Trans Rights Advocacy Coalition – Public Comments
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Senate Bill 460
Maryland Medical Assistance Program – Gender-Affirming Treatment
Trans Health Equity Act
February 28, 2023
Support

Dear Chair Griffith, Vice Chair Klausmeier, and members of the Senate Finance Committee,

The Trans Rights Advocacy Coalition is proud to present the public comments of **more than 200 Maryland residents** who strongly support the Trans Health Equity Act. From Montgomery County to Baltimore City to Wicomico County, the people of Maryland want to ensure that everybody – regardless of income – can receive the life-saving gender-affirming care they need to thrive. This document contains comments from trans Marylanders, loving family members and friends of trans people, mental healthcare professionals, and more, who all agree: the General Assembly must pass SB 460 and ensure that Maryland remains a safe and welcoming place for all.

Public Comments:

A few years ago I was lost. I felt ill constantly and had no recourse. 2 years ago I finally decided to start HRT, and since then my health, both physical and mental, has only improved. I've been able to improve my life and see a path forward. Every trans person deserves to have that feeling.
John Mack, Baltimore City

I have several friends and loved ones who have received gender affirming care. Their mental well-being has been positively impacted by this care. Without it, they would be left in a very unwell place and left to suffer physically and psychologically.
AJ Jensen, Baltimore City

As a cisgender queer woman, I know that my safety is intrinsically tied to that of my trans neighbors. Trans folks deserve unfettered access to the healthcare they need in order to live their best lives.
Sarah Dwyer, Prince George's County

I support THEA so my community can receive equitable Healthcare like anyone else, and so that they can live as their most authentic selves without having to jump through so many unnecessary bureaucratic hoops.
Erin Maxwell, Baltimore City

All Marylanders deserve adequate healthcare which includes gender affirming procedures.
Nicole Wrinn, Frederick County

I firmly believe everyone should get access to health care, which includes gender-affirming care. People have a right to the care medical professionals can provide and it would be unethical and create a huge risk to trans and gender queer communities to do otherwise. It is 2023. It's time to include gender affirming care.
Jacky Mueck, Howard County

Everyone deserves access to healthcare that will improve their quality and comfort of life.
Maddie, Baltimore County

Gender-affirming care is necessary for the livelihood for trans individuals.
Suzanne Montour, Baltimore County

I support THEA because we have the responsibility to protect and care for all people. Everyone has a right to autonomy and trans people are no different. To protect and affirm trans people we are saving lives AND helping people get one step closer to living a happy and fulfilled life.
Kristy Gizinski, Harford County

I'm a trans Marylander on Medicaid. It's unacceptable that we're not given coverage for all gender-affirming procedures.
Cassandra Cox, Washington County

The Trans Health Equity Act must be passed this year to protect some of the most vulnerable populations in the state. This act will help Marylanders receiving Medicaid to receive life-saving, gender affirming care at a more affordable cost. At a time when many other states are actively attacking basic human rights of our trans siblings, Maryland must step up to care for all of its citizens.
Julia Chadwick, Baltimore City

I want people, all people, to live and not die. Trans people are more than worth it.
Johnita Dickerson, Baltimore City

Access to gender affirming care has made me happier and more at peace with my body. Prior to transition, I was depressed, bleak and hopeless; now, I'm joyful, vibrant and positive. I want everyone who feels like I did to have the opportunity to become a better version of themselves.
Luisa Wayman, Anne Arundel County

I am the mother of a trans daughter. Her health, safety, and security, and the ability for her to live a long and happy life as her true self are of the utmost importance to me and my family.
Sarah Garifo, Howard County

Because all people deserve to have their medical needs met. Ignoring the needs of someone who is transgender, does not change that they are transgender, nor that they need medical care. It only means that these individuals as people will not be cared for in the way they need. Picking and choosing what medical care a specific community deserves based on the opinions of individuals outside of that community (that are misinformed and discriminatory) has consistently led to problems in our medical care system. Accepting people, and specifically individuals in the transgender community, as they are, and treating them from a medical and human perspective as such, is the least we can do to meet the needs of a community that will still face numerous hurdles feeling safe and cared for within our society.
Tai Black, Cecil County

I support THEA because gender affirming care is proven to save lives, and all people, regardless of income, deserve life saving care. I have friends who are trans, and gender affirming care has made an enormously positive impact on their lives.
Joelle Mornini, Montgomery County

Gender-affirming healthcare is a basic human right!
Sarah Fox, Montgomery County

I support THEA because it affirms the right of each person to get lifesaving care. It also affirms the existence and value of gender diversity which is an asset to our society and world at large. This law would help to set MD apart as a place where all are welcome and cared for. Many transgender people face a multitude of barriers when it comes to accessing vital services like healthcare and this is a chance to make impactful and long lasting improvements.
Ambrose L., Baltimore City

My entire voting life has been dedicated to voting for people and issues in Maryland that promote equity. I believe that Maryland needs to be on the forefront of issues like this and too often we wait until something is the obvious right choice. Let’s set an example not only for the other blue states but for the country as a whole. Also I love my niece.
Kevin McIntire, Montgomery County

The Trans Health Equity Act is incredibly important when it comes to the progression of Transgender rights. Healthcare must be addressed, and provided to everyone in the most equitable manner possible. It is time that transgender individuals receive the same consideration as cisgender people.
Treston Melvin & Raquel Ndirangu, Worcester County

Trans people deserve to exist as their true selves without fearing death due to insufficient healthcare.
Emma, Somerset County

Because I want my home to be safe for me and other trans humans to feel safe in. I want to be able to grow the way I was intended to.
Finn Kitchens, Wicomico County

It’s incredibly important for trans people to be protected just like every other person in America, and each state must do their part in taking care of all the types of people who live in this country.
Lori, Wicomico County

Our youngest child knew they were different very early in life. It was never a phase. They socially transitioned at 4 and changed their name and pronouns at 6. Now at 10 we are seeking puberty blockers. I don’t want our insurance to be a roadblock on their journey to self acceptance.
Kim Long, Caroline County

Gender-affirming healthcare is healthcare. Life saving healthcare. My partner is trans and HRT and surgery have saved her life. Trans kids need gender-affirming care as well. Puberty blockers, being respected and validated by medical professionals - it goes so far to help trans people feel their situation is valid and that they aren’t broken - when often so many of them have been told by people in their lives or society at large that they are.
Chelsea, Prince George’s County

Trans people need medically-affirming care; it is essential to our survival and necessary to ensure we can be healthy adults. Too many of us deal with depression and anxiety related to medical providers not knowing how to be affirming with basic care, and we need more providers on board to provide affirming and competent care, along with far less barriers to receive all care as trans people.
Sommer Gray, Baltimore City

These treatments are necessary and all people deserve quality of life.
Emma Curran, Howard County

Because my friends are trans and I want to support them.
Dulce Antonio, Wicomico County

Every individual, regardless of gender or identification deserves access to healthcare and everything else.
Jenifer Rayne, Worcester County

As a trans person myself, having my rights to healthcare taken away from me just because of my gender identity, would be devastating.
Finn Roper, Wicomico County

Gender supporting healthcare saves lives. All medicaid recipients should be afforded the same health coverage.
Stefanie Hoffman, Wicomico County

Gender supporting healthcare saves lives. All Medicaid recipients should be afforded the same health coverage.
S.M., Montgomery County

Because I am a transgender guy and want to stay safe and have rights.
Bailey, Wicomico County

I am a firm advocate for trans rights and as someone with loved ones who are trans, I wish their struggles with healthcare upon no Maryland citizen. All trans people should not have to suffer because they lack proper healthcare coverage.
Keily Wolff, Wicomico County

As an educator and member of the community, I have seen first hand how affirming safe spaces can transform a young person's mental health and over well being. As a trans person, I can vouch for the mental health benefits of gender-affirming care.
Cassandra Whitaker, Worcester County

It allows my friend to live a very healthy and happy normal life!!
Madi, Wicomico County

Trans rights are human rights. Transgender people deserve the right to live freely without harm. They deserve all the healthcare and resources they can get to help them and potentially SAVE their lives.
Autumn Hunt, Wicomico County

Everyone should be entitled to the best medical care possible. Health care is a human right, and trans people are humans.
Mark Schroder, Baltimore County

Gender affirming care has saved the lives of many people I love. I want Maryland to be a place where all people are free to make medical decisions with their healthcare providers that help them prosper.
Jenny Egan, Baltimore City

Transgender care is healthcare! Trans people are people and deserve the same care as everyone does.
Sara Lloyd, Talbot County

We can't continue to dehumanize trans people. Healthcare for trans people saves lives. It builds a more compassionate society and not a destructive one.
Erika Franz, Anne Arundel County

Every human deserves access to healthcare and gender affirming healthcare falls under that umbrella. Denying that is just cruel.
Cori, Baltimore City

My niece is transgender, and she should have every opportunity to be who she is, inside and out.
Katie Crucillo, Dorchester County

Gender affirming care is healthcare and deserves to be provided like any other kind of health care!
Gina Weaver, Baltimore City

The Trans Health Equity Act is incredibly important when it comes to the progression of Transgender rights. Healthcare must be addressed, and provided to everyone in the most equitable manner possible. It is time that transgender individuals receive the same consideration as cisgender people.
Monisha, Worcester County

Transgender health care and gender-affirming services are not only medically necessary, they are also life-saving. By making gender-affirming healthcare accessible under Medicaid, we would be making a significant impact on the mental, physical and spiritual wellbeing of individuals across the state. As a transgender Marylander, a social worker, and a psychotherapist, I am deeply invested in seeing our state continue to support and uplift marginalized communities. I have the privilege of having my gender-affirming healthcare covered by insurance - everyone deserves the right to be able to make informed medical decisions and have those decisions covered by their insurance.
M. McKelvie, Frederick County

As a trans person this care is absolutely necessary in order for folks like myself to survive and thrive. Without it we will not make it.
Charles Henry, Baltimore City

Gender affirming health care saves lives and should be accessible to trans individuals.
Leianna, Wicomico County

I am a psychotherapist who specializes in gender-affirming mental healthcare for trans and gender-expansive Marylanders. A majority of my patients identify as trans. I see the impact of restrictive laws and attitudes on the mental health and well-being of my patients every day. This legislation would reduce shame and isolation and increase access to life-saving treatments for my patients and all trans people in MD.
Rebecca Wenstrom, Baltimore City

As a physical therapist, I'm well aware of the consequences for health outcomes of patients with gender dysphoria who are not able to receive gender affirming care. Trans folks are still marginalized by society, and healthcare inequity results in a lifetime of stress and emotional trauma that increases the cost burden to the system and can result in outcomes as severe as suicide. There is strong evidence to support that gender affirming care saves lives. It seems common sense that a treatment strategy with such strong research to back it up should be a part of Medicaid benefits. I support THEA because I care about the health of every individual in Maryland.
Elizabeth Bellinger, Baltimore City

My daughter is trans and I agree that all humans should be able to get the healthcare they need to be their best.
Lisa Feingersh, Montgomery County

I support THEA because gender affirming care saved my life. I have suffered from severe depression most of my life, until I came out when I was 25. Being able to start testosterone was a game changer. This year, I'm having two gender affirming surgeries and I'm excited to finally feel myself.
Shawn Finner, Wicomico County

Gender affirming healthcare saved my life, and those of others who are close to me. With many trans youth facing unsupportive parents, many of them turn to paying for gender affirming care out of pocket and/or look into seeking their own coverage through public insurance. The expansion of Medicaid coverage to include gender affirming care in Maryland would reduce the financial and emotional stresses of having to pay out of pocket for medically necessary care, especially in the face of other burdens of discrimination that the trans community faces.
Theo Ng, Montgomery County

As a trans man myself, I want to make sure there are plenty of opportunities for transgender youth to receive the help they seek and need. Not only is it so difficult to ask for help, it's incredibly difficult to receive it, many U.S. medical hospitals still view gender affirming treatments as unnecessary, dangerous, or merely aesthetic procedures as many kids AND adults are struggling to be comfortable as they are, were doing our best to be comfortable in the bodies we have but we shouldn’t be consistently denied access to healthcare treatments that could be lifesaving.
Timothy O’Malley, St. Mary’s County

I’m a trans non binary person and without equitable access gender affirming care, I probably wouldn’t be alive anymore. It is vital to my existence, and my mental and physical health.
SJ Janjua, Baltimore City

