1979

Medicaid Funding for Transsexual Surgery

Minn. L. Rev. Editorial Board

Follow this and additional works at: https://scholarship.law.umn.edu/mlr

Part of the Law Commons

Recommended Citation

https://scholarship.law.umn.edu/mlr/3125

This Article is brought to you for free and open access by the University of Minnesota Law School. It has been accepted for inclusion in Minnesota Law Review collection by an authorized administrator of the Scholarship Repository. For more information, please contact lenzx009@umn.edu.
Medicaid Funding for Transsexual Surgery

Jane Doe, a genetically male transsexual, was one of a number of carefully screened candidates selected by the University of Minnesota Hospitals as eligible for sex conversion surgery. Doe, a recipient of hormone therapy since 1968, lived as, and developed the physical attributes of, a female. Certified by the Minnesota Medical Assistance Program as totally disabled, she applied to the Hennepin County Welfare Department for funding for the surgical procedure.

1. The name was a pseudonym.
2. Transsexuals are individuals with the anatomy of one sex who believe so firmly that they belong to the other sex and so totally identify themselves as that other sex, that they are obsessed with the compulsion to alter their appearance, social status, and bodies to conform to that other gender. See R. Stoller, Sex and Gender (1968); Pauly, Adult Manifestations of Male Transsexualism, in Transsexualism and Sex Reassignment 48 (R. Green & J. Money eds. 1969); Dorland's Illustrated Medical Dictionary 1632 (25th ed. 1974). See also notes 33 & 76 infra.

The sex change procedure is composed of three stages. First, as an attempt to determine if the patient can adjust to a new sexual role, the patient is required to crossdress and function in society totally as a member of the opposite sex. During this phase, which lasts about one year, the patient receives female hormone injections. Only if the first stage has been successful will surgery—the second stage—be performed. In the final stage, the newly transformed individual receives assistance in adjusting to her new sexual status. Comment, Transsexuals in Search of Legal Acceptance: The Chromosome Test, 15 San Diego L. Rev. 331, 337 (1978).
5. Doe was an eligible recipient of funds under title XIV of the Social Security Act providing aid for the disabled. The disability was based on psychological factors due to the transsexual condition. Doe v. Minn. Dept't of Pub. Welfare, 257 N.W. 2d at 817-18; Brief for Appellant at A-2, Doe v. Minn. Dept't of Pub. Welfare, 257 N.W. 2d 816 (Minn. 1977). See 42 U.S.C. §§ 1351-1355 (1976). See also note 20 infra and accompanying text. To be certified as disabled, one must be unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment. This impairment must last for a continuous period of not less than 12 months, and be of such severity that the person cannot engage in any kind of substantial gainful work, regardless of whether a job vacancy exists or whether he would be hired for work if he applied. See 42 U.S.C. §1382c(a)(3) (1976).
necessary to overcome the final obstacle to her complete sexual transformation—the removal of her male sexual organs and the construction of their female counterparts. After she was initially denied funding, Doe presented evidence at a hearing demonstrating her need for the surgical procedure. From uncontradicted evidence, a hearing officer determined that the operation was "medically necessary" and ordered that it be funded. This determination was overruled by the Minnesota Department of Public Welfare for two stated reasons: first, the agency's *Physicians' Handbook* provided that transsexual surgery was not covered by the Medical Assistance Program; and second, Doe had failed to prove conclusively that the procedure would remove her disability and make her self-supporting. This final administrative decision was affirmed in district court on the second

---

7. The hearing was conducted on appeal from the county agency's original denial of funding. Brief for Appellant, *supra* note 5, at A-1. *(See Act of June 1, 1967, ch. 16, § 10 1967 Minn. Laws 2072 (repealed 1976).)*

Doe had undergone five days of intensive testing by the gender committee at the University Hospitals, University of Minnesota, Minneapolis, Minnesota. This committee, composed of specialists in a variety of fields, evaluates potential candidates based on all relevant physical, mental, social, and economic factors before concluding that surgery should be undertaken as treatment for transsexualism. Only a select few — in the current year one-tenth — meet the criteria and are recommended for the sex conversion procedure. Doe presented the favorable result of the gender committee's exhaustive inquiry as evidence that her surgery was medically necessary. Furthermore, she testified that surgery was required to correct physical and medical problems caused by her hormonal treatments, and that she hoped surgery would eliminate her need to depend on welfare for support. Brief for Appellant, *supra* note 5, at A-2, A-3; Telephone Interview with Dr. Lloyd Sines, Department of Psychiatry, University Hospitals, University of Minnesota, Minneapolis, Minn. (Dec. 18, 1978). *(See note 40 *infra*.)

8. The Department of Public Welfare (DPW) presented no medical reports, examinations, or opinions as to the necessity of the requested procedure, but only the bare fact that a DPW publication, *see* note 10 *infra* and accompanying text, listed transsexual surgery as a noncovered service. Brief for Appellant, *supra* note 5, at A-2, A-3.


11. 257 N.W. 2d 816, 818; Order of the Commissioner of the Minnesota Department of Public Welfare (Jan. 21, 1976), *reprinted in* Brief for Appellant, *supra* note 5, at A-8. The state agency had authority under Act of June 1, 1967, ch. 16, § 10, 1967 Minn. Laws 2072 (repealed 1976) to review and reverse the hearing officer’s determination on its own motion without further investigation, but its decision had to be consistent with the provisions of the Medical Assistance program.

