been challenged in court, the courts do not uphold them. Nonetheless, survey respondents reported varying degrees of coverage. Some states covered SRS and other transition operations, while respondents reported other states denying SRS and hormone treatment. In Massachusetts, a doctor discovered that a woman had a cancerous cyst, which was due to her leaky silicon breast implants that had been implanted twenty-five years earlier. The doctor recommended removal of the cyst and new breast implants, a routine procedure for post-mastectomy women. The state Medicaid program refused on the basis that the woman was in actuality a transsexual and therefore the breast implants were part of her sex-reconstruction surgery. The state program made this rule despite the fact that the woman transitioned twenty-five years ago. See *Matter of Germaine G. Berger*, Mass. Bd. of Hr'g, Div. of Med. Assistance, No. 9902394 (Aug. 25, 1999) (on file with author). The need to eliminate the state exclusion clauses is pressing, but unfortunately beyond the scope of this note.

⁷⁸ *R v. North West Lancashire Health Authority*, (Q.B. 1998). The British court found that the international and English medical community overwhelmingly endorsed the procedure, the cost was minimal, and that transsexuals diagnosed with gender dysphoria who were denied the procedure suffered devastating consequences. *Id.*

⁷⁹ See *infra* notes 149-51 & 170-73 and accompanying text.

⁸⁰ For an excellent overview of the medical profession's development, application, and later renunciation of treating children for gender identity disorder, see Shannon Minter, *Diagnosis and*

Treatment of Gender Identity Disorder in Children *in Sissies and Tomboys: Gender Nonconformity and Homosexual Childhood* (Matthew Rottnek ed. 1999). Although usually pre-teens are treated, diagnosis begins as early as two to four years old, and the problem behaviors as described in DSM-IV include boys who "have a marked preoccupation with traditionally feminine activities." DSM-IV, *supra* note 14, at 532-38. The definition also includes: "dressing in girls' or women's clothes," and "drawing pictures of beautiful girls and princesses," playing with "stereotypical female-type dolls, such as Barbie," and playing a "mother-role" while playing house, not playing "rough-and-tumble play and competitive sports" or having "little interest in cars and trucks." *Id.* Girls who purportedly suffer from GID suffer from symptoms such as eschewing playing with "dolls or any form of feminist dress up or role-play activity" *Id.* In addition, girls diagnosed with GID identify with "intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire," prefer to wear "boy's clothing and short hair," admire "powerful male figures, such as Batman or Superman," prefer to play with boys "with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games," DSM-IV, *supra* note 14, 532-38, *cited in* Minter, *supra*, at 10-11. Therapists treat children with gender identity disorder through behavior modification techniques that reward the child for playing with her gender's toys and punish her for playing with her opposite gender's toys. *Id.* at 15-16. The diagnosis and treatment of childhood GID was devised specifically with the intent to prevent adult homosexuality and transsexuality. *Id.* at 18-19. Therapists say things such as: "as [you] grow up, and if [you] continue to do sissy things, [you] won't have many friends, and people will not like you." Richard Green, *The "Sissy Boy" Syndrome and the Development of Homosexuality* (1987) *quoted in* Minter, *supra*, at 16. In the extreme cases, kids with gender identity disorder are sent to mental institutions where they are subjected to abuse, prodding to conform into proper gender socialization. *See* Daphne Scholinski, *The Last Time I Wore A Dress* (1997) (the autobiographical story of a young woman institutionalized at age fourteen for not acting like a girl. Even though she was housed with insane adults, she was not released from the mental hospital until her eighteenth birthday). In addition to being ineffective treatment, most children are traumatized from growing up in a mental hospital inhabited by insane adults. As parents have complete legal authority over their children, children are forced into these institutions until age eighteen, when they are no longer legally obliged to stay there and most insurance companies end their medical coverage of the condition. *Id.*

⁸¹ Modern psychology recognizes that the problems experienced by gay, lesbian, bisexual, and transsexual youth arise from external societal intolerance and not innate defects caused by sexual orientation or gender identity. Minter, *supra* note 80, at 28-29. Doctors who embrace childhood GID do so with the goal of eliminating homosexuality or transsexuality in adults. *Id.* at 18-19. For example, Dr. Richard Green who advocates for childhood GID asserted, "Suppose that boys who play with dolls rather than trucks, who role-play as mother rather than as father, and who play only with girls tend to disproportionately to evolve as homosexual men. Suppose that parents know this, or suspect this. The rights of parents to oversee the development of children is a long-established principle. Who is to dictate that parents may not try to raise their children in a manner that maximizes the possibility of a heterosexual outcome?" *Id.* at 22 (quoting Dr. Green). Dr. Green's preference for a "heterosexual outcome" is a result contrary to the medical profession's understanding that homosexuality is not an abnormality requiring readjustment. *Id.*

Hong, Kari. "Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals." *Columbia Journal of Gender & Law* vol. 11: 88-126.