Every person regardless of their sexual orientation deserves to live with dignity and acceptance and to be treated fairly, especially in the medical world.
Kathleen Olson, Montgomery County

All Maryland citizens have the right to fair and equitable treatment in the state, without prejudice. All state and federal resources are for all of its citizens, not selectively given out to only those members of the society who adhere to the governing body’s personal beliefs and values. Please pass this critically important legislation for all trans citizens of our community.
Mark Olson, Montgomery County

Trans people deserve to have their medical and mental needs met. It is unacceptable to deny them the medical care that keeps them healthy and safe.
Brandi Smith, Washington County

I'm a trans person who has been out for the last 2+ years. I've been on hormones for a year and a half. Having access to hormones so I can live my true self, I have never been happier with who I am. I used to struggle with self esteem issues and never quite fit in with others. Now that I have been able to live as my true self, I have been able to experience joy in a way that I could never do before. It is important that all people, no matter who they are, are able to access HRT so they can live as their true selves and experience the joy that comes with it.
Randy Helton, Baltimore City

Access to trans care is life saving and should not be a privilege for the few. Why should I have to jump through hoops to get hormonal care when cis people can just ask? Why do the circumstances of my hormones affect coverage? How does it affect anyone but me? Why should it be up to the state why I should or should not be able to be who I am? A majority of us need Medicaid to survive, and an expansion of provided services is long overdue.
Sybille, Baltimore City

Research and history shows us that gender affirming care is life saving, and all Marylanders deserve equal and equitable access to receiving life affirming healthcare. I implore all readers and members of the medical community to support the Trans Health Equity Act which is a low-cost solution to bringing adequate care for all and bringing Maryland Medicaid into compliance with federal law and modern medical standards.
Feitian Ma, Baltimore City

Everyone deserves access to life-saving healthcare!
Maia Eskin, Montgomery County

Transgender surgical care, as recognized in the most recent standards from the World Professional Association of Transgender Health, are the best known treatment for the recognized condition of gender dysphoria by consensus of medical experts across the world. Failure to provide care to the minimum of these standards set by many states and health care providers is unjust and cruel to a marginalized and often persecuted population with a medical condition seeking known effective treatments. Continuing to fail to provide access to care is Maryland continuing to condemn its transgender population to unnecessary suffering and often substantial endangerment in just going about their lives. When there is known effective treatment, and none is offered, that is evil. Take care of your citizens instead.
Melanie Scheirer, Baltimore City

Our trans community needs to know that their health care rights are protected. The statistics are staggering on suicide due to inability to receive gender-affirming healthcare. Keep trans individuals safe!
Mimi Kress, Montgomery County

Gender-affirming care saves lives. Maryland should ensure its policies are up to date with federal regulations and expert medical consensus.
Lauren Bopp, Montgomery County

Healthcare services should be available, and between a patient and their care provider regardless of the patient's financial standing. When a person's healthcare needs are addressed they have better mental health outcomes which leads to higher productivity. Gender affirming services are necessary healthcare and all healthcare should be accessible to all who need it, especially those most financially vulnerable.
Yahmilah Berkley, Montgomery County

Gender affirming care is not just surgery and hormones. It can be therapy to help you understand yourself or to help others understand you. I myself don't want any medical intervention (other than hair removal), but when I was able to get help to understand myself and figure out how to help others to understand me, it made a huge difference in my life and mental health. No one should have to suffer because they can't afford life-saving care.
Mychel Vandover, Montgomery County

Gender-affirming healthcare is necessary and saves lives. It needs to be covered by Medicaid, just like every other type of healthcare. Trans people are depending on the government to do the right thing.
Timothy Vandover, Montgomery County

I have paid over $30K in electrolysis beard reduction. This was and is a tremendous financial burden on me. This should not be an elective procedure. This legislation would acknowledge that being transgender requires necessary body modifications that include electrolysis.
Bonnie Smith, Baltimore County

I have a transgender stepdaughter who resides with her mom in Maryland. The changes and joy that she has experienced in being out are beautiful. To be able to aid her emotional growth with physical support would be amazing.
Zahos Laura, Washington County

As a nurse I support this bill because it's a basic right for people to be able to choose the healthcare they want to receive without discrimination from healthcare providers working directly with patients and for those who provide care coverage like Medicaid. Gender affirming care is an evidence-based practice that allows our Maryland citizens to live a healthier, more fulfilling life. It is not for me as a nurse to decide how and why people engage in healthcare and it isn’t Medicaid’s either, healthcare adjusts to the needs of the people and public health issues. There are more than enough heartbreaking and startling statistics in regards to the LGBTQ especially trans community losing rights to their bodies and minds, Maryland should be an exception and refuse to allow Marylanders to be treated less based on sex, race, gender, income, religion, abilities, etc. As a human that chooses to live, work, and pay taxes in Maryland, I believe trans affirming care is absolutely without any question a right and should be covered by Maryland Medicaid.
Elizabeth Spradley, Baltimore City

I believe transgender people need that care to affirm their mental health and to allow their bodies to be seen how they feel. I know many transgender adolescents and adults struggling and they need to be able to get life-affirming care - without it, many will not survive their internal mental health struggle.
Christine Pappas, Harford County

I am a trans male myself and I think that getting the medical assistance we need is important.
Lohgann Dayn, Wicomico County

Gender-affirming care is life-changing for trans people. If you're poor and trans and on Medicaid, you basically have no options for care besides waiting and hoping. This act would change that and improve so many people's lives.
Ross Tajvar, Prince George's County

They are God's children and deserve to be treated as such, need to be treated with respect and dignity.
Don Brunner, Prince George's County

I am lucky enough to have employer-provided health insurance coverage. With it, I was able to receive counseling on medications and procedures, therapy, hormone replacement therapy medication, and bottom surgery. I am so much happier now than I was before I started my transition several years ago, and I believe that everyone should have the ability to pursue gender-affirming care that I did. It makes me sad that right now, not everyone can.
Maggie, Baltimore County

I'm a trans woman who wants equality for everyone. My life is hard enough already and I need more help to make my life better. Also including other people as well.
Michelle Phipps, Howard County

As a mental health counselor, a trans ally, and a community member, I believe that gender affirming care is suicide prevention and therefore, life-saving care. It is vital that we ensure access to all gender affirming care for anyone who needs it.
Ann Brokmeier, Baltimore City

As an employee of Johns Hopkins and a parent of a trans child, I support you.
Jennifer Golling, Baltimore City

Because political talking points should never be the reason medical consensus is overridden, especially if the outcome will harm and, or, prevent the pursuit of life, liberty, etc.
Dana Stone, Allegheny County

I am a trans human who is extremely grateful to have Gender Affirming Care. I am also the LGBTQ+ Affirming Care Coordinator at my therapy practice. LGBTQ+ affirming care is extremely important, and reduces anxiety,depression, suicidal thoughts, and generally improves overall mental health and physical health outcomes for LGBTQ+ people.
Katie Dant, Baltimore County

I support my neighbors and family members [being able to] live in their truth and have the legal protections they deserve.
Kailah Carden, Baltimore City

Trans rights are human rights. Period.
Kayani Turner, Baltimore City

I support THEA because trans Marylanders deserve the same quality of life and access to healthcare as all other Marylanders. Plenty of research makes it clear that gender-affirming care is life-saving, and I personally have several friends who have gotten gender-affirming care that has improved their quality of life to an incredible degree. As a cisgender Marylander, I stand with trans Marylanders and their right to gender-affirming healthcare.
Meghan Balot, Baltimore City

Trans citizens deserve to have a voice over their body and over their representation! Let's love, respect, accept our trans peers and elders!!
Stephanie Lindo-Washington, Anne Arundel County

Because whatever a person identifies as, THEY ARE STILL HUMAN BEINGS. Human beings who still deserve respect and should not be denied health care.
Alex Kenlon, Wicomico County

Gender-affirming healthcare has literally saved my life. Anything that saves lives should be available to everyone who needs it. Healthcare systems exist to keep people as healthy as they can be. Just because 93% of folks don't get appendectomies doesn't mean healthcare systems shouldn't try to help the other 7% survive. The World Health Organization affirms that healthcare is a human right. Trans people are human and we deserve this right.
Ashley Sterner, Baltimore City

Access to healthcare saves trans lives. Trans people deserve dignity and equality.
Isabella, Worcester County

Getting access to gender affirming care substantially improved my mental health and quality of life across the board. All Marylanders should be able to access the essential care they need regardless of their economic status, and the efficacy of gender affirming care has been proven by medical studies and upheld by major medical organizations including the AMA, the AAP, and the APA.
Connor, Montgomery County

I have a number of trans friends who have had gender reaffirming surgeries and it has made a world of difference. They are happier and more confident in the bodies they inhabit. My friends are lucky enough to have private health insurance, but I think every trans person who needs it should have equal access to it, including those on Medicare.
Colleen Parker, Montgomery County

I spent 30 years knowing I was transgender and thinking there was nothing I could do about it. I spent 30 years waiting to die because I knew I wasn't happy and thought I never could be. I don't wish that pain on anyone especially when all I needed was a clear path to help and this act can offer that to others.
Philecia Hoover, Baltimore City

We cannot leave trans folks behind in getting appropriate gender-affirming healthcare. It's a life or death situation.
Aimee Harmon-Darrow, Baltimore City

It is extremely well-documented that gender-affirming healthcare saves lives. Unfortunately much of it is also very expensive, making it out of reach for many people, especially less advantaged people. Everyone deserves access to quality, life-saving care, and the THEA would ensure that lower income Marylanders could obtain the care they need.
Rylie, Howard County

I support the Trans Health Equity Act as a nonbinary individual because every transgender person in Maryland deserves the same access to gender-affirming healthcare that I have been privileged to receive. My insurance covered my hormone replacement therapy, and will likely at the very least partially cover the gender-affirming surgeries I intend to receive. I have a friend here who is unable to access hormone replacement therapy because Medicaid does not cover it, and she cannot afford to cover it. This deeply upsets me because it is significantly impacting her quality of life and her mental health is suffering as a result. She deserves to receive the life-saving treatments that I was so quickly and easily afforded.
Zoe Sharp, Anne Arundel County

I am a trans woman on medicaid who is DIRECTLY impacted due to lack of coverage from my plan. I have been denied coverage for treatment in the form of hormone replacement therapy. This act could directly change my life in the way I need it to right now. Thank you for hearing me out.
Sarah Roberts, Anne Arundel County

I support the THEA because I have first hand seen the impact that access to gender affirming healthcare can have on a person. My spouse is trans and their quality of life and happiness has benefited from accessing gender affirming healthcare with our private insurance. Knowing that Marylanders who access healthcare through Medicaid are denied this same opportunity is unacceptable.
Brittany Johnstone, Baltimore City

Everyone should have access to whatever healthcare improves their lives, whether it's insulin, mental healthcare, physical therapy, blood pressure medication...we are all one human race and should be treated equally.
Sarah, Carroll County

Everyone deserves healthcare opportunities. It should not depend on where you live or who you are.
Kay Schuyler, Baltimore County

Healthcare is a human right. No one should be denied health care because of where they live or who they are.
James Schuyler, Baltimore County

As a pediatric critical care nurse, I have had too many teens and children come to my unit after trying to kill themselves because of the lack of support that they have, whether financial or social. This isn't about providing care only to adults. This is about providing preventive care to teens and young adults. Medicaid already pays for these medications and procedures for other types of patients. Let's rewrite policy so that trans individuals also can get access to these treatments.
Shelby Blevins, Anne Arundel County

I support THEA because equitable access to health care services shouldn't be decided by income. This is particularly the case when young people are estranged from their families after disclosing their gender identities to them. The negative effects on the mental health of people who wish to transition, but are unable to, including dying by suicide, are too great to ignore.
Keri Jowers, Baltimore City

Because everyone deserves the right to live their life as their true self.
Elizabeth, Montgomery County

Access to health care is a basic human right for all people, regardless of their gender identity. Denying coverage for gender-affirming care is an unjust and discriminatory practice based on nothing more than ignorance and ideology. This practice must end.
Carl Graziano, Howard County

Gender-affirming care is life-saving healthcare. Covering it is an absolute necessity.
Daniel Tabor, Baltimore City

I cannot stand silently while fellow Americans are actively discriminated against and their liberties restricted by a government founded for personal freedom. Do not be the shame of our children; be a role model for the nation. Support this Act, and the rights of all people.
Erin Hysom, Montgomery County

