Garfunkel Wild Thought Leadership in Action Speaker Series
presents

TRANSforming the Landscape:

Health Care Law & Advocacy for Transgender Clients

Wednesday, November 16, 2016 | 8-11:30 a.m.

Hofstra University Club | David S. Mack Hall, North Campus | Hempstead, NY 11549

This lecture is designed to acquaint the practicing Bar and law students alike with the nuts and bolts of health care law as it relates to transgender persons. Topics covered will include private and public insurance coverage, statutory and administrative regulation, and ethical considerations in representing trans people.

This program qualifies for **2.0** transitional/nontransitional **CLE credits in Ethics and Professional Practice**.

The Maurice A. Deane School of Law at Hofstra University is certified by the New York State Continuing Legal Education Board as an accredited provider of continuing legal education (CLE) in the state of New York.

New York CLE credits are available to satisfy the mandatory, nontransitional requirement for attorneys attending the symposium.

This breakfast lecture qualifies for one (1) Ethics CLE credit and one (1) CLE credit in Areas of Professional Practice.

Credit will be given for the full event. No credit can be given for partial attendance.

Please advise the CLE service secretary at the registration desk if you wish to receive CLE credit. You will be required to complete a sign-in sheet at the start and conclusion of the day. Additionally, you must complete an evaluation for the program.

Lawyers admitted in jurisdictions other than New York should check with those jurisdictions to determine CLE requirements in their states.

For more information, please contact Michelle Wallace at the Gitenstein Institute for Health Law and Policy at 516-463-6128 or Michelle.Wallace@hofstra.edu.

This event is free and open to the public, but seating is limited and RSVP to the event is required.
Please visit law.hofstra.edu/transforming to RSVP.

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Presented by The Gitenstein Institute for Health Law and Policy as part of the Garfunkel Wild, P.C. Thought Leadership in Action Speaker Series.

GW GARFUNKEL WILD, P.C.
ATTORNEYS AT LAW

Transgender Health Care – Needs & Opportunities

1 The need: a snapshot of transgender health care needs

Health care access is a predominant concern among transgender people. The nearly 6,500 transgender and gender non-conforming respondents to the 2011 National Transgender Discrimination Survey ranked health care access twice among their top four highest-rated policy priorities:

1. Protecting transgender/gender non-conforming people from discrimination in hiring and at work (70%)
2. **Getting transgender-related health care covered by insurance** (64% overall, but 72% for transgender men—it was their top priority)
3. Passing laws that address hate crimes against transgender/gender non-conforming people (47%)
4. **Access to transgender-sensitive health care** (43%).[1]

Health care access problems fall into three major categories: (1) access to transgender-specific care, (2) access to sex-specific care, and (3) provider discrimination and ignorance.

1.1 Access to transgender-specific care

In the 1930's Alan L. Hart, M.D., pioneered the use of x-ray screening for early detection of tuberculosis, saving many thousands of lives.

He also pioneered another area of medicine: he was the first person in the U.S. to undergo sex reassignment surgery (a hysterectomy and oophorectomy) in 1917.

Hart had to convince his surgeon that it was the right course of action. Eventually the surgeon agreed, concluding: "Let him who finds in himself a tendency to criticize to offer some constructive method of dealing with the problem on hand. He will not want for difficulties. The patient and I have done our best with it."[2]

One hundred years later, transgender Americans still struggle to access the same lifesaving health care.

Transgender-related health care is designed to change the primary or secondary sex characteristics for the purpose of alleviating "the symptoms of excessive pain, anguish, agitation, restlessness, and malaise" that transgender people often experience.[3] A mismatch between the body and the brain's expectations of the body creates cognitive dissonance. This "gender dysphoria" is "[o]ften experienced as depression, anxiety, irritation, and/or agitation, [it] describes the sense that

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[1] Jamie M. Grant, et al. INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 178 (2011) [hereinafter INJUSTICE AT EVERY TURN].
[2] J. Allen Gilbert, *Homo-sexuality and its Treatment*, 52 J. OF NERVOUS AND MENTAL DISORDERS 297, 321 (1920).
[3] Arlene Istar Lev, TRANSGENDER EMERGENCE: THERAPEUTIC GUIDELINES FOR WORKING WITH GENDER-VARIANT PEOPLE AND THEIR FAMILIES 10 (2004).

something is very wrong . . . ."[4] Before treatment, individuals with gender dysphoria "live in a dissociated state of mind and body."[5]

The American Medical Association recognizes that gender dysphoria "is a serious medical condition" that if left untreated "can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicide and death."[6]

Transgender health care is widely recognized as safe and effective, and insurance coverage for transgender-related care has been endorsed by the leading medical groups, including the American Medical Association,[7] the American Psychological Association,[8] the American Psychiatric Association,[9] the American Academy of Family Physicians,[10] the American College of Physicians,[11] the American Congress of Obstetricians and Gynecologists,[12] the American College of Nurse-Midwives,[13] the Endocrine Society,[14] the National Association of Social Workers,[15] the World

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[4] Randi Kaufman, *Introduction to Transgender Identity and Health*, in THE FENWAY GUIDE TO LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH 331, 337 (Harvey Makadon et al. eds., 2008).

[5] David Seil, *The Diagnosis and Treatment of Transgendered Patients* in TRANSGENDER SUBJECTIVES: A CLINICIAN'S GUIDE 115 (eds. Ubaldo Leli & Jack Drescher) (2004) (describing the diagnosis and treatment of 271 transgender patients between 1979 and 2001).

[6] American Medical Association House of Delegates, *H-185.950 Removing Financial Barriers to Care for Transgender Patients*, ¶¶ 11-13, (2008).

[7] *Id.*

[8] Barry S. Anton, *Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the Council of Representatives, February 22-24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the Board of Directors*, 64 AMERICAN PSYCHOLOGIST 372 (2009).

[9] Jack Drescher, Ellen Haller, M.D., & APA Caucus of Lesbian, Gay and Bisexual Psychiatrists, American Psychiatric Association, *APA Official Actions: Position Statement on Access to Care for Transgender and Gender Variant Individuals* (2012).

[10] *See* American Academy of Family Physicians, *Summary of Actions: 2009 National Conference of Special Constituencies, Resolution No. 9* (2009).

[11] Hilary Daniel & Renee Butkus, for the Health and Public Policy Committee of the American College of Physicians, *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians,* 163 ANNALS OF INTERNAL MEDICINE 135 (2015).

[12] American College of Obstetricians and Gynecologists, *Committee Opinion No. 512: Health care for transgender individuals*, 118 OBSTET GYNECOL 1454 (2011).

[13] American College of Nurse-Midwives, *Position Statement on Transgender/Transsexual/Gender Variant Health Care* (2012).

[14] *See* Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: Endocrine Society Clinical Practice Guideline*, 94 Journal of Clinical Endocrinology & Metabolism, 3132 (2009) (medical necessity being implicit in the issuance of clinical practice guidelines).

[15] National Association of Social Workers, *Transgender and Gender Identity Issues*, in SOCIAL WORK SPEAKS: NATIONAL ASSOCIATION OF SOCIAL WORKERS POLICY STATEMENTS 2009-2012, 347 (8th ed. 2009).

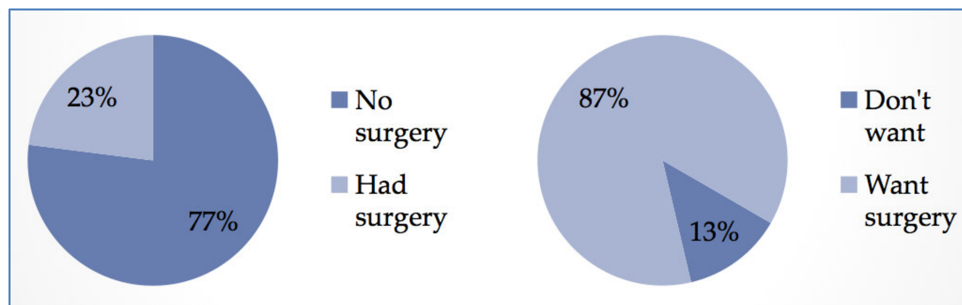
Medical Association,[16] and the World Professional Association for Transgender Health.[17]

Yet these endorsements have not yet translated into widespread practice. While other Americans are enjoying increased access to health care under the Affordable Care Act, transgender Americans still face categorical exclusions for transgender care.

1.1.1 Explicit exclusions for transgender care

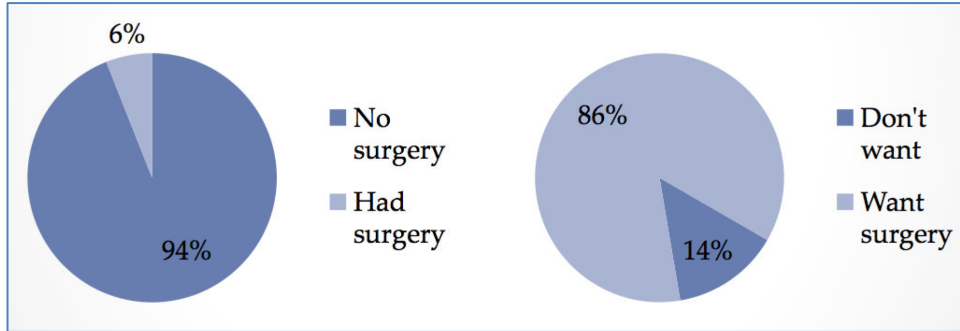
The majority of Americans get their health care through private plans—49% from employers and 6% from individual plans.[18] But only 5% of employer health plans cover transgender-related health care,[19] and almost all individual plans offered through the Marketplace—including benchmark plans—have explicit exclusions for cross-sex hormone therapy, transgender surgery and sometimes even mental health care for gender dysphoria.[20] This means the estimated 700,000 transgender people in America[21] pay insurance premiums that subsidize the health care of others, while still needing to pay out-of-pocket for their own health care.