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at 28. Moreover, his justification belies the fear that improper gender roles have the potential to cause homosexuality, effeminate boys, and although notably absent from the male researchers' caseloads, presumably mannish girls. *Id.* at 17-19, 22, 27. Based on their own follow-up studies, researchers found that their interventions were ineffective as the children studied were more likely to be gay than the general population. *Id.* at 20-21. Practitioners who continue to "cure" children are driven by ideological or religious reasons, that are contrary to (1) the medical profession's recognition that one's comfort with one's sexual orientation and gender identity is a reflection of self-actualization; and (2) medical and ethical support. *Id.* at 12-13.

⁸² See generally Urvashi Vaid, *Virtual Equality* (1995).

⁸³ 42 U.S.C. § 12211 (1994). Senators Armstrong and Hatch introduced the original Amendment No. 722. For its text, see 135 Cong. Rec. 112,158 (1989).

⁸⁴ See 42 U.S.C.A. § 12211 (1994).

⁸⁵ 566 F.2d 659, 663 (9th Cir. 1977).

⁸⁶ *Id.* at 663-64. In constitutional jurisprudence, the Supreme Court has held that certain provisions will be given heightened scrutiny if the law implicates a fundamental right or involves a suspect class, which is a historically defined group that has been targeted for disadvantage. *United States v. Carolene Products, Co.*, 304 U.S. 144, 153 n.4 (1938). Race and gender are examples of a categorization of people that constitute a "suspect class." *E.g.*, *Korematsu v. United States*, 323 U.S. 214 (1944); *Craig v. Boren*, 429 U.S. 190 (1976).

⁸⁷ 566 F.2d at 663.

⁸⁸ *Id.* at 663 n.8, citing *Id.* at 662 n.3.

⁸⁹ See *Brown v. Zavaras*, 63 F.3d 967, 971 (10th Cir. 1995) (stating that the court is "following Holloway and holding that Mr. Brown is not a member of a protected class"); *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984) (following the Holloway explanation that "sex" as defined by Title VII does not include transsexuals).

⁹⁰ *Kirkpatrick v. Seligman & Latz, Inc.*, 475 F. Supp. 145, 147 (D. Fla. 1979) (finding plaintiff did not allege any way in which she was treated differently than other biological males and therefore failed to make an equal protection or equal privileges and immunities claim).

⁹¹ *Id.*

⁹² *Voyles v. Ralph K. Davies Med. Ctr.*, 403 F. Supp. 456, 457 (N.D. Cal. 1975) (conflating transsexuals with "homosexuals or bi-sexuals" and citing the failure of the amendments to include sexual preference).

⁹³ See *United States v. Carolene Products*, 304 U.S. 144, 152 n.4 (1938) (holding that legislation that implicates fundamental rights or is directed toward minorities will be reviewed by the Court with "more exacting judicial scrutiny").

⁹⁴ See Bruce A. Ackerman, *Beyond Carolene Products*, 98 *Harv. L. Rev.* 713, 718 (1985) (enumerating the four categories).

⁹⁵ See *Korematsu v. United States*, 323 U.S. 214, 216 (1944).

⁹⁶ See, e.g., *Frontiero v. Richardson*, 411 U.S. 677, 688 (1973).

⁹⁷ *Korematsu*, 323 U.S. 214.

⁹⁸ *Craig v. Boren*, 429 U.S. 190 (1976).

⁹⁹ See Peter H. Irons, *Brennan v. Rehnquist: The Battle over the Constitution* 71 (1994). See also, Ackerman, *supra* note 94, at 735 (arguing that purpose of the Carolene Products analysis is to target "prejudice").

¹⁰⁰ *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. 2000).

¹⁰¹ *Id.* at 1195.

¹⁰² *Id.* at 1201-02.