Because I'm a nurse and I care about all of my patients, including those that are trans. Because I'm best friends with trans people. Because my kids might be trans. Because I'm a good human.
Crystal Guengerich, Baltimore City

It is critical that low-income transgender Marylanders receive gender-affording healthcare in order to support their physical and mental health.
Mary Haas, Montgomery County

Gender-affirming healthcare should be comprehensive, and available to all who need it. Without quality care, many trans people suffer, some die.
Naomi Patton, Prince George's County

Without Gender Affirming Care for my child, they may not be here. All people should be able to find the care they need no matter what race, gender, or ethnicity. Without this care individual lives will be lost. Care is not denied based on ethnicity or race so why should it be limited due to gender? A human is a human.
Jennifer Roussillon, Howard County

I support this legislation because I have a family member who this affects. It is a human right to have appropriate health care and to live their life in the body they know they belong in. Please pass this legislation so that all humans can live healthy lives.
Kristin Meadows, Howard County

Trans people need and deserve gender-affirming care. As a Marylander currently enrolled in a Medicaid plan, it is important to me that the program comes into compliance with federal law and meets current medical standards. As we are seeing a rise in anti-Trans legislation, Maryland must set an example and affirm that trans Marylanders can have safe, affirming, and prosperous lives - access to needed medical care is an important piece of this.
Rianna Eckel, Baltimore City

I support this because even private insurance companies are being discriminatory. If the government cannot support in covering medications, treatments, procedures, etc. for the Trans Community, then what chance does anyone else have? Make it a human right so that everyone gets the care they need. The government should cover these expenses for trans folks; it's lifesaving, and people are much more likely to be responsible, contributing members of society when they are supported by basic human rights.
Carrie Heath, Howard County

Because it would provide people like me and my friends who are trans and low-income with life-saving gender affirming healthcare on Medicaid.
Saoirse Gowan, Prince George's County

I'm a mental health provider and work quite extensively with trans clients. I can certainly vouch for the need for trans affirming and equitable access to healthcare specific to their needs. I have seen firsthand the mental decline that occurs for my clients denied treatment for a variety of reasons, as well as the dramatic improvement that happens the first time they start hormone treatment or are provided with affirming healthcare. THEA is absolutely necessary and should just be an equal right that we shouldn't even be discussing or having to vote on. Please allow these beautiful individuals that I see every week access to the same rights as cisgender Americans.
Lauren Ortiz, Anne Arundel County

I am a therapist who sees all too often how trans people are impacted by things like lack of health care coverage and access to gender affirming surgeries. This would help ease that.
Krista Verrastro, Baltimore County

We need to ensure that trans Marylanders have the gender affirming healthcare they need and it should be able to be accessed by Medicaid. This legislation will save lives and should be passed as soon as possible.
Eileen Singleton, Howard County

Everyone deserves access to safe and beneficial medical care decided between them and their doctor. Gender affirming healthcare has vigorous research to show that it is safe and has positive outcomes. There's no reason for it to be denied by anyone who isn't receiving, providing, or researching it.
Concetta G., Caroline County

Because I want my daughter not to become another statistic. I want her to thrive and have the full life she deserves.
Enidia Santiago, Anne Arundel County

This is simple and easily saves lives.
Nicholas Brown, Anne Arundel County

My kid is transgender and am very concerned when they turn 26 and come off of my employer-provided health insurance they will not have low-income health care options if needed. Also I have met so many low-income trans youth whose parents do not accept them nor help support them. I have attended many healthcare appointments with my kid and know how important it is to have access to gender-affirming healthcare.
Melanie Keller, Anne Arundel County

As a social worker, therapist, and mental health professional, gender affirming healthcare saves lives. Marylanders need access to lifesaving care.
Melina Maule, Baltimore City

I'm a therapist and have people in my personal and professional life who are transgender or non-binary. Trans people are at high risk of suicide and barriers to healthcare access contribute to that problem.
Lauran Reagan, Anne Arundel County

As the parent of a trans child, I strongly support this life-saving legislation.
Ying Matties, Howard County

I'm a mental health therapist who works with a lot of trans folks. Gender-affirming care is life saving medical treatment that should be treated no differently than other life saving medical treatment. It should be accessible to everyone, regardless of their income.
Rebecca Gibson, Baltimore County

Everyone deserves healthcare no matter the reason.
Claritza M., Howard County

I support THEA because trans people deserve their health right, just like everyone else!
Peng Zhang, Baltimore City

I support THEA because Maryland needs to be a safe and welcoming place for everyone, including our transgender residents. Listen to the medical community; its members are telling us that this is life-saving care. In addition, why is the state out of compliance with federal law covering gender-affirming care?
Sandra Graziano, Howard County

Gender-affirming healthcare is transformative and lifesaving; equitable access to it is necessary for the well-being of not just the trans community, but also the many cisgender people who have a trans person in their life in some capacity. Lowering barriers to healthcare should be a priority for everyone but especially marginalized groups such as the trans community. Equitable healthcare = happy and healthy individuals and communities, which strengthens our society as a whole.
Ash Baker, Howard County

Everyone deserves to be able to be the gender they want to be. This will make people who aren't the gender they were born with happier and healthier in the long run.
Holly French, Howard County

THEA would show that Maryland values trans lives. Covering gender affirming care under Medicare would grant many trans Maryland residents access to necessary care that they would not otherwise have access. Trans people should not be responsible to pay for their medically necessary procedure. During a time when many states are passing legislation stripping away trans rights, Maryland should stand as a beacon of hope for trans people and pass this legislation.
Glenn Burnett, Montgomery County

All individuals deserve inclusive care. We can’t say we don’t discriminate but then provide care that is not inclusive of that.
Carlada Razmus, Anne Arundel County

As a clinical psychologist working with youth and adults who identify as transgender, THEA is critical to the livelihood, stability, and safety of our community. Without such, we will continue to see rates of self-harm, suicide, and mental health issues within the trans community, which will ultimately create more costs for our health care system.
Kara Koenig, Baltimore County

We're not yet able to stop transphobic people from advancing bills to threaten trans rights. Those threats to trans rights are a constant reminder that the threat to trans people's lives are real and persistent. But by entrenching and furthering trans rights we not only improve the lives of trans people, we show they have allies, and that we will fight to entrench their rights so they become as difficult as possible to dislodge. We combat fear by persistently building a world that is safe for our trans friends and loved ones.
Cameron LaFortune, Baltimore County

As a non-binary Marylander, having hair removal as part of the definition of gender-affirming care is extremely important to me. Dysphoria takes many forms and it's extremely frustrating when insurance assumes you are a binary trans person and will cover SRS but refuse to cover hair removal even if hair is the #1 trigger of your dysphoria and you don't want SRS, which is my case.
Mark Buhl-Eaton, Howard County

Gender-affirming care including surgeries is Medically Necessary, as documented by ALL health-related professional associations in this country (eg, American Psychological Association, American Medical Association) and discrimination is outlawed by the Affordable Care Act. Not covering gender-affirming surgeries is discrimination. Period.
Kris Gebhard, Baltimore City

It genuinely saved my life and made my life worth living again and it's done this for so many others in my life as a trans person and as a licensed clinical therapist over the last decade.
Shir, Baltimore City

I support all people in Maryland living in their truths and having full access to the healthcare that allows them to do so. THEA is lifesaving, without a doubt, because gender affirming care truly keeps trans people alive, supports us to thrive, and be the unique contributors to our rich society that we are all meant to be. As a trans person living in Baltimore City and a health care professional licensed in Maryland, I want to feel confident that we are showing up and caring for people of all genders equitably!
Britt Walsh, Baltimore City

As a healthcare provider, I believe it's important that EVERY human has access to care. I provide affirming-care as a mental health therapist and have encountered barriers to trans clients being able to access appropriate care when they are low-income or older. It's important that every Maryland individual is able to receive services.
Shari Cain, Baltimore County

It can be difficult, if not impossible, for many trans individuals to access care that can save their lives. And those that can often face countless barriers of access to those services from incorporative and uncaring insurance systems and providers. The Trans Health Equity Act goes a long way to removing those barriers and providing the care needed to provide Maryland's trans community with agency over their lives that they never had before. This would be a ray of hope in a world that seems to be closing in around the trans community at every turn in our current political landscape. THEA must pass to save and to celebrate the lives of our trans siblings so that they may continue to enrich all of our lives and the state of Maryland.
Emma, Baltimore City

Gender affirming care is critical, life or death medical treatment! Not providing this to folks on Medicaid is discriminatory and contributes to health disparities.
Rachel Romeo, Prince George's County

Gender affirming treatment such as hormone treatment, facial feminization surgery, and chest masculinization surgery are essential for many transgender people's mental health and for their safety in public. I have been helped immeasurably by gender affirming care, and it is the right of all Marylanders that need it to have it with reach regardless of their financial means.
Maeve Mulholland, Howard County

It just makes sense. These services are a benefit to ourselves and to our community members. There is medical consensus to back this up in case anyone has any doubts. There also seems to be a legal imperative to do this since there is federal law requiring this.
Diego Contreras, Baltimore City

This legislation is critically needed to provide life saving medically necessary care to transgender and gender diverse individuals. The current exclusions for Medicaid patients is discriminatory and serves to further disparities for patients who already have more financial barriers than patients with other insurance types. THEA is needed to correct this situation.
Jessica Rothstein, Baltimore County

Because we know how critically important gender-affirming healthcare is to promoting life.
Rachel LaFleur, Baltimore City

Availability of healthcare coverage for trans youth saves lives, improves health and mental health outcomes.
Lauren DeMarco, Harford County

As a psychologist, I have seen the devastating effects for transgender clients when they do not receive gender-affirming health care and mental health care. Transgender individuals are at higher risk for suicide. THEA is an essential first step in saving lives.
Maria Zimmitti, Montgomery County

Everyone should have access to the healthcare they need. Creating barriers that increase mental health crises and suicide are not productive to the kind of society we are trying to create. If we are trying to improve everyone's quality of life, then we need to support each other in order to save lives.
Katelyn Tjarks, Howard County

I support this act because it will allow low income trans Marylanders to live with dignity and access gender-affirming care that is currently only accessible to those with the funds to cover it. As a transgender person myself, and a health care provider, I know hundreds of people whose lives would be dramatically improved were they able to access even some of these procedures. The inability to access these procedures can also put some of our most vulnerable trans individuals in dangerous situations, because being openly transgender is not safe in every part of our community. Many of these procedures make it possible for trans individuals to "pass," meaning that others around them would not have any idea that they are transgender. Though that is not important to all of us, it is critical for some people to feel safe in their neighborhoods, to access employment, and feel safe in the community at large. The ability to access facial feminization surgery, for example, could be the difference between a trans woman living or dying, given the amount of discrimination and prejudice that sector of our community faces. This act would allow Maryland to set a strong example in this time when gender-affirming care is under attack in other parts of this country, and I hope for the lives of transgender Marylanders that the legislature passes this important bill.
Jess Romeo, Prince George's County

This is an equity issue. No Ifs no buts. Life is hard enough for people trying to affirm their identity in a world that discriminates against them. No Trans or Gender expansive person makes the decision to embark on such an arduous journey frivolously. We owe it to them to make this state safer to live in.
Doha Chibani, Montgomery County

Because trans rights are human rights and access to care is imperative to well being.
Elizabeth Harring, Baltimore City

It is so important to support the mental and physical well being of those who identify as trans. This is a growing portion of our society and their needs should be recognized and honored.
Vivian Morgan, Baltimore County

Trans people are people. Period. They deserve all benefits/treatments/attention anyone else might get.
Zoe Alpert, Montgomery County

I support the THEA because transgender medical care should be considered a basic human right. Providing access to care for transgender patients will not only result in improved outcomes for the patient population, but can result in improvements in the healthcare industry overall. Current research is showing that medical providers are interested in and do want education on working with and providing care for transgender and gender non-conforming patients. Consistent barriers are outdated educational materials and outdated laws designed to prevent providers from giving care. As a student currently working towards a masters in nursing, I feel strongly that all patients are worthy of human-centered care that is built on respect. Currently our laws regarding affirming care for transgender patients denies human rights and human dignity. I stand with the THEA.
Miriam Cummons, Baltimore City