12. 257 N.W.2d at 818. The district court was empowered under Act of June 1, 1967, ch. 16, § 11, 1967 Minn. Laws 2073 (repealed 1976) to review the state agency's reversal either on the record or de novo only to determine whether the order of the state agency was based on an erroneous theory of law or was arbitrary, capricious, or unrea-
ground advanced by the state agency for denial of funding. On appeal, the Minnesota Supreme Court reversed and ordered that the surgery be funded, holding that (1) total exclusion of transsexual surgery from Medical Assistance coverage is void under federal regulations governing state Medicaid programs; (2) a standard of medical necessity that requires conclusive proof that a procedure will eliminate disability and render the applicant self-supporting is impermissible; and (3) the decision to deny Medical Assistance funding in the absence of evidence to contradict the applicant's showing of medical necessity is arbitrary and unreasonable. Doe v. Minnesota Department of Public Welfare, 257 N.W. 2d 816 (Minn. 1977).

Medicaid, title XIX of the Social Security Act, was enacted by Congress in 1965 to enable "each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance . . . [to those] whose income and resources are insufficient to meet the costs of necessary medical services." Participation by the states in the Medicaid program is voluntary, but every state save one has enacted a state plan to provide the medical assistance funding authorized under title XIX.

An embodiment of the concept of "cooperative federalism," Medicaid allows states considerable freedom to devise and administer their own programs in accordance with their particular needs and abilities. To be eligible for federal financial participation, however, a state plan must comport with title XIX and its accompanying regulations. Although participating states may give medical assistance to all needy persons, they must at a minimum offer it to the

---

sonable. Id. The district court in this case did not take new evidence, but instead upheld the state's decision as based on substantial evidence, not founded on an erroneous theory of law, and not arbitrary, capricious, or unreasonable.


15. Arizona does not have a Medicaid Plan. See [1977] 2 MEDICAID & MEDICARE GUIDE (CCH) ¶ 15,500.


"categorically needy"—those who receive cash payments under specified categories of social welfare funding. To persons so characterized, they must provide medical care of five broad denominations: inpatient hospital services; outpatient hospital services; laboratory and X-ray services; nursing facility, family planning, and health screening services; and physicians' services. States are required to set standards determining the extent of medical assistance they will provide under their programs. Not only must these standards be reasonable, but they must also comport with the general objectives of Medicaid. No state may deny covered services arbitrarily, nor reduce their amount, duration, or scope, solely because of an applicant's "diagnosis, type of illness or condition." The only basis on which a state may limit covered services is on criteria such as the need to safeguard against waste of program funds or lack of medical necessity.

20. *Id.* § 1396a(a)(10)(C). The "categorically needy" include persons receiving cash payments under: old age assistance or medical assistance for the aged, title I, *id.* §§ 301-306; aid for the blind, title X, *id.* §§ 1201-1206; aid for the disabled, title XIV, *id.* §§ 1351-1355; supplemental income for the aged, blind, and disabled, title XVI, *id.* §§ 1381-1383c; or aid to families with dependent children, title IV, Part A, *id.* §§ 601-610. Any state participating in the Medicaid program must provide medical benefits to these categories of recipients. *Id.* § 1396a(a)(10)(A). States may also choose to give assistance to other needy persons. If, however, a state opts to provide funds for any recipient class other than those defined as categorically needy, it must also include all individuals who would, except for income and resources, be eligible to receive cash payments under the above-enumerated assistance programs and whose income and resources are nonetheless insufficient to meet the costs of necessary medical services. *Id.* § 1396a(a)(10)(C). This latter group is called the "medically needy." Doe was a recipient of aid for the disabled and therefore among the categorically needy for purposes of Medicaid eligibility. See note 5 supra and accompanying text.

21. 42 U.S.C. § 1396d(a)(1)-(5) (1976). These five areas of mandatory minimum coverage are subsumed in the definition of "medical assistance" for purposes of Medicaid. *Id.* § 1396d(a). The statutory definition of medical assistance also includes: home health care services; private duty nursing services; clinic services; dental services; physical therapy and related services; prescribed drugs, dentures, prosthetic devices, and eyeglasses; other diagnostic, screening, preventative and rehabilitative services; services for persons aged 65 or older in an institution for tuberculosis or mental diseases; intermediate care facility services; inpatient psychiatric hospital services for persons under age 21; and any other type of medical or remedial care furnished by licensed practitioners within the scope of their practice as defined by state law. *Id.* § 1396d(a)(6)-(17). For the "medically needy," states may provide the same five minimum categories of service it offers to the categorically needy, or any combination of at least seven of the sixteen listed categories of care. *Id.* § 1396a(a)(13)(C)(ii).

22. *Id.* § 1396a(a)(17).


25. *Id.* § 440.230(c)(2) (utilization control). Medical necessity is discussed in notes 41 & 57 infra.
The State of Minnesota participates in Medicaid through its Medical Assistance Program. The Minnesota enabling legislation explicitly states that the program must comply with title XIX provisions. The Minnesota Department of Public Welfare, which administers the Medical Assistance Program, issues regulations and guidelines governing individual determinations of eligibility and medical necessity under the state plan. At the time Doe requested funding for her conversion surgery, the Physicians' Handbook of the Department of Public Welfare Medical Assistance Program contained an absolute prohibition against payment for transsexual surgery by Medical Assistance. The state agency relied in part on this outright prohibition, to deny Ms. Doe's application for funding.

Ms. Doe challenged the decision to deny funding for her sex conversion surgery. In order to assess the merit of her appeal, the court first reviewed the medical literature on transsexualism, concluding that the only known successful treatment for this condition

---


29. See MA PROGRAM MANUAL, supra note 26.

30. PHYSICIANS' HANDBOOK, supra note 10, at § 205(10).

31. The Physicians' Handbook was intended to be only advisory, but since the agency had relied on the Physicians' Handbook to justify its denial of Doe's funding, the court on review regarded the handbook as having an effect equivalent to a "formal" rule of law. See 257 N.W.2d at 819.