The National Transgender Discrimination Survey found that while 87% of trans women need genital reassignment surgery, only 23% have had it.[22]



[16] World Medical Association, *Statement on Transgender People* (2015).
[17] World Professional Association for Transgender Health, *WPATH Clarification on the Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A.* (2007).
[18] The Kaiser Family Foundation State Health Facts. *Health Insurance Coverage of the Total Population*, Data Source: Census Bureau's March 2015 Current Population Survey (CPS: Annual Social and Economic Supplements) (2014), http://kff.org/other/state-indicator/total-population.
[19] Society for Human Resources Management, 2015 EMPLOYEE BENEFITS: AN OVERVIEW OF EMPLOYEE BENEFIT OFFERINGS IN THE U.S., 10 (2015).
[20] *See* Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight, *Information on Essential Health Benefits (EHB) Benchmark Plans*, https://www.cms.gov/cciio/resources/data-resources/ehb.html (last visited: Feb. 9, 2016).
[21] Transgender people comprise about 0.3% of the population. Claire Cain Miller, *The Search for the Best Estimate of the Transgender Population*, N.Y. TIMES, June 8, 2015.
[22] INJUSTICE AT EVERY TURN at 79.

For transgender men, the situation is more extreme. While a similar percentage of people need genital surgery (86%), only 6% have been able to access it.



In contrast, because mastectomy and male chest reconstruction is much more affordable out-of-pocket than genital surgery, 43% have undergone it, while 50% have this need unmet.

Forthcoming regulations under the Affordable Care Act propose to ban transgender exclusions in most public and private plans,[23] but the adoption of those regulations will not immediately end the exclusions, but rather will kick off the long process of implementing this policy, which will likely be subject to a variety of challenges, including claims of religious exemption.

1.1.2 Medical necessity-based denials

The ACA provisions only ensure that there are no unique exclusions for transgender health care; they do not mandate affirmative coverage. Even once explicit exclusions are removed, coverage is not automatic. Even in plans that do not have explicit exclusions, people face a variety of barriers to care including being under 18 or having the care labeled "cosmetic" or "not medically necessary."

A clear consensus has emerged around the fact that hormone therapy for adults, genital reconstruction for men and women, and male chest reconstruction for trans men are types of care that cannot be excluded. But feminizing facial reconstruction, breast reconstruction and permanent hair removal are all health care needs exclusive to trans women, and the are procedures most likely to be deemed "cosmetic" or not medically necessary. But even male nipple reconstruction for trans men undergoing double mastectomy has also been considered "cosmetic" in insurers's written medical policies.

1.2 Access to sex-specific care

Transgender people face insurance denials where the sex associated with the treatment does not match their current sex. A transgender man may need gynecological care but be listed as male on his insurance. A transgender woman who

[23] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

is listed as female may need a prostate cancer screening. Such denials are generally automatically generated by the insurance company's computer system.

For example, Marco[24] is a transgender man whose insurance provider denied payment for a hysterectomy stating: "member's gender not valid for procedure." He paid $11,000 out-of-pocket, which was 1/4 of his annual income. His employer-based plan had an explicit exclusion for transgender health care, so there was a risk that even if he were able to get past the gender marker barrier, the insurer would deny it on that basis. Thankfully, when Marco appealed the denial, he was able to get the claim paid, but other have not been so lucky. Insurance companies have traditionally used these administrative mismatches to withhold coverage for sex-specific care or tell the insured that they must change their gender marker if they want to get coverage.

1.3 Provider discrimination and ignorance

Many health care providers treat transgender patients with discrimination and ignorance that results in refusals of treatment, harassment in health care settings, patients needing to educate their providers about their treatment, and postponing needed medical care because of discrimination from providers.[25] The far-reaching effects of such discrimination can be particularly devastating in the mental health field.

Transgender people experience higher rates of substance use, which is directly related to coping with discrimination and the lack of access to appropriate treatments for gender dysphoria.[26] For example, study of intake records at the New York City LGBT Center's Gender Identity Project found high rates of substance use in the transgender community, with about 1 in 4 reporting alcohol or drug abuse.[27]

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[24] A pseudonym.
[25] INJUSTICE AT EVERY TURN at 6.
[26] Lisa Miller and Anthony Grollman, *The Social Costs of Gender Nonconformity for Transgender Adults: Implications for Discrimination and Health*, 30 SOCIOLOGICAL FORUM 809, 825 (2015); National Research Council, THE HEALTH OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER PEOPLE: BUILDING A FOUNDATION FOR BETTER UNDERSTANDINg 218 (2011) (indicating "substance abuse may be a major concern among transgender people"); Jessica Xavier et. al., THE HEALTH, HEALTH-RELATED NEEDS, AND LIFE COURSE EXPERIENCES OF TRANSGENDER VIRGINIANS (2007); G. Kenagy, *The health and social service needs of transgender people in Philadelphia*, 8 INT'L J. OF TRANSGENDERISM 49 (2005); G. Kenagy, G. & W.Bostwick, *Health and social service needs of transgender people in Chicago*, 8 INT'L J. OF TRANSGENDERISM 57 (2005); J. Risser et al., *Sex, drugs, violence, and HIV status among male-to-female transgender persons in Houston, Texas*, 8 INT'L J. OF TRANSGENDERISM 67 (2005); CN.C. Brown, *Special concerns populations: Transgender needs assessment. Chicago Department of Public Health, Office of Gay and Lesbian Health* (2002); N. Sanchez et al., *Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City*, 99 AM. J. OF PUB. HEALTH 713 (2009).
[27] D. Valentine, GENDER IDENTITY PROJECT: REPORT ON INTAKE STATISTICS, 1989-APRIL 1997 (1998).

And transgender youth report dramatically higher rates of substance use than non-transgender youth.[28]

Despite high rates of substance use, transgender people often face challenges when accessing substance use treatment. Providers may be hostile, lack competency or regard gender dysphoria as something that must be "resolved" before treatment can begin.

Because substance use programs typically have single-sex aspects, transgender people are often unfairly excluded from these programs or are forced to participate according to their sex assigned at birth. In one instance, Donisha McShan, a transgender woman, was paroled to a halfway house to complete her sentence and begin a drug rehabilitation program.[29] She was told to act like a man, the staff members addressed her with male pronouns and titles, and she was forced to sleep in a room with four men. The staff periodically raided her belongings and confiscated anything they viewed as remotely feminine. They took her makeup, clothing, pedicure kit, magazines, and curlers. They even took her pink shower cap. Only after Lambda Legal wrote a demand letter, did the facility apologize and began treating her as the woman she is.[30]

Similarly, Sabrina Wilson was a 32-year-old homeless transgender woman who was arrested for a drug offense and given the opportunity to participate in a drug treatment program as an alternative to incarceration. The residential program she was assigned to in Brooklyn, NY, required her to room with men, to use the men's bathroom, and prohibited her from wearing a wig or high heels. The program also denied her participation in women's support groups and she had to attend all-male counseling sessions. These actions effectively forced her out of the facility, which resulted in her being sentenced to 2-½ years in jail. When she was released, she successfully filed discrimination charges against the facility under New York law, [31] but she never should have had to go to jail in the first place.

Transgender people who use substances are much more likely to experience challenges completing an education, obtaining stable housing and employment, and many find that their substance abuse disqualifies them from participating in programs specifically intended to assist them with these challenges.[32] Access to

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[28] The LGBT Community Center, LGBT SAINT: SERVING LESBIAN, GAY, BISEXUAL AND TRANSGENDER ADOLESCENTS IN NEED OF SUBSTANCE USE TREATMENT (2015); R. Garofalo et al., *Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth*, 38 J. OF ADOLESCENT HEALTH 230 (2006).
[29] Donisha McShan*, In My Own Words: Donisha McShan*, Lambda Legal Blog (June 10, 2014), http://www.lambdalegal.org/blog/20140610_donisha-mcshan-in-my-own-words.
[30] *Id.*
[31] *Wilson v. Phoenix House*, 978 N.Y.S.2d 748 (Sup. Ct. Kings County 2013).
[32] Nina Kammerer et al., *Transgender Health and Social Service Needs in the Context of HIV Risk*, *in* TRANSGENDER AND HIV: RISKS, PREVENTION AND CARE (Walter Bockting & Sheila Kirk ed. 2001); K. Clements et al., *HIV prevention and health service needs of the transgender community in San Francisco*, 3 INT'L J. OF TRANSGENDERISM 1 (1999); J. Sperber et al., *Access to*

culturally-competent prevention and treatment providers is essential in addressing the current health disparities facing transgender individuals.