Transgender Marylanders need to be able to receive Medicaid coverage for gender-affirming healthcare. Many gender-affirming procedures are not currently covered by Medicaid. These procedures are critical to the emotional and physical well-being of transgender individuals.
Bethany Brand, Baltimore City

Gender affirming healthcare is a human right and a mental health necessity.
Benna Sherman, Anne Arundel County

Trans rights are human rights. ALL humans deserve to be treated with dignity and respect.
Ellen Burgess, Montgomery County

Gender-affirming procedures are medically necessary. This is a low-cost solution that will improve the quality of life of Marylanders.
Carly Hunt, Baltimore County

This is critical for kids' mental and physical health, and for their families' well-being.
Dana O'Brien, Montgomery County

The Trans Health Equity Act is important for people who identify as Trans and are in need of gender affirming procedures that will improve the quality of their lives. Most have experienced a lifetime of bullying, discrimination and harassment.
Monya Cohen, Montgomery County

I think everyone should be true to their authentic selves.
Brenda Prevas, Baltimore County

I strongly support this because health care is a basic human right and our trans friends, neighbors and community members are suffering needlessly when they are denied this type of care.
Abbie Ellicott, Anne Arundel County

Because equality matters and everyone is deserving of this.
Thalia Kirimlis, Montgomery County

Everyone has the right to affirming, safe care!
Jaclyn Halpern, Montgomery County

As a psychologist I can affirm both through my familiarity with the research and my experience as a clinician working with trans folks that this is essential to their physical and mental health.
Jessica Dunn, Baltimore City

As a psychology professor who has taught Human Sexuality and has treated a number of trans children, I feel that providing psychical and mental health care to children who believe that they are in the wrong body. Both Kennedy Krieger and National Children's Hospital do amazing work in this area. Many of these children receive their health insurance through Medicaid.
Mindy Milstein, Baltimore County

All Americans should be able to access gender affirming care!
Jacob Roth, Montgomery County

I believe in equal rights for all individuals, and quality of life is a basic human right.
Briana Estes, Baltimore City

I believe transgender people have the same rights to health care for their medical concerns as any other person.
Tom Holman, Montgomery County

Gender-affirming healthcare saves lives. We need to pass the Trans Health Equity Act (THEA) and ensure that trans Marylanders can access gender-affirming healthcare under Medicaid.
Ethan McNary, Baltimore County

It is a basic human right to have equal access to health care evidence treatments for those whose identities do not necessarily reflect the gender assigned at birth.
Janice Caro, Montgomery County

Because trans folks who have Medicaid are experiencing oppression by being denied access to gender-affirming procedures. This is transphobia and unjust.
Bernasha Anderson, Montgomery County

Lack of gender-affirming care is fatal. There is no excuse for adding barriers to care for trans individuals.
Shari Kim, Baltimore City

Equality across all resources is an important goal, and this includes gender affirming care.
Joyce Cooper-Kahn, Anne Arundel County

I believe access to gender affirming healthcare will improve the health and wellbeing of transgender individuals.
Jin Northmann, Baltimore County

I am concerned about the health and mental health outcomes of all transgender individuals. Access to health care that will improve mental health and physical health outcomes is critical!
Beth Warner, Prince George's County

How could I not? Everyone should be granted access to ALL the care they need and deserve.
Amy Brown, Anne Arundel County

I have a 7 year old trans/non-binary child. At the age of 5, my child began to tell us that they are a different gender than what was assigned at birth. Since then, my child has been asking questions related to puberty and expressing signs of being uncomfortable with their body. I know that gender affirming healthcare is live saving.
Rachel Pathak, Baltimore City

I think it is very important to provide necessary medical care to all that need it. Passing this will ensure medical coverage for necessary procedures to our most vulnerable.
Pamela Smith, Howard County

I have seen individuals' overall functioning significantly improve when they have felt more comfortable in their bodies.
Leslie Zirkin, Montgomery County

Because everyone deserves healthcare that treats ALL of them. Because we can't just decide that some aspects of care aren't necessary.
Camilla Reminsky, Baltimore City

It is imperative that every American have the right to the healthcare they need. That is one measure of a civilized society. Maryland needs to be a leader on this. We need to care for and about all of our citizens!
Jennifer Haber, Carroll County

My name is Mark Ridderhoff, my pronouns are he/his, and I am The President of Baltimore Pflag. I support bill HB283, the Trans Health Equity Act. I urge the Committee to issue a favorable report, including sponsor amendments. This legislation will allow low-income transgender patients to access lifesaving, medically necessary gender affirming healthcare. Affordable healthcare should be for everyone, no exclusions, no exceptions. Please support this bill so our fellow Maryland citizens can prosper and grow.
Mark Ridderhoff, Baltimore City

I support THEA because the procedures it would cover are medically necessary to treat some cases of gender dysphoria.
Catherine Smithmyer, Queen Anne's County

All major medical, psychological, and psychiatric organizations are in agreement that gender-affirming healthcare is medically necessary. It is a basic human right and is often life-saving.
Courtney Cook, Baltimore City

Gender affirming care is so important and necessary for everyone in the trans community. Risk of depression and suicide is so high but can be easily reduced by just giving everyone access to the care they need. This could be the difference between life and death for some.
Rae, Baltimore County

Transgender people deserve equitable healthcare.
Louisa Meyerson, Anne Arundel County

There are plenty of transgender people that I am friends with who can't afford gender affirming health care. It would help them if their gender affirming procedures were covered.
Joey Silkworth, Anne Arundel County

I work at a Safeway and far too often, I have seen my poor transgender coworkers unable to receive the lifesaving gender affirming treatment they need. Too often, I have noticed my transgender friends at work teeter on the edge of suicide because of their inability or in even worse cases, the loss of an ability to receive gender affirming medical treatment due to their inability to pay for it. By including transgender Americans in the Maryland Medical Assistance Program, we can save hundreds of lives and brighten hundreds of others.
Kasey Brown, Anne Arundel County

I myself am an individual who's generally a part of that community. Healthcare, both local and worldwide, ignores the similar needs of cis and transgender pupils. Discrimination in high within every level of healthcare, so to have help could make a huge difference
Ashton, Anne Arundel County

Without this act, the lives of transgender people, including children and those living in poverty will be greatly impacted. Suicide statistics among trans people are already high and not being able to get life saving gender affirming care will not make the statistics any lower. We can start by making a difference in our local community and change medical standards in Maryland, which will hopefully influence other states to rework harmful anti trans laws.
Olivia Mawhinney, Anne Arundel County

SB 460 is important because it will increase safety, health, and wellness for transgender people who rely on these health insurances, especially transgender feminine people of color who are more likely to suffer the effects of discrimination and negative social determinants of health outcomes due to lack of access to medically necessary health care. This bill will open access to so many who have otherwise been suffering. Many of the patients I work with have been negatively impacted by the absence of the equity that this bill is offering to bring.
Rachel Smith, Baltimore County

Gender affirming care for Trans individuals is necessary for overall health. If a transgender individual is not allowed to live their life as their gender, it takes a significant toll on their behavioral health which then affects all aspects of their health and impacts the health of those around them. Trans health doesn't just affect the trans individual, it affects the whole community.
Elizabeth Jones, Baltimore County

Please pass this act to ensure that our trans Marylanders have access to quality gender-affirming health care!
Kathi Foley, Anne Arundel County

All people deserve quality healthcare that is accessible, including trans people. It just makes sense that we need to make life saving procedures available for all trans people in Maryland.
Reese Chapman, Anne Arundel County

Trans Marylanders need access to gender-affirming healthcare under Medicaid. To deny them coverage is to subject them to more abuse, discrimination and harassment, and to increase the likelihood of suicide among this segment of the population.
Kathy Machan, Anne Arundel County

Healthcare is a human right. Denying people access to medically necessary care for any person denies their constitutional right to life, liberty, and the pursuit of happiness.
Christy Russell, Queen Anne's County

Medical care is a basic human right, and it's something many trans individuals sorely lack. For many, it can be the difference between whether or not they ever feel comfortable in their own bodies. Having gender-affirming healthcare available literally saves lives. This is something we need.
Jamie Bates, Anne Arundel County

I believe that everyone deserves a right to healthcare. It is only human to provide someone with the ability to feel like themselves. Everyone deserves to be who they want to be which is why I support the THEA.
Delaney Thornton, Anne Arundel County

I support THEA because I've grown up seeing peoples rights slowly taken away. Trans rights are no different and unfortunately have been pushed to the background. Trans rights are human rights. It's as simple as that. I support it for my friends, my community, and myself in hopes for a better future where no one has to fight for what they deserve.
Addison Thornton, Anne Arundel County

Gender-affirming healthcare truly saves lives. These procedures are medically necessary and reduce suicide, abuse, discrimination, and harassment. I have seen how necessary they are firsthand as loved ones have been harassed and assaulted simply for being transgender. THEA will not only improve quality of life, it will actually save lives.
Robyn Rothamel, Anne Arundel County

Healthcare is a human right, and Maryland should be striving to ensure that everyone has access to the care they need. Gender affirming care in particular is crucial for trans folks, and medically necessary treatments must absolutely be covered by Medicaid. Refusing coverage will only exacerbate existing systemic inequality that disproportionately affects those who hold marginalized identities. Lifesaving interventions should not be withheld from anyone, period.
Alex Lane, Prince George's County

Because as a trans person myself, I want to keep my rights as a human being. As I plan to receive gender affirming surgery in the future, having this law pass would not only help me become comfortable in my own skin, but also the many other trans folks out there.
Orion, Baltimore City

I am a social worker, I work with young trans students who want to get reassignment surgery when they are 18. They are low income individuals who have Medicaid. This surgery as well as gender affirming health care should not just be for wealthy individuals or those who can afford private insurance. Most private insurance companies do cover gender-affirming health care. We should not be discriminating against low income trans people.
Khristine Smith, Anne Arundel County

If their doctors deem it necessary their care should be covered.
Elizabeth Getzoff, Baltimore County

Because trans health care is medically necessary and because trans people should have equal access to life-saving treatment.
Jessica Simon, Montgomery County

I support the act because I suffer from gender dysphoria and cannot get full access to the gender affirming care I need under current Maryland state policy. I want all transgender Marylanders to not be minimized.
Erica Burns, Howard County

My oldest child is a Trans teen and while I provide as much support as I can from home, they still face bullying and harassment while at school and all over social media. They have the support of their mother, but not all children do and they struggle to get the care they need. Children should feel safe and be able to express who they are without fear. Gender affirming care is not questioned when someone is cis, so why is it such a controversy for trans kids and people?
Emily, Carroll County

As a trans Marylander who is medically transitioning, I understand how life saving gender affirming care can be. It is also prohibitively expensive when not covered. Treatments like facial feminization surgery and hair removal (laser or electrolysis) can exponentially improve the quality of life for Transfeminine people and should not be treated as cosmetic. Many of us need these treatments to live safely and comfortably, this is life saving care.
Emily Kalaris, Prince George's County

People should have the same rights no matter the race, gender, or sexual preference.
Lisa Lucas, Baltimore City

Gender affirming care should not be treated any differently than any other medically necessary care! Healthcare decisions remain solely between patients and their providers and Maryland must ensure that trans Marylanders can access the care they need under Medicaid!
Claudia Balog, Baltimore City

I support healthcare for all.
Natina Newsome, Baltimore City

I support this bill because everyone deserves healthcare no matter their gender.
Donta Marshall, Baltimore city

My son Castin came out as transgender during the pandemic. We also have several friends who are transgender. When my child came out, I knew I needed to support him, no matter what. He has a right to his identity, to a good life, to proper medical care. It breaks my heart that transgender persons are treated so badly in our society. I am determined not to let that happen to my son or to any others.
Jeneva Stone, Montgomery County

Gender-affirming care is so important in the context of mental health, physical health, and the overall wellbeing of humans who are struggling with the identity they are forced to show the world. Allowing them to become who they are SUPPOSED to be will help reduce associated emotional struggles, as well as the stigma that continues to be very problematic for this population.
Christina Jones, Prince George's County

Trans rights are human rights.
Dustin Sentz, Baltimore City

We need to support trans people.
Molly Hauck, Montgomery County

Supporting THEA is supported by research and medical/psychological best practice. Supporting all procedures to help gender diverse people align their bodies and brains should be considered covered preventative care.
Katharine Shaffer, Baltimore City

Trans people deserve health care.
Ryan Stanley, Anne Arundel County

I have multiple trans friends and wish for them to have just as easy access to the surgeries they need as anyone else.
Jimmy Beans, Worcester County

All Americans deserve equal health care and protection! That includes medical as well as mental health.
Dennis Rivenburgh, Baltimore County

SB 460_Maryland Coalition of Families_Fav.pdf
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Position: FAV

SB 460 – Maryland Medical Assistance Program – Gender Affirming Treatment (Trans Health Equity Act)

Committee: Senate Finance
Date: February 28, 2023
POSITION: Support

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) helps families who care for a loved one with behavioral health needs. Using personal experience, our staff provide one-to-one peer support and navigation services to family members with a child, youth or adult with a mental health, substance use or gambling challenge.