32. The Physicians' Handbook absolutely excluded the following from funding:
1. Medications dispensed by the physician when the necessary medications can reasonably be dispensed by a pharmacy. . . .
2. Medical services or supplies purchased by the recipient himself.
3. The cost of an autopsy.
4. Failed appointments.
5. Telephone calls or other communications between the provider and recipient.
6. Routine reports (social security, insurance, etc.).
7. Investigational surgery or procedures (i.e. research efforts that are not essential to the patient's health).
8. Illegal operations.
10. Transsexual surgery.

PHYSICIANS' HANDBOOK, supra note 10, at § 205(10).
is sex conversion surgery. Accordingly, the court held that the state agency's absolute exclusion violated the federal Medicaid regulation prohibiting a state from arbitrarily denying eligible recipients medical care and services solely because of the "diagnosis, type of illness or condition." The court also found no merit in the agency's second contention, that Doe should be required to prove that the operation would allow her to become self-supporting. Since the hearing officer's determination of medical necessity stood unimpeached, the court ordered the state agency to grant Doe medical assistance funding for her surgery.

The court's rationale for striking the absolute funding exclusion was clearly sound, but there is additional support for the court's result. As well as prohibiting states from denying medical services on
the basis of the type of condition, title XIX requires that any attempt by a state to limit the extent of medical assistance be reasonable and consistent with title XIX objectives. An absolute exclusion from coverage without consideration of whether a surgical procedure is necessary to the health of the individual fails that test. What may be a frivolous treatment for one individual may well be essential for another. A refusal by a state to fund treatment that is medically necessary is surely not consistent with title XIX's objective of furnishing medical assistance to those who cannot afford necessary medical treatment.

39. See Beal v. Doe, 432 U.S. 438, 444 (1977) (While it is not unreasonable for a state to refuse to cover unnecessary procedures, "serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage.") Coe v. Hooker, 406 F. Supp. 1072 (D.N.H. 1976) ("There is no mandatory requirement on the states that Medicaid benefits be limited to only 'necessary medical services.'" Additionally, the court stated that "[i]f the states themselves impose such a requirement, they may not . . . categorically decide without reasonable justification that a specific treatment is 'unnecessary'.")
40. See Rush v. Parham, 440 F. Supp. 383, 391 (N.D. Ga. 1977), appeal filed sub nom. Rush v. Poythress, No. 77-2743 (5th Cir. Apr. 1978). When confronted with medical procedures of doubtful medical necessity, most, if not all, state programs make the assumption that the service is unnecessary and hence ordinarily do not pay the costs of the procedure. At the same time, however, they provide that in exceptional circumstances the procedure will be funded. For example, cosmetic surgery is usually considered necessary to repair disfigurement caused by accidental injury. See, e.g., Code of Md. Reg., Health & Mental Hygiene 10.09.02.06(A)(1); Ore. Adm. Rules, Pub. Welf. Reg. 461-13-010(5). To handle requests for sex conversion surgery in a similar manner would be consistent with the realities of transsexualism. It is universally agreed by experts on the subject that the only effective method of treating transsexualism is sexchange surgery. See note 33 supra and accompanying text. Yet, the operation is certainly neither proper nor desirable for every individual who experiences gender role disorientation. Sex conversion patients are carefully selected from the large numbers of candidates who apply to the few centers that provide it. For example, of the approximately 250 inquiries each year made to the University Hospitals at the University of Minnesota, only 12 to 20 operations are performed there annually. Sines Interview, supra note 7. Most applicants are disapproved for psychological, mental, or social reasons. Id. An evaluation team typically considers the transsexual's motive for having the operation, whether the patient is psychotic (in which case surgery is not performed), and to what extent the person will be able to adjust to life in the desired new sexual role without experiencing insuperable problems with employment, living arrangements, and social interaction. Knorr, Wolf & Meyer, supra note 33, at 275-79. See generally Stoller, Male Transsexualism: Uneasiness, 130 Am. J. Psych. 536 (1973) (more cautious evaluation by restrictive standards needed before recommendation of surgery).
41. States may legitimately regulate to some extent the manner in which medical services are provided "to protect the medical interests of the recipients." Doe v. Beal, 523 F.2d 611, 621 (3d Cir. 1975), rev'd on other grounds, 432 U.S. 438 (1977). States may impose specific medical requirements when "this would, in the particular in-
stance, be consistent with sound medical practice. Gratuitous interference with medical decisions by doctors, on the other hand, would create a system of medical obstruction rather than of medical assistance." Id.

Since state and federal public welfare monies are not without limit, however, there must necessarily be some restriction on the amount and scope of services that will be funded. Therefore, states generally require that treatment be "medically necessary" in order to be covered by Medicaid. Although authority for this restriction is not made explicit in the text of title XIX, see Roe v. Norton, 522 F. 2d 928, 933 (2d Cir. 1975), reud sub nom. Maher v. Roe, 432 U.S. 464 (1977); Coe v. Hooker, 406 F. Supp. 1072, 1081 (D.N.H. 1976); 42 U.S.C. §§ 1396-1396k (1976), sections of the Medicaid statute do refer indirectly to necessity as a limitation. See id. § 1396a(a)(30) (1976) (state plans must "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services"); id. § 1396a(a)(31) (state plans must include a program of "medical evaluation of each patient's need for intermediate care"). See also Roe v. Norton, 522 F.2d 928, 939 (2d Cir. 1975) (Mulligan, J., concurring in part and dissenting in part) ("The whole tenor of Title XIX indicates the intent to place some limit on medical assistance.").

Furthermore, legislative history leaves little room for doubt that a medical necessity restriction must be read into the Medicaid program. The legislative history of the 1965 amendments to the Social Security Act relates both to the revisions then being made to the Medicare program, title XVIII, and to the newly created Medicaid program, title XIX. Passages from the Report of the Senate Committee on Finance, S. Rep. No. 404, 89th Cong., 1st Sess. 46 (1965), reprinted in [1965] 1 U.S. Code Cong. & An. News 1943 [hereinafter cited as S. Rep. No. 404], strongly support an implied medical necessity limitation. See, e.g., id. at 1987 ("[T]he bill would require that a physician certify that the services were required for an individual's medical treatment . . . and that the services were necessary for such purpose."); id. at 1989 ("The bill would bar payment for health items or services that are not reasonable and necessary for the treatment of illness or injury.").

The regulations promulgated under title XIX also indicate that Medicaid contains an implied "medical necessity" standard. The states are expressly authorized to place limitations on the amount, scope, and duration of services based on reasonable criteria such as medical necessity, to establish utilization control, and to review program criteria promulgated pursuant to the mandate of title XIX, which criteria are also to be based on necessity or medical necessity criteria. 42 U.S.C. § 1396a(a)(30) (1976); 42 C.F.R. § 440.230 (1978). The utilization control plans are to be set up by the states as "safeguards against unnecessary or inappropriate utilization of care and services" provided. Id. § 450.18(a). Federal regulations concerning utilization review of institutional care require an independent committee to review the attending physician's decision as to medical necessity for admission. Id. § 450.19(a)(1)(viii). Any lingering doubt as to the implied authority to limit services based on medical necessity was dispelled by the Professional Standards Review Organization (PSRO) program. 42 U.S.C. §§ 1320c-1 to -19 (1978) (enacted in 1972). This statutory scheme is designed to assure that payments made under Medicare and Medicaid will be limited to those that are medically necessary. Id. § 1320. It provides for a network of professional medical organizations, (PSROs), which are authorized to monitor and control use of funded services through physician-established norms to check individual services for medical necessity, appropriateness, and quality. Id. §§ 1320c-4(a)(1), -5. When the program is fully implemented, PSROs will act as final arbiters of medical necessity, preempting the utilization controls and review procedures currently in force. See generally Gosfield, Medical Necessity in Medicare and Medicaid: The Implications of Professional Standards Review Organizations, 51 Temp. L.Q. 229 (1978).
Yet, Congress has given some indication that cost-based limitations on the extent of Medicaid coverage may be reasonable. As originally enacted in 1965 and as amended in 1969, title XIX required states to make efforts to broaden the scope and extent of covered care and services and to liberalize eligibility requirements with a view toward furnishing comprehensive care and services by 1977.42 In light of the drastic increase in health care costs and in the number of eligible recipients during the ten-year period following enactment of the Medicaid program, however, Congress found it necessary in 1972 to repeal this provision of the Social Security Act.43 The net effect was to permit states wider latitude in setting program limitations, especially in the optional coverage categories.44 It would, therefore, not appear unreasonable for a state to devise limitations on services based on excessive costs involved.45 Although no such justification

---

44. See id. Indeed, the report of the Ways and Means Committee relaxed the pressure on the states to provide optional services, in order to assure a maintenance of effort with regard to basic services. H.R. Rep. No. 231, 92d Cong., 2d Sess. 117 (1972), reprinted in [1972] 3 U.S. CODE CONG. & AD. News 4989, 5086-87. It should be noted, however, that the reductions and cutbacks were made specifically in view of the fiscal difficulties being experienced by state programs, and did not represent evidence of withdrawal of congressional intent to make the programs comprehensive as soon as feasible. See id. at 5086.

An example of the states' response to the repeal of § 1396b(e) is illustrated in Medical Soc'y v. Toia, 560 F.2d 535 (2d Cir. 1977). That opinion notes that New York, motivated by fiscal necessity, "attempted to limit authorized surgery to that which is urgently necessary or which, if delayed, might cause an increased medical risk, jeopardize life or essential function, or cause severe pain." Id. at 537. The court did not pass on the validity of the state's assertion that this limitation was designed to safeguard against unnecessary use of medical care and services thereby ensuring that medical payments were not in excess of reasonable charges consistent with quality of care, 42 U.S.C. § 1396a(a)(30) (1976), and as such was an appropriate limit "based on such criteria as medical necessity." 560 F.2d at 538-39 (citing 45 C.F.R. § 249.10(a)(5)(i) (earlier codification of 42 C.F.R. § 440.230).

Similarly, the court in Virginia Hospital Ass'n v. Kenley, 427 F. Supp. 781 (E.D. Va. 1977), adjudicating the validity of Virginia's 21-day limitation on inpatient hospital coverage, held that states may, consistently with title XIX, limit the days of coverage of inpatient hospital care, and that this limitation was a reasonable one. Id. at 786. For a discussion of the validity of fiscally motivated limitations on Medicaid funding, see Note, State Restrictions on Medicaid Coverage of Medically Necessary Services, 78 COLUM. L. REV. 1491 (1978).

45. See Lawrence v. Maher, [1976-1978 Transfer Binder] Pov. L. Rep. (CCH) ¶ 24,565 (D. Conn., Mar. 21, 1977) (state may limit periodontal services while allowing other services, because the limitation was based on cost and thus was reasonable). See Note, supra note 44, at 1503-10.
was proffered by the state in Doe, if the state had justified the absolute exclusion of transsexual surgery on the basis of excessive cost, then it might have been less obvious that the court should overturn the exclusion.

Nevertheless, had the state made such an argument, the proper course would been to have reject it. The cost of a treatment plan culminating in transsexual surgery ranges from $7,500 to $10,000. In Minnesota, fewer than twenty such procedures are performed each year. Even if all such transsexual patients were eligible to receive Medicaid funding, which is certainly not the case, the state could not save enough by an absolute refusal to pay for transsexual surgery to justify overriding the federally-mandated policy of providing necessary medical care to indigents.

An even better approach would have been for the court to hold that title XIX requires states to fund all "medically necessary" procedures falling within the categories of care a participating state must provide to eligible recipients. Such a holding would dispose of all cost-based exclusions which purport to economize at the expense of those who are both financially and medically in need.

Support for this desirable but unarticulated alternative holding may be drawn from two recent federal court opinions that have interpreted the meaning of the medical necessity standard implicit in the Medicaid program. In Beal v. Doe, the United States Supreme Court held that states are free to refuse coverage for care and services that are determined, by standards reasonable and consistent with title XIX, to be medically unnecessary. At the same time, however,

46. The cost is approximately $7,500 for biological males and $10,000 for biological females. These are the current figures at the University of Minnesota Hospitals, Minneapolis, Minnesota. Sines Interview, supra note 7.

47. Id.

48. According to Dr. Sines, in the past three years, only one transsexual who applied for treatment at the University Hospitals and who met all of the qualifications for surgery could not afford to pay. Id.

49. See note 57 infra.


51. Id. at 444-45. In Beal, the issue for decision was whether title XIX requires states participating in Medicaid to fund the cost of nontherapeutic abortions. The Pennsylvania Medicaid program would only pay for those abortions certified by physicians as medically necessary according to program guidelines. The Court determined that the Pennsylvania definition of medical necessity was broad enough to encompass the factors found in Doe v. Bolton, 410 U.S. 179, 192 (1973), to be constitutionally relevant to the physician's judgment as to whether an abortion is necessary for a woman's health and well-being. 432 U.S. at 441 n.3. Noting that title XIX gives the states broad discretion in adopting standards for limiting the extent of medical assistance, requiring only that the standards be reasonable and consistent with the objectives of the Act, the Court held Pennsylvania's regulation to be consistent with title
the Court intimated that states are required to fund all necessary medical treatment within the categories of mandatory Medicaid coverage. Subsequent to these pronouncements, a Georgia federal court in *Rush v. Parham* interpreted *Beal* as holding that "[b]enefits for medically necessary services . . . are the irreducible minimum coverage which states must provide." The *Rush* court, however, went further, concluding that judgments of medical necessity are to be made for individual patients by their attending physicians. Noting *XIX and not unreasonable. The state; it said, has a valid and important interest in encouraging childbirth; title XIX does not make efforts to protect this interest unreasonable. Thus, the Court declined to assume that Congress intended to require funding of non-therapeutic abortions as a condition to a state's receipt of federal Medicaid money, absent evidence of such intent in the statute or legislative history. Since Pennsylvania's plan did allow for funding of necessary abortions, the Court was not called upon to decide whether title XIX mandates coverage of all necessary procedures within the five minimum areas of coverage. But see note 52 infra and accompanying text.

52. See 432 U.S. at 444-45 ("Although serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary—though perhaps desirable—medical services.") (emphasis in original).


54. 440 F. Supp. 383, 389. Georgia was ordered to pay the cost of petitioner's transsexual surgery which was diagnosed as "urgently indicated" by the attending physicians. *Id.* at 386. But see *Preterm, Inc. v. Dukakis*, 591 F.2d 121, 126 (1st. Cir. 1979); *Note*, supra note 44, at 1498-1502.

The First Circuit Court of Appeals came to the contrary conclusion that Medicaid does not mandate coverage for all medically necessary services. See 591 F.2d at 126. The court, noting the absense of a direct statutory order to fund all necessary services, was reluctant to read the broad "necessary medical services" language in the preamble to title XIX as an affirmative requirement for state Medicaid plans. Nonetheless, the court reached an essentially identical result by applying the "reasonable standards . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of Title XIX." See notes 23, 38-41 supra and accompanying text. In any event, the eventual implementation of the PSRO system for determining medical necessity, see note 41 supra, would tend to delimit the implications of the First Circuit view, since upon a finding of necessity by the PSRO the state will be required to make payment for the prescribed care. See *Gosfield*, supra note 41, at 238.

55. 440 F. Supp. at 390. This holding is strongly, albeit indirectly, supported by the congressional history of the Professional Standards Review Organization system. See note 41 supra. This congressional history reveals that Congress was troubled by the prevalent practice of allowing clerical personnel in the employ of insurance companies and government to make decisions regularly as to the necessity of medical care for which payment under Medicaid was requested. Congress therefore wanted to establish a bridge between medicine and government that would both ensure the funding of necessary care and prevent improper utilization and over-utilization of services. The PSRO program was seen as eliminating the isolation existing between the medical professionals responsible for prescribing and providing necessary medical services and...
that what is unnecessary for one individual could well be essential for another, the court said a state may not categorically deny coverage for any service or procedure.\(^5\)

Unfortunately, there is no generally acknowledged definition of medical necessity.\(^5\) It is instead a policy limitation designed to serve the government that pays for such services. The bridge was built of medical professionals, sensibly recognizing their primacy in the medical necessity decision. See S. Rep. No. 1230, 92nd Cong., 2d Sess. 262 (1972); note 75 infra.

56. 440 F. Supp. at 390. In dictum, the court noted that “[t]he state may choose to list presumptively covered or uncovered medical services. However, clear guidance on the availability and procedure for rebutting the presumptions of the list must also be provided.” Id. at 391 n.16.

57. There are many possible ways to define medical necessity. One writer has suggested that a useful definition would be that prevailing in the medical community: “the care which is responsive to the problem for which it is offered.” Butler, The Right to Medicaid Payment for Abortion, 28 Hastings L.J. 931, 955 (1977). The physician first identifies the condition and prescribes treatment. If that treatment is “safe and efficacious for that condition,” it is medically necessary. Id. Though such a standard would seem to allow funding for such arguably unnecessary procedures as cosmetic surgery, the states would be free to exercise their broad discretion to exclude such procedures based on other reasonable grounds, such as economy and prevention of unnecessary use of program resources. See Beal v. Doe, 432 U.S. 438 (1977); 42 U.S.C. § 1396a(a)(30) (1976). See also Doe v. Beal, 523 F.2d 611, 620-21 (3d Cir. 1975) rev’d, 432 U.S. 438 (1977). See generally Butler, supra, at 954-61; Note, supra note 44. Most state plans do not even define “medical necessity.” Nonetheless, states generally use the term to signify some purpose such as restoration or maintenance of health by correction of some defect, cure or prevention of illness, or removal of disability. See, e.g., Cal. Welf. & Inst. Code § 14059 (West 1972); N.Y. Soc. Serv. Law § 365-a(2) (McKinney 1976). The Maryland plan describes medically necessary physicians’ services as those “[c]learly related to the recipient's individual medical needs as diagnostic, curative, palliative, or rehabilitative services.” Code of Md. Reg., Health & Mental Hygiene 10.09.02.04(B)(2). Idaho reimburses recipients for “necessary hospitalization” for “treatment of medical or surgical conditions of any nature which are a threat to the life or health of the patient.” Idaho Health & Welfare Reg. 3-1410.01. New Mexico refuses coverage “considered not medically necessary for the diagnosis and treatment of illness or injury or not required by the condition of the recipient.” New Mexico Medical Assistance Bureau, Dep't of Human Services, Medical Assistance Program Manual § 303-B(2) (1978). Oregon refuses to pay for those items or services not “reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member or for correction of an organic system.” Ore. Pub. Welf. Reg. 461-13-010 (1974). The somewhat unusual Michigan approach has as its primary objective ensuring the provision of “essential health care services” found to be medically necessary by the attending physician, meanwhile recognizing that “there occasionally may be recipients for whom this same principle of medical necessity indicates a need for services beyond those ordinarily covered.” In those cases, the patient may apply through his physician for an independent determination of funding. Michigan Dep't of Social Services, Covered Medical Services, in Medical Assistance Eligibility Manual (1978) (statement of departmental policy). Under the PSRO system, see note 41 supra, payment cannot be made for any service not medically necessary, and in the absence of controlling federal statutory definitions of the terms “necessity,” “therapeutic,” or “elective,” the PSRO bases its determina-
broad programmatic functions. Limited public funds must be channelled to the most urgent uses. Only if additional funds remain should they be expended on less "necessary" treatments. For this reason, the amount of money a state has available for its Medicaid program, to a certain extent, determines the stringency of the medical necessity standard to be applied. This is one area in which states must exercise their broad discretion. As long as the standards applied are "reasonable" and "consistent with the objectives of Medicaid," states should be free to employ such guidelines as they see fit. That does not mean, however, that a state could select a single medical procedure—such as transsexual surgery—as the sole means to implement its cost reduction program.

Perhaps recognizing the fatal weakness of its absolute prohibition on sex conversion surgery, and unable to justify its actions on

---


58. The preamble to the Medicaid statute itself acknowledges that there are inherent limitations on each state's fiscal ability to furnish medical care to indigents. See text accompanying notes 13-14 supra. Yet, no state should be permitted to place purely arbitrary limits on coverage under the guise of medical necessity. At the least, when reasonable medical minds could not differ as to the necessity of a given procedure, the state is required to fund it. See Beal v. Doe, 432 U.S. 438, 444 (1977); Rush v. Parham, 440 F. Supp. 383, 389 (N.D. Ga. 1977), appeal filed sub nom. Rush v. Poythress, No. 77-2743 (5th Cir. Apr. 1978). The First Circuit Court of Appeals has said that for a state to apply a definition of medical necessity that allows funding only when the patient would die without treatment would violate federal regulations and also be inconsistent with the objectives of Medicaid. See Preterm, Inc. v. Dukakis, 591 F.2d 121, 126 (1st Cir. 1979).

59. See text accompanying note 23 supra.

60. See text accompanying notes 45-48 supra.

61. On appeal, the state abandoned any argument in support of the absolute exclusion, and was unwilling even to acknowledge that there was such a restriction. Instead, it merely averred that "the district court decision in this case in no way forecloses appellant from meeting the required showing of medical necessity at some later date." Brief for Respondent at 11, Doe v. Minn. Dep't of Pub. Welfare, 257 N.W.2d 816 (Minn. 1977). The facts, however, clearly reflect the absolute exclusion. The Physicians' Handbook listed transsexual surgery as a noncovered service. See note 32 supra. This provision explicitly formed one basis of the state agency's denial of funding for Doe's surgery. 257 N.W.2d at 818. Furthermore, at the time the case was argued, the state agency had proposed a new rule governing the Medical Assistance program that listed transsexual surgery as excluded. Reply Brief for Appellant at 7. Subsequently, Department of Public Welfare Rule 47 was implemented with a revision to reflect the decision in Doe. It now requires prior authorization for funding of transsexual surgery. See 12 Minn. Code of Agency Rules § 2.047(B)(1)(k), as amended by Letter from Edward J. Dirkswager, Jr., Acting Commissioner of the Department of Public Welfare, to the Directors of County Welfare Departments (Sept. 13, 1977) (amending Rule 47).
fiscal grounds, the state agency also adopted an alternative theory upon which to deny Ms. Doe her surgical metamorphosis. Exercising its "broad discretion" under title XIX, it asserted that for an applicant to qualify for Medical Assistance funding for a surgical treatment, she must present conclusive evidence that it will not only remove her disability but also render her self-supporting.\footnote{257 N.W.2d at 818.}

The state made no effort to rebut the obvious inference that this standard had been specially contrived to deny Doe funding.\footnote{Doe alleged that this draconian burden of proof had not previously been imposed on any applicant. See Brief for Appellant, supra note 5, at 48, 52. The state's only refutation of this assertion was that the medical assistance program "has always been administered in compliance with state and federal laws." Brief for Respondent, supra note 61, at 11 n.5. Doe was never informed that this new "standard" would be applied in her case. Brief for Appellant, supra note 5, at 49.  
Brief for Appellant, supra note 5, at A-1 (finding of Fact No. 7 by Local Evidentiary Hearing Officer). See text accompanying note 9 supra.  
Id. at A-8 (Order of the Commissioner of Public Welfare denying funding (1-21-76)). See note 11 supra and accompanying text.  
See Brief for Appellant, supra note 5, at A-17 (conclusion of law by Hennepin County Dist. Ct.).}

A reading of the record suggests that its origin, ironically, was in the aspirations Ms. Doe voiced at her hearing. The hearing examiner found that "[s]urgery is imperative to alleviate the physical and medical problems caused by the hormonal treatments. [Doe] must live a secret life. She is hoping that after the surgery she would be able to be self-supporting and independent of welfare."\footnote{Id. at A-8 (Order of the Commissioner of Public Welfare denying funding (1-21-76)). See note 11 supra and accompanying text.}

On appeal, the state agency reversed the hearing examiner's approval of funding because "[n]o conclusive evidence was presented to support the petitioner's contention that, if she has the surgery, her psychological problems will be alleviated to the point that she will no longer be disabled and will become self-supporting."\footnote{See Brief for Appellant, supra note 5, at A-17 (conclusion of law by Hennepin County Dist. Ct.).}

By the time the district court passed on the case, Ms. Doe's "contention" had become "the required standard of medical necessity" she failed to satisfy.\footnote{257 N.W.2d at 821.}

Fortunately, the supreme court refused to lend its support to such a standard. The court illustrated the absurdity of the agency's position by noting its effect on more conventional medical treatment: A cancer patient would be unable to prove by conclusive evidence that removal of her tumor would eradicate her disease.\footnote{Id. at A-17 (conclusion of law by Hennepin County Dist. Ct.).}

Moreover, a requirement that the treatment be able to remove the applicant from the welfare rolls would be "ludicrous," since it would entail denying a terminally ill patient amelioration of her agony merely because she lacked any prospect of becoming self-supporting as a result of the treatment.\footnote{Id.}
Though the court’s reasoning possesses common sense appeal, useful resort could have been had to the language of title XIX itself. Any standard for determining eligibility for and extent of medical assistance must be reasonable and consistent with Medicaid’s objectives. Judged by the consequences of its operation, this agency standard, like the absolute exclusion from coverage, clearly failed the most minimal test of reasonableness; nor could any state plan comport with title XIX’s general objective of furnishing medical assistance to individuals who cannot afford the costs of necessary medical services if it effectively bars many eligible individuals from receiving the very assistance the Medicaid program was designed to provide.

When the Minnesota court invalidated the absolute exclusion of transsexual surgery funding in the Medical Assistance program, it also decreed a procedure for determining necessity in future cases. Henceforth, there must be a case-by-case, “thorough, complete, and unbiased medical evaluation” performed by the individual agencies. This requirement, the court said, was consistent with the Medicaid statute and a “practical, equitable solution to the rather unique and complicated problem posed by transsexualism.”

This analysis is undoubtedly correct. Such a procedure comports with the title XIX mandate that the states safeguard against unnecessary use of program funds, yet assures that care and services will be provided in a manner consistent with the best interests of the individual recipient. Moreover, it complies with federal regulations by basing the decision to fund on a medical determination of necessity rather than on diagnosis, type of illness, or condition. To place with the medical community the responsibility to decide whether a given patient needs a certain treatment is consistent with Congress’ discernible intent to leave the matter to the judgment and discretion of the physician. See text accompanying note 38 supra.

70. 257 N.W.2d at 820. For the state agency’s implementation of the Doe procedure, see note 61 supra. The same approach should govern arguably similar procedures such as bypass surgery to correct obesity, mammary implants following mastectomy, orthodontia, cosmetic surgery, and contact lenses. Medical necessity in cases of this kind depends on individualized evaluation of the medical, psychological, and other circumstances of the particular case. This procedure parallels the PSRO system, see notes 41 & 57 supra, in methodology and function.
71. 257 N.W.2d at 820.
73. See id. § 1396a(a)(19).
75. See, e.g., S. Rep. No. 404, supra note 41, at [1965] 1 U.S. Code Cong. & Ad. News 1966 (“[T]he physician is to be the key figure in determining utilization of health services . . . [and] it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments, and determine the length of stay. . . .
of the examining physicians who are best acquainted with their transsexual patients' condition and history.6

The result in Doe v. Minnesota Department of Public Welfare parallels the handful of other cases that have addressed the issue of whether Medicaid programs must fund sex conversion surgery for transsexuals. In two recent California cases,7 transsexual plaintiffs offered the opinions of a number of medical experts7 that their surgery requests were necessary and reasonable.79 Relying on the opinion of an ophthalmological medical consultant and without performing an independent medical examination or introducing other evidence, the California Medical Assistance Director refused their applications, asserting that the operations were "cosmetic," since they would change the appearance of the external genitals.80 The court, noting that "[m]ale genitals would have to be considered more than just skin," found it "clearly impossible to conclude that transsexual surgery is cosmetic surgery."81 Therefore, it reversed the director's decision as arbitrary, and ordered funding.82

[T]he bill would require that payment could only be made if a physician certifies to the medical necessity of the services furnished."). For a discussion of whether Congress intended the definition of medical necessity to fall within state discretion, see Butler, supra note 57, at 954-55 n.146 (1977).

76. Such an allocation of decision making is eminently sensible in the case of transsexualism. Gender-role dysphoria is a highly complex disorder that is not wholly understood even by those most expert in the field. The transsexual's desire to become a member of the opposite sex begins in the first few years of life and never abates. See R. Stoller, supra note 33, at 147. All attempts to change such false gender orientation have failed. See note 33 supra. Surgery has been quite successful in relieving the transsexual's suffering and in improving social adjustment, but the decision whether to recommend the sex conversion operation can only be made after extensive testing and study. See note 40 supra. The state agency's flat prohibition against coverage and bare assertion that surgery is not medically necessary for transsexuals is therefore well replaced by the court's individualized medical determination of necessity.


78. The experts included specialists in plastic surgery, psychiatry, internal medicine, and psychology. Among them were the codirector of and a consultant to the Stanford University Gender Dysphoria Program, and a doctor from the Gender Identity Clinic at the Johns Hopkins Medical Institute. 80 Cal. App. 3d at 68, 145 Cal. Rptr. 557; 80 Cal. App. 3d at 93, 145 Cal. Rptr. at 571.


80. 80 Cal. App. 3d at 95, 145 Cal. Rptr. at 572; 80 Cal. App. 3d at 67, 145 Cal. Rptr. at 556. California's medical assistance program defined cosmetic surgery as "[s]urgery to alter the texture or configuration of the skin and its relationship with contiguous structures of any feature of the human body." 80 Cal. App. 3d at 70, 145 Cal. Rptr. at 558.

81. 80 Cal. App. 3d at 70-71, 145 Cal. Rptr. at 558-59.

82. Id. at 71, 145 Cal. Rptr. at 559; 80 Cal. App. 3d at 95, 145 Cal. Rptr. at 572.
In Rush v. Parham, a Georgia federal court also concluded that transsexual surgery may be medically necessary for purposes of a state Medicaid plan. The applicant in that case had been diagnosed by at least two physicians as a true transsexual for whom surgery was "urgently indicated" to "alleviate her depression and remove the threat of suicide." The court struck down Georgia's absolute exclusion against funding of sex conversion surgery as violative of title XIX and its regulations. The court also rejected the state's assertion that in any event the surgery was unnecessary, holding that judgments of medical necessity must be made on an individual basis, without state interference, between patient and physician.

In Denise R. v. Lavine, the New York Appellate Division reviewed a denial of funding for surgery for a transsexual who had presented psychiatric evidence of "severe psychopathology." The Department of Social Services made no independent medical examination, and no other evidence was presented at the hearing. The court held that the department's denial of funding in such circumstances, which was purported to be predicated on a "medical basis" but which actually lacked any supportive evidence or explanation, was arbitrary and capricious. In vacating that decision and upholding denial of funding, the New York Court of Appeals by a 4-3 vote found that the director was entitled within his discretion to rely on one of two arguably conflicting medical opinions offered by the applicant's physician, one of which could be interpreted as indicating that the patient was not indeed qualified for funding, having no formal disturbance in thinking. Although it would have been desirable for the agency to have conducted a separate examination or to have adduced its own evidence against necessity, the agency's failure to do so did not render the adverse decision arbitrary as a matter of law.

84. Id. at 386 (footnote omitted).
85. Id. at 390-91. The Rush Court, like the Minnesota court in Doe, relied on the federal regulation prohibiting arbitrary denials of or reductions in coverage based solely on diagnosis, type of illness, or condition. See 42 C.F.R. § 440.230 (1978).
88. Id. at 559.
90. Id. at 282, 347 N.E.2d at 895, 383 N.Y.S.2d at 570. The three dissenting judges agreed with the appellate division that the sex change operation fell clearly within the coverage of the New York Medicaid statute and was medically indicated for the petitioner. They pointed out that the isolated analysis of the patient, an analysis that revealed no formal disturbance in thinking, did not when read in context with
It is heartening that the Minnesota court rejected this New York decision as having any effect on its determination in *Doe*, although at the time it was the only appellate decision addressing the issue of transsexual funding, except for the opinion it overruled. It is a credit to the Minnesota court that, when confronted with the sensitive, perhaps politically volatile issue of sex conversion surgery for transsexuals, it chose a route of principled decision making to reach an obviously just and justified result, rather than choosing the path of least resistance by upholding the administrative decision as within discretion. Perhaps the true test of the merit of the court's holding, however, is revealed in the fact that the decision has, in its short life, already been cited several times as authoritative by courts and commentators free to reject its approach for another.\footnote{G.B. v. Lackner, 80 Cal. App. 3d at 77-81, 145 Cal. Rptr. at 562-64, 80 Cal. App.3d 64, 69, 145 Cal. Rptr. 555, 557 (1978) (analyzed and distinguished in dissenting opinion by Justice Scott); Pinneke v. Preisser, 47 U.S.L.W. 2790 (N.D. Iowa May 11, 1979).}

the rest of the doctor's report, justify refusing payment for the surgery. In his report, the doctor ultimately concluded that the patient was suffering from severe psychopathology, and recommended referral for surgery at an appropriate institution. 39 N.Y.2d 279, 283-84, 347 N.E.2d 893, 895-96, 383 N.Y.S.2d 568, 570-71.