¹⁰³ *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

¹⁰⁴ *Schwenk*, 204 F.3d at 1202.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* at 1198

¹⁰⁸ *Id.* at 1200.

¹⁰⁹ 581 F. Supp. 821 (N.D. Ill. 1983), overruled by *Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984).

¹¹⁰ See *Ulane*, 581 F. Supp. at 828.

¹¹¹ 538 F. Supp. 793 (N.D. Ill. 1982).

¹¹² See *id.* at 795, quoted in *Ulane*, 581 F. Supp. at 823-24.

¹¹³ *Ulane*, 581 F. Supp. at 824.

¹¹⁴ See *id.* at 825.

¹¹⁵ See *Ulane*, 742 F.2d at 1085.

¹¹⁶ See Case C-13/94, *P. v. S. & Cornwell County Council*, 1996 E.C.R. I-2143. For a defense of this reasoning, see Jennifer L. Nevins, *Getting Dirty: A Litigation Strategy for Challenging Sex Discrimination Law by Beginning with Transsexualism*, 24 *N.Y.U. Rev. L. & Soc. Change* 383, 386-92 (1998).

¹¹⁷ 979 F. Supp. 248, 249 (S.D.N.Y. 1997) (refusing to let the fact that the plaintiff was not a biological female serve as a defense against liability for sexual harassment against her).

¹¹⁸ 626 N.Y.S.2d 391, 395-96 (N.Y. Sup. Ct. 1995) (holding that as an employer's inappropriate comments about a woman's breasts constitutes sexual harassment, harassing a transsexual because of his sex change is a form of sex discrimination).

¹¹⁹ 404 U.S. 71, 76 (1971).

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- ¹²⁰ 420 U.S. 636 (1975), cited in *Nabozny v. Podlesny*, 92 F.3d 446, 455 (7th Cir. 1996).
- ¹²¹ 458 U.S. 718, 725 (1982), cited in *Nabozny*, 92 F.3d at 456.
- ¹²² 417 U.S. 484 (1974).
- ¹²³ 429 U.S. 125 (1976).
- ¹²⁴ *Geduldig*, 417 U.S. at 497 n.20.
- ¹²⁵ 479 U.S. 272, 289 (1986).
- ¹²⁶ *Guerra*, 479 U.S. at 289, quoting *Gilbert*, 429 U.S. at 159 (Brennan, J., dissenting) (footnote omitted).
- ¹²⁷ See Paisley Currah & Shannon Minter, Unprincipled Exclusions: The Struggle to Achieve Judicial and Legislative Equality for Transgender People, 7 Wm. & Mary J. Women & L. 37, 41 & nn.20-21 (2000).
- ¹²⁸ See Kimberle Crenshaw, Demarginalizing the Intersection of Race and Sex: A black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, 1989 *U. Chi. Legal F.* 139, 141-50 (1989) (discussing three cases where black women brought claims of Title VII violations).
- ¹²⁹ See *DeGraffenreid v. General Motors*, 413 F. Supp. 142, 144 (E.D. Mo. 1976) (holding that even though GM did not hire any black women before 1964, GM did not discriminate against these plaintiffs as GM had hired white women), cited in Crenshaw, *supra* note 128, at 141.
- ¹³⁰ See *Moore v. Hughes Helicopter, Inc.*, 708 F.2d 475, 484 (9th Cir. 1983) (denying plaintiffs' claim of race discrimination as statistics failed to demonstrate that black men were significantly disadvantaged as compared to white men), cited in Crenshaw, *supra* note 128, at 145-46.
- ¹³¹ See, e.g., *DeGaffenried*, 413 F. Supp. at 145 (denying black women protections because Congress never intended to create a "new classification of 'black women' who would have greater standing than, for example, a black male"), cited in Crenshaw, *supra* note 128, at 142.
- ¹³² Crenshaw, *supra* note 128, at 150.
- ¹³³ Crenshaw, *supra* note 128, at 149.
- ¹³⁴ See Crenshaw, *supra* note 128; see also *infra* Part III.
- ¹³⁵ 40 F.3d 1551 (9th Cir. 1992).
- ¹³⁶ *Id.* at 1561.
- ¹³⁷ See *id.* at 1562 & n.20.
- ¹³⁸ 979 F. Supp. 248 (S.D.N.Y. 1997).
- ¹³⁹ 225 F.3d 1084 (9th Cir. 2000).
- ¹⁴⁰ 626 N.Y.S.2d 391 (N.Y. Sup. Ct. 1995). The flexibility of the approach is necessary to ensure that a transsexual will neither have to prove too much nor too little to sustain her claim of bias against her. "The focus on the most privileged group members marginalizes those who are

multiply-burdened and obscures claims that cannot be understood as resulting from discrete sources of discrimination." Crenshaw, *supra* note 128, at 140.

¹⁴¹ The Fourteenth Amendment applies to actions by a state. *See supra* note 25 for explanation as to how ADA must comply with equal protection provision of the Fifth Amendment.

¹⁴² 135 Cong. Rec. S10,753 (1989) (statement of Sen. Armstrong).

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ 135 Cong. Rec. S10,765 (1989) (statement of Sen. Helms).

¹⁴⁷ 135 Cong. Rec. S10,768-72 (1989) (statement of Sen. Kennedy and National Commission on AIDS report).

¹⁴⁸ 135 Cong. Rec. S10,766 (1989) (statements of Sen. Harkin).

¹⁴⁹ 135 Cong. Rec. S10,765 (1989) (statement of Sen. Harkin).

¹⁵⁰ *Id.*

¹⁵¹ *See* Susan Faludi, *Backlash* (1992). *See also* Marilyn Linton, *Earning World's Respect Toronto Centre's Studies are Spanning the Globe*, *Toronto Sun*, Jan. 30, 2000, at 42 ("Two decades ago, women's health research was not even on the map; the money designated for it was peanuts.").

¹⁵² *See* Faludi, *supra* note 151.

¹⁵³ *See* Colleen Dunn Bates, *Medicine's Gender Gap; Research on Women Picks Up Steam*, *Chi. Trib.*, Jan. 12, 2000, at 3. Before the 1993 government mandate, researchers avoided conducting trials on female humans and animals. Since the mandate, "research on women is picking up steam."

¹⁵⁴ *See* Bates, *supra* note 153, at 3 (detailing the post-1993 findings that women are more likely to have heart disease and immune disorders than believed, women experience headaches differently than men, and women need to take medicine in different dosages than men).

¹⁵⁵ *See* Catherine A. MacKinnon, *Feminism Unmodified: Discourses on Life and Law* ch. 2 (1987), *reprinted in* John H. Garvey & T. Alexander Aleinikoff, *Modern Constitutional Theory: A Reader* 591 (4th ed. 1999); *see also* Wendy W. Williams, *The Equality Crisis: Some Reflections on Culture, Courts, and Feminism*, 7 *Women's Rts. L. Rep.* 175, 176-200 (1982), *reprinted in* Garvey & Aleinikoff, *supra*, 573-88.

¹⁵⁶ *See supra* notes 73-76 and accompanying text.

¹⁵⁷ *See* MacKinnon, *supra* note 155, at 591.

¹⁵⁸ *See supra* notes 103-06 and accompanying text.

¹⁵⁹ *See United States v. Virginia*, 518 U.S. 515, 533 (1996).

¹⁶⁰ *Id.* at 533.

¹⁶¹ See legislative history discussed *infra* notes 173-77 and accompanying text.

¹⁶² *Yick Wo v. Hopkins*, 118 U.S. 356, 373-74 (1886), quoted in *Nabozny v. Podlesny*, 92 F.3d 446, 458 (7th Cir. 1996).

¹⁶³ 517 U.S. 620 (1996)

¹⁶⁴ The full text of the ordinance is: "No Protected Status Based on Homosexual, Lesbian or Bisexual Orientation. Neither the State of Colorado, through any of its branches or departments, nor any of its agencies, political subdivisions, municipalities or school districts, shall enact, adopt or enforce any statute, regulation, ordinance or policy whereby homosexual, lesbian or bisexual orientation, conduct, practices or relationships shall constitute or otherwise be the basis of or entitle any person or class of persons to have or claim any minority status, quota preferences, protected status or claim of discrimination. This Section of the Constitution shall be in all respects self-executing." *Id.* at 624

¹⁶⁵ *Id.* at 625.

¹⁶⁶ *Id.* at 631.

¹⁶⁷ *Id.* at 632.

¹⁶⁸ *Id.* at 634 (citing *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942) (quoting *Yick Wo*, 118 U.S. at 369)).

¹⁶⁹ See *supra* note 24.

¹⁷⁰ E.g., *Skretvedt v. E.I. DuPont de Nemours and Co.*, No. 00-2918, 2001 WL 1185796, at *10 (3rd Cir. Oct. 5, 2001) (relying upon DSM-IV as authoritative source); *S.M. v. J.K.* 262 F.3d 914, 922 (9th Cir. 2001); *United States v. Scholl*, 959 F. Supp. 1189 (D. Ariz. 1997), *aff'd* 166 F.3d 964 (9th Cir. 1999) (as amended) ("mental disorders that are not specifically described in the DSM-IV generally will not meet the Daubert scientific validity test..."); *United States v. LiButti*, Crim No. 92-611 (JBS), 1994 WL 774647, at * 11 & n.11 (D.N.J. Dec. 23, 1994) (experts agree criminal defendant manifests criteria for pathological gambling under DSM "authoritative classification system"), *aff'd without op.*, 72 F.3d 124 (3d Cir. 1995), *cert. denied*, 517 U.S. 1121 (1996); *Rowland v. Mad River Local School Dist.*, 730 F.2d 444, 454 (6th Cir. 1984) (stating: "Note: The DSM is one of the most authoritative diagnostic manuals for the conduct of psychiatric examinations in the United States, and constitutes the complete listing of currently recognized psychiatric diagnoses.").

¹⁷¹ 135 Cong. Rec. S10,773 (1989) (statement of Sen. Armstrong).

¹⁷² *Id.*

¹⁷³ 135 Cong. Rec. S10,772 (1989) (statement of Sen. Armstrong).

¹⁷⁴ *Id.*

¹⁷⁵ 135 Cong. Rec. S10,768 (1989) (statement of Sen. Harkin).

¹⁷⁶ 135 Cong. Rec. S10,768 (1989) (statement of Sen. Helms).

¹⁷⁷ 135 Cong. Rec. S10,772 (1989) (statement of Sen. Helms).

¹⁷⁸ For an excellent description of this theory, see Adrienne L. Hiegel, Note, Sexual Exclusions: The Americans with Disabilities Act as a Moral Code, *94 Colum. L. Rev.* 1451, 1461-67 (1994) (detailing history of how society has pathologized social outcasts).

¹⁷⁹ See Heigel, *supra* note 178, at 1464 (discussing *Jew Ho v. Williamson*, 103 F. 10 (C.C.D. Cal. 1900), in which the district court "found the quarantine of San Francisco's entire Chinatown to be racially discriminatory"). At the time, white Americans imputed Chinese people to be more likely than whites to be infected with syphilis. *Id.*

¹⁸⁰ See *id.* at 1486-88 (discussing the ADA as a moral mandate); see also Hazel Glenn Beh, Sex, Sexual Pleasure, and Reproduction: Health Insurers Don't Want You to Do Those Nasty Things, *13 Wis. Women's L.J.* 119, 144, 163-75 (1998) (discussing how insurers deny treatment to conditions imputed to have an immoral content).

¹⁸¹ Suspect classifications of race and sex only serve to demonstrate that the government classification is *prima facie* improper. Even if suspect classifications are not present, under the Fourteenth Amendment, the Court is authorized to examine whether the government has a permissible justification for its classification. See *Romer*, 517 U.S. at 632-34.

¹⁸² *Id.* at 632 (finding authority in *New Orleans v. Dukes*, 427 U.S. 297 (1976); *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483 (1955); *Railway Express Agency, Inc. v. New York*, 336 U.S. 106 (1949); *Kotch v. Board of River Port Pilot Comm'rs*, 330 U.S. 552 (1947)).

¹⁸³ See *supra* notes 24 & 175-79 and accompanying text.

¹⁸⁴ *Romer*, 517 U.S. at 634 (citing *U.S. Dep't of Agriculture v. Moreno*, 413 U.S. 528, 534 (1973) (finding a "desire to harm a politically unpopular group cannot constitute a *legitimate* government interest").

¹⁸⁵ See *supra* Part I.A.

¹⁸⁶ *Romer*, 517 U.S. at 635.

¹⁸⁷ 448 U.S. 297 (1980).

¹⁸⁸ *Id.* at 322, quoted in *Nabozny v. Podlesny*, 92 F.3d 446, 446 (7th Cir. 1996).