MCF enthusiastically supports SB 460.

Data shows that transgender people experience rates of mental illness and substance misuse at rates much higher than the general population. This is especially true of transgender children and adolescents. A 2020 survey, done by the Trevor Project, showed that 52% of all transgender and nonbinary young people in the U.S. seriously contemplated killing themselves in 2020. Another study of 2020 found that 56% of transgender youth reported a previous suicide attempt and 86% reported suicidality.

Gender affirming treatment can have a profound impact on the behavioral health of transgender individuals. A study published in 2020 in the American Journal of Psychiatry found that among transgender individuals, undergoing gender-affirming surgery was significantly associated with a decrease in mental health treatment over time.

In this matter, I have the personal experience of my own family to draw on.

Our son (born a girl) experienced gender-questioning behavior from the age of 2. At the age of 13, he developed significant mental health problems, including severe self-injurious behavior and multiple suicide attempts, which was at the same time that he decided for himself that he was not of the gender assigned to him at birth. Because of his significant mental health issues, we (mistakenly) did not permit him to undertake any gender reassignment measures as an adolescent.

His mental health continued to decline, and he developed serious substance use issues. At a significant cost to the state, he:

- Spent 9 months in a Maryland Residential Treatment Center (RTC) (paid for by Medicaid)
- Experienced multiple inpatient hospitalizations (paid for by Medicaid)
- Lived for one year in a Residential Rehabilitation Program (RRP) (paid for by Medicaid)

At the age of 19, when he began his gender affirming treatment, his mental health challenges dramatically improved. He stopped self-injuring, there were no more suicide attempts, and furthermore he:

- Got sober
- Moved into his own apartment
- Finished college
- Got off of SSI
- Got off of SSDI
- Is now employed as a software engineer with a well-paying job.

He has joined the ranks of Maryland taxpayers. The cost savings to the state are inestimable.

Our son's gender-reassignment surgery was truly transformative. All transgender individuals should have the opportunity to live a happy and productive life. SB 460 would ensure this.

We urge a favorable report.

Director of Public Policy
The Maryland Coalition of Families
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SB 460_PJC_Favorable_FIN.pdf
Uploaded by: Ashley Black
Position: FAV

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SB 460
Maryland Medical Assistance Program – Gender-Affirming Treatment (Trans Health Equity Act)
Hearing of the Senate Finance Committee
February 28, 2023
1:00 PM

SUPPORT

The Public Justice Center (PJC) is a not-for-profit civil rights and anti-poverty legal services organization which seeks to advance social justice, economic and racial equity, and fundamental human rights in Maryland. Our Health and Benefits Equity Project advocates to protect and expand access to healthcare and safety net services for Marylanders struggling to make ends meet. We support policies and practices that are designed to eliminate economic and racial inequities and enable every Marylander to attain their highest level of health. **The PJC stands in strong support of SB 460**, the Trans Health Equity Act of 2023, which would require the Maryland Medical Assistance (Medicaid) Program to cover medically necessary gender-affirming treatment.

Maryland is home to more than 22,000 individuals who identify as transgender. Nationally, the transgender community experiences higher rates of poverty compared to cisgender people.[1] Similarly, Black, Asian and other non-white LGBT people experience higher rates of poverty compared to their cisgender, straight same-race counterparts.[2] Transgender Marylanders are navigating a tiered healthcare system where certain gender affirming care that would be covered in private insurance is not covered for Medicaid beneficiaries. Further, the existing list of gender-affirming care that is currently covered by Medicaid is outdated and does not cover comprehensive medically necessary and life-saving care. The lack of access to gender-affirming care impacts low-income transgender Marylanders by leaving them vulnerable not only to discrimination in various areas of life, but also to physical and mental health complications.

SB 460 aims to correct this glaring disparity by requiring Medicaid to expand the gender-affirming care that it covers, allowing Maryland to join more than 10 other states that provide more comprehensive care. If passed, SB 460 would increase health equity and improve health outcomes, including mental and physical health, for

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[1] Badgett, M.V. Lee, *et al.* UCLA School of Law Williams Institute, *LGBT Poverty in the United States* (2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf.

[2] *Id.*

The Public Justice Center is a 501(c)(3) charitable organization and as such does not endorse or oppose any political party or candidate for elected office.

transgender Marylanders. For these reasons, the Public Justice Center urges the committee to issue a **FAVORABLE** report for **SB 460.** If you have any questions about this testimony, please contact Ashley Black at 410-625-9409 x 224 or blacka@publicjustice.org.

The Public Justice Center is a 501(c)(3) charitable organization and as such does not endorse or oppose any political party or candidate for elected office.

Support - SB 460- Gender Affirming Healthcare - K
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Position: FAV

Unitarian Universalist Legislative Ministry of Maryland

Testimony in Support of SB 460 -
The Maryland Medical Assistance Program--Gender-Affirming Treatment
(Trans Health Equity Act).

TO: Senator Melony Griffith, Chair and Members of the Finance Committee
FROM: Kari Alperovitz-Bichell, MD MPH, Advocate for Reproductive Health Care Rights
Unitarian Universalist Legislative Ministry of Maryland,
DATE: February 28, 2023

I am Kari Alperovitz-Bichell, MD representing myself as a physician and also representing the Unitarian Universalist Legislative Ministry of Maryland. I am requesting your support for **SB 460 - The Maryland Medical Assistance Program- Gender-Affirming Treatment (Trans Health Equity Act).**

As a primary care physician who has treated many transgender and gender-diverse patients, I am very aware of the medical necessity of gender affirming medical care in general, and also of each of the specific medical services enumerated in this bill. None of these are superfluous or luxurious, they are part of what is needed to appropriately and successfully treat these patients. Furthermore, the bill's requirement that insurance denials should be made only by a clinician who is knowledgeable and experienced in providing gender affirming care is important. Even for relatively common conditions that have no stigma attached, treating physicians like me often find that insurance company denials are dictated by algorithms or insurance company employees who do not have sufficient knowledge. Given that patients in need of gender affirming care are fairly rare, and that there continues to be significant bias against them, this problem with uninformed insurance denials is likely to be exacerbated.

As a Unitarian Universalist, I am called by our First Principle to affirm the inherent worth and dignity of every human being. Therefore my faith calls on me to advocate for necessary medical care for all, including gender affirming care. Furthermore, this care should be available to all who need it, including patients insured through Medical Assistance. It should not be available to only those wealthy enough to afford it.

I personally, and we of the Unitarian Universalist Legislative Ministry, strongly urge you to support SB 460.

Respectfully submitted,
Kari Alperovitz-Bichell, MD MPH -
Unitarian Universalist Legislative Ministry Advocate for Health Care Rights
Annapolis, Md District 30A

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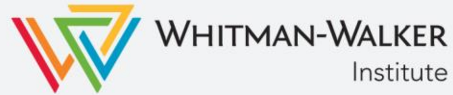
Position: FAV



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Testimony in Support of SB 0460
Maryland Medical Assistance Program – Gender-Affirming Treatment
(Trans Health Equity Act)
Maryland Senate Finance Committee
February 28, 2023

Kellan E. Baker, PhD, MPH, MA
Executive Director, Whitman-Walker Institute

Dear Chair Melony Griffith and Members of the Committee:

Thank you for the opportunity to testify in support of Senate Bill 0460.

I am the Executive Director of Whitman-Walker Institute, which is the research, policy, and education arm of Whitman-Walker, a Federally Qualified Community Health Center based in Washington, DC. We serve 20,000 patients per year from across the Washington metropolitan area, of whom almost 20% come from Maryland.

I am a health services researcher trained at the Johns Hopkins School of Public Health in Baltimore, where I received my PhD from the Department of Health Policy and Management as a Centennial Scholar and Robert Wood Johnson Health Policy Research Scholar. My research focuses on transgender population health, with a particular emphasis on the economic and legal elements of coverage for gender-affirming care. For the last decade, I have worked with Medicaid programs in more than a dozen states, including Maryland, to ensure that transgender people can access the gender-affirming services that are medically necessary for their health and well-being.

Parity in coverage of medically necessary treatments prescribed by clinicians for different indications, following expert standards of care, is a well-established principle in the Medicaid program.[1] Gender-affirming care is routinely provided by clinicians and covered by insurers for a variety of indications, which may be met by transgender and cisgender people alike: medically necessary reconstructive breast and chest surgeries, for instance, are performed for cisgender and transgender people of all genders.[2] Abdominoplasty is a common intervention for people who have had bariatric surgery,[3] while puberty delay medications were first prescribed to treat precocious puberty in non-transgender children.[4] The provision of gender-affirming clinical services to transgender people is guided by the expert standards laid out by the World Professional Association for Transgender Health, which has maintained these standards continuously since 1979.[5] The authority of these expert standards is recognized by major public and private plans and coverage programs

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[1] § 440.230(c) of the Federal Medicaid statute provides that "the Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition."

[2] American Society of Plastic Surgeons. (2020). ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Breast Reconstruction for Deformities Unrelated to Cancer Treatment. https://www.plasticsurgery.org/Documents/Health-Policy/Reimbursement/insurance-2018-breast-reconstruction-deformities.pdf

[3] Ngaage, L. M., Elegbede, A., Pace, L., Rosen, C., Tannouri, S., Rada, E. M., Kligman, M. D., & Rasko, Y. M. (2020). Review of Insurance Coverage for Abdominal Contouring Procedures in the Postbariatric Population. *Plastic and Reconstructive Surgery*, *145*(2), 545–554. https://doi.org/10.1097/PRS.0000000000006513

[4] T'Sjoen, G., Arcelus, J., Gooren, L., Klink, D. T., & Tangpricha, V. (2019). Endocrinology of Transgender Medicine. *Endocrine Reviews*, *40*(1), 97–117. https://doi.org/10.1210/er.2018-00011

[5] Coleman, E., Bockting, W., Botzer, M., et al. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. *International Journal of Transgenderism*, *13*(4), 165–232. https://doi.org/10.1080/15532739.2011.700873

across the country; for instance, the Federal Employee Health Benefits Program (FEHBP) requires carriers to adopt "one or more recognized entities in order to guide evidence-based benefits coverage and medical policies pertaining to gender-affirming care and services, such as the World Professional Association of Transgender Health (WPATH) Standards of Care, the Endocrine Society, and the Fenway Institute. These entities provide evidence-based clinical guidelines for health professionals to assist transgender and gender diverse people with safe and effective pathways that maximize their overall health, including physical and psychological well-being."[6]

Evidence indicates that insurance coverage of gender-affirming care for transgender people is low-cost and highly cost-effective. A California Department of Insurance assessment of a state law that broadly prohibited insurance discrimination against transgender beneficiaries, for instance, showed that a major state university–sponsored plan had a gender-affirming care utilization rate of only 0.062 per 1,000 covered persons over the 6.5 years following the law's enactment; across the state, impacts on premium costs were "immaterial," leading the Department to conclude that "the benefits of eliminating discrimination far exceed the insignificant costs."[7] An economic model evaluating the cost-effectiveness of care for transgender men that included hormone replacement therapy, mastectomy, abdominoplasty, hysterectomy, genital reconstruction, and other services underscores this conclusion, finding that the incremental cost-effectiveness ratio (ICER) of these services was less than $8,000 per quality-adjusted life year (QALY) gained over a ten-year time horizon.[8] This is far below a typical U.S. "willingness to pay" threshold of $100,000 per QALY.[9] This study also found that, on a per member per month (PMPM) basis, coverage of surgical and other services for transgender men and women together cost just $0.016. My own recent research indicates that each covered transgender person in a major national commercial insurance database incurred an average of less than $1,800 in costs per year for gender-affirming hormone therapy (including puberty delay medications) and surgeries (including facial surgeries) combined.[10] Considered on a PMPM basis, the budget impact of covering gender-affirming care was $0.73 per year, or $0.06 PMPM. Similarly, an actuarial assessment conducted for the North Carolina State Health Plan estimated a PMPM cost range of $0.06-$0.15 (0.011% to 0.027% of premiums),[11] and estimates from other states show equally low utilization and related low costs, with Alaska estimating costs at 0.011% to 0.027% of premiums[12] and Wisconsin noting costs to its state employee plan are "immaterial at 0.1% to 0.2% of the total cost."[13] Cost estimates of coverage for gender-affirming care under Wisconsin Medicaid were "actuarially immaterial, as they are equal to approximately 0.008% to 0.03%"[14] of Wisconsin's share of its Medicaid budget. An analysis in the military context concluded that the cost of