Forthcoming regulations under the Affordable Care Act will make it clearer to providers that programs receiving federal funding cannot discriminate on the basis of transgender status,[33] but without a concerted effort to enforce the provision, the status quo exclusion of transgender people from not only substance use treatment, but also other routine forms of health care will continue.

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health care for transgendered persons: Results of a needs assessment in Boston, 8 INT'L J. OF TRANSGENDERISM 74 (2005); T. Nemoto et al., *Health and social services for male-to-female transgender persons of color in San Francisco*, 8 INT'L J. OF TRANSGENDERISM 5 (2005); Samuel Lurie, *Identifying training needs of health-care providers related to treatment and care of transgendered patients: A qualitative needs assessment conducted in New England*, 8 INT'L J. OF TRANSGENDERISM 93 (2004); E.L. Lombardi & G. van Servellen, *Building culturally sensitive substance use prevention and treatment programs for transgendered populations*, 19 J. OF SUBSTANCE ABUSE TREATMENT 291 (2002); U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, A PROVIDER'S INTRODUCTION TO SUBSTANCE ABUSE TREATMENT FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER INDIVIDUALS (2012); A. D. Marcel, *Determining barriers to treatment for transsexuals and transgenders in substance abuse programs.* Transgender Education Network, Boston (1998).

[33] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

2 Challenging categorical exclusions

Affordable Care Act

Section 1557 of the Patient Protection and Affordable Care Act (ACA) prohibits sex and disability discrimination in health programs or activities that receive federal financial assistance.[34] Section 1557 has been in force since the passage of the ACA in 2010. The federal Department of Health and Human Services (HHS), the sole agency given authority to issue regulations under 1557,[35] issued proposed regulations that clarify its interpretation of 1557.[36] Proposed regulation § 92.207(4) explicitly states that it is unlawful to "[c]ategorically or automatically exclude from coverage, or limit coverage for, all health services related to gender transition."[37]

The ACA also has requirements regarding Essential Health Benefits that must be provided: "An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's . . . other health conditions."[38] There is a prohibition on sex and gender identity discrimination.[39]

Cases & enforcement actions:

- *Rumble v. Fairview Health Servs.*, No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, at *1 (D. Minn. Mar. 16, 2015*)* (brought against provider, not insurer).
- Baker v. L-3 Communications, No. 3:2015cv03679 (N.D. Tex. *filed* Nov. 16, 2015).
- Tover v. Essentia Health, No. 0:16-cv-00100-RHK-LIB (D. Minn *filed* Jan. 15, 2016).
- U.S. Dep't of Health & Human Services Office for Civil Rights, The Brooklyn Hospital Center Implements Non-Discriminatory Practices to Ensure Equal Care for Transgender Patients (July 14, 2015), http://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/TBH C/statement.pdf.
- U.S. Dep't of Health & Human Services, OCR Enforcement under Section 1557 of the Affordable Care Act Sex Discrimination Cases, http://www.hhs.gov/civil-rights/for-individuals/section-1557/ocr-enforcement-section-1557-aca-sex-discrimination/index.html.

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[34] 42 U.S.C. 18116(a) (2016).
[35] 42 U.S.C. 18116(c) (2016).
[36] Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54172 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).
[37] *Id.* at 54220.
[38] 45 CFR 156.125(a).
[39] 45 CFR 156.125(b); 45 CFR 156.200(e).

2.1 State Nondiscrimination Law and Administrative Guidance

- 16 jurisdictions prohibit categorical exclusions of transition-related care.
  - CA, CO, CT, DE, IL, MD, MA, MI, MN, NV, NY, OR, RI, VT, WA, DC (see separate handout)
- Based on state insurance laws, non-discrimination laws, unfair trade practice laws. Some also rely on ACA non-discrimination provisions.
- Applies to insured plans within those states. Self-funded plans are not subject to these rules.

2.2 Title VII – Federal employment sex discrimination

Title VII prohibits sex discrimination with respect to "compensation, terms, conditions, or privileges of employment."[40] It is well settled that transgender people are protected under the category of sex,[41] so an exclusion that targets transgender individuals or health care needed exclusively by transgender individuals is discriminatory. Moreover, a categorical prohibition on treatments that change sex characteristics is inherently discrimination "because of sex."

Cases & enforcement actions:

- United States v. Southeastern Oklahoma State Univ., No. 5:15-cv-00324-C (W.D. Oka. *filed* July 10, 2015).
- EEOC v. Deluxe Financial Servs., No. 0:15-cv-02646-ADM-SER (D. Minn. Jan. 20, 2016) (consent decree agreeing to remove categorical exclusions).
- *See also* ACA cases above.

2.3 Americans with Disabilities Act

The ADA prohibits employers from discriminating on the basis of disability in the provision of health insurance to their employees. The ADA prohibits disability discrimination with respect to all terms, conditions, and privileges of employment.[42] This includes "[f]ringe benefits available by virtue of employment, whether or not administered by the covered entity."[43] Recently the United States issued a statement of interest in a pending case supporting the position that gender dysphoria is

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[40] 42 U.S.C. § 2000e-2(a)(1) (2016).
[41] *See, e.g.*, *Fabian v. Hospital of Central Conn.*, No. 3:12-cv-01154-SRU, 2016 U.S. Dist. LEXIS 34994 (D. Conn., Mar. 18, 2016) (concluding that "discrimination on the basis of transgender identity is cognizable under Title VII."); *Schroer v. Billington*, *supra* note **Error! Bookmark not defined.** at 306-08; *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004); *Macy v. Holder*, EEOC DOC 0120120821, 2012 WL 1435995 (EEOC Apr. 20, 2012).
[42] 42 U.S.C. § 12112(a) (2015).
[43] 29 C.F.R. § 1630.4(vi) (2011).

protected under the ADA,[44] meaning that an exclusion for treatment of gender dysphoria, which has no nondiscriminatory basis, would be an unlawful disability-based exclusion.

2.4 Other notable developments

- *Norsworthy v. Beard*, No. 14-CV-00695-JST, 2014 WL 6842935, at *11 (N.D. Cal. Nov. 18, 2014) (holding that denying transgender-related surgery for inmates violated Equal Protection).
- The U.S. Office of Personnel Management announced that as of 2016, "no carrier participating in the Federal Employees Health Benefits Program may have a general exclusion of services, drugs or supplies related to gender transition or 'sex transformations.'"[45]
- May 2014 decision from HHS Appeals Board: categorical exclusions not valid under "reasonableness standard" governing Medicare coverage. DHHS Medicare NHD 140.3 re: Transsexual Surgery (Docket No. A-13-87, Dec'n No. 2576, May 30, 2014).
- Jan. 21, 2016 ruling from Medicare Appeals Council No. M-15-1069 finding that Medicare Advantage (Part C) insurer, United Healthcare/AARP Medicare Complete (HMO) had to pay for genital reassignment surgery for Charlene Lauderdale.
- Executive Order 13672 prohibits federal contractors from discriminating on the basis of gender identity. Enforced by Office of Federal Contract Compliance Programs within Dep't of Labor (see separate fact sheet).

2.5 Avenues for Challenging Medical Necessity Denials

- Plan's internal appeal process.
- External review of medical necessity denials to state administrative agency.
- Nondiscrimination challenges (ACA, Title VII , ADA, or state law).
- ERISA claims where denials run contrary to plan terms, or represent unreasonable interpretation of plan terms (employer-sponsored plans).

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[44] Second Statement of Interest of the United States at 6, *Blatt v. Cabela's Retail*, No. 5:14-cv-4822-JFL (E.D. Pa. *filed* Aug. 15, 2014) (urging the court to "adopt this proposed construction, under which Plaintiff's gender dysphoria would not be excluded from the ADA's definition of 'disability.'").

[45] FEHB Program Carrier Letter No. 2015-12, "Covered Benefits for Gender Transition Services" (June 23, 2015), https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-12.pdf.

EO 11246 prohibits Federal contractors from discriminating on the basis of gender identity

Transgender health exclusions can be challenged under Executive Order (EO) 11246, as amended by EO 13672.[1] Federal contractors are barred from discriminating against any employee because of sex or gender identity, including in "rates of pay or other forms of compensation."[2] The Department of Labor's Employment Standards Administration's Office of Federal Contract Compliance Programs (OFCCP) enforces EO 11246 and is accepting complaints based on sex and gender identity.[3] A contractor in violation of EO 11246 may have its contracts canceled, terminated, or suspended in whole or in part, and the contractor may be debarred, i.e., declared ineligible for future government contracts.[4]

Entities subject to the requirements of Executive Order 11246

If a business or organization has a Federal contract, subcontract, or federally assisted construction contract it may be subject to the requirements of Executive Order 11246. Generally speaking, any business or organization that (1) holds a single Federal contract, subcontract, or Federally assisted construction contract in excess of $10,000.00; (2) has Federal contract or subcontracts that combined total in excess of $10,000.00 in any 12-month period; or (3) holds Government bills of lading, serves as a depository of Federal funds, or is an issuing and paying agency for U.S. savings bonds and notes in any amount will be subject to requirements under one or more of the laws enforced by OFCCP.

How to find out if a business is a federal contractor

1. Go to sam.gov and search for the name of the company. This will reveal d/b/a's and subsidiaries.
2. Select export results and open the spreadsheet.
3. Go to usaspending.gov and search for each DUNS number. You can enter the DUNS number in the search box that says "Recipient name."
4. Look for contracts for the current fiscal year.

This search will not reveal subcontractors. A "Federal subcontract" is an agreement or arrangement with a Federal contractor either (1) for the furnishing of supplies or services or for the use of real or personal property, which is necessary to the performance of any one or more Federal contracts; or (2) under which any portion of the Federal contractor's obligation under any contracts is performed, undertaken, or assumed.

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[1] Exec. Order No. 11,246 § 202, 30 Fed. Reg. 12319, 3 CFR, 1964-1965 Comp., p. 339; Exec Order No. 13672, 79 Fed. Reg. 42971 (July 23, 2014).

[2] 41 C.F.R. § 60-1.4 (2016).

[3] OFCCP, Directive 2015-01, Handling individual and systemic sexual orientation and gender identity discrimination complaints (April 15, 2015), http://www.dol.gov/ofccp/regs/compliance/directives/DIR_2015-01_EO_13672ComplaintAuthority_JRF_QA_508c.pdf.

[4] 41 C.F.R. § 60-1.4(a) (2016).

DOING GENDER, DETERMINING GENDER:

Transgender People, Gender Panics, and the Maintenance of the Sex/Gender/Sexuality System

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This article explores "determining gender," the umbrella term for social practices of placing others in gender categories. We draw on three case studies showcasing moments of conflict over who counts as a man and who counts as a woman: public debates over the expansion of transgender employment rights, policies determining eligibility of transgender people for competitive sports, and proposals to remove the genital surgery requirement for a change of sex marker on birth certificates. We show that criteria for determining gender differ across social spaces. Gender-integrated spaces are more likely to use identity-based criteria, while gender-segregated spaces, like the sexual spaces we have previously examined (Schilt and Westbrook 2009), are more likely to use biology-based criteria. In addition, because of beliefs that women are inherently vulnerable and men are dangerous, "men's" and "women's" spaces are not policed equally—making access to women's spaces central to debates over transgender rights.

Keywords: *gender; sexuality; transgender; doing gender; sports; heteronormativity*

AUTHORS' NOTE: *As with our previous article, all work was shared equally between the two authors. We are extremely grateful to Joya Misra and the anonymous reviewers for the detailed and thoughtful feedback that they provided.* *Correspondence concerning this article should be addressed to Laurel Westbrook, Grand Valley State University, 1 N. Campus Dr, Allendale, MI 49401, USA; e-mail: westbrol@gvsu.edu.*

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In 1989, Christie Lee Cavazos married Jonathon Littleton, a marriage that lasted until Jonathon's untimely death in 1996. Christie filed a medical malpractice suit against the Texas doctor she alleged had misdiagnosed her husband. What might have been an open-and-shut case, however, was complicated by her biography: In the 1970s she had undergone what was then termed a surgical "sex change" operation. Before considering her case, the court first examined the validity of her marriage as a transgender woman to a cis-gender man. At the center of this case was the determination of her gender. Christie had undergone genital surgery, legally amended all of her government documents to categorize her as "female," had a legal marriage, lived as a woman for 20 years, and had medical experts who testified that she was, physically and psychologically, a woman. Yet, the court ruled that she was, and would always be, chromosomally male and, therefore, could not file a malpractice suit as a spouse. Musing about the nature of gender in his ruling, Chief Justice Hardberger wrote, "There are some things you cannot will into being. They just are" (*Littleton v. Prange* 1999).

The Littleton case illustrates two competing cultural ideologies about how a person's gender[1] is to be authenticated by other people. The judge's ruling that gender is an unchangeable, innate fact illustrates what we term a "biology-based determination of gender." In contrast, the validation of Littleton's identity as a woman by others highlights what we term an "identity-based determination of gender." Such a premise does not mean seeing gender identity as fluid, or as an "anything goes" proposition. Rather, under an identity-based gender ideology, people can be recognized as a member of the gender category with which they identify if their identity claim is accepted as legitimate by other people determining their gender—in the Littleton case, her husband, friends, and medical experts.

We term this social process of authenticating another person's gender identity "determining gender." In face-to-face interactions, determining gender is the response to doing gender. When people do gender in interactions, they present information about their gender. Others then interpret this information, placing them in gender categories and determining their gender. Yet, the process of gender determination does not always rely on visual and behavioral cues. Expanding upon interactional theories of gender attribution (Kessler and McKenna 1978; West and Zimmerman 1987), we examine gender determination criteria in policy and court cases, where a great deal of biographical and bodily knowledge is known about the person whose gender is in question, as well as how gender is determined in imagined interactions—namely, cis-people's imagined interactions

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with trans-people, where the knowledge about the person's body and identity are hypothetical. We use "determining gender" as an umbrella term for these diverse practices of placing a person in a gender category. Additionally, we explore the consequences of gender determination, an exploration that goes beyond "How is gender socially attributed?" to an analysis of "How does gender attribution challenge or maintain the sex/gender/sexuality system?"

We examine the criteria for gender determination in moments of ideological collision. As we have previously argued (Schilt and Westbrook 2009; Westbrook 2009), many people use genitalia (biological criteria) to determine another person's gender in (hetero)sexual[2] and sexualized interactions. Yet, since the advent of the "liberal moment" (Meyerowitz 2002), a cultural turn in the 1960s toward values of autonomy and equality, there has been more acceptance of a person's gender self-identity in spaces defined as nonsexual,[3] such as many workplaces (Schilt 2010). When questions of access to gender-segregated locations arise, however, identity-based and biology-based determinations clash. We center our analysis on three such moments: (1) federal and state proposals made between 2009 and 2011 to prohibit discrimination based on gender identity and expression in the arena of employment, housing, and public accommodations (often called "transgender rights bills"); (2) a 2006 proposed policy in New York City to remove the genital surgery requirement for a change of sex marker on birth certificates; and (3) controversies over trans-people participating in competitive sports.

Our cases address different social milieu: sports, employment, and government documents. Yet, each case is, at its core, about upholding the logic of gender segregation. In these ideological collisions, social actors struggle with where actual and imagined trans-people fit in gender-segregated spaces, such as public restrooms. These struggles provoke what we term "gender panics," situations where people react to disruptions to biology-based gender ideology by frantically reasserting the naturalness of a male–female binary. When successful, this labor, which we term "gender naturalization work," quells the panics. In our cases, enacting policies requiring surgical and hormonal criteria for admission into gender-segregated spaces ends the panic. As in sexual and sexualized interactions, genitals determine gender in gender-segregated spaces, as it is often fears of unwanted (hetero)sexuality that motivates gender identity policing.

These cases demonstrate that criteria for determining gender vary across social situations. In gender-integrated public settings, such as the

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workplace, identity-based criteria can suffice to determine a person's gender. However, in interactional situations that derive their form and logic from gender oppositeness, such as heterosexual acts and gender-segregated sports competitions, social actors tend to enforce more rigid, biology-based criteria. Yet, gender-segregated spaces are not evenly policed, as the criteria for access are heavily interrogated only for women's spaces. Exploring the implications of this difference, we posit that bodies (mainly the presence or absence of the penis) matter for determining gender in women's spaces because of cultural ideologies of women as inherently vulnerable and in need of protection (Hollander 2001) that reproduce gender inequality under the guise of protecting women. We argue that, in the liberal moment of gender, access to gender-segregated spaces is not determined by unchangeable measures such as chromosomes but, instead, by genitals—a move that suggests a greater acceptance of an identity-based determination of gender. However, as we show, by using changeable bodily aspects to determine gender, the basic premises of the "sex/gender/sexuality system" (Seidman 1995) are maintained, as the system repatriates those whose existence potentially calls it into question, thereby naturalizing gender difference and gender inequality.

CONCEPTUAL FRAMEWORK

Sociologists of gender emphasize the social, rather than biological, processes that produce a person's gender. Focused on the interactional level, such theories illustrate how people sort each other into the category of "male" or "female" in social situations on the basis of visual information cues (such as facial hair) and implicit rules for assigning characteristics to particular genders (women wear skirts; men do not). Such visual cues act as proxies for biological criteria invisible in many interactions. This categorization process, termed "gender attribution" (Kessler and McKenna 1978, 2) or "sex categorization" (West and Zimmerman 1987, 127), is theorized as an inescapable but typically unremarkable hallmark of everyday social interactions—except in instances of ambiguity, which can create an interactional breakdown, generating anxiety, concern, and even anger (Schilt 2010; West and Zimmerman 1987).

This theory is a useful counterpoint to essentialism. Yet, the focus on face-to-face interactions can be analytically limiting. Kessler and McKenna note, "The only physical characteristics that can play a role in gender attribution in everyday life are those that are visible" (Kessler and

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McKenna 1978, 76). West and Zimmerman, too, see characteristics that are visible in interaction as paramount to sex categorization, arguing, "Neither initial sex assignment (pronouncement at birth as female or male) nor the actual existence of essential criteria for that assignment (possession of a clitoris and vagina or penis and testicles) has much—if anything—to do with the identification of sex category in everyday life" (West and Zimmerman 1987, 132). While such propositions may hold in many nonsexual interactions, genitals play a much more key role in gender determination in sexual and sexualized interactions (Schilt and Westbrook 2009). In addition, as the Littleton case demonstrates, invisible characteristics, such as chromosomes, can override visual cues as the appropriate criteria for determining gender when legal rights are at stake.

We seek to expand these theories beyond face-to-face interactions by proposing a broader conceptualization, offering "determining gender" as an umbrella term for the different subprocesses of attributing or, in some cases, officially deciding another person's gender. Gender determination does occur at the level of *everyday interaction*, a process already well documented in the literature. Both cis- and transwomen, for instance, may find their biological claim to use a public women's restroom challenged by other women if they do not present the expected visual cues warranted for access (Cavanagh 2010), while both groups may have their gender self-identity affirmed in gender-integrated interactions. Gender determination also occurs at the level of *legal cases* and *policy decisions*, where social actors with organizational power devise criteria for who counts as a man or a woman (and therefore who gains or is denied access to gender-specific rights and social settings) (Meadow 2010). In addition, gender determinations occur at the level of the *imaginary*. Illustrating this point, as trans-inclusive policies and laws are discussed in the media, opponents and supporters often draw on hypothetical interactions with trans-people in gender-segregated spaces, such as bathrooms. In these imagined interactions, hypothetical knowledge of the person's genitals or their self-identity, rather than visible gender cues, is used to determine their gender.

When social actors officially or unofficially determine another person's gender, accepted criteria differ across contexts. Face-to-face interactions rely mostly on implicit, culturally agreed on criteria. Imagined interactions and legal or policy decisions, in contrast, often demand more explicit, officially defined criteria. Such a focus on developing explicit criteria for determining gender has grown alongside new surgical possibilities for gender transitions (Meyerowitz 2002). To receive legal and medical gender validation, trans-people have had to follow particular

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protocols, such as genital reconstructive surgery, that symbolically repatriate them from one side of the gender binary to the other. These criteria, which reflect dominant understandings of sex/gender/sexuality, allowed liberal values of self-determination to co-exist with beliefs about the innateness of the gender binary (Meyerowitz 2002).

This co-existence faced greater challenges in the 1990s when the hegemony of the "stealth model" of transitioning (Schilt 2010) began to dissipate, and transsexual, intersex, and transgender groups organized in an effort to gain greater cultural recognition and civil rights (Stryker 2008). With this push came wider coverage of trans-people in the media, including debates about where transmen and transwomen fit in institutions, such as legal marriage, and in public gender-segregated spaces, such as bathrooms, prisons, and sports competitions. Policy and lawmakers began to grapple with how to balance trans-inclusivity in a social system predicated on clear, fixed distinctions between men and women, and how to address some cis-gender concerns that the cultural validation of trans-people was a direct challenge to a biologically-determined and/or God-given gender binary.

Cultural beliefs about the sanctity of gender binarism naturalize a sex/gender/sexuality system in which heterosexuality is positioned as the only natural and desirable sexual form. Showing the interrelatedness of ideas about (hetero)sexuality and gender difference, men and women's assumed psychological and embodied distinctions are widely held to be complementary and to require particular relationships with one another (Connell 1995). In nonsexual interactions, in contrast, men and women sometimes are physically segregated on the basis of those same assumed differences in their bodies, capabilities, and interests (Fausto-Sterling 2000; Goffman 1977; Lorber 1993), as well as widely shared beliefs about what activities are normal and appropriate for each gender. While men and women freely interact in many social settings, such as the workplace, the creation of "men's space" and "women's space" "ensure[s] that subcultural differences can be reaffirmed and reestablished in the face of contact between the sexes" (Goffman 1977, 314). In these spaces, gender differences are highlighted, though the same differences are minimized in other settings.

Media coverage of transgender people in the late 2000s provides a useful case study for how gender is determined in various social spaces, what larger cultural beliefs motivate deployment of biology-based and identity-based criteria, and how such criteria are forged in moments of gender ideology collision. We develop the concept of gender determination

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beyond face-to-face interactions through an analysis of policy and law debates and imagined interactions, situations that often display a call for explicit criteria for deciding who counts as a man or as a woman. At stake in such determinations are the criteria by which trans-people's gender identities are recognized and their rights defined and protected.

METHODS

Our data come from a textual analysis of newspaper coverage gathered from LexisNexis. Such a focus is warranted, as the media tend to both reflect and shape prevailing understandings (Gamson et al. 1992; Macdonald 2003). Investigating beliefs about an issue presented in the news media allows researchers to map out the existing dominant viewpoints within the marketplace of ideas, as news is a commodity for attracting audiences who can then be sold to advertisers (Gamson et al. 1992), and, as such, it has to make cultural sense to its audience (Best 2008). Mainstream journalists write stories that reflect commonsense understandings held by (college educated, middle-class, usually white and heterosexual) journalists and their similarly socially situated audience. While there is no single understanding of gender in our society, the dominant views are visible in the mainstream news.

Media scholars have demonstrated that the media do not only represent reality, they also participate in constructing it (Berns 2004; Gamson et al. 1992; Jansen 2002; Macdonald 2003). The mainstream news media do this by providing audiences with narratives, frames, and belief systems that shape interpretations of the world as well as actions within it. While media do not determine the audience viewpoint (Gamson et al. 1992), they greatly influence it, particularly for people with little preexisting knowledge of an issue (Berns 2004). Examining news coverage allows us to see what ideas might be disseminated to readers who had never before thought about transgender people changing their birth certificates, competing in sports, or seeking protection from employment discrimination.

To explore the criteria for determining gender in nonsexual contexts, we sought out instances in which biology-based and identity-based gender ideologies collided. As the visibility of transgender lives increased broadly in the 2000s, we centered our search in that decade. We looked for moments where who counts as a man or a woman was openly discussed, thus making the process of determining gender more visible. We identified five possible moments of ideological collision surrounding

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trans-people: sports inclusion, prison housing, inclusion of transgender children in schools, employment rights, and altering of government documents. All of these cases provided instances of cis-people grappling with how trans-people "fit" into previously unquestioned systems and locations. We chose not to examine schools or prisons because we wanted, respectively, all cases to have a comparative focus on adults and to not involve penal settings. Our three remaining cases generated substantial public debate and represented, on our initial selection, different issues: employment nondiscrimination laws, birth certificate alteration policies, and sports participation. We did not focus solely on cases of gender-segregated spaces; however, it is these locales that emerged as salient points of focus.

Birth certificate laws usually get amended with little fanfare. By contrast, a New York City proposal allowing people to change sex markers on their birth certificates without requiring genital surgery generated extensive media coverage. We gathered all the available stories that mentioned "New York" and "birth certificate" and included coverage of the proposed change in policy during 2006–2007, the time period when the amendment was proposed, discussed, and abandoned (a total of 42 articles).

Transgender employment nondiscrimination laws have been debated since the 1990s. Because we were interested in analyzing current criteria for determining gender, we limited our focus to a two-year period (January 1, 2009, to December 31, 2010). We searched for articles that mentioned "transgender" and "nondiscrimination" and were about trans-rights legislation. After a preliminary analysis of the articles, we also searched "bathroom bills," an often applied moniker. We compiled all news stories on the three bills proposed during this time: a federal bill and state-level bills in New Hampshire and Massachusetts (a total of 57 articles).

Since scholars have extensively analyzed most of the major controversies over trans-people in sports, we employ this literature in our analysis. Because this scholarship focuses almost exclusively on transwomen, we supplemented it with media coverage of two cases about transmen from 2009 to 2011: Kye Allums, a transman who played women's basketball, and "Will," a transman who played Australian men's football (a combined total of 92 articles).

We thematically coded each of the 191 articles for beliefs about gender, with a focus on gender determination criteria (such as chromosomes, genitals, or self-identity), and the types of spaces that generated panic (gender-integrated or gender-segregated). We each coded articles from all three of the cases, ensuring intercoder reliability through extensive discussions

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about themes. Through this preliminary analysis, we recognized the importance of gender-segregated social spaces to each of our three cases. Upon this analytic shift, we further coded the rationales offered in these moments of gender panic for blocking trans-people's access to gender-segregated spaces (such as safety, privacy, and fairness), the final criteria adopted for determining gender (biology-based, identity-based, none), and the gender of the trans-people at the center of these panics. This second wave of analysis revealed the greater policing of transwomen's access to women-only spaces, and the greater ability of biology-based criteria, rather than identity-based criteria, to quell gender panics.

FINDINGS

Messages in news stories are rarely homogeneous (Gamson et al. 1992). To avoid accusations of biased coverage, journalists typically try to provide at least two sides to a story (Best 2008) that typically represent dominant understandings of a particular topic. In our cases, reporters regularly presented the perspectives of people who supported identity-based determination of gender as well as the views of people who positioned biological criteria as essential for determining gender. These inclusions suggest that, in the late 2000s, the identity-based model and the biology-based model represent the two most dominant and competing understandings of gender. An examination of these ideologies provides a deeper understanding of the sex/gender/sexuality system in the liberal moment of gender, the criteria for determining gender, and how gender determination (re)produces inequality.

Ideology Collision, Gender Panics, and Gender Naturalization Work

Modern athletic competition, like all gender-segregated spaces, rests on and reproduces an idea of two opposite genders (Lorber 1993). Because of its influence on other athletic organizations, we focus here on policies enacted by the International Olympic Committee (IOC) that determine under what circumstances and in what categories transgender and intersex athletes can compete. In the modern Olympics, almost all events are gender-segregated (Tucker and Collins 2009). To maintain this segregation, IOC officials have devised policies on coping with athletes who do not fit easily into this binary. This question of where to place transgender athletes first gained national attention in 1977, when the New York Supreme Court ruled that Dr. Renee Richards, a postoperative transsexual

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woman, could participate in the U.S. Women's Open Tennis Tournament because her testes had been removed and her body was physically "weakened" by the resulting loss of testosterone (Birrell and Cole 1990; Shy 2007). Following similar logic, in 2003 the IOC adopted the Stockholm Consensus, which allows trans-athletes to compete as the gender they identify as if they have undergone bodily modifications that "minimize gender related advantages" (Ljungqvist and Genel 2005). According to the IOC Medical Commission (2003), the criteria for appropriate transgender bodies are:

> Surgical anatomical changes have been completed, including external genitalia changes and gonadectomy.
>
> Legal recognition of their assigned sex has been conferred by the appropriate official authorities.
>
> Hormonal therapy appropriate for the assigned sex has been administered in a verifiable manner and for a sufficient length of time to minimize gender-related advantages in sport competitions.

In June 2012, the IOC added an additional set of criteria, stating that athletes competing as women cannot have a testosterone level "within the male range" unless it "does not confer a competitive advantage because it is non-functional" (IOC Medical and Scientific Department 2012), thus minimizing what is viewed as an unfair hormonal advantage. These explicit criteria allow the IOC to incorporate trans and intersex athletes, and thus to validate the liberal moment of gender, without challenging the premise that modern competitive athletics rests on: the presumption that there are two genders and all athletes must be put into one of those two categories for competition.

These biology-based criteria quieted a slow-burning gender panic that resurfaced with each new case of a trans or intersex athlete (for discussion of intersex athletes, see Buzuvis 2010; Dreger 2010; Fausto-Sterling 2000; Nyong'o 2010). These cases raised questions about whether or not it is fair for cis- and trans-people to compete against one another (Cavanagh and Sykes 2006). The answer hinged on which gender ideology is given primacy (i.e., fair to whom?). While transwomen might self-identify as women, people who subscribed to biology-based ideologies of gender view these athletes as males who carry a size and strength advantage over females. The official goal of the IOC policies is to be fair to all athletes, which means that trans-athletes could compete as the gender with

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which they identify, but only if they met the aforementioned criteria. With such explicit criteria, cis-gender people could have confidence that only transwomen who were as "weak" as cis-women were able to compete, a move that diffused gender panic and upheld the logic of gender segregation in the arena of sports.

In the New York birth certificate case, a policy proposal intended to improve the lives of transgender people set off a rapid gender panic. Since many trans-people do not have genital surgery, they are often unable to have a sex marker that reflects their self-identity and gender presentation on their official documents (Currah and Moore 2009). In 2006, the City of New York proposed legislation that validated identity-based determination of gender by removing the genital surgical requirement for a change of sex marker on the birth certificate if applicants were over 18 years of age, had lived as their desired gender for at least two years, and had documentation from medical and mental health professionals stating that their transitions were intended to be permanent. Under this amendment, trans-people were still regulated by the medical institution but their genital configurations would not determine their gender. The New York City Board of Health worked closely with other officials and trans-rights advocates in writing the new policy, and politicians and transgender activists lauded the amendment, which was, by all accounts, expected to pass (Caruso 2006b; Cave 2006a).

Journalists initially presented the amendment in positive terms (e.g., Caruso 2006a; Colangelo 2006; Finn 2006). However, the proposed policy resulted in an intensely negative public reaction. The Board of Health was inundated with calls and emails from people asking how this policy change would affect access to gender-segregated spaces, such as restrooms, hospital rooms, and prison blocks (Currah and Moore 2009). To quell the panic, the Board of Health withdrew the proposal and quickly amended it to maintain emphasis on genitals as the criteria for determining gender. Transgender people in New York could change their sex marker, but like the requirement to compete in the Olympics, they would have to provide proof of genital surgery. In this way, the Board of Health attempted to balance biology-based and identity-based gender models that had come into collision, doing the gender naturalization work of symbolically restoring the primacy of bodies (here, genitals) for determining gender while still validating the possibility for gender transitions.

The "transgender rights" bills we analyzed also resulted in gender panics by embracing identity-based determination of gender. At both the federal and state level, these bills typically offer protections for "gender

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identity and gender expression" or "transgender expression" in the realms of employment, housing, and public accommodations. In an attempt to make such protections widely inclusive, there is no definition of "expressions" or explicit bodily criteria for trans-people. The resulting gender panics center on this lack of definitional criteria. In response to the proposed bill in New Hampshire, some opponents worried that the bill "did not adequately define transgender individuals" (*The Lowell Sun* 2009). A similar argument was raised about the Massachusetts bill, with concerned citizens worrying that "transgender identity and expression" was too vague (Letter to the Editor 2009a) and created "dangerous ambiguity" over who was legally transgender (Prunier 2009) and therefore had access to men's or women's bathrooms. Highlighting this concern about bathroom access, one opponent in Massachusetts noted, "This bill opens the barn door to everybody. There is no way to know who of the opposite sex is using the [bathroom] facility for the right purposes" (Ring 2009). In these cases, what appears to critics as too much validation of identity-based determination of gender sets off panic, panic that is quelled if the bills do not pass into law. When the bills do pass, opponents continue to raise concerns about the potential for danger to women and children in public restrooms, a point we return to in the following sections.

By enforcing explicit bodily criteria for determining gender, the IOC and New York City policies shore up the fissures created in the strict two-category model of gender by the visibility of trans-people while also allowing for some degree of identity-based determination of gender. Similar to judicial rulings permitting name and sex marker changes on government documents (Meyerowitz 2002), policies about birth certificates and athletes work to balance liberal values of autonomy with the belief that there are two genders and that all people (trans or cis) can be put into one category or the other. A lack of bodily criteria, in contrast, appears as a threat to the gender binary. An editorial opposing federal protections for trans-people highlights this fear clearly: "The Left seeks to obliterate the distinction between men and women. This distinction is considered to be a social construct. . . . For those of us who believe that the male-female distinction is vital to civilization, the Left's attempt to erase this distinction is worth fighting against" (Prager 2010). Similarly, Shannon McGinley, of the conservative Cornerstone Policy Research group, worried that the goal of transgender rights bills was "to create a genderless society" (Distaso 2009). These concerns illustrate our concept of "gender panic," as public debate centers on the necessity of culturally defending a rigid male–female binary that is simultaneously framed as stable and innate. These concerns further underscore the

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extensive naturalization work that goes into legitimating the current sex/gender/sexuality system. Yet, this work did not evenly center on gender-segregated spaces, or on all biological characteristics that could be used as criteria for determining gender. Rather, opposition gathered around "people with penises" in spaces designated as women-only.

Genitals = Gender: Determining Gender in Women-Only Spaces

In our three cases, concerned citizens and journalists posed many questions about what genitals would be allowed in which gender-segregated spaces. This overwhelming focus on genitalia as the determinant of gender is interesting when considered against other possible criteria. Within biology-based gender ideology, gender is determined at birth by doctors on the visible recognition of genitalia. However, such gender categorization is assumed by many to be the result of other, less visible, biological forces, namely, chromosomes and hormones. While genitalia and hormones can be modified, chromosomes are static—meaning, on some level, XY and XX could be the best criteria for maintaining a binary gender system. Within the transgender rights case, opponents to such bills occasionally drew on chromosomes to further their case for why such bills would be problematic. As one man wrote to a newspaper in Michigan: "Your DNA is proof of your genetic code and determines race [and] sex. . . . There is also one fact that transgender individuals cannot deny: your DNA proves if you are a man or a woman. It does not matter what changes you have made to your sexual organs" (Letter to the Editor 2009b). Yet, such responses comprise a very small part of the discourse in our cases.

That less weight is given to chromosomes in these cases of gender determination is interesting. In everyday interactions, chromosomes are poor criteria for gender attribution, because they are not visible (Kessler and McKenna 1978). Athletes can be tested for chromosomal makeup. Yet, the IOC did not include chromosomes as part of the criteria for competition, as such a requirement would bar trans-athletes from competition. Similarly, our other cases do not use chromosomes as gender determination criteria, because such rigid genetic criteria would effectively invalidate the possibility of gender transitions. Where we saw a call for chromosomal criteria was in cis-people's imagined interactions with trans-people, scenarios that sought to delegitimize calls for identity-based determination of gender. That chromosomes did not figure widely in policy decisions, in contrast, suggests that identity-based gender ideologies have gained some degree of cultural legitimacy. To balance both

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ideologies, institutions cannot use unchangeable criteria, such as chromosomes, to determine a person's gender.

Genitalia are the primary determiner of gender in all of our cases. Starting with the sports case, which has the most clearly defined criteria for determining gender, the IOC permits transwomen (who are assumed to have XY chromosomes) to compete as women as long as they undergo the removal of the testes and the penis.[4] While testes are a source of testosterone, which is a central concern in sports competition,[5] the IOC does not state why transwomen athletes must undergo a penectomy to compete as women, since penises themselves do not provide advantages in sports. Such a requirement may be partially due to deep cultural beliefs that a person with a penis cannot be a woman (Kessler and McKenna 1978), and so they cannot compete with women in athletics. Moreover, this requirement may be a result of a widely held belief that people with penises present a danger to women, a question we take up later in this article.

This emphasis on determining gender through hormone levels and genitalia is applied only to athletes attempting to compete as women. If an athlete competing as a woman has her gender called into question (usually for performing "too well" for a woman), her hormone levels are tested for "irregularities." In contrast, people who want to compete as men (cis or trans) are allowed to inject testosterone if their levels are seen as lower than "those naturally occurring in eugonadal men" (Gooren and Bunck 2004, 151). Thus, in this sex/gender/sexuality system, testosterone is a right of people claiming the category of "men." Further, while no athlete with a penis can compete as a woman, athletes are not required to have a penis to compete as men. Highlighting this point, "Will," an Australian transman who played football on a men's team, was required to undergo a hysterectomy in order to change his sex marker, but he was not required to have phalloplasty (Stark 2009). Moreover, his use of testosterone was not seen as an unfair advantage because his levels did not exceed those of an average cis-gender man.

The heightened attention to the presence or absence of a penis in spaces marked as "women only" was reflected in all of our cases. In news stories about the New York City birth certificate policy and the transgender rights bills, opponents frequently hinged their concerns on "male anatomies" (Cave 2006b) or "male genitalia" (Kwok 2006) in women's spaces. A common imagined interaction that generated gender panic was transwomen with "male anatomies" being housed with female prisoners (Cave 2006b; Staff 2006; Weiss 2006; Yoshino 2006), or transwomen "who still have male genitalia" using women's bathrooms (Kwok 2006; Yoshino

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2006). While several articles included interviews with transmen activists who emphasized how hard it would be for them as people with facial hair to be forced to use a women's restroom on the basis of the sex marker on their birth certificates, only one opponent cited in the same articles used the example of transmen in the bathroom rather than transwoman.[6] Thus, biology-based gender ideologies were more likely to be deployed when debating transgender access to women's spaces. Those debates suggest that it is penises rather than other potential biological criteria that are the primary determiner of gender because male anatomies are framed as sexual threats toward women in gender-segregated spaces.

Separate and Unequal: Reproducing Gender Inequality in Gender-Segregated Spaces

Women-only spaces generate the most concern in these moments of gender ideology collision. In the resulting gender panics, ideas about "fairness" and "safety" work to naturalize gender difference and to maintain unequal gender relations. In these moments of ideological collision, two persistent ideologies about womanhood are deployed to counter identity-based determination of gender: Women are weaker than men, and, as a result, women are always at (hetero)sexual risk. This construction produces "woman" as a "vulnerable subjecthood" (Westbrook 2008), an idea that what it is to be part of the category of woman is to be always in danger and defenseless.[7] Conversely, men, or more specifically, penises, are imagined as sources of constant threat to women and children, an idea that reinforces a construction of heterosexual male desire as natural and uncontrollable. Women-only spaces, then, can be framed as androphobic and, as a result, heterophobic, due to the assumed inability of women to protect themselves from men combined with the assumption that all men are potential rapists. These ideas carry enough cultural power to temper institutional validation of identity-based determination of gender. What people are attempting to protect in these moments of ideological collision, we suggest, is not just women, but also the binary logic that gender-segregated spaces are predicated on and (re)produce.

Within the sports case, the IOC focused on the issue of fairness when determining when a transwoman can compete against cis-women. Attempting to maintain both the values of identity-based determination and the logic of gender difference that justifies gender-segregated athletic competitions, sports officials put transwomen athletes into a peculiar situation: In order to gain access to the chance to compete in tests of strength

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and endurance, they must first prove their weakness (Buzuvis 2010; Shy 2007). This equation of women with weakness also accounts for the regulation of women's, but not men's, sports: If women are inherently weak, they must be protected from competing with stronger bodies (e.g., men). Cis-men, in contrast, should not need such protection from people with XX chromosomes.

Gender panics around the issue of trans-athletes also focus on the question of safety. The United Kingdom's 2004 Gender Recognition Act, a law intended to grant more rights to transgender people, includes a provision that prohibits trans-athletes' competition in cases that endanger the "safety of competitors" (Cavanagh and Sykes 2006). Discussion of safety in this case revolved around regulating access to contact sports. Yet, during debate around this act, another meaning of safety surfaced. Lord Moynihan is reported as saying that "many people will be greatly concerned at the idea of themselves or their children being forced to share a changing room with a transsexual person" (Mcardle 2008, 46). The allusion is that transgender people present a sexual danger to vulnerable others, conflating transgenderism and sexual deviance.

This portrayal of transgender people as potential sexual dangers in gender-segregated spaces appeared repeatedly in our other two cases. People advocating biology-based determination of gender worried about protecting women and children, another group generally vested with vulnerable subjecthood, from sexual risk from people with penises who would, with the new policies, be legally able to enter women-only spaces. When opponents to the New York City birth certificate policy worried about "male anatomies" in women's prisons (Cave 2006b), they were hinting at the possibility that those "male anatomies" would sexually assault the women with whom they shared prison space. While most articles about the New York City proposal merely suggested this possibility, some were more explicit. An opinion piece argued that one of the dangers of the proposed law was "personal safety: Many communal spaces, like prison cells and public bathrooms, are segregated by sex to protect women, who are generally physically weaker than men, from assault or rape" (Yoshino 2006). Explaining his opposition to the transgender rights bill, New Hampshire Representative Robert Fesh similarly noted, "Parents are worried about their kids and sexual abuse" (Macarchuk 2009). In these imagined interactions, opponents to identity-based criteria for determining gender both rely upon and shore up an idea that women are uniquely susceptible to assault. Moreover, they position transwomen as dangerous, a perspective that is often used in other contexts to justify violence against them (Westbrook 2009).

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Since the panics produced in these moments of ideology collision focus on the penis as uniquely terrifying, "gender panics" might more accurately be termed "penis panics." In these hypothetical interactions, opponents give penises the power to destroy the sanctity of women's spaces through their (presumed natural) propensity to rape. The imagined sexual threat takes three forms in the news stories we examined. Most commonly, the threat is stated in general terms, such as opponents claiming that passage of transgender rights bills in New Hampshire and Massachusetts would put "women and children at risk" (Love 2009) in public restrooms. Second, some opponents imagined cis-men pretending to be transwomen in order to gain access to women's restrooms for sexually nefarious purposes. Contesting the vague criteria of who counts as transgender, Representative Peyton Hinkle of New Hampshire stated his opposition to the bill by calling it an "invitation . . . to people with predatory tendencies to come and hide behind the fact that they are having a transgender experience" (Fahey 2009). A spokesperson for the Massachusetts Family Institute told a reporter that the anti-discrimination bill allowed sexual predators to enter women's restrooms under the "guise of gender confusion" (Nicas 2009). Finally, transwomen themselves (not cis-men pretending to be trans) are imagined as the potential threat. Dr. Paul McHugh, chair of the psychiatry department at Johns Hopkins University, is reported to have written an email protesting the proposed New York City policy that stated: "I've already heard of a 'transgendered' man who claimed at work to be 'a woman in a man's body but is a lesbian' and who had to be expelled from the ladies' restroom because he was propositioning women there" (Cave 2006b). In these imagined interactions, transwomen have legal permission to enter gender-segregated spaces without the proper biological credentials. As such, their presence transforms a nonsexual space into a dangerously (hetero)sexual one. Within this heteronormative logic, all bodies with male anatomies, regardless of gender identity, desire female bodies, and many of them (enough to elicit concern from the public) are willing to use force to get access to those bodies.[8]

That these imagined sexual assaults occur only in women-only spaces is worth further analysis, as women share space with men daily without similar concerns. We suggest that women-only spaces generate intense androphobia because, by definition, these spaces should not contain bodies with penises. If women are inherently unable to protect themselves, and men (or, more specifically, penises) are inherently dangerous (Hollander 2001), the entrance of a penis into women's space becomes

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terrifying because there are no other men there to protect the women. The "safe" (read: gender-segregated) space is transformed into a dangerous, sexual situation by the entrance of an "improper body." These fears rely on and reproduce gender binarism, specifically the assumption of strong/weak difference in male/female bodies, as opponents assume that people who could be gaining access to women's space (people with penises) are inherently stronger than cis-women and easily able to overpower them.

This emphasis on the sexual threat of penises in women-only spaces shows that gender panics are not just about gender, but also about sexuality. In the sex/gender/sexuality system, all bodies are presumed heterosexual. This assumption makes gender-segregated spaces seem safe because they are then "sexuality-free zones." Because there are only two gender categories, gay men and lesbians must share gender-segregated spaces with heterosexual men and women, respectively, an entrance that is tolerated as long as such entrants demonstrate the appropriate visual cues for admittance and use the bathroom for the "right" purpose (waste elimination). The use of public restrooms for homosexual sex acts can, of course, create a panic (Cavanagh 2010). Gender-segregated spaces, then, can be conceived of as both homophobic and heterophobic, as the fear is about unwanted sexual acts in supposedly sex-neutral spaces. Unlike normative sexual interactions, where gender difference is required to make the interaction acceptable (Schilt and Westbrook 2009), in gender-segregated spaces, gender difference is a source of discomfort and potential sexual threat and danger. Rhetoric about women and children as inherently vulnerable to sexual threats taps into cultural anxieties about sexual predators and pedophiles, who are always imagined to be men (Levine 2002); such fears have been repeatedly successful in generating sex panics. Because unwanted sexual attention is seen as a danger to women and children, but rarely, if ever, as a danger to adult men (Vance 1984), men's spaces are not policed. This differential policing of gender-segregated spaces illustrates the cultural logics that uphold gender inequality and heteronormativity—two systems whose underlying logic necessitates male–female oppositeness.

CONCLUSION

In this article, we examine the process of determining gender. We argue that collisions of biology-based and identity-based ideologies in the liberal moment have produced a sex/gender/sexuality system where the criteria for determining gender vary across social spaces. Many people

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have long assumed that biological factors, such as chromosomes, are always the ultimate determiner of gender. Contrary to the dominant assumption, we suggest that the sex/gender/sexuality system is slowly changing. As it has encountered liberal values of self-determinism, the criteria for determining gender have shifted away from pure biological determinism. In nonsexual gender-integrated spaces, identity can be used to determine gender, as long as that identity is as a man or a woman (Schilt and Westbrook 2009). By contrast, in gender-segregated spaces, a combination of identity and body-based criteria is used, allowing someone to receive cultural and institutional support for a change of gender only if they undergo genital surgery. Finally, in heterosexual interactions, biology-based criteria (particularly genitals) are used to determine gender (Schilt and Westbrook 2009).

While most cis-gender people keep the same classification in all spaces, transgender people may be given different gender classifications by social actors depending on the type of interaction occurring in the space. Thus, one could speak of a trans-person's "social gender," "sexual gender," and "sports (or other gender-segregated space) gender." To illustrate this point, Kye Allums, a trans-man who played college basketball on a woman's team, has a social gender of "man" and a sports gender of "woman." Within the criteria for trans-athletes, he can continue to play basketball with women as long as he does not take testosterone or have genital surgery (Thomas 2010), a modification that would change his sports gender from "woman" to "man." Another way to conceptualize this point is to say that access to gender-integrated social spaces is determined by identity while access to gender-segregated spaces is mostly determined by biology, a point we summarize in Table 1.

The criteria for gender determination vary across social spaces because of the different imagined purposes of interactions that should occur in these settings. Heterosexual encounters and gender-segregated spaces both justify and reproduce an idea of two opposite genders. In spaces in which a higher level of oppositeness is required from participants, visual and behavioral gender cues often are not considered sufficient for determining gender and, instead, the participants must also demonstrate bodily oppositeness. Because heterosexual interactions and gender-segregated spaces rely on (and reproduce) gender binarism, it is these spaces where validation of identity-based determination of gender produces panics and biology-based gender ideologies reign. In contrast, validation of identity-based determination of gender is more likely to occur when it cannot be framed as endangering other people, particularly others seen as more worthy of protection than trans-people (cis-women and children). In

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TABLE 1: Criteria for Determining Gender across Contexts

	Nonsexual, Gender-Integrated	*Nonsexual, Gender-Segregated*	*Heterosexual*
Trans-men	Identity-based criteria determine gender.	Identity-based criteria determine gender.	Biology-based criteria determine gender.
	Changes to genitalia are not typically required to establish legitimacy of their gender.	Changes to genitalia are not typically required to gain access to men's spaces.	Changes to genitalia required. This criterion is not typically enforced in a violent way.
Trans-women	Identity-based criteria determine gender.	A combination of identity-based and biology-based criteria determine gender.	Biology-based criteria determine gender.
	Changes to genitalia are more typically required to establish legitimacy of their gender.	Changes to genitalia are required to gain access to women's spaces.	Changes to genitalia required. This criterion is often enforced in a violent way.

gender-integrated workplaces, for example, coworkers may not feel endangered by working with a trans-man who has the "cultural genitals" to support his social identity as a man, such as facial hair, particularly if he identified himself as crossing from one side of the gender binary to the other (Schilt and Westbrook 2009). It is important to add, however, that, in these spaces, identity-based determination of gender is more likely to be accepted by others when the person in question is, in the social imagination, "penis free" (all trans-men as well as "post-op" trans-women), as the penis is culturally associated with power and danger. These attitudes have profound consequences for transgender rights.

The criteria for determining gender also differ for placement in the category of "man" or "woman." Here, we have focused on the criteria for accessing women-only spaces because it is those spaces that produced the most panic in our media sources and that have the clearest criteria for admission. This focus of cultural anxiety on trans-women is unsurprising. We have detailed how the mainstream media portrayed trans-women as dangerous to heterosexual men because they use their feminine appearance to trick men into homosexual encounters (Schilt and Westbrook 2009; Westbrook 2009). In these cases, it is again trans-women who are

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portrayed as dangerous, yet this time they are positioned as endangering women and children.

We do not take the lack of attention to trans-men in men-only spaces to mean that trans-men are more accepted by people who vocally oppose trans-women. In contrast, we suggest that trans-men and trans-women are policed differently. Transmen's perceived lack of a natural penis renders them, under the logic of vulnerable subjecthood, unable to be threatening (and, therefore, unlikely to generate public outcry). Cis-gender men, the group who would share a bathroom or locker room with trans-men, also are not seen in the public imagination as potential victims of sexual threat, as such an image is contradictory to cultural constructions of maleness and masculinity (Lucal 1995). Trans-men enter a liminal state, in some ways, as they cannot hurt men (making them women), but are not seen as needing protection from men (making them part of a "pariah femininity" [Schippers 2007] that no longer warrants protection). Thus, because of gender inequality, the criteria for the category "man" are much less strict than those for the category "woman," at least for access to gender-segregated spaces.

But why do genitals carry more weight in determining gender in these segregated spaces? Our research hints at three possible answers for further exploration. First, genitals are changeable criteria, unlike chromosomes, which allows for some validation of liberal values of self-determination. Second, male and female genitals are imagined to be opposite, so using them as the criteria for determining gender maintains a binaristic gender system. Finally, genitals play a central role in gender panics because gender and sexuality are inextricably intertwined. The social actors opposed to identity-based determination of gender assume that all bodies, regardless of gender identity, are heterosexual. Although genitals are not supposed to be used in interactions in gender-segregated spaces, a fear of their (mis)use drives the policing of bodies in those spaces, making sexuality a central force in deciding which criteria will be used to determine gender.

By using genitals as the criteria for determining gender, the sex/gender/sexuality system is able to adapt to new liberal ideals of self-determination and to withstand the threat that trans-people might pose to a rigid binary system of gender. Although the existence of transgender and genderqueer people is seen as capable of "undoing gender" (Deutsch 2007; Risman 2009), the binaristic gender system tends to adapt to and re-absorb trans-people (Schilt and Westbrook 2009; Westbrook 2010).

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Rather than being undone, gender is constantly "redone" (Connell 2010; West and Zimmerman 2009). Like all other norms and social systems, people create gender. Challenges to the gender system modify rather than break it. Gender crossing can receive some validation in the liberal moment, but only when a binary remains unquestioned. By providing criteria for who can transition and how they can do it, the sex/gender/sexuality system is both altered and maintained.

NOTES

1. Following Kessler and McKenna (1978), we highlight the social construction of both "sex" and "gender" by using the term "gender" throughout this article, even in moments where most people use the term "sex" (e.g., "gender-segregated" rather than "sex-segregated"). We reserve "sex" for references to intercourse, unless using a specific term such as "sex marker".

2. We use the term "(hetero)sexuality" to highlight that when many social actors speak of "sexuality" they are inferring heterosexuality.

3. As sexuality and sexualization are social processes, it is difficult to draw a conceptual line between a sexual and nonsexual space. Workplaces, for example, can contain sexualized interactions, though the dominant understanding of a workplace might be nonsexual. We use this term to refer to settings in which the commonly agreed on purpose is nonsexual. Sexual interactions do, of course, occur in these settings, but many see such interactions as a violation of the expected purpose of these spaces.

4. It is notable that women athletes do not have to possess what would be considered female genitals in order to compete. The criteria for determining gender in sports are thus very similar to Kessler and McKenna's findings that "penis equals male but vagina does not equal female" (1978, 151) when determining gender.

5. This use of "sex hormones"—mainly the levels of testosterone—to determine gender emerged only in the sports case because of the belief that testosterone provides a competitive advantage.

6. The image of a trans-man in men-only spaces was referenced by opponents only once in our analysis. A conservative activist told a reporter that allowing "men" to go into women's bathrooms legally would create discomfort for women and put them at sexual risk. The reporter asked what bathroom transgender men should use, as their male appearance could also make cis-women uncomfortable in the bathroom. The activist replied, "They [trans-men] should use the women's bathroom, regardless of whom it makes uncomfortable because that's where they are supposed to go" (Ball 2009).

7. Often, it is actors with good intentions, such as antiviolence activists, who, in their attempt to protect a particular group, unintentionally (re)produce an idea

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that the group is constantly prone to attack and unable to protect themselves (Westbrook 2008).

8. The ability to harm others attributed to trans-people in these narratives should be problematized. The trans-people described by biological determiners function as monstrous specters, so there is often little nuance in these portrayals of trans lives. By contrast, arguments made for trans rights bills and for access to gender-segregated spaces often include descriptions of trans-people as victims of violence and harassment rather than as perpetrators.

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