EXPLORATION OF HOW MEDICAID HAS LIMITED ACCESS TO HEALTHCARE SERVICES FOR TRANSGENDER INDIVIDUALS IN THE UNITED STATES OF AMERICA

Master of Arts: Critical Sociology Major Research Paper

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ABSTRACT

When laws are enacted, the state paints the picture that it is for the betterment of everyone. Before now, advocates clamored for laws to protect the rights of gender non-conforming people. When these laws were finally made, the states were applauded for having these people in mind. People do not realize that the supposedly 'best' laws, when further analyzed and scrutinized, show that they favor some people more than others. This paper exposes the inequities in the health system by analyzing how the Medicaid program in the United States of America has limited trans individuals from accessing health care services and how the woes of some individuals are further deepened because of their race, age, sex and income. The paper also proposes some recommendations on how the Medicaid program can widen its scope of support.

CHAPTER ONE

INTRODUCTION

1.1 Background

Despite the diversity within the trans community, non-trans people are often confused and conflate the different ways this identity is claimed. (Aguayo-Romero et al., 2015). Transgender or trans is a general term for people whose gender at birth is different from the gender they want to be identified with. Hence, the personal experiences of trans people have led to some being identified as trans men or trans women, while others choose to identify as non-binary, queer, non-conforming, agender, and the likes (Taylor, Lewis & Haider-Markel, 2018). During the transition process, some trans individuals go in for hormones while others may settle for surgery. We also have another section of trans individuals who may change their pronouns or appearances. Regardless of which path trans individuals take, the process of transitioning is essential (Johnson & Edmiston, 2018).

According to Pearce (2018), transition is a process that some trans individuals go through when they live their lives differently from those assigned at birth and prescribed by society. This can take various forms or interventions; some choose medical components like hormone therapy and surgery. Nevertheless, it is salient to stress that some transitions do not include medical interventions (Keeling, 2019). Not all people who identify as transgender go through surgery and/or make hormonal changes, and some do a selective mix. Also, not all surgeries are for sex assignment. (Plemons, 2017).

The number of trans people keeps increasing daily (Pearce, 2018); however, despite this increase, trans individuals continue to be viewed as the most marginalized or ‘odd’ ones within

2SLGBTQIA+ communities and often face profound stigma (Spade, 2015; Serano, 2017; Payne et al. 2018).

1.2 Problem statement

The ill-treatment and systemic oppression faced by trans people has led to the emergence of a trans liberation movement, trans studies, and trans politics. However, Bettcher (2014) argues that despite the flowering of trans studies and trans politics, many scholars seem to have started on the wrong foot as they do not represent the most pressing challenges faced by trans individuals (Prosser, 1998; Rubin 2003; Namaste, 2005). In particular, many early queer theories provided a vision of politics that left no room for trans people who did not identify beyond the binary.

According to the Human Rights Campaign (HRC) Foundation (2020), trans people face oppression and discrimination in many different contexts, from lawmakers to family members. According to HRC (2020), "only 30% of women's shelters are willing to house trans women, 27% of trans people have been fired or denied promotion because of their trans identity". The report also shows that 55% of trans adults of color are deprived of voting because they cannot access the appropriate identity documents. Stigma also exists within the 2SLGBTQIA+ communities. According to Pearce (2018), trans individuals are likely to be oppressed or marginalized from decision-making in 2SLGBTQIA+ communities because of the continuing unease about the process of gender transition.

This oppressive context has led to trans people organizing to advocate for justice. It is clear that being visible alone does not solve these complex problems; instead, trans people need an equal chance to succeed and thrive (Scheim & Bauer, 2015). Trans advocacy for more

equitable policies has led to the passing and implementation of several laws to protect citizens from discrimination based on their gender identity (Spade, 2015). The aim was that these laws and policies would lessen the discriminations trans people face and increase their access to basic social amenities. Unfortunately, some of these initiatives have had the reverse effect and made life increasingly unbearable for trans people (Spade, 2015). In light of this research, this paper seeks to use a human rights approach to focus on healthcare access, in particular, exploring how the Medicaid program has limited trans people's access to health care services.

1.3 Objectives of the study

This paper focuses on the Medicaid program in order to better understand the blatant injustices faced by trans people who are often constrained in accessing relevant health services in the United States of America.

Taking up this line of inquiry exposes the inequities in this health system and answers the overarching question: How has the Medicaid program in the United States of America limited trans individuals from accessing health care services?

Specifically, this Major Research Paper (MRP)

i. Identifies reasons why people undergo trans surgery, hormonal changes, and treatments.
ii. Explores why some trans people may decide not to seek any medical interventions.
iii. Locates the loopholes within the Medicaid program that prevents trans individuals from accessing health care services.
iv. Pinpoints how these loopholes in Medicaid may affect people differently based on their gender, race, and class

v. Explains how these policies have prevented some trans individuals from accessing specific necessary and appropriate health services.

1.4 Methodology

The paper relies on an analysis of secondary data. First, it identifies research findings and scholarly works that are particularly promising and interesting in the subject area. While I do not purport to offer an exhaustive review of all scholarship in trans studies, I will focus on trans access to health services (Ablon, Libicki & Golay, 2014). I will employ a Google-based directed search through all the major peer-reviewed journals to conduct a complete search on all the prominent authors' websites in this field (Marino & Colvin, 2015).

1.5 Definition of concepts

Agender: These are individuals who choose not to identify as having a specific gender; they prefer to be identified as people without a gender identity (Goyette, 2021)

Cisgender: According to Currans (2020), a cisgender person's gender identity is the same as the one that was assigned to them at birth.

Gender Binary: This is the notion that gender can be categorized into two main groups, and everyone can be categorized into these groups, namely, male/men/masculine or female/woman/feminine based on the sex assigned at birth (Guenther, 2020).

Gender Conforming: This refers to people whose gender identity conforms with the one prescribed by cultural norms (Smith & Smith, 2016).

Gender expression: Wilson (2018) describes gender expression as outward appearance. This can be expressed in diverse ways such as haircut, clothing and behavior.

Gender identity: According to Nordmarken (2019), gender identity refers to how individuals see themselves and what they are called and want to be called. This may or may not be the same as what was assigned at birth.

Gender Non-Conforming: According to Smith & Smith (2016), a person whose gender identity does not conform with the one prescribed by cultural norms is referred to as a gender non-conforming person.

Genderqueer: This also refers to persons who are neither males nor females. This gender identity is beyond genders and/or combines genders (Vowles, Coffe & Curtin, 2017).

Intersex: According to Amato (2016), this refers to people whose sex characteristics do not conform to the gender binary. This is entirely different from transgender.

Sexual orientation: According to HRC (2020), this refers to "emotional, romantic, sexual, and relational attraction to someone else. This can refer to gays, lesbians, bisexuals, straight".

Trans: Trans individuals live their lives as a different gender compared to the one they were assigned at the time of birth (Halberstam, 2018; Guenther, 2020).

Transition: This is a process where people do not live as the gender they were assigned at birth but rather as the gender they identify with (Pearce, 2018)

2SLGBTQIA+: An acronym commonly used to refer to Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex and Asexual individuals and communities. (McMaster & Seck, 2020)

1.6 Relevance of study

This study is timely and justified as it looks at an often neglected area. A lot of scholarly works have explored the challenges faced by trans people. However, very few focus on the

problems faced by a subset of trans people due to their social-economic background (Tomchin, 2013; Baril, 2015; Shuster, 2016; Spade, 2015; Plemons, 2017 & Keeling, 2019). This paper explores how barriers in accessing the Medicaid program have affected trans people who disproportionately live in poverty and thus cannot access private healthcare. This study adds knowledge to the growing number of scholarly works on the intersection of socioeconomic backgrounds and gender identity. It also creates awareness regarding patterns of injustice and social and structural inequalities affecting trans individuals, often in complicated ways.

1.7 Organization of paper

This paper consists of six chapters. The first chapter introduces readers to the study by defining the concepts that it will rely on; it further explains its relevance in the twenty-first century. The second chapter reviews very relevant literature while digging deeper into the lives of trans people, including the processes of transitioning and the challenges trans people go through. The third chapter provides an analysis of the barriers trans individuals face while accessing health care services in the United States of America. The fourth chapter explores health insurance coverage in the U.S. and focuses on Medicaid's origin, eligibility, services, and finances. The fifth chapter addresses the specific objectives of the paper. It answers the overarching research question by explaining how the Medicaid program has limited trans people from accessing health care services in the United States of America. This paper concludes in chapter six with a summary of the paper while proposing recommendations to help create awareness of the plight of trans people and their access to healthcare services in the United States of America irrespective of their race, gender and socioeconomic background.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter aims to review relevant literature in the area under study by identifying promising research findings and scholarly works in the subject area. This chapter touches on who trans individuals are, the history of trans identity in the US, the process of transitioning, policies that have been made to benefit trans people, challenges faced by trans people and health care access for trans people.

2.2 Trans people

Trans is mainly used as an abbreviation for transgender (Green & Maurer, 2015). According to Luzano-Verduzco & Melendez (2019), "Transgender refers to those who do not identify with their assigned sex and prefer to live their lives as another gender" (p.1). Also, the term transgender "describes people who have gender identities, expressions, or behaviors not traditionally associated with their birth sex" (Gender Education & Advocacy, 2001). Hence, these people have resolved to live their lives differently from what they were allocated at birth (Taylor, Lewis & Haider-Markel, 2018).

2.3 Narratives of trans people's activism in the United States of America

Historically, there are several well-known stories of people who lived their lives as a gender other than that assigned at birth in the US (Katz, 1976; Conn, 1974; Bolin, 1988; Benjamin, 1966). One that is worth mentioning is Billy Tipton. Tipton was assigned a female gender at birth but lived over fifty years as a man. Despite having long-term relationships with women, none of them, including his adopted children, knew of his gender at birth. He finally

died of a treatable illness when he refused to go to the hospital because he feared disclosing his identity. However, despite his desire to live as a man, after his death biographers said otherwise. For example, Middlebrook (1998) preferred to use both male and female pronouns because he could not agree with Tipton's decision to live his gender differently from the one assigned to him at birth. Cromwell (1999) criticizes Middlebrook's assumptions and points out that "when someone like Tipton dies or is discovered, they are discounted as having been not real men or unreal men" (p.4). This is not peculiar to Tipton as other trans men and women have similar experiences; for instance, some trans people, despite having lived for years as a different gender, are assumed to have taken this course of action because of their socioeconomic necessities or end up being considered as "lesbians or gays" (Middlebrook 1998:90).

As the number of trans people has kept increasing, discrimination and marginalization has also escalated, and there are many reports of trans people being brutalized (Lewis, Flores, Haider-Markel, Miller, Tadlock & Taylor, 2017). At the same time, transgender individuals continued to advocate for their rights (Stryker, 2008). In 1966 there was a riot that broke out in San Francisco's Compton's cafeteria when the police attempted to apply force to disperse some trans people protesting. The police officers were able to overpower the trans people, with some sustaining life-threatening injuries and others being arrested (Morris, 1974). Surprisingly, those arrested during this raid found ways to escape (Faderman & Timmons, 2006; Stryker, 2008). This move on the part of LGBTQ individuals was shocking as before then; police had simply pushed them around against their wishes and rights. This change in the attitude of trans people was so evident that the Deputy Inspector, Seymour Pine, noticed the shift and had this to say about one of the riots held at Stonewall "For those of us in Public morals, things were completely changed, suddenly (LGBT people) were not submissive anymore" (Duberman, 1993:203). After

critically analyzing the ill-treatment that they had gone through in the past, LGBTQ youth began to see why they needed to empower themselves if their rights were to be respected. This empowerment paid off because, before the Stonewall riots, gay rights only existed in six colleges in the United States. But in 1971, many groups sprung up in universities and colleges around the country, and most of them preferred to be called Gay Liberation Front (Beemyn, 2003)

Dubberman (1993) notes that many transgender individuals helped form the Gay Liberation Front. However, despite their central role after a short period, gender non conforming people were largely abandoned because the Gay Liberation Front wanted to appear more acceptable to the mainstream society (Middlebrook, 1998). Shortly after, a coalition of mostly White middle-class gay groups named the Gay Activist Alliance (GAA) became prominent, and their aim was to work solely for the rights of gays (Dubberman, 1993:232). Hence, this group excluded transgender people (Dubberman, 1993).

This move to exclude transgender people from early organizing happened across many parts of the US simultaneously and was not restricted to gay men. Here the story of Beth Elliott, a transgender woman who was an active member of the San Francisco chapter of the groundbreaking lesbian group the Daughters of Bilitis in 1971. In 1973, the well-known feminist activist, Robin Morgan, during the West Coast Lesbian Feminist Conference attacked Elliott and "referred to her as a male transvestite who was leaching off women who have spent their entire lives as women in women bodies" (Stryker 2008:104). The aftereffect left Elliot traumatized, and she left the organization because she did not feel a sense of belonging (Stryker, 2008). So, apart from the discrimination of trans individuals by outsiders, they were not spared even within gender non-conforming people.

Despite these forms of exclusion, the 1970s was a new beginning for trans people as more of them focused on activism to let their voices be heard. This activism may have enabled Steve Dain to come out as the first public trans man who fought and won the right to teach in 1976 (Green, 2003). In places like Los Angeles and New York, trans male support groups also sprang up in the 1970s and early 1980s (Green 2004). In 1990, Lou Sullivan, a gay man, compiled the first guide for trans men. This book profiled a trans man by the name Jack Bee Garland, who was "a female-assigned journalist and social worker who lived as a man for 40 years in San Francisco in the late nineteenth and early twentieth centuries" (Stryker 2008:27).

The 1990s saw the development of a more significant rights movement and the meaning of the term transgender became a more all-encompassing umbrella including any identity that did not conform to societal norms of the gender assigned to them at birth. This broader definition was bringing together gender non-conforming people from diverse forms of life (Stryker, 2008), and by the late 1990s it was used by a wide range of writers including Bornstein, 1994; Feinberg, 1992, 1996, 1998; and Rothblatt, 1994. However, despite this growth in activism, memoirs and scholarship, trans people continued to be brutalized and discriminated against with a high rate of "hate crimes against transgender people" (Califia 1997:232).

The rise of the internet played a significant role in developing a national transgender movement. For instance, Shapiro (2010) mentioned that the internet allowed "transgender people to connect more easily, especially those who live in geographically isolated places… by giving individuals ways to experiment with defining their gender" (p.132). Online activism has been beneficial to trans people as it created awareness of how the "American Psychiatric Association is pathologizing transgender people in the Diagnostic and Statistical Manual" (Shapiro, 2010:24). For instance, for over forty years, Tina, a cross dresser, confessed that "I learned from reading,

but I was liberated by the internet" (Beemyn & Rankin, 2011:58). This online environment created more accessible spaces for transgender people but at the same time, scholarly writers were also laying the groundwork for transgender scholarship (Anzaldua, 1987; Butler, 1990; Lauretis, 1991).

Before 2000, none of the states in the U.S. except Minnesota had a nondiscrimination law on gender identity; however, by 2013, the results were overwhelming, seventeen states, including the District of Colombia, having passed nondiscrimination laws on gender identity. Additionally, "cities and counties with transgender rights ordinances have grown from three in the 1980s to more than 150 in 2012, by 2013 forty-five per cent of the U.S. population was covered by a transgender-inclusive nondiscrimination law" (National Gay and Lesbian Task Force 2012, 2013). In schools, over 720 colleges and universities included gender identity in their nondiscrimination policies (Beemyn, 2013).

Despite this legal progress, transgender individuals still face harsh treatment. According to the National Transgender Discrimination Survey (2010), “63% of the respondents had experienced a serious act of discrimination, 41% reported attempting suicide compared to 1.6% of the general population, with rates rising for those who lost a job due to bias (55%), trans people who were harassed/bullied in school (51%), had low household income, or were the victim of physical assault (61%) or sexual assault (64%)," (Grant, Mottet, & Tanis, 2010:2). Within trans communities, Black individuals continue to be singled out for discrimination as mainstream queer activism continue to be dominated by white people (Trans Bodies, Trans Selves online survey, 2013).

2.4 Process of transitioning

Transition is a process trans individuals undergo when they resolve to live as a different gender than the one they were assigned at birth (Luzano-Verduzco & Melendez, 2019). It must be mentioned that transition does not mean a trans person is becoming a man or woman but instead have just openly started living their lives as their true gender (Webster, Adams, Maranto, Sawyer & Thoroughgood, 2018). Not all transitions include medical components. Some trans individuals may choose to undergo hormonal therapy and/or surgery (Melendez, 2019). According to Pearce (2018), transitioning does not necessarily involve medical interventions as not all people that identify as transgender go through surgery and/or make hormonal changes; and some do a selective mix. In addition, not all surgeries are for sex assignment, so not all trans individuals undergo these treatments (Plemons, 2017). This leads to two different types of transition, namely, social transition and medical transition (Keeling, 2019; Drydakis, 2017).

The path towards transition is dependent on several factors, which may include trans individual's desires, the kind of family they come from, the society they are associated with, societal discrimination, and the financial capabilities of the individual, all of which can influence the transition process (Bizana et al., 2019; Schmidt & Levine, 2015; Gigs, & Brewages, 2007).

Borlaug (2018) states that the most common medical intervention for transgender people is hormone therapy. Before this is done, Borlaug (2018) noted that a "physician evaluates the patient's gender dysphasia and judges if the patient can provide informed consent for hormone treatment; such consent would require that the patient understands the risks and benefits of the treatment, is aware of alternatives, and understands the limitations of the treatment. Some changes due to hormone therapy are reversible. In contrast, others are permanent, and anyone

contemplating hormone therapy should be obvious on which is which before beginning treatment" (p.37).

There have been many misconceptions amongst people outside the trans community about the process of transition. As mentioned earlier, not every transition involves medical intervention. Even though some trans individuals want to undergo surgery, they may not have access to it (Tube, Allan & Bell, 2019). Those who decide to transition socially need to affirm their identity through social meanings associated with gender. This involves changing pronouns to suit their choice (Wilson, Chen, Arayasirikul, Wenzel & Raymond, 2015). Some also do this by changing their identity documents like social security cards, health insurance cards and driver's licenses. As Spade (2015) mentions, this is a very complex and time-consuming process.

2.5 Challenges faced by trans individuals

Despite some trans individuals going through surgery and fitting into the gender binary, scholarly works show that trans individuals continue to face many challenges, which includes but are not limited to; getting the necessary documents to match their gender, sex segregation, discrimination, poverty and so on (Spade, 2015; Gijs, & Brewaeys, 2007).

Trans individuals face significant challenges in obtaining several identity documents, especially when changing the gender on official documents to suit their present and preferred gender. According to Spade (2015), this happens "when an agency, institution or organization that keeps data about people and/or produces identity document (e.g. driver's licenses, birth certificates, passports, public benefits cards and immigration documents) has incorrect or outdated information or information that conflicts with that of another agency, institution or organization" (p. 78). These difficulties have prevented many trans individuals from obtaining

identity documents that reflect their chosen gender. The inability to obtain accurate identity documents can have adverse effects on the lives of trans people, especially in terms of obstructing how they access employment, services, travel etc. which can end up exposing them "to harassment, violence, refusal of service, job loss and other problems" (Kismodi, Cabral & Bryne, 2016:16). To prevent these problems, trans individuals frequently feel they are forced to change their identity documents even though getting these new documents tends to be very strenuous and expensive. As GLAAD's (2016) report noted: "changing each form of government-issued I.D. can be onerous and expensive, requiring the filing of numerous applications, payment of filing fees, publishing notices of a name change, court appearances and in some states, background checks. Historically, state and federal governments have imposed intrusive and burdensome requirements such as court orders and proof of transition-related surgery that have made it impossible for many transgender people to obtain accurate and consistent I.D." (p.8). Apart from this, before some agency, institution, or organization accepts these changes, they require evidence that the trans person has undergone some form of surgery or may require a letter from a doctor to ascertain this fact (Spade, 2015). This implies that many trans people who cannot go through this strenuous process and or may not be able to provide the proof needed may not be able to have their identity document changed to reflect their preferred gender (Grant, Mottet, Tanis, Herman, Harrison & Keisling, (2010)

Largely as a result of these difficulties, many trans individuals continue to be misclassified (Spade, 2015). And, misclassification has led to discrimination and violence in a range of different areas, including education, public accommodations and employment. A typical example is how bathrooms are being used and segregated. Public bathrooms are a key site where trans people are harassed and abused (Spade, 2015). This, no doubt, has affected the mental,

physical and emotional health of trans people (Reisner, White, Dunham, Heflin, Begenyi & Cahill, 2015). Despite this harassment, very few states forbid discrimination against transgender people in public accommodations because of their chosen gender (Movement Advancement Project, 2015). Discrimination as a result of misclassification is particularly evident in the lives of trans women who need shelter, as they may prefer to remain on the streets because they believe the "homeless shelter system will place them in men's facilities, guaranteeing sexual harassment and possibly assault" (MAP, 2015:81)

Transgender individuals also continue to face pervasive discrimination at work. In particular, transgender individuals of color report higher job loss rates and employment discrimination than any other group (Reisner, White, Dunham, Heflin, Begenyi & Cahill, 2015). Some of the most common forms of discrimination at work include "unfairly firing or refusing to hire someone because they are transgender; prohibiting a transgender employee from dressing or appearing in accordance with their gender identity; limiting a transgender employee's interactions with customers; denying access to restrooms consistent with the employee's gender identity; using the wrong name or pronouns; outing a transgender employee to others or asking inappropriate questions; requiring a trans [people] to have updated identification documents or certain medical procedures in order to work or be hired as their self-identified gender" (GLAAD, 2015:5). The National Center for Transgender Equality and The Task Force (2011) reported that “90% of transgender people report experiencing harassment, mistreatment or discrimination on the job” (p.2). Statistics suggest that, compared with the general public transgender people are “four times more likely than the general population to experience poverty, twice as high as national unemployment rates” (National Center for Transgender Equality and The Task Force, 2011:2). Unfortunately, the discrimination faced by trans people also includes mistreatment or a

failure to protect by police across many jurisdictions (National Center for Transgender Equality and The Task Force, 2011; Duncan & Hatzenbuehler, 2014).

2.6 Medical interventions

Scholarly works have shown that gender classification systems continue to affect the lives of transgender individuals and the ways they access health care services. Boslaugh (2018) divides the types of gender-affirming interventions sought by transgender and non-binary people into three categories, namely; "medical interventions (primarily hormone therapy), surgical interventions, and other interventions (such as facial hair removal, speech therapy, genital packing or tucking, and chest binding)" (p. 36). However, some transgender people may desire one or any combinations of these interventions while some decide or desire no interventions at all thereby eroding the misconception that trans individuals must undergo some medical interventions during transitioning (Keeling, 2019; Plemons, 2017).

Hormonal therapy is the most common medical intervention within trans communities (Erlick, 2018). In the past, physicians required patients to present letters from a mental health professional before they agreed to perform this medical intervention; however, as the years passed, some physicians have shifted this approach and simply require informed consent (Heijer, Bakker & Gooren, 2017). This consent includes making it known to the patient the risk and benefits of the treatment and its limitations (Zengin, 2014). Examples of hormonal therapy are feminizing hormone therapy and masculinizing hormone therapy. Feminizing hormone therapy helps transgender women to suppress male secondary characteristics and their development of secondary female sex characteristics, including breast development, fat redistributions, usually around the hips and thighs, and muscle loss (Bryant-Davis & Moore-Lobban, 2019). However, prescribing feminizing hormones is complicated mainly because the drugs exist in multiple

forms, not all of which may be available at the pharmacy (Halbach, 2015). On the other hand, masculinizing hormone therapy is used by transgender men to suppress female secondary characteristics and develop male secondary sex characteristics. This includes the development of facial hair, increased muscle and changes in sweat patterns and body odor and growth of the clitoris (Wibowo & Wassersug, 2014).

Some transgender people may have one or more surgeries during their transition, while others may never have surgery (Zengin, 2014). Several surgical interventions are available for persons undergoing gender transition. The top surgery refers to surgeries on the chest that includes removing breast tissue and breast argumentation to make the chest more male looking or more female looking (Hakberstam, 2018). Bottom surgery involves genital or internal reproductive organs; however, it is more complex and expensive than top surgery. Despite this, some transgender people feel this is "exactly what they need to reflect their gender identity" (Hakberstam, 2018:38). Some of the bottom surgery includes orchiectomy (testicles are removed), penectomy, which involves removing the penis, metoidioplasty (increasing the length of the clitoris), hysterectomy (removal of the uterus), vaginoplasty (construction of vagina), clitoroplasty (creation of clitoris). (Malatino, 2020; Zurn, 2021)

2.7 Health access

The International Organization for Migration (2011) defines healthcare "as the prevention, diagnosis, treatment, and management of disease and illness through health professionals wide range of services". According to Gulzar (1999), healthcare can be defined in different ways depending on the stage and societal development. Apart from this, certain features of the system and the user influence healthcare access; this may include pricing, health status, and cultural needs (Gulzar, 1999). Healthcare access can be defined as the "capability to attain

healthcare that includes available healthcare providers, services, transportation, admittance by facility, ability to meet the financial obligation, and insurance benefits" (Norris & Aiken, 2006:56).

Stigma and discrimination experienced by trans individuals influence how they access and utilize health care services (Heijer, Bakker & Gooren, 2017). Available scholarly works show that some trans individuals "have avoided medical care because of negative experiences or fear of such experiences" (Bauer & Hammond, 2015:24). The lack of access to healthcare services directly affects the skyrocketing rates of suicide, HIV and depression within the trans communities, and reflects experiences of continuous stigmatization and discrimination (Haas et al., 2010; Kattari & Hasche, 2015). This has been compounded as many trans people also insist their mental needs are rarely met. (Simeonov, Steele, Anderson, & Ross, 2015). Bryant-Davis & Moore-Lobban (2019) opines that "stigma, transphobia, discrimination, and a lack of knowledge and training about trans healthcare needs make for a poor healthcare experience for trans individuals. The consequences range from sheer avoidance of treatment to depression and suicide" (p.64)

A critical look at the various barriers in accessing healthcare services for trans people shows that these barriers are mainly structural (Erlick,2018). Some of the prevalent and common barriers in healthcare services for the trans population include the lack of "training, exposure to transgender patients, available qualified mental health providers, stigma and discrimination, and insurance reimbursement" (Vance, Halpern-Felsher, & Rosenthal, 2015:12). Certainly, this explains why trans medical care is intentionally excluded from the training of medical personnel a phenomenon mainly attributed to anti-trans stigma and discrimination (Poteat, German, & Kerrigan, 2013).

Snelgrove et al. (2012) examined some of these barriers and found that they can be "grouped into five themes: accessing resources, medical knowledge deficits, ethics of transition-related medical care, diagnosing vs pathologizing trans patients, and health system determinants" (Snelgrove et al., 2012:23). During this study, medical personnel failed to refer trans patients to people who are specialized in the healthcare of trans people (Snelgrove et al., 2012). Additionally, some providers discourage trans people from disclosing their sexuality within the treatment settings, resulting in their being isolated. Overall, the authors mention that “therapeutic neutrality magnifies the challenges of ensuring access to quality care for this population" (p.45). These problems are further compounded in rural areas "because of the lack of education on the mental health issues of trans people" (Willging et al., 2006:23). Some trans individuals, because of the inability to secure the funds needed for their healthcare, have resorted to "non-prescribed hormone uses and self-performed surgeries like orchiectomy or mastectomy" (Sevelius et al., 2014:21). Despite trans individuals relying on medical care, they continue to be exempted from health insurance. In fact, "only about 40% of respondents of the National Transgender Discrimination Survey access the health insurance scheme" (Grant, Mottet, Tanis, Harrison, Herman & Keisling, 2011:56).

These experiences of discrimination against trans individuals at the hands of healthcare providers cannot be overemphasized in the United States of America (One Colorado Education Fund, 2014). For example, “a survey in Colorado shows that trans individuals reported almost twice the number of days they experienced poor physical and mental health compared to the general public” (Reisner, White, Dunham, Heflin, Begenyi & Cahill, 2015:32). Similarly, “in Massachusetts, 19% of transgender individuals had intentionally postponed and avoided necessary care due to mistreatment or discrimination from health care workers” (National Center

for Transgender Equality, 2016). Over and above that, trans people are also denied certain routine preventive services, which are usually easily available to non-transgender people. What makes it more difficult for trans people is that "these services may not correspond with a transgender person's gender identity or the gender marker on I.D. documents or health records. Coverage may be denied through the insurance carrier or overlooked or denied by the patient's health care provider" (Spade, 2015:29). Despite this ill-treatment, some federal and state laws do not expressly prohibit such discrimination” (Reisner, White, Dunham, Heflin, Begenyi & Cahill, 2015:13).

CHAPTER THREE
TRANS ACCESS TO MEDICAL SERVICES

3.1 Introduction

This chapter delves deeper into the lives of trans people while focusing on the barriers and challenges they face while accessing health care services. This chapter starts by comparing the trans population with the general population and justifies why special attention must be given to the unique health needs of trans people; it goes further to make some intersectional analysis of trans studies focusing on factors that hinder healthcare. This chapter ends with a summary of the main barriers that trans people face at the individual, interpersonal, organizational and societal levels.

3.2 Trans individuals' vs General population

Even though trans individuals may share specific health needs similar to the general population, certain trans people may require specialized health care services (Brown, Rice, Rickwood & Parker, 2016). Some trans individuals may have to go through specific medical care that is tailored to their gender identity including "hormonal therapy, genital construction, breast or chest surgery, hysterectomy or facial reconstructions, reproductive care, gynecologic and urologic care and mental health services some of which are rarely required by the general population" (Coleman et al. 2012:33)

As mentioned earlier, since there is much variation in the health needs of trans people compared to the general population, they require specified programs and services geared towards meeting their specific and unique health needs. A typical example is seen in the disparities that exist in the rate of HIV infections among the trans population compared to the general population. For example, according to the U.S. National Transgender Discrimination Survey

(NTDS) report, “transgender individuals in the United States of America experience over four times the national average of HIV infection and are over 25 times more likely to have attempted suicide as a result of discrimination" (NTSD, 2015). Additionally, globally, trans people have a higher likelihood of experiencing poverty and being without homes than the rest of the population. What this means is that the needs of trans people are special. As such, specialized and unique care must be given to them instead of the ill-treatment they go through to access informed and necessary health care services (Bauer & Scheim, 2016).

These differences in the experiences of trans people have contributed significantly to their negative and poorer health outcomes (Vermeir, Jackson & Marshall, 2017; Logie, James, Tharao & Loutfy, 2012; Kattari & Hasche, 2016). Studies show that in the United States of America, transgender individuals suffer twice the unemployment rate compared to the general population (Roberts & Fantz, 2014) and “almost seven times the rate of homelessness compared to the entire population” (Yu, 2010). This is not peculiar to only the United States of America, as Canada also experiences a similar trend. "A study conducted in Ontario in 2013 reported that about 29% of transgender individuals who needed emergency services were denied access to these services because of their gender identity” (Bauer, Scheim, Deutsch, Massarella, 2014:67).

3.3 Trans identity and intersectionality

Sometimes understanding the plight of trans people in isolation is not enough, especially in regard to accessing health care services. The concept of intersectionality is of paramount interest when we examine the factors that are likely to influence trans individuals access to healthcare services. Intersectionality refers to "how different social identities are interconnected and how they overlap to produce interdependent and reciprocal systems of inequity and discrimination” (Stroumsa, 2014:78). Based on this definition, one will notice that the

discrimination trans people go through may be heightened due to their "race, age, sexual orientation and socioeconomic status" (Grant et al., 2010:23). This is evident in the studies conducted by NTDS, which showed that indigenous transgender individuals are more likely to encounter discrimination in healthcare settings as compared to their white counterparts; it also showed that Native American transgender individuals experience higher rates of HIV infection than the general US population (Grant, et al., 2010). Apart from this, "sex work, illicit drug use, homelessness and incarceration disproportionately affect transgender individuals more than the general population, putting them at a greater risk of poor health outcomes and further stigmatization" ((Bauer, Scheim, Deutsch, Massarella, 2014:17).

Further, though most transgender people are faced with significant barriers in healthcare settings, the challenges are more complex and troubling for those who also fall within one or more other marginalized groups. Studies have reported a lot of barriers to accessing health care for different populations; this includes transgender men (Johnson, Nemeth, Mueller, Eliason & Stuart, 2016; Dutton, Koenig & Fennie, 2008) transgender women (Sanchez, Sanchez & Danoff, 2009), HIV positive transgender women (Sevelius, Patouhas, Keatley & Johnson, 2014), African American HIV-positive transgender women (Wilson, Arayasirikul & Johnson, 2013), transgender youth (Brown, Rice, Rickwood & Parker, 2016; Corliss, Beler, Forbes & Wilson, 2008), transgender seniors (Kattari & Hasche, 2016), immigrant Latino transgender individuals (Tanner et al., 2014), ex-convicts who are transgender individuals, those engaged in sex work and those into the use of illicit drugs (Stroumsa, 2014). Overall, the more axis of marginalization a trans individual faces, the more likely they are to experience discrimination in trying to access health care services.

3.4 Transgender identity and barriers to health services

To further understand the barriers trans individuals face, it is pivotal that we look at this at different levels. First, transgender people face barriers at the individual level, which is likely to affect how they access health care and the need to do so. On the individual level, studies have shown that many transgender individuals have lost trust in health care providers, services and institutions (Stroumsa, 2014; Vermeir, Jackson & Marshall, 2017; Logie, James, Tharao & Loutfy, 2012; Kattari & Hasche, 2016; Sevelius, Patouhas, Keatley & Johnson, 2014) because of previous negative experiences with providers and their experiences within the health care environments (Dutton, Koenig & Fennie, 2008; Bauer, Scheim, Deutsch & Massarella, 2014). These past experiences have resulted in trans people limiting the number of times they seek medical attention because of fear of being stigmatized (Bauer, Scheim, Deutsch & Massarella, 2014). Other transgender people, despite their past experiences, still want to access health care services but lack the knowledge of where they can find trans-competent care (Corliss, Belzer, Forbes & Wilson, 2008). Some know where to find the kind of care they desire but cannot afford the cost of the health care. This is particularly worrying for transgender individuals who face high rates of unemployment (de Haan, Santos & Arayasirikul, 2015). This accumulation of problems, no doubt, affects transgender people's mental health and can prevent them from accessing health care services. For example, "NTDS reported that the lifetime suicide rate for transgender individuals stood at 41% compared to 1.6% for the general population; the same applies to substance use, which is likely to interfere with transgender individuals' ability to seek medical care" (Stroumsa, 2014:14).

Another site where trans people meet barriers is at the interpersonal level. This may be due to problems in the patient-provider relationship, as providers lack of competency is one of

the reasons that transgender individuals desist from seeking medical attention. Once trans people are made to feel that providers do not have the requisite knowledge to test, diagnose and treat them, they are likely to avoid seeking medical care from these providers (McCann & Sharek, 2016; Roberts & Fantz, 2014; Corliss, Beler, Forbes & Wilson, 2008). Studies have shown that this is not limited to trans-related health services, as one U.S. study shows "that lack of transgender-specific knowledge did not vary with the type of provider, indicating that this barrier was persistent across health care environment" (Sanchez, Sanchez & Danoff, 2008:47) In rare cases where providers were available it is documented that only a few of such providers can provide trans-competent care, and this shortage has hindered many trans people from accessing healthcare services (Stroumsa, 2014). These problems are particularly troubling when trans people go in for hormonal therapy or surgery (Stroumsa, 2014; Sevelius, Patouhas, Keatley & Johnson, 2014) HIV infection (Roberts & Fantz, 2014), substance abuse (McCann & Sharek, 2016) and mental health (de Haan, Santos & Arayasirikul, 2015). In cases where providers exist and provide services, some scholarly works have shown that health care providers exhibit transphobic behaviors such as harassing and assaulting trans individuals seeking services, with some going so far as to refuse trans people the services they require (Stroumsa, 2014; Vermeir, Jackson & Marshall, 2017; Logie, James, Tharao & Loutfy, 2012; Kattari & Hasche, 2016; Sevelius, Patouhas, Keatley & Johnson, 2014). A typical example is recounted by a transgender woman who reported to her provider, but instead of addressing her concerns, they concluded she was a sex worker, and referred her to substance abuse programs (Wilson, Arayasirikul & Johnson, 2013). In some other instances, trans people have reported being intentionally called by the wrong pronoun or name and an experience that can cause trans individuals to discontinue

care ((Stroumsa, 2014; Logie, James, Tharao & Loutfy, 2012; Kattari & Hasche, 2016; Sevelius, Patouhas, Keatley & Johnson, 2014).

Transgender individuals also face blocks when trying to access healthcare services at the organizational level. First, the physical location of health services is a considerable barrier to trans individuals; studies have described transgender-specific facilities are rare and are often usually unsafe and lack privacy (Vermeir, Jackson & Marshall, 2017; Corliss Belzer, Forbes & Wilson, 2008). Apart from the physical location for health care services, some institutions also restricted public restrooms by gender, and this lack of "any gender-neutral restrooms made the environment very unsafe for transgender individuals" (Stroumsa, 2014:21). Other locations also lacked waiting rooms and emergency departments, resulting in trans patients having to discuss their health issues in front of other patients and consequently being harassed (Brown, Rice, Rickwood & Parker, 2016; Stroumsa, 2014). In places where all these facilities exist, studies have also found that medical paperwork can pose a significant problem, as this paperwork usually does not include transgender identities, and trans-friendly posters and pamphlets are absent (Dutton, Koenig & Fennie, 2008; Corliss, Belzer, Forbes & Wilson, 2008). The problem of having to fill in gender binary forms in medical centers poses issues for transgender individuals since "health care I.T. solutions, electronic health records (EHRs), billing and coding systems and laboratory information systems often rely on binary male/female identification of patients, thereby either misclassifying trans people or preventing them from accessing these services" (Roberts & Fantz, 2014:5). All together these institutional barriers result in some trans people refusing to seek medical attention as a result of healthcare settings that were not sensitive to their gender identity (Sevelius, Patouhas, Keatley & Johnson, 2014; Wilson, Arayasirikul & Johnson, 2013).

The interpersonal, institutional, and organizational barriers to health care access are normalized and enabled by a widespread societal hostility or indifference to trans health. While trans people have over time advocated on their own behalf to draw attention to the lack of policies to help them meet their health related needs, this advocacy is often met with indifference or refusal (Logie, James, Tharao & Loutfy, 2012). This "lack of transgender-specific information in education, healthcare and other institutions no doubt reinforce inaccessibility. For instance, trans-specific training is absent in many medical, nursing, and paramedical school curricula" (Loutfy, 2012:8). In some cases, before surgeries can be performed, trans people are required to meet some basic requirements for the surgeries, and in most cases, the processes are not just complicated but deeply emotional (Cohen & Alderson, 2014). This overall context explains why trans activists think programs such as Medicaid are crucial for meeting the specific needs of trans people.

CHAPTER FOUR
HEALTH INSURANCE COVERAGE

4.1 Introduction

This chapter explores health insurance coverage in the U.S.; and looks explicitly at private and public insurance coverage. It also provides an overview of the Medicaid program, its origin, goals, eligibility, services, and policies in the U.S.

4.2 Health insurance coverage in the USA

In the United States of America, health insurance coverage is an avenue where people's health care expenses are financed by either private companies or the government (Kliff & Katz, 2021). Health insurance coverage is aimed at paying for the medical expenses of clients. Hence, insurance coverage protects against the costs of medical services; this may include social insurance and welfare programs. This health care insurance coverage “pools resources and spreads the financial risk associated with significant medical expenses across the entire population to protect everyone” (Kliff & Katz, 2021:24). Usually, health coverage is said to be comprehensive "when it can meet and cover all essential health care needs, this excludes single service plans such as accident, disability, dental or even prescription medicine plans; it explains why the Indian Health Service (IHS) is often not considered to be comprehensive. The IHS delivers care to American Indians and Alaska Natives; it protects the eligible from paying the full costs of medical services when injured or sick” (Saad, 2019:18). The federal and state systems in the U.S. help monitor health insurance activities, irrespective of how it is owned or managed. Despite the availability of health insurance in the U.S., a segment of the population does not have any insurance package, and in 2019, this number stood at 9.2% of the population (Keisler-Starkey & Bunch, 2020).

4.3 Private health insurance coverage

Comprehensive private health care coverage can take three forms; when an employee is issued coverage through an employer or union, the plan is bought directly from the insurance company or a marketplace and coverage through TRICARE (Buchmueller & Monheit, 2009). While individuals can purchase private health insurance, some can be bought on a group basis. The number of health insurance companies keep increasing; for example, as of 2018, "there were 953 health insurance companies in the United States; despite this vast amount of insurers, the top 10 accounts for about 53%, while the top 100 accounts for almost 95% of revenue" (Keisler-Starkey & Bunch, 2020:46).

Employment-based insurance is the most commonly used insurance in the United States of America (Lane, 2019; Kolata, 2021; Kofman, Libster & Bangit, 2018). Employers pay for employer-sponsored health insurance for their employees as an incentive (Jacobs, 2008). In this type of insurance, the onus falls on the employers to make a substantial contribution of about "85% of the employee's insurance and about 75% of the premium for their employee's dependents, while the employees bear the remaining fraction of the premium" (Fronstin, 2017:33). Consequently, workers who benefit from this employer-sponsored health insurance receive a lesser amount of wages than the amount they would have received if they were not benefitting from the employer-based insurance. Some employees who seek to extend their health insurance benefits can seek more than one insurance; for example, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) helps extend the coverage of those who already have employer-based insurance coverage (Thomasson, 2003). There is also college-sponsored health insurance for students; in these schools, students must be enrolled in the health coverage provided by the school or be ready to provide an alternative health insurance coverage that can

be compared to the one provided by the school (Lee, 2013). Apart from this, an individual can also decide to buy coverage directly from the insurance company. However, sometimes this is met with barriers; for instance, before 2014, someone with an underlying health condition could not purchase health insurance, but this seems to be gradually phasing out (Kliff & Katz, 2021). Those who are self-employed are entitled to some tax deduction regarding their health insurance to enable them to decide where and when to buy their coverage (Buchmueller & Monheit, 2009).

4.4 Public health insurance coverage

Public health insurance coverage programs are usually targeted at certain people. This may include; seniors, low-income children and families who meet specific eligibility criteria; examples of such programs are Medicare, Medicaid and the CHIP (Keisler-Starkeu & Bunch, 2020). Medicare provides insurance to "those over 65 who become totally or permanently disabled and includes the end stage of renal diseases and Amyotrophic lateral sclerosis" (Lane, 2019:29). Medicare came with some lapses, so under the Balanced Budget Act of 1997, the Medicare Advantage was initiated to help manage spending, increase, and come up with alternatives for beneficiaries (Fronstin, 2017; Thomasson, 2003). The other public health insurance, Medicaid, is the case study of this paper.

4.5 Medicaid

In 1965 former President Lyndon Johnson signed the Social Security Amendments Act creating dual programs, Medicare & Medicare (Blase, 2019). However, even though the Medicaid program allows states to design their programs, they are subjected to federal minimum standards (Courtemanche, Marton & Yelowitz, 2019). The federal government must approve the criteria state's put in place for people to benefit from the program. When the program was

initiated, eligibility was limited to people who were eligible for welfare, but this changed over time as more people started applying for it because of its benefits. (Keith-Jennings & Chaudry, 2018). The Center on Budget & Policy & Priorities (2020) acknowledges that "Medicaid provides more comprehensive benefits at a low cost than other private insurance coverage in the United States of America".

The Social Security Amendment of 1967 repealed the 1965 Social Security Amendments Act, which made room for people below 22 years of age in psychiatric hospitals to be taken care of with any expenses (The Center on Budget & Policy & Priorities, 2019). When the supplementary Security Income (SSI) was created in 1972, it helped fund income assistance programs for people with disabilities and low-income earners irrespective of their sexualities (Sommers & Rosenbaum, 2011). To help monitor the program's progress the fraud control unit was established in 1977 (The Center on Budget & Policy & Priorities, 2019). The fraud control unit was "certified by the Secretary of the U.S. Department of Health and Human Services; its role was to help investigate and prosecute health care providers who defrauded the Medicaid program and to look at reports of abuse and/or neglect of residents in health care facilities, board and care facilities and Medicaid beneficiaries in non-institutional or other settings" (Keith-Jennings & Chaudry, 2018:41).

Over time there have been many changes in the Medicaid program; for instance, they are now allowed to apply Section 1115 waiver authority which extends services to low income and uninsured individuals and their families. Based on the initial eligibility criteria, these people may not have qualified under the program (Yelowitz, 2018). In 2010, the Medicaid program was expanded to include non-elderly adults with low incomes (The Center on Budget & Policy & Priorities, 2019). For one to qualify individuals must meet the income standards for Medicaid;

however, this criterion still left most people unqualified for this program, including trans individuals (Blase, 2019). The ACA allowed "individuals without dependent children to be covered, but this required that all states modernize and streamline their Medicaid eligibility and enrolment processes" (Blase, 2019:5).

As mentioned earlier, Medicaid also covered the non-elderly and the non-disabled (The Center on Budget & Policy & Priorities, 2019). The key eligibility is income level; however, the income definition is usually based on welfare programs. This was used by "Aid to Families with Dependent Children (AFDC) and known as Temporary Assistance for Needy Families ((TANF)" (The Center on Budget & Policy & Priorities, 2020). The gross income of beneficiaries was expected to be smaller than the states' needs standards; a segment of the income must also be below the state's payment standard. (Keith-Jennings & Chaudry, 2018; Blase, 2019). So, this program was geared towards the very needy and people who could not afford health care services because their income was low.

Although Medicaid created room for the elderly and the disabled, they were required to meet one of four criteria (Wagner, 2016). First, they could qualify through the Supplementary Security Income (SSI) program. Through this program, the income of the elderly is measured below a certain threshold with accountable assets (The Center on Budget & Policy & Priorities, 2019). Secondly, the elderly can also qualify through the medically needy program; this criterion is "designed for people whose gross resources are above welfare levels, but due to high medical expenditures and bills, their net resources are below some certain minimal level" (Sommers & Rosenbaum, 2011:66). The 300% rule is the next path; under this stream, the state absorbs the medical expenses of those whose assets and/or income are below 30% of the supplementary security income (The Center on Budget & Policy & Priorities, 2020). The last route is for people

to be eligible through the home and community-based services due to the rapidly growing number of state waivers in their state. However, for individuals with disabilities, an additional element was added to include those "who work their way off the SSI rolls; this coverage is available for a limited period and up to a limited income level" (Blase, 2019:22).

Hence, the Medicaid program targets seniors, children or persons with disabilities, and people from low socioeconomic families. Although the federal government partly funds the Medicaid program, the states handle implementing their program, within federal guidelines. This gives states the room to operate specifically for the needs of its members and explains why the Medicaid eligibility and benefits differ from state to state ((Blase, 2019; Courtemanche, Marton & Yelowitz, 2019; Keith-Jennings & Chaudry, 2018; Keith-Jennings & Chaudry, 2018; The Center on Budget & Policy & Priorities, 2019)

Under normal circumstances, individuals who are categorically needy in terms of their income level should be entitled to the services rendered by Medicaid. These services, among many others, include "inpatient hospital services, outpatient hospitals services, rural health and federal services, federal health center services, laboratory and X-ray services, nursing facility services for individuals, family planning services, physician services, home health services, services of certified nurse practitioners and certified family nurse practitioners" (The Center on Budget & Policy & Priorities, 2020:5). Certain alternative services can also be rendered; this may include clinical, optometrists, eyeglasses, dental, and transportation services (Keith-Jennings & Chaudry, 2018). Hence, it can be argued that Medicaid funds a wide range of services for the population; this includes coverage for any services mandated by law. Unlike commercial health insurance that may frown at services at nursing home care, Medicare covers any cost that individuals may incur due to their stay in nursing homes.

It is prohibited for states to charge premiums for people with an income level below 150% of the Federal Poverty Level (FPL). It will be in the right direction to conclude that "it is illegal for Medicaid to deny coverage to medically necessary transition-related care or people because of their sexual orientation or gender identity" (Spade, 2015:11). Medicaid also covers mental health needs, and since it can be said that the mental and physical needs of transgender individuals are unique, Medicaid would have been the best answer for trans people (Blase, 2019). Trans individuals have unique medical needs mainly due to the discrimination and marginalization they face which hinders them from accessing the healthcare they deserve and need (Obedin-Maliver et al., 2011; Vance, Halpern-Felsher, & Rosenthal, 2015). When transgender individuals undergo medical interventions, they may encounter health needs that are related to their gender transition, which may force them to depend on the medical system for essential services. In this context, Medicaid would have been the best answer to their medical needs (The Center on Budget & Policy & Priorities, 2019).

Under the initial Medicaid program, it was the duty of the states to use their discretion to plan how to reimburse physicians. So, far as rates were reasonable and adequate, physicians were reimbursed under the Boren Amendment of 1980 (The Center on Budget & Policy & Priorities, 2020). Most states moved from the retrospective system to a new system where individuals can decide to pay a fixed amount daily or pay the total amount when admitted to the hospitals for a particular diagnosis. Some states also were of the habit of negotiating with hospitals; however, the state's mode of reimbursing physicians and hospitals was a success; reports have it that as of 1990, the American Hospital Association estimated that the Medicaid program was able to reimburse hospitals roughly 80% of their cost (Keith-Jennings & Chaudry, 2018).

The Medicaid program had deferral options, which allowed states to use several methods outside the one prescribed by the federal guidelines of Medicaid. States were allowed to limit the choice of the providers as outlined by enrollees and innovate with alternatives to institutional-based care, which was different from the traditional procedure (Keith-Jennings & Chaudry, 2018). Nevertheless, the cost of managing the Medicaid program keeps increasing, for instance, "between 1993 and 2001, enrollment in Medicaid managed care increased by 450% and by 2001, 58% of Medicaid beneficiaries were enrolled in some form of managed care". (The Center on Budget & Policy & Priorities, 2020:6). So, Medicaid has two main ways of managing the program: i) where Medicaid assumes the entire financial risk for the services and ii) where Medicaid pays the individual health provider a monthly amount. (Blase, 2019).

4.6 Public health insurance vs Private health insurance

More Americans possess private health insurance than public insurance coverage (Census Bureau, 2021). For instance, in 2019, 68% and 34.1% of the entire population had private and public coverage at some point, respectively (Keisler-Starkey & Bunch, 2020). However, employment-based insurance stood the highest within private health insurance, covering about 56.4%, followed by Medicaid covering 19.8% of the population (Keisler-Starkey & Bunch, 2020). This high rate in employment base insurance may be attributed to a decrease in the direct purchase of private insurance as more people were now inclined to take the opportunity of benefitting from coverage where their employers bore most of the cost of their health insurance as compared to bearing it themselves (Saad, 2019; Fronstin, 2017). Social and economic factors have their way of determining who gets insured and the kind of insurance they opt for.

Age influences determining who gets insured in America (Freeman, Kadiyala, Bell & Martin, 2008). Older adults ages 65 and more and children under the ages of 19 have more

opportunities to have health insurance than those between the ages of 19-65 years (Saad, 2019). This is mainly because those above 65 and below 19 are easily qualified for specific public health insurance programs like Medicaid and Medicare (Kliff & Katz, 2021). This explains why very few people within these age brackets are uninsured. A study done in 2019 shows that only 1.1% of the population is uninsured above 65 years, while 5.2% of the uninsured population was children under 19 years (Keisler-Starkey & Bunch, 2020). Uninsured children were living within the poverty level (Kolata, 2021).

The race of an individual also determines the health insurance coverage status of people in America. It is a known fact that health insurance coverage differs across races (Census Bureau, 2021). Blacks and Hispanics have the highest number of insured individuals among race and ethnic groups (Keisler-Starkey & Bunch, 2020). This can be attributed to the systemic racism they continue to face in America (Spade, 2015). These races face stiff barriers in places of work and housing; this problem is further compounded for Blacks and Hispanics who are illegal residents in the U.S. (Spade, 2015). Apart from their inability to secure a good job, they are also exempted from employment-based insurance, a common type of insurance in the U.S. (Saad, 2019). Those willing and able to purchase private insurance meet stiff opposition as they do not have the correct documentation to do so (Health Insurance Association of America, 1997). Public insurance is a no go area as they are limited to only citizens or permanent residence, making it difficult for others to secure these coverages.

The resources and income of a family also determined the kind of insurance one is likely to get and if they will even look at getting insurance in the first place. This is determined by the income-to-poverty level ratio, which compares a family's income with the applicable threshold. Hence, those whose family or individual income levels are lower than the poverty threshold are

classified as poverty (Alonso-Zaldivar, 2010). In 2019, data showed that the uninsured rate was highest among people in poverty, as about 15.9% of the uninsured were people living in poverty (Keisler-Starkey & Bunch, 2020). This is likely to be affected by the kind of jobs they do and the duration of the work. Full-time workers are less likely to be uninsured than casual or part-time workers. This explains why most poor people had no option but to seek public coverage compared to those with private health insurance coverage in the United States of America (Kolata, 2021; Lane, 2019).

4.7 Consequences for Medicaid

It is clear that most Americans are covered by private health insurance rather than public health insurance, mainly because their employers provide them with this insurance and bear most of the cost (Kliff & Katz, 2021). In 2019, when the ACA provided the options for states to expand Medicaid and to include people who fell below a particular threshold, only about 32 states embraced this option, while 18 refused to implement this expansion (Kliff & Katz, 2021). Consequently, the results were overwhelming and instant with the number of uninsured people in states that embraced this expansion decreasing to 9.8% compared to 18.4% in states that did not (Keisler-Starkey & Bunch, 2020). This means that formerly, people did not have insurance because they did not qualify under public insurance. A slight expansion in the eligibility criteria can go a long way to increase access to health care services especially for low income people.

Hence, trans people in states that have not embraced the expansion are hindered from accessing health care services, and this situation is further aggravating for trans individuals of color and those in poverty as they cannot access this necessary medical care they may desire ((Markwick, 2016; Lim, Johnson & Eliason, 2015). However, it is not all rosy for those in states where this expansion has started, as trans related services are still being refused and categorized

as unnecessary, which these same services are offered to people seeking them for reasons that are unrelated to trans health. Trans people who also possess private insurance also find it difficult to access certain medical services as they are frequently seen as medically unnecessary (McCord, 2019).

CHAPTER FIVE

DISCUSSION AND ANALYSIS5.

5.1 Introduction

This chapter focuses on addressing the specific objectives of this paper highlighting the systemic barriers within the Medicaid program that can prevent trans individuals from accessing health care services and explains how these challenges are likely to affect people differently based on gender, race and class. I conclude by analyzing how Medicaid, despite its successes, has prevented the trans individual from accessing specific necessary and appropriate health services.

5.2 Medical interventions and trans people

Scholarly works have shown over time that people living in poverty struggle to access healthcare services (Gardner, 2013; Collier, 2015). This becomes more worrying for trans individuals because the law dictates who can have access to particular services and surgeries using a cis-normative framework that discounts trans needs (Spade, 2010). Over time, people have developed a misconception that all transgender individuals go through some form of medical intervention. Spade (2010) reiterates this misconception; "the most common misunderstanding is the belief that all transgender people undergo genital surgery as a primary medical treatment for changing gender" (p.497). It is imperative to mention that the decision to seek or refuse gender-confirming healthcare is based on the choice of the individual; hence the kind of treatments and the surgery that an individual may choose is dependent on the individual and their pre-existing conditions (Markwick, 2016; Lim, Johnson & Eliason, 2015). However, those who want to undergo medical interventions but cannot secure access to these may be

negatively affected, leading to real distress because of the mismatch between their biological sex and gender identity; some scholars refer to this as gender dysphoria.

Gender dysphoria is a severe medical condition that needs attention (Coleman, Bockting & Botzer, 2012). It refers to “the distress that may accompany the incongruence between experienced or expressed gender and ones assigned gender” (Baker, 2017:29). However, not all transgender people experience uneasiness because of this mismatch. Still, some are distressed because their desires for physical interventions are not met through hormones and/or surgery (Meyer, Bockting, Cohen et al., 2001). The effect of gender dysphoria when left untreated can be severe; reports have it that some trans individuals face psychological distress and have developed substance abuse disorders and consider suicide due to their inability to address the mismatch between their experienced and assigned gender (McCord, 2019). What makes it more alarming is that when trans individuals fail to get medical support to address this conflict, they face a "high level of stigmatization, discrimination and victimization which often leads to a negative self-concept, increased rates of mental disorders, comorbidity, school dropout, economic marginalization, increase in unemployment and suicidal attempts" (Flores, Brown & Herman, 2016:23).

Gender dysphoria received a great deal of attention in the latter part of the 20th century when medical professionals started to provide services to trans people. by attending to patients ready to undergo surgeries or hormonal treatment to suit their preferred gender (Frey, Poudrier & Chiodo, 2017; Ettner & Ettner, 2016). Benjamin (1966) acknowledged the scope of gender nonconformity; early on, clinical methods dwelled on the criteria that must be met before qualifying for medical interventions that can change or alter how they look physically (Green & Fleming, 1990; Hastings, 1974). In trying to treat gender dysphoria, various therapeutic options

exist. There is no limit to the number of medical interventions a trans individual can undergo, and these interventions do not have a particular order in which they can take place; thus, it solely depends on the individual and the degree of access they can obtain through relevant medical systems (Bockting, Knudson, & Goldberg, 2006; Rachlin, Hansbury, & Pardo, 2010). When trans people decide to seek treatment, there are a variety of options which may include the following: "changes in gender expression and role, hormonal therapy to feminize or masculinize the body; surgery to change the primary and/or secondary sex characteristics like the breasts/chest, external and/or internal genitalia, facial features, body contouring and psychotherapy all to explores gender identity, role, expression and addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience" (James, Herman & Rankin, 2015:12). Recently, certain health professionals are beginning to identify that not all trans individuals want to undergo hormonal therapy or surgery because of gender dysphoria (Bockting & Goldberg, 2006). Hence, it is evident that not all trans people require medical interventions (Bockting, 2008; Lev, 2004).

5.3 Transgender individuals with no medical intervention are not 'weird'

It is beginning to emerge "that not everyone who is transgender prioritizes or desires procedures such as hormone therapy and gender-affirming surgeries required for a complete medical transition" (Spade, 2010:55). Thus, it must be mentioned that while some trans individuals choose medical interventions, some genuinely refuse medical interventions not because they cannot afford it but because they have resolved not to undergo this intervention (Sherman, Anderson & Dal Pan, 2016). Therefore, some have decided not to undergo any medical procedures even though they do not associate with the gender ascribed to them at birth.

For example, according to the 2011 National Transgender survey, "61% of trans and gender-nonconforming respondents reported having medically transitioned, and 33% said they had surgically transitioned about 14% trans women and 72% of trans men said they do not ever want full genital construction surgery" (NTS, 2011:2). While some individuals are gender dysphoric, others experience gender euphoria from expressing a gender different from that assigned at birth (Martinez & Sawyer, 2017; Padula, Heru & Campbell, 2016).

In some cases, certain trans people with gender dysphoria cannot access medical treatments because of the high cost involved for surgeries, and some insurance companies fail to cover these treatments, as was discussed in the previous chapter (Garcia, Christopher, Thomas & Philip, 2017). Hence, some may dress as the gender they prefer instead of going through medical treatments they cannot afford (Saleem & Rizvi, 2017). There are various ways to cope with gender dysphoria. Some may decide to participate in online social networks to help them cope with discrimination and isolation (Houssayni & Nilsen, 2018; Saleem & Rizvi, 2017; Garcia, Christopher, Thomas & Philip, 2017). Others "choose to express their felt gender in private only because they are either uncomfortable or fearful of publicly expressing their felt gender" (Dowshen, Christopher & Gruschow, 2019:11).

As discussed earlier, some trans individuals are unable to go through the medical transition because of cost while others can but prefer not to; whatever the case, maybe we should always understand that how people decide to transition is a private affair and should be respected (Saleem & Rizvi, 2017). Some trans individuals who choose not to go through medical transitioning may or may not decide to go through some of these non-medical options such as living as the gender they prefer by changing their clothing, name, speech, hairstyle, but this depends solely on what feels most comfortable for them in expressing their gender identity.

Some also choose options such as “packing by using a penile prosthesis; this gives masculine genital contour; others also go through tucking when placing the testes into the inguinal canal to provide a feminine genital contour. Some go through binding using a tight chest garment to flatten their breasts to have a masculine chest contour and some transgender individuals increase their breasts, hips or buttocks, insert clothing or bra to augment breast, hip, or buttock size” (Coleman, Bockting & Botzer, 2012:17). Other trans people feel they do not require medical intervention to express how they feel (Schechfer, D’Arpa & Cohen, 2012).

5.4 Medicaid square peg in a round hole for transgender individuals

As already mentioned, transgender people “includes individuals whose gender identity, gender expression, or gender behavior does not typically conform to the sex they were assigned at birth" (Cruz, 2014). Deciding to live as a different gender comes with its challenges including being marginalized and discriminated against and the refusal of services including health services (Collier, 2015). Discrimination in the health sector against trans people does hinder them from accessing healthcare services (Cruz, 2014). Statistically, "about 28% of transgender persons report postponing medical care due to discrimination in the healthcare settings, while 19% reported that doctors have refused to provide them care because of their transgender status. Another 28% report facing harassment in the medical setting, 2% report facing violence in a doctor's office and 50% per cent reported that they had to teach their doctor about transgender healthcare" (Winter, Diamond, Green et al., 2016:24). Sometimes, even when transgender individuals can receive care, the insurers continue to routinely deny them treatment related to medical transitions (Downing & Przedworski, 2018).

Medicaid is a program initiated by the federal government but managed by the state to enable people with low-incomes to access healthcare services without any hindrance (Lee, 2000).

Hence, even though the federal government provides funding for Medicaid, the onus falls on the state government to decide what the Medicaid program may or may not cover and how it is run (Garcia, Christopher, Thomas & Philip, 2017). To start with, most healthcare that seeks to affirm the gender of trans individuals is expensive; hence trans individuals who are poor are often unable to bear the financial cost that comes with it. This further worsens as some state Medicaid programs intentionally exclude any healthcare affirming gender (Cruz, 2014). States that do not expressly cover gender-affirming treatments either "expressly deny Medicaid coverage of gender-affirming healthcare or deny coverage because it is not medically necessary" (Giblon & Bauer, 2017:18). Other states like New York that do cover gender-affirming treatments restrict accessibility on the grounds of age (Nolan & Kuhner, 2019). Based on these hindrances, trans individuals who cannot afford the high costs of gender-affirming healthcare often rely on private insurance or Medicaid to come to their aid. However, the cost of this healthcare can be overwhelming; for example, in 2001, "a study found out that the average price for male-to-female gender-affirming surgery and hormones was close to $20,000, while the average cost of female-to-male gender-affirming surgery and hormones was $16,512 over three years. Recent reports suggest that the cumulative costs could be between $ 40,000 and $100,000" (Quinn, Nash, Hunkeler et al., 2017:67).

Consequently, if trans individuals are left to bear the high cost alone, individuals with low incomes are likely to be unable to seek and get the gender-affirming healthcare they desire (Dahl, Feldman, Goldbury & Jaberi, 2015; Giblon & Bauer, 2017). In addition, a disproportionate number of trans individuals face employment discrimination and wage discrimination (Winter, Diamond, Green et al., 2016). This is evident in a 2011 study that reported that "fifteen per cent of respondents reported making $10,000 or less per year, a

percentage nearly four times that of the general population" (Hofer, Abraham & Moscovice, 2011:34). Comparing the amount earned by transgender individuals with the amount needed for trans surgery, one may wonder how many years it would take trans individuals to save for such medical interventions. Similarly, transgender youths are often unable to foot the cost of this treatment as most of them depend on their parents or guardians to access the healthcare treatments (Hofer, Abraham & Moscovice, 2011).

To better understand how coverage of the Medicaid plan is organized, Abu-Ghname, Grome, Raj et al. (2021) categorize the states into three groups. The first group comprises states that have openly excluded any gender-affirming healthcare from the Medicaid program. This makes up the minority. Even in these states, their language varies in breadth. For instance, while some "limit the exclusion to gender-affirming surgical procedures, others use broader language that excludes all forms of gender-affirming healthcare" (Abu-Ghname, Grome, Raj et al., 2021:23). The second category belongs to the majority; states that belong to this group "do not have regulations that expressly deny coverage for gender-affirming healthcare or gender-affirmation surgery; they have a practice of not extending coverage because the treatments are not medically necessary" (Abu-Ghname, Grome, Raj et al., 2021:23). These states have been dragged to federal courts several times because they failed to extend coverage to include gender-affirming treatments. However, these states came out victorious since under 'states rights' they have the prerogative to decide what should be medically necessary or not (Dahl, Feldman, Goldbury & Jaberi, 2015). The third group includes "a growing minority of states adopting regulations that expressly extend Medicaid coverage for gender-affirming healthcare. Among these states is New York, which repealed its blanket exclusion of gender-affirming healthcare in

2014" (Abu-Ghname, Grome, Raj et al., 2021:24). Hence, the prerequisite for accessing healthcare services through Medicaid requirement differs widely from state to state.

I must also mention that because some trans advocates have been pushing for changes in the policies of Medicaid, some states have recently begun to embrace all trans individuals and allow medical interventions under the Medicaid program. For example, before 2014, the state of New York did not include any gender-affirming healthcare under Medicaid for trans people. Additionally, "when section 505.2 was promulgated in 1998, it denied coverage for all care, services, drugs, or supplies rendered for gender reassignment or intended to promote such treatments" (Cruz, 2014:2). However, the story changed in December 2014. The State Department of Health in New York sent a proposal asking for the discriminatory regulation to be amended to include trans people who needed medical attention (Houssayni & Nilsen, 2018; Saleem & Rizvi, 2017; Garcia, Christopher, Thomas & Philip, 2017). This proposal and amendment resulted from several years of advocacy by transgender people who believed that the rights of trans individuals were violated since they could not access necessary healthcare services as everyone does (Winter, Diamond, Green, et al., 2016). Based on this, Section 505.2 was amended "to authorize Medicaid coverage for transgender-related care and services, and indeed, the amendment explicitly extended coverage for medically necessary hormone therapy and gender-affirming surgery for the treatment of gender dysphoria" (Mallory & Tentindo, 2019:12).

To advocate for the extension of medical care for trans people in all states, two central arguments have persistently been advanced to support this coverage, which has led to several differential results in courts. The first strategy was to challenge those saying that trans healthcare is not necessary. They argued that these healthcare treatments are not just medically important but also that such treatments are safe and effective (Spade, 2010). They base their argument on

the fact that this treatment has been a success for over sixty years and has been very beneficial to trans people (Spade, 2010; Collier, 2015; Cruz, 2014). Indeed, a lack of healthcare access often results in severe physical and mental health consequences. As this care has been proven to be effective and medically necessary for some trans people, coupled with risks denial may cause, advocates argue that a program like Medicaid should cover trans individual's health care. The second argument suggests that any state that excludes gender-affirming treatment violates Federal Medicaid regulations because it prevents some people from accessing healthcare based on diagnosis (Mallory & Tentindo, 2019). According to the Federal Medicaid regulations, "when a state decides to provide coverage through a Medicaid program, it cannot pick and choose amongst groups of people to give coverage based on diagnosis" (Abu-Ghname, Grome, Raj et al., 2021:55). This means that even though states can make various Medicaid decisions, they do not have the power to exclude coverage to a group of people on the grounds of diagnosis (Spade, 2010).

Interestingly, most people do not know that these same treatments and services denied to trans people are offered to other people who do not have a transgender diagnostic profile (Spade, 2010). For example, "testosterone and estrogens are frequently prescribed to non-transgender people for various conditions, including hypogonadism, menopause, late onset of puberty; chest surgery is provided and insured for non-trans men who develop the common condition gynecomastia, where breast tissue grows in abnormal amounts. In addition, treatments designed to help create genitals that meet social norms of appearance are frequently provided and covered for children born with intersex conditions" (Abu-Ghname, Grome, Raj et al., 2021:44). However, all these treatments have been denied to trans individuals under the Medicaid program (Spade, 2010). Hence, denying care to transgender individuals and providing the same care to others

violates the federal Medicaid statute and regulations (Giblon & Bauer, 2017). As trans individuals continue to win legal battles against private insurance, there continue to be an increase in the number of legal cases against the public health system (Nolan & Kuhner, 2019).

A critical look at the health system's regulations shows that whenever trans people are denied access to healthcare services, it violates nondiscrimination laws and constitutional provisions of the federal and state governments. This explains why some advocates have headed to court when they think they have been discriminated against due to their gender identity (Collier, 2015). For instance, when we look at federal statuses, one that comes to mind is the Affordable Care Act (ACA). Transgender people mostly rely on "Section 1557 of the Patient Protection and ACA, which supports their access to coverage for gender-affirming care. It specifically prohibits any form of discrimination in health programs and activities based on sex" (Nolan & Kuhner, 2019:17). Some trans individuals who have the financial resources and the emotional strength have taken their cases to court and came out victorious. For example, in 2019, "a federal district court in Wisconsin held that the state's ban on Medicaid coverage for gender-affirming care violated Section 1557; the court saw it as a clear case of discrimination against transgender individuals and made it a straightforward case of sex discrimination" (Mallory & Tentindo, 2019:25).

Some advocates also take solace from the Social Security Act, mainly because it dictates a broad spectrum within which the state Medicaid can act. The Social Security Act mentions explicitly that “states must provide medical assistance to all categorically needy individuals and that such service be provided equally among individuals within beneficiary groups” (Cruz, 2015:22). Also, according to the US Supreme Court, the Availability Provision mandates that states are supposed to provide healthcare services to everyone who meets the requirements,

including transgender individuals (Spade, 2010). Some courts of law have no doubt been upholding these provisions; for instance, "in New York, in 2016 a federal court held that the state's blanket ban on cosmetic surgeries related to gender transition violated the Availability Provision when it refuses coverage for treatments that could be medically necessary for transgender beneficiaries. They also claimed that it violated the Comparability Provision Statute by providing coverage for cosmetic treatments for conditions not related to gender transitions" (Giblon & Bauer, 2017:44).

Despite these laws, there are still have about twenty states who have decided not to extend their healthcare coverage to include gender-affirming health services under the Medicaid program. However, even though they do not have policies to show that trans health care is covered, some services may be approved for trans people (Tomchin, 2013; Baril, 2015; Shuster, 2016 & Spade, 2015). Although some trans individuals have reported accessing Medicaid coverage in these states, significant barriers exist. While some are denied coverage for specific treatments, others receive inconsistent information from different medical practitioners regarding coverage (Tomchin, 2013). Presently, some states still insist on denying coverage to trans people, especially when the care is related to gender-affirming treatments through statute or administrative policy (Stroumsa, 2014). Even though laws support the availability of this care for trans individuals, some Departments continue to deny them trans care. For example, "in 2010, the Alaska Department of Health and Human Services issued a regulation excluding surgical procedures or secondary consequences from Medicaid coverage. In 2019 a transgender woman denied care under Alaska's Medicaid program filed a lawsuit challenging the law. Also, in Iowa in 1994, the Iowa Department of Human Services issued a regulation expressly excluding gender-affirming care from Medicaid coverage; in 2019, the Iowa Supreme Court held that the

exclusion violated the state's nondiscrimination law, which prohibits discrimination based on gender identity in public accommodations and as such could not be enforced" (Mallory & Tentindo, 2019:15).

5.5 Race, gender and class worsen trans access to Medicaid

When trans individuals are excluded from accessing healthcare services under Medicaid, it affects low-income trans people the most. This is because they are denied access to the only healthcare treatment available to them and are prevented from living their lives as trans people (Spade, 2010). Irrespective of the fact that not all trans people want or require specific healthcare treatment, most of them want to undergo some medical interventions to affirm their gender identity. Based on the laws discussed earlier, trans individuals who need and require healthcare services should be allowed to receive such care without fear of being denied access on the grounds of identity (Padula, Heru & Campbell, 2016). As activists argue, "the ideal thing is to have a world where irrespective of one's income, individuals cannot be prevented from accessing consensual medical care when they need to improve their health, well-being, quality of life, and length of life without having their identities pathologized" (Cruz, 2014:22). The barriers faced by low-income earners when they are denied transition-related health care coverage can lead to "further psychological, physical, political, social, and economic damage and disenfranchisement in a system in which they are already precariously positioned" (Spade, 2015:66). Therefore, when Medicaid excludes trans individuals from accessing certain health care services, they disproportionately affect trans individuals who belong to the low-income bracket, especially when Medicaid is their only hope to access the necessary healthcare services that Medicaid can provide (Collier, 2015).

Scholars have shown that people of color are more likely to have low incomes than the general population; hence when trans individuals are denied this access, trans people of color are likely to suffer the most (Kijakazi, 1999). Apart from this, "people of color are more likely to face severe social and health consequences when they are denied Medicaid coverage, mainly because of the intense surveillance they experience from various state systems and the racism they encounter when trying to gain access to health care" (Abu-Gnhname, Grome, Raj, et al., 2021:23). The woes of trans people of color are further deepened in cases where some states have categorically decided to exclude gender-affirming treatments from Medicaid. This is a clear breach of state and federal laws which are supposed to protect the rights of people in marginalized groups, including trans people and people of color (Zwickl, Wong, Bretherton et al., 2019).

Although there are limited statistics available concerning trans people the very few available suggest that a disproportionate number of trans individuals have low incomes (Houssayni & Nilsen, 2018; Saleem & Rizvi, 2017; Garcia, Christopher, Thomas & Philip, 2017; Abu-Gnhname, Grome, Raj, et al., 2021). For instance, Abu-Gnhname, Grome, Raj, et al. (2021) reported that only 58% of trans individuals were employed in paid positions while 29% had no income, while another 31% had an annual income was less than $10,000. This was further bolstered by the Sylvia Rivera Law Project (SRLP) to provide free legal services to trans people of color. The project found out that out of the trans people of color that came for their services, a whopping 85% had an annual income of less than $9,570 (Sylvia Rivera Law Project, 2007). The poverty level of trans individuals of color is deepened by the continuous racism they continue to face in every aspect of life (Sylvia Rivera Law Project, 2007). This marginalization is evident in schools, homes and even on the job. All these certainly worsen the plights of trans individuals as

they are forced to depend on the Medicaid program (Minter & Daley, 2003; SRLP, 2007; Xavier, 2000). Apart from this, trans individuals cannot access supports provided by states and the federal governments to help lessen the burden of poverty individuals because of the level of discrimination and marginalization they face within various government systems (SRLP, 2007). The gender identity of trans individuals makes them prone to being arrested and incarcerated; this no doubt exacerbates the increasing poverty rate in trans communities (Lee, 2003; SRLP, 2007). This disproportionate rates of poverty makes Medicaid coverage essential for trans people, as it is one of the only available forms of health insurance available (Saleem & Rizvi, 2017).

When trans people need healthcare treatments and are denied these services through Medicaid, they are compelled to look out for other alternative treatments and ways of paying for this treatment. Often trans people are forced to engage in survival crimes as the only way to get the medical attention they need (Clements, Wilkinson, Kitano, & Marx, 1999). For example, some trans people contacting the black market to purchase hormones (Lunievicz, 1996; Raverdyke, 2002). However, “those who engage in these survival crimes are far more likely to experience police harassment, arrest, and incarceration" (Spade, 2015:25). In addition, trans peoples lack of access to medical interventions to confirm their chosen gender makes it difficult to provide identification that corresponds with their chosen gender (Spade, 2010).

Consequently, when these trans people are stopped by the police and a request for ID is made, there is a high likelihood of being arrested. This is because when police are deciding whether to make an arrest or not, people without valid ID are more prone to be detained than people with ID (Murray, 2004; LexisNexis, 2005). This has led to many trans individuals having criminal records. Having criminal records come with its consequences, as it affects how "trans

people obtain housing, employment, benefits, and appropriate identity documents. These social consequences contribute to the deepening and prolonging of poverty" (Barnett, 2004:45).

The inability to provide ID deepens the disproportionate rates of poverty amongst trans people (Spade, 2015), and this can expose them to violence in several ways (Coleman, Bockting, Botzer, et al., 2012). Some of this violence flows from criminalization; for instance, "people supporting themselves through survival crimes often have hazardous work conditions. Low-income sex workers can be attacked, harassed, raped, beaten, or killed on the job. Those trans people who are incarcerated due to their survival crimes are also likely to experience further violence. Jails and prisons are dehumanizing institutions for anyone, and non-trans inmates and correction officers disproportionately target trans inmates for intense harassment, rape, and assault. Apart from this, trans people are routinely denied access to the health care they need while incarcerated" (Sex Workers Project at the Urban Justice Center, 2005:3).

People of different ages are affected differently regarding their inability to access the Medicaid program. For instance, within the medical community, children may experience gender dysphoria; however, it is believed that children can only have a sense of their gender identity when they are between five and seven years old (Saleem & Rizvi, 2017). Surprisingly States like New York who have openly extended Medicaid coverage to include trans individuals who seek gender-affirming treatments, still restricte access based on age (James, Herman & Rankin, 2015). For instance, Section 505.2 limits certain individuals from accessing hormonal treatment or surgeries based on their age. This section focuses on providing services to trans patients 21 years and above (Ettner & Ettner, 2017). In some states, the regulation for age limits is further dropped to include patients eighteen or older (Cruz, 2014). Vermont also has an age restriction at it excludes people under the age of twenty-one years from accessing the Medicaid program

(Edmiston, Donald, Sattler et al., 2016). This means that despite being in a state that extends services for gender-affirming treatments, one may be hindered from getting the necessary healthcare treatments because of their age.

5.6 Medicaid prevents trans people from healthcare services

A critical look at the Medicaid program shows that states differ in their approaches to the Medicaid program. As noted above, about twenty-eight states do not have explicit laws on whether trans individuals can access healthcare services. In such a case, they handle cases as they present themselves and can accept or reject reimbursement (Mallory & Tentindo, 2019; Abu-Gnhname, Grome, Raj, et al., 2021). Section 1396(a) of the Medicaid Act mandates that "all states provide coverage for seven broad categories of medical assistance, namely; inpatient hospital, outpatient hospital, laboratory and x-ray, nursing facility, physician, nurse-midwife and nurse-practitioner services" (Abu-Gnhname, Grome, Raj, et al., 2021:17). However, in cases where states want to provide other optional services, they must do so within federal regulations (Abu-Gnhname, Grome, Raj, et al., 2021; Selix & Rowniak, 2016). In determining the scope of coverage, states must use "reasonable standards for determining eligibility for and the extent of medical assistance" (Spade, 2010:501). Per law, the Medicaid program is not supposed to decline services to people based on diagnosis, type of illness or condition (Spade, 2010:504). Failure to uphold these policies has led to many cases being taken to court, with some enjoying favorable results.

CHAPTER SIX
CONCLUSION

6.1 Introduction

In this concluding chapter I summarize the most salient analysis regarding trans peoples access to the health care services they need. I then make some recommendations regarding changes that would help ease the burden trans people face in accessing necessary health care and suggest how the Medicaid program can widen their scope of support in all states. I end with some final thoughts.

6.2 Summary

It can be extremely difficult and expensive to change your gender identity from the one you were assigned at birth. The process one goes through is known as the transition. This may involve medical interventions. However, as mentioned earlier, not all transitioning involves medical procedures; some trans people decide to go through a social transition, which consists of changing pronouns, and changing names on their identity documents etc. (Spade, 2015; Wilson, Chen, Arayasirikul, Wenzel & Raymond, 2015). Other trans people who want to undergo medical interventions cannot do so because of the mounting barriers they face when they try to access health care services (Keeling, 2019; Tebbe, Allan & Bell, 2019).

While previous studies show that the average cost for male-to-female and female to male gender-affirming surgery and hormones is between $40,000 and $100.000 over three years, most trans people earn below $ 10,000 annually, making it extremely difficult for them to pay for these services, out of pocket (Quinn, Nash, Hunkeler et al., 2017). Gender-affirming healthcare is very expensive, and the high cost may hinder trans people from getting the necessary care if their only hope is to bear the cost themselves (Giblon & Bauer, 2017). Importantly, most trans people face discrimination in employment and access to fair wages, making it almost impossible

for them to access medical care (Winter, Diamond, Green et al., 2016). Given the disproportionate rates of poverty and discrimination faced by trans people, it would take them years to save for such an intervention. Transgender youth face similar issues because they depend on their parents, many of whom are not ready to foot the bill, and many states deny access to trans related care for youth under age 21 (Hofer, Abraham & Moscovice, 2011). Consequently, trans people have an extraordinary need for a program that will enable them to access affordable health care services.

Some hoped that the Medicaid Program would be the 'Messiah' trans people had waited for and would give them access to health care services, since eligibility is mainly based on income and most trans individuals are low-income earners (The Center on Budget & Policy & Priorities, 2020). Adding to these hopes, any denial of coverage by the Medicaid program was thought to contravene the laws of the federal and state government with regards to accessing healthcare. However, despite these laws, some states have intentionally decided not to include medical care for trans people, others have remained silent, causing inconsistent and unpredictable coverage (Tomchin, 2013; Baril, 2015; Shuster, 2016 & Spade, 2015). To make states a comfortable place for trans people advocates suggest we would need a system where everyone can access health care services irrespective of their sexual orientation and gender identity. As Cruz (2014) argues only "this will help improve their health, well-being, quality of life, and length of life without having their autonomy robbed or identities pathologized" (33). However, a critical look at the Medicaid program shows trans people cannot access health care services in many states due to their race, age and socioeconomic class. Also, those who are not marginalized on these grounds can still face barriers as a result of the inadequate education given

to medical providers, and problems and inconsistencies in the reimbursement of the Medicaid services, and failures in the availability of services.

6.3 Recommendations

This paper has shown that trans people are disproportionately affected when it comes to accessing healthcare services. I, therefore, propose the following suggestions to enable gender-affirming healthcare to be readily available and accessible to all trans people who genuinely seek them. The recommendations are as follows;

1. There is a need to make coverage for transition-related healthcare readily accessible. This will help solve the issues faced by trans people in low income trans communities. There is a need to encourage more people to enroll on the Medicaid program. To make it more attractive, application process should be straightforward and agencies that can guide and educate prospective applicants should be readily available.
2. The federal government should make sure that they regulate states' policies by mandating them to remove all the barriers that prevent trans people from accessing healthcare services. This will give trans individuals who were initially excluded the opportunity to enjoy these services.
3. To encourage surgeons to accept Medicaid payment, the mode of reimbursement should change, with rates paid to medical personnel set at a minimum that is higher than the prevailing market prices. This will encourage surgeons to accept clients who are in the program.
4. There is a need for the federal government to turn their attention to providers. They need to be educated on trans issues so that they can provide competent and respectful health care services.

5. Another set of people who need to be trained is legal aid workers, who provide services to people with low incomes.
6. Studies should focus on and make recommendations to address the differential experiences of trans people based on their race, age and legal status.

6.4 Final Thoughts

This paper has explored how the Medicaid program has provided limited access to health care services for trans individuals. While the federal Medicaid scheme, should be a sign of hope for low-income people – frequently it is not. I have made recommendations for change on several levels to help increase access to health services for trans people. All hands are needed to address the discrimination faced by trans people in accessing respectful and competent medical care. Working together for these changes is the only way to bring equality in health care access that much closer to reality.

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