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[6] United States Office of Personnel Management. (2022). Federal Benefits Open Season November 14, 2022 – December 12, 2022. https://cdn.govexec.com/media/gbc/docs/pdfs_edit/093022ew1.pdf

[7] State of California Department of Insurance. (2012). Economic Impact Assessment: Gender Nondiscrimination in Health Insurance. http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf

[8] Padula, W. V., Heru, S., & Campbell, J. D. (2016). Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis. *Journal of General Internal Medicine*, *31*(4), 394–401. https://doi.org/10.1007/s11606-015-3529-6

[9] Cameron, D., Ubels, J., & Norström, F. (2018). On what basis are medical cost-effectiveness thresholds set? Clashing opinions and an absence of data: a systematic review. *Global health action*, *11*(1), 1447828. https://doi.org/10.1080/16549716.2018.1447828

[10] Baker, K., & Restar, A. (2022). Utilization and Costs of Gender-Affirming Care in a Commercially Insured Transgender Population. *Journal of Law, Medicine & Ethics, 50*(3), 456-470. doi:10.1017/jme.2022.87

[11] Schatten, K. R., & Viera, K. C. (2016). Memorandum to Mona Moon, Administrator, North Carolina State Health Plan, re: Transgender Cost Estimate. https://www.shpnc.org/media/22/download

[12] Plaintiffs' Motion for Partial Summary Judgment, *Fletcher v. Alaska*, No. 1:18-cv-00007-HRH (D. Alaska July 1, 2019), https://www.lambdalegal.org/sites/default/files/legal-docs/downloads/fletcher_ak_20190701_plaintiffs-motion-for-partial-summary-judgment.pdf

[13] *Boyden v. Conlin*, 341 F. Supp. 3d 979, 1000 (W.D. Wis. 2018).

[14] *Flack v. Wis. Dept of Health Servs.*, 395 F. Supp. 3d 1001, 1008 (W.D. Wis. 2019).

covering gender-affirming care was "too low to matter"[15] or, as military leadership noted, "'budget dust,' hardly even a rounding error."[16]

As evidence has mounted that eliminating discrimination against transgender people in insurance coverage has both moral and economic advantages, many Medicaid programs have taken steps to fulfill their historical imperative to cover medically necessary care without diagnosis- or condition-based restrictions.[17] Maryland became one of the early leaders in this area by removing its blanket exclusion of gender-affirming care in 2015. In the last several years, however, as the field of transgender medicine has continued to advance, it has become apparent that further clarification is needed of the appropriate scope of coverage for gender-affirming care.[18]

In Washington State, for instance, legislators enacted reforms to the state's Medicaid program in 2021 to clarify coverage of a broad range of "surgical and ancillary services," as well as puberty-delay medications, for transgender people.[19] The legislation indicates that the list of covered services is not exhaustive and requires that a "health care provider with experience prescribing and/or delivering gender-affirming treatment must review and confirm the appropriateness of any adverse benefit determination."[20] The law also directs the insurance commissioner, in consultation with the Medicaid agency, to issue a report on geographic access to gender-affirming treatment across the state and estimates a minimal annual burden of time and cost to produce this report. This report, like that envisioned by SB 0460, is essential given the difficulty transgender people often face in accessing providers willing and able to serve them.[21]

Colorado recently took a similar step through its Essential Health Benefit (EHB) program.[22] With approval from the Federal Centers for Medicare & Medicaid Services, EHB plans in the state are now required to cover the following procedures, at a minimum, for transgender people: gender-affirming hormone therapy, chest reconstruction, augmentation mammoplasty, genital surgeries, facial feminization surgeries, and laser or electrolysis hair removal.[23] An actuarial analysis commissioned by the state to assess the cost of these procedures estimated that their long-term steady state cost will be 0.04% of total allowed claims.[24]

Maryland has previously been a nationwide leader in helping to ensure that transgender people can access the health care they need. Maryland's commitment to the health and wellbeing of its Medicaid population is particularly laudable, given that gender-affirming care is not expensive when considered from a payer or societal perspective but can easily be beyond the individual reach of transgender people who rely on

[15] Belkin A. (2015). Caring for our transgender troops – The negligible cost of transition-related care. *New Eng J Med, 373*, 1089–1092. https://www.nejm.org/doi/full/10.1056/NEJMp1509230

[16] Declaration of Raymond Edwin Mabus, Jr., Former U.S. Secretary of the Navy, in Support of Plaintiff's Motion for Preliminary Injunction, *Doe v. Trump*, No. 17-cv-1597-CKK (D.D.C.) filed Aug. 31, 2017, at 41). http://files.eqcf.org/wp-content/uploads/2017/09/13-Ps-App-PI.pdf

[17] Baker, K. E. (2017). The Future of Transgender Coverage. *New England Journal of Medicine*, *376*(19), 1801–1804. https://doi.org/10.1056/NEJMp1702427

[18] Zaliznyak, M., Jung, E. E., Bresee, C., & Garcia, M. M. (2021). Which U.S. States' Medicaid Programs Provide Coverage for Gender-Affirming Hormone Therapy and Gender-Affirming Genital Surgery for Transgender Patients?: A State-by-State Review, and a Study Detailing the Patient Experience to Confirm Coverage of Services. *The Journal of Sexual Medicine*, *18*(2), 410–422. https://doi.org/10.1016/j.jsxm.2020.11.016

[19] Washington State Legislature. SB 5313 (2021-2022). https://app.leg.wa.gov/billsummary?BillNumber=5313&Initiative=false&Year=2021

[20] Washington State Healthcare Authority. (2022). Transhealth Program. https://www.hca.wa.gov/billers-providers-partners/programs-and-services/transhealth-program

[21] Terris-Feldman, A., Chen, A., Poudrier, G., & Garcia, M. (2020). How Accessible Is Genital Gender-Affirming Surgery for Transgender Patients With Commercial and Public Health Insurance in the United States? Results of a Patient-Modeled Search for Services and a Survey of Providers. *Sexual medicine*, *8*(4), 664–672. https://doi.org/10.1016/j.esxm.2020.08.005

[22] Keith, K. (2021). Unpacking Colorado's New Guidance on Transgender Health. https://www.commonwealthfund.org/blog/2021/unpacking-colorados-new-guidance-transgender-health

[23] Colorado Benchmark Plan for 2023: https://drive.google.com/file/d/1IFH38vhQyJNyn_cE5upNQ_jfTw8HoSQG/view?usp=sharing

[24] Wakely Consulting Group, LLC. (2021). Benchmark Plan Benefit Valuation Report: Report to the State of Colorado Division of Insurance. https://drive.google.com/file/d/1rTeY63imbtlmFIzFHerSeyfHKE6hZSN8/view?usp=sharing

Medicaid. Such communal assistance to individuals in need reflects the fundamental social compact of the Medicaid program, and clarifying that Medicaid supports transgender Marylanders in seeking essential health care services is both a moral and economic imperative. I strongly urge you to support SB 0460.

Thank you for your time and consideration.

Sincerely Yours,

Kellan E. Baker, PhD, MPH, MA
Executive Director, Whitman-Walker Institute
1377 R St. NW, Washington, DC 20009
kbaker@whitman-walker.org | (202) 797-4417

Senate Bill 460 Maryland Medical Assistance Progra

Uploaded by: Bonnie Smith

Position: FAV

Senate Bill 460 Maryland Medical Assistance Program – Gender-Affirming Treatment Trans Health Equity Act February 28, 2023

Support

Dear Chair Griffith, Vice Chair Klausmeier, and members of the Finance Committee,

My name is Bonnie Kingsley Smith. I am a resident of District 43B. I am submitting this testimony in support of SB0460, the Trans Health Equity Act, which would expand Maryland Medicaid to cover lifesaving gender-affirming care.

As a 65-year-old male-to-female transgender person I find day to day presenting as my female self a critical part of my emotional wellbeing. I have spent a considerable amount of money clearing my facial hair through electrolysis. This is a long and painful process that I endure to be passable as my true self in public. My grey beard does not work with the more economical laser hair removal. Electrolysis is not an "elective" procedure with me. The only option I have *is* electrolysis.

The cost of electrolysis has been a heavy financial drain on my savings. I urge you to pass SB0460 to help alleviate some of the financial anxiety I endure. Electrolysis is already painful enough without depleting my savings in the process!

I respectfully urge this committee to return a favorable report on SB0460.

SB0460 Trans Health Equity Act of 2023 FAV.pdf
Uploaded by: Cecilia Plante
Position: FAV

TESTIMONY FOR SB0460
Maryland Medical Assistance Program - Gender-Affirming Treatment (Trans Health Equity Act)

Bill Sponsor: Senator Washington
Committee: Finance
Organization Submitting: Maryland Legislative Coalition
Person Submitting: Cecilia Plante, co-chair
Position: FAVORABLE

I am submitting this testimony in strong support of SB0460 on behalf of the Maryland Legislative Coalition. The Maryland Legislative Coalition is an association of activists - individuals and grassroots groups in every district in the state. We are unpaid citizen lobbyists and our Coalition supports well over 30,000 members.

This bill would help trans individuals to convert to their correct gender by requiring the Maryland Medical Assistance Program to cover gender-affirming treatments that are medically necessary and proscribed in accordance with the current clinical standards of care. The program may not deny coverage by saying that these treatments are cosmetic; or by limiting the treatments; or having a separate health care provider approve them.

Our members feel that it is important to live comfortably in your own skin, and in order to live a healthy and productive life, these treatments are essential for trans individuals. Their concerns are not superficial, and they should not be ignored or denied as such.

We strongly support this bill and recommend a **FAVORABLE** report in committee.

MC Federation of Families Testimony in Support of

Uploaded by: Celia Serkin

Position: FAV

Montgomery County Federation of Families for Children's Mental Health, Inc.
Colesville Professional Center
13321 New Hampshire Avenue, Terrace B
Silver Spring, MD 20904
301-879-5200 (phone number) 301-879-0012 (fax number)
info@mcfof.org (email) www.mcfof.org (website)

Senate Bill 460 Maryland Medical Assistance Program – Gender–Affirming Treatment
(Trans Health Equity Act)
Senate Finance
February 28, 2023
TESTIMONY IN SUPPORT

My name is Celia Serkin. I am Executive Director of the Montgomery County Federation of Families for Children's Mental Health, Inc., a family support organization providing family peer services, family navigation, group support, education, recovery coaching, and advocacy to help parents and other primary caregivers who have children, youth, and/or young adults with behavioral health challenges (mental health, substance use or co-occurring disorders). We serve families from diverse cultural, racial, ethnic, social-economic, and religious backgrounds. The organization is run by parents who have raised children with behavioral health challenges. I have two children, now adults, who have behavioral health challenges.

The Montgomery County Federation of Families for Children's Mental Health, Inc., is pleased to support Senate Bill 460, requiring, beginning on a certain date, the Maryland Medical Assistance Program to provide medically necessary gender–affirming treatment in a nondiscriminatory manner; requiring that the gender–affirming treatment be assessed according to nondiscriminatory criteria that are consistent with current clinical standards; prohibiting the Program from issuing an adverse benefit determination related to gender–affirming treatment unless a health care provider with experience prescribing or delivering gender–affirming treatment has reviewed and confirmed the appropriateness of the determination; and generally relating to gender–affirming treatment and the Maryland Medical Assistance Program.

The Montgomery County Federation of Families for Children's Mental Health, Inc. firmly believes that gender-affirming healthcare save lives. These practices lower rates of mental health issues, build self-esteem, and improve an individual's overall quality of life. This medically necessary, life-saving care must be accessible for low-income Marylanders on Medicaid, just as it is under many private insurance plans. Research evinces that gender-affirming care greatly improves the mental health and overall well-being of gender diverse, transgender, and nonbinary children and adolescents. This low cost, high impact legislation will dramatically increase mental wellbeing, reduce suicidality, and save lives. It brings Maryland into compliance with federal legal guidelines. The federal government has named gender-affirming care as an "essential health benefit" protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Every major medical association, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics, found that this care is medically necessary. This bill ensures Maryland Medicaid offers comprehensive healthcare coverage to

the transgender community, in compliance with internationally recognized, best medical practices. Moreover, it reduces the significant health inequities faced by Maryland's transgender community.

This intervention is cost effective. These services are federally reimbursable and cost only 0.005% of our Medicaid budget. Maryland will save costs from reduced long-term physical and mental health complications, such as a 84% reduction in suicide attempts. Reducing discrimination is a cost saving measure - without gender-affirming care, transgender people are more likely to be "outed." 24% of trans Marylanders are evicted or denied housing because they are transgender, and nationwide are 4 times more likely to be victims of violent crime.

This bill will improve behavioral health outcomes and save lives. **For these reasons, the Montgomery County Federation of Families for Children's Mental Health, Inc. urges this committee to pass SB 460.**

Support SB 460 - THEA.pdf
Uploaded by: Eileen Lorenz
Position: FAV

SENATE - FINANCE

Senate Bill SB 460
Maryland Medical Assistance Program – Gender-Affirming Treatment
Trans Health Equity Act
February 28, 2023

Testimony of Eileen Lorenz

Bowie, MD (District 23)

Dear Chair Griffith, Vice Chair Klausmeier, and members of the Senate Finance Committee,

I am submitting this testimony in support of SB460, the Trans Health Equity Act, which would expand Maryland Medicaid to cover lifesaving gender-affirming care. I am not a medical or mental health expert, but I do know a basic fact that should dictate the future of this bill: trans people are people and should be treated with dignity and respect. My nephew will be 11 this coming April. He is one of the best kids I've ever known. He brings joy to any room he enters and is always beaming with a confidence I wish I had. As he gets older, I fear that his body could become a source of anxiety and insecurity if he does not have access to proper treatment. He deserves every opportunity that the cis population has to feel seen as himself– to have his exterior match his internal identity. I want him to know that the society he lives in values his health and would support his need for gender-affirming medical treatment, should that be his circumstance. There is no reason gender-affirming treatment should be approached any differently than other medical treatments. It has the power to save lives. Our trans friends, family members, and neighbors are all watching this legislative process. This vote can and will tell them whether the state of Maryland prioritizes their livelihood.

I respectfully urge this committee to return a favorable report on SB460.

Thank you,

Eileen Lorenz

SB 460_EMD_Favorable_FIN.pdf

Uploaded by: End Medical Debt Maryland

Position: FAV

Testimony on **SB 460**
Maryland Medical Assistance Program - Gender-Affirming Treatment
Trans Health Equity Act
Hearing of the Senate Finance Committee
February 28, 2023
1:00 PM

Position: **FAVORABLE**

To Chair Griffith & Members of the Senate Finance Committee:

As a coalition of more than 60 organizations across the state of Maryland fighting injustice in our healthcare system, End Medical Debt Maryland endorses **SB 460**: **Trans Health Equity Act.** We urge the committee to issue a **FAVORABLE** report.

Gender-affirming care, like most healthcare in the United States, can be astronomically expensive. The Maryland Medical Assistance (Medicaid) Program fails to cover certain types of gender-affirming care, and as a result, thousands of low-income transgender Marylanders are unable to receive coverage for lifesaving treatments. Marylanders who seek gender-affirming care are left to depend on employer-provided insurance or purchase private insurance at high costs, a luxury that is not accessible to all. Even those fortunate enough to have private insurance coverage often find their plans do not cover gender-affirming care. Employers frequently purchase plans that do not cover the health needs of transgender workers, whether out of transphobia or a general lack of awareness about the necessity of gender-affirming care to save lives.

By expanding the Maryland Medicaid program, we can ensure low-income Marylanders have coverage for gender-affirming care regardless of their employment status.

No Marylander should be made to choose between pursuing the care they need and accumulating medical debt. That is the choice we are currently requiring of low-income transgender Marylanders who depend on Medicaid for healthcare coverage. Either option can lead to devastating consequences.

End Medical Debt Maryland respectfully urges the Committee to remove barriers to gender-affirming healthcare by voting **YES** on the **Trans Health Equity Act**.

Sincerely,

Brige Dumais, *Coalition Chair*
End Medical Debt Maryland
brigette.dumais@1199.org

***End Medical Debt Maryland** is a statewide coalition of 60+ organizations and community members working together to pass comprehensive medical billing reform, educate Marylanders on their rights as patients, and eliminate barriers to healthcare. We are labor unions, faith leaders, patient advocates, consumer rights proponents, lawyers, healthcare providers, and people directly impacted by medical debt. Collectively, we represent over 350,000 Marylanders. Learn more at www.bit.ly/emdmaryland.*

SB460_FAV_AlzheimersAssociationMD.pdf
Uploaded by: Eric Colchamiro
Position: FAV

Testimony of the Alzheimer's Association Greater Maryland and National Capital Area Chapters
SB 460 - Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)
Position: Favorable

Chair Griffith and Vice Chair Klausmeier,
The Alzheimer's Association – representing the over 110,000 Marylanders with Alzheimer's and other forms of dementia, along with their caregivers – is here today in strong support of Senate Bill 460, the Trans Health Equity Act. This legislation requires, beginning on January 1, 2024, the Maryland Medical Assistance Program to provide gender-affirming treatment in a nondiscriminatory manner; requires that the gender-affirming treatment be assessed according to nondiscriminatory criteria that are consistent with current clinical standards; prohibits the issuance of an adverse benefit determination related to gender-affirming treatment unless a certain experienced health care provider has reviewed and confirmed the appropriateness of the determination.

There are over 110,000 Marylanders with Alzheimer's and dementia in Maryland; a number that is expected to grow to over 130,000 by 2025. Of this population, research has shown that 7.4% of them are living with Alzheimer's and related dementia (ADRD). Our transgender and gender nonbinary adults are more likely to report worsening memory and thinking, functional limitations and depression compared to cisgender (non-transgender) adults. [i]Transgender adults — individuals who identify with a gender different than the one assigned to them at birth — were nearly twice as likely to report SCD and more than twice as likely to report SCD-related functional limitations, such as reduced ability to work, volunteer or be social.

Our state needs to step up and help. 51% of LGBT people report being very concerned about having enough money to live on. And 40% say their support networks have become smaller over time. This bill suggests a solution which brings Maryland into compliance with federal guidelines, allows for federally reimbursable services, and costs only .0005% of our Medicaid budget. We urge a favorable report on this legislation.

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[i] https://aaic.alz.org/releases_2021/transgender-adults-cognition.asp

2_28_23 - SB460 Trans Health Equity Act.pdf
Uploaded by: Ericka McDonald
Position: FAV

TESTIMONY TO THE FINANCE COMMITTEE

SB460 - Trans Health Equity Act

Position- Support

By: Nancy Soreng, President LWVMD

Date: February 28, 2023

My name is Ericka McDonald. I'm testifying on behalf of the League of Women Voters, representing concerned citizens in districts throughout Maryland, in support of the Trans Health Equity Act. I'm also a parent of a transgender child who has benefited from gender-affirming care.

The League is a nonpartisan organization that works to influence public policy through education and advocacy. At the 2020 LWVUS Convention, delegates voted to amend the LWVUS bylaws to include the League's commitment to its Diversity, Equity, and Inclusion (DEI) Policy in Article II as one of the foundational policies of the organization alongside the Political Policy (also referred to as the Nonpartisan Policy).[1]

The League advocates for the health and safety of transgender Americans. The League's Health Care Policy states that affordable access to a basic level of quality care should be provided *for all U.S. residents*.[2] The League fights for equal rights for every person and is dedicated to creating a more inclusive and fair society.[3]

For those of you who are not familiar with transgender people, please understand that gender affirming care is treatment for a medical condition called gender dysphoria. Treatment for gender dysphoria is based on medical standards. It is endorsed by leading medical associations, including the American Medical Association.[4][5]

There are many misconceptions about gender dysphoria. The International Classification of Diseases specifies that it is a medical condition, not a mental disorder.[6] Treatment is not elective, cosmetic care. Detransitioning is extremely rare. Receipt of gender affirming care is proven to dramatically reduce rates of suicide attempts,

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[1] https://www.lwv.org/league-management/bylaws/lwvus-bylaws-and-certificate-incorporation
[2] https://www.lwv.org/sites/default/files/2020-12/LWV-impact-2020.pdf
[3] https://www.lwv.org/blog/major-lgbtq-rights-cases-happening-now
[4] https://www.ama-assn.org/health-care-advocacy/advocacy-update/march-26-2021-state-advocacy-update
[5] https://www.ama-assn.org/press-center/press-releases/ama-reinforces-opposition-restrictions-transgender-medical-care
[6] https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd

decreased rates of depression and anxiety, decreased substance use, and may other positive effects.[7]

Access to gender affirming medication and surgery - which my private insurance pays for - saved my child's life. Before receiving gender affirming care, my son suffered from suicide ideation, depression, and crippling anxiety. With care these problems are significantly reduced. He is healing; able to maintain friendships and pursue his education.

The League's mission is to empower voters and defend democracy, which depends on equitable treatment and protections under law for all Americans.[8] Marylanders who rely on Medicaid do not have the same access to necessary healthcare as those who have private insurance. And Black transgender Marylanders - who are disproportionately impacted by violence and homelessness - especially need this life saving care.[9]

I urge you, on behalf of my family and the League of Women Voters, Maryland, to return a favorable report.

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[7] https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf
[8] https://www.lwv.org/league-urges-us-senate-pass-equality-act
[9] https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

Testimony on Trans Health Equity Act 2_27_23.pdf

Uploaded by: H Victoria Hedian

Position: FAV

Senate Bill 460
Maryland Medical Assistance Program – Gender-Affirming Treatment
Trans Health Equity Act
Senate Finance Committee
February 28, 2023
Support

Dear Chair Griffith, Vice Chair Klausmeier, and Members of the Senate Finance Committee:

Thank you for the chance to testify in support of Senate Bill 460.

I am a native Maryland resident, a graduate of our University of Maryland School of Law, and a retired attorney who practiced law for 35 years in Maryland. My family in Baltimore dates back to the 1840s.

I believe that SB 460 is important because trans people are all around us, in every community and in far greater numbers than many realize, and they need gender-affirming health care. Among my own relatives there are two trans or nonbinary people in a group of fewer than 30. Among my friends, at least two have nonbinary grandchildren.

Members of this community face barriers because some people do not realize how common this is, and how difficult it can be to live in a body that feels wrong. Gender-affirming medical care can address this medical condition, but it is often seen as cosmetic or optional, when in fact is it an absolute necessity. Passing this bill would expand the coverage of gender-affirming medical care for Maryland Medicaid recipients. It would make a big difference in the lives of these Marylanders.

Please do what you can to support this community and see that gender-affirming care is available to all who need it.

I respectfully urge this Committee to return a favorable report on SB 460.

Thank you for your consideration.

H. Victoria Hedian
3107 Juneau Place
Baltimore, MD 21214

SB0460.LOS.pdf
Uploaded by: Heather Forsyth
Position: FAV

ANTHONY G. BROWN
Attorney General

CANDACE MCLAREN LANHAM
Chief of Staff

CAROLYN A. QUATTROCKI
Deputy Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

FACSIMILE NO. 410.576.6571

WRITER'S DIRECT DIAL NO. 410.576.6513

February 27, 2023

To: The Honorable Melony Griffith
Chair, Senate Finance Committee
From: The Office of the Attorney General
Re: SB0460 – Maryland Medical Assistance Program – Gender Affirming Treatment (Trans Health Equity Act)

The Office of the Attorney General writes to urge your favorable report for SB0460. This bill clarifies the definition of covered gender-affirming treatment for enrollees in the Maryland Medical Assistance Program. It requires assessment of treatment requests in accordance with current clinical standards of care and prohibits the denial or limitation of coverage without review by a health care provider with experience delivering gender-affirming treatment and confirmation that the denial or limitation is appropriate. The bill also requires each Managed Care Organization contracted with the Maryland Department of Health to compile annually the names and locations of each provider the MCO has a contract with to provide gender-affirming treatment, and the types of treatment offered. This information is to be included in provider directories, on the Department's website, and in an annual report on geographic access to gender-affirming treatment across the state. In totality, this bill intends to reduce as many barriers as possible to access to gender-affirming treatment for those who seek it.

Transgender individuals often face multiple barriers to obtaining care; they are also more likely than their peers to be uninsured, in poor health, suffer from psychological distress (including a higher risk of suicide), and to have low household incomes. Nearly 1 in 10 transgender adults in the U.S. are income-eligible for Medicaid services. Recently, the Biden Administration asserted it will enforce sexual orientation and gender identity protections under Section 1557 of the Affordable Care Act which prohibits discrimination based on sex. https://www.kff.org/womens-health-policy/issue-brief/update-on-medicaid-coverage-of-gender-affirming-health-services/

The World Professional Association for Transgender Health notes in its Standards of Care, 7th version (originally published in 1979), that its clinical guidance is established

to help health professionals assist transsexual, transgender, and gender nonconforming people maximize their overall health, psychological well-being, and self-fulfillment. World Professional Association for Transgender Health. (2012). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* [7th Version]. https://www.wpath.org/publications/soc. The American Medical Association also supports access to quality, evidence-based health care regardless of gender or sexual orientation. https://www.ama-assn.org/delivering-care/population-care/advocating-lgbtq-community

Support of the Trans Health Equity Act is consistent with the goals and priorities of the Office of the Attorney General to promote policies and initiatives that combat systemic inequities and protect the rights, responsibilities, and privileges of all Marylanders.

We urge your favorable support of SB0460.

Dr. Hedian Support Tesimony SB460.pdf
Uploaded by: Helene Hedian
Position: FAV

Government and Community Affairs

SB460
Favorable

TO: The Honorable Melony Griffith
Finance Committee

FROM: Dr. Helene F. Hedian, M.D.
Johns Hopkins Medicine

DATE: February 28, 2023

RE: SB460 – Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

On behalf of Johns Hopkins University and Medicine, thank you for this opportunity to testify in support of the Trans Health Equity Act of 2023 (SB460).

My name is Dr. Helene F. Hedian, and I am an internal medicine physician who provides primary care in the Baltimore region. I completed my medical school and training in Maryland, and I have been in independent practice for several years.

A large portion of my patient panel is transgender or nonbinary. I provide gender-affirming care, including hormone prescribing for medical affirmation (also referred to as "transition"). I have met and cared for hundreds of transgender people. I teach doctors in training about the medical needs of transgender people. I have lectured on this subject at local hospitals and health systems and at national conferences. I belong to professional organizations which focus on transgender health, in order to ensure I'm providing the optimal standard of care for my patients. And in partnership with other experts in the field of transgender care, I have written a pocket guide to make it easier for other primary care doctors to begin gender-affirming hormones for patients who need it. This pocket guide has been downloaded in several countries around the world.

The current coverage for transgender care is important, and I am very grateful for the expansion of coverage which occurred about 10 years ago. Because of the current coverage, many of my patients have been able to access medically necessary care such as hormones, mental health care, and chest or genital surgery for feminization or masculinization. And by following the guidelines set forth by their insurance companies, they have received coverage for these services.

Happily, this expansion of services has not caused significant financial strain on the insurance system. In one study which compared the cost of healthcare in a privately insured population before and after expansion of coverage to include gender-affirming care, the cost was minimal when spread out over the entire insured population: the additional cost totaled 6 cents per member per month (source: https://jscholarship.library.jhu.edu/handle/1774.2/64057).

Yet the current coverage leaves several critical gaps. Hair removal and hair transplantation, speech

therapy and voice surgery, facial feminization surgery, body contouring, and fertility preservation are all excluded from the current coverage. You might ask yourself – why are these procedures medically necessary? Especially given that patients may take hormones which are covered by their current plans.

Taking feminizing or masculinizing hormones causes reversible changes to muscle bulk and body fat distribution. These changes are an important component of achieving a gender expression. But hormones do not change bone structure, hair growth, or voice. As a result, they do not always lead to sufficient changes. There may also be medical reasons which limit someone's ability to take hormones. For example, a transgender woman with a genetic predisposition to breast cancer might wish to minimize exposure to estrogen to reduce her risk of developing cancer. These procedures would help her achieve a more feminine appearance without putting herself at additional medical risk.

These procedures are not cosmetic.

They are not elective.

In our society, many people unconsciously ascribe a gender to a person that they see or meet. They examine hairstyles, clothing, bone structure, speech patterns, mannerisms, and accessories in a split-second and decide whether to say "How can I help you, sir?" or "Excuse me, ma'am."

This unconscious analysis is how we categorize and understand people. This process is not malicious. Yet there are people who will challenge, confront, and even assault a person who doesn't appear to fit neatly into a category of "man" or "woman." As a result of this intolerance, many people - especially transgender women of color - have lost their lives from acts of discrimination and violence.

The lack of tolerance and compassion that leads some people to inflict harm on those they don't understand is a larger problem. And there should be space in our society for gender nonconformity and a celebration of the gender spectrum. But the sad truth is that when people are not immediately identifiable as transgender by their appearance or the sound of their voice by a malicious stranger on the street, they are safer.

Yet for many young people starting hormones for the first time – often without the financial support of a family network – saving money for procedures like this simply isn't realistic.

And this – ultimately – is the point. Each of the procedures set forth in this bill is medically necessary. Some of these procedures are relatively inexpensive for a health plan but cost prohibitive for an individual. These are the procedures that are most likely to be widely adopted if this bill passes. Each person is unique – not every transgender person will need or utilize each service. Procedures which are more expensive will not be used by as many people. And compared to the total population of Maryland, the number of transgender people is relatively small: 0.6%. As shown in earlier research on this subject, the financial impact of this expansion of coverage will be relatively small when spread out over the entire insured population.

I have seen firsthand the improved physical and mental health which comes from living in a body which is finally aligned with one's internal gender identity. As a pragmatic observation from a healthcare provider: people who are happier in their bodies take better care of them. And people who

take better care of their bodies have fewer healthcare expenses.

Passing this bill will not only dramatically improve the lives of people who need and deserve this care, it is also – happily – a smart financial decision.

I urge you a favorable report on the Trans Health Equity Act (SB460).

Thank you for your time and consideration.

Best Regards,

Helene F. Hedian, MD

SB0460 Trans Health Equity Act Testimony Annapolis

Uploaded by: Jaden Farris

Position: FAV

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February 28, 2023

SB0 460 - Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)
Position: FAVORABLE

The Board of Directors of Annapolis Pride enthusiastically supports Senate Bill 0460, which is essential in helping to create an equitable and inclusive healthcare system in Maryland. It is vital that transgender individuals have access to the medical care they need without fear of discrimination or denial of services.

The legislation would update the Maryland Department of Health's policy on gender-affirming care to ensure coverage for all medically necessary treatments related to an individual's gender identity. These treatments would be prescribed by a licensed healthcare provider, and would adhere to the most up-to-date, non-discriminatory standards. By doing so, the bill would bring the state's Medicaid program in line with the latest best practices. The bill specifies that the Medicaid program cannot adopt blanket denials for types of transition-related care, and instead creates a policy that medical necessity must always be determined in the context of the individual's circumstances.

Medicaid currently has over 30 categorical exclusions that have been in place for decades. By passing this vital legislation and removing these exclusions, Maryland will be joining other states in providing a best-practice standard of care for transgender individuals, which includes many procedures that are essential to their daily lives.

This legislation will also establish nondiscriminatory criteria, ensuring transgender individuals are not denied care due to their gender identity, as well as reducing the stigma and discrimination faced by transgender individuals.

For these reasons, Annapolis Pride respectfully requests an unfavorable report on HB 0359.

Respectfully submitted,

Jaden T. Farris
Board Member
Annapolis Pride

Senate Trans Health Equity Act Testimony.pdf

Uploaded by: Jamie Grace Alexandeer

Position: FAV

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The Honorable Chair Katherine Klausmeier
3 East
Miller Senate Office Building
Annapolis, Maryland 21401
February 28th, 2023

Testimony of FreeState Justice
IN SUPPORT OF SB460: Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

To the Honorable Chair Katherine Klausmeier and esteemed members of the Senate Finance Committee:

I'm here representing FreeState Justice, civil rights, legal & advocacy organization representing Maryland's LGBTQ+ community. We write today in support of SB460.

You'll hear from our panels many reasons why this bill should be passed. I want to briefly discuss what would happen if this bill does not pass & acquaint you with he problems this lack of coverage currently causes in my community.

This healthcare has been called elective or cosmetic but for Maryland's trans community it is anything but. Trans people will prioritize this critical gender affirming care over fun, housing, & even food. A trans person may stay at a job they hate or are discriminated against at in order to afford this care out of pocket. Frequently, the money being used on these procedures could have been applied instead to significant investments that would also improve their quality of life, like moving out of an unsupportive parent's home. In some cases, trans people will even go without basic necessities in order to save money for expensive surgeries.

On the flip side, this care can often make a difference in a person's upward mobility. Counterintuitively, passing is almost required for many entry level jobs in the service & retail industry where being perceived as trans can mean abuse from customers & even fellow employees. Often, access to these surgeries will open them to opportunities previously closed to them because of bias, allowing their natural talents to shine. Embodying oneself fully as these procedures allow our transgender community members to do, makes all areas of life easier –especially employment.

When our community cannot access reliable employment or healthcare, their options for survival are limited. Many people turn to other sources for hormones, which are cheaper on the black market than for people who are uninsured. Others engage in sex work as the only employment where their trans identity isn't a problem & are compensated substantially above minimum wage.

When the cost of these out of pocket procedures are not personal, their burden is shared by our community. Every day, members of our community fundraise to meet the expenses required for these critical healthcare interventions. Using social media, trans people pass the same 5 -15 dollars around to meet each others fundraising goals.

Imagine, if that investment both on an individual & community level could be reinvested in the same way. Our community is weakened financially by the out of pocket costs of this healthcare & could truly thrive when it is covered more fully by this bill.

Finance Committee, these services are federally reimbursable and are estimated to cost less than a half a percent of the state's Medicaid budget, and the cost saved on social and legal services as a result of Marylanders receiving this care reduces the net cost further. This legislation is thus a low-cost solution that improves the quality of life of our the most marginalized within our community, based on the mainstream consensus of a broad swath of medical science and mirrors policy already in place across our country.

Jamie Grace Alexander

Policy Coordinator, FreeState Justice

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[1] COMAR 10.09.02.01(11) "Medically necessary" means that the service or benefit is:
(a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
(b) Consistent with current accepted standards of good medical practice;
(c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
(d) Not primarily for the convenience of the consumer, family, or provider.

Trans Health Equity Act Testimony (Senate) (1).pdf
Uploaded by: Jamie Grace Alexandeer
Position: FAV

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The Honorable Chair Katherine Klausmeier
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Annapolis, Maryland 21401
February 28th, 2023

Testimony of FreeState Justice
IN SUPPORT OF SB0460: Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

To the Honorable Chair Katherine Klausmeier and esteemed members of the Senate Finance Committee:

I'm here representing FreeState Justice, civil rights, legal & advocacy organization representing Maryland's LGBTQ+ community. We write today in support of SB460.

You'll hear from our panels many reasons why this bill should be passed. I want to briefly discuss what would happen if this bill does not pass & acquaint you with he problems this lack of coverage currently causes in my community.

The healthcare covered by this bill is called elective or cosmetic by the bill's opponents. For Maryland's transgender community it is anything but elective or cosmetic, and by COMAR's own definitions it is "medically necessary."[1] Trans people will prioritize their gender affirming care over hobbies, housing, and even food. A trans person may stay at a job where they are being

[1] COMAR 10.09.02.01(11) "Medically necessary" means that the service or benefit is:
(a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
(b) Consistent with current accepted standards of good medical practice;
(c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
(d) Not primarily for the convenience of the consumer, family, or provider.

discriminated against in order to afford this care, especially if they do not have insurance. Rather than making significant investments that could improve their quality of life, they spend large sums on life-saving healthcare even as the same procedures are covered by private insurance. In some cases, trans people will even go without basic necessities in order to save money for expensive surgeries.

This care can often make a difference in a person's upward mobility. For instance, passing[2] is almost required for many entry level jobs in the service and retail industry where being perceived as trans can mean abuse from customers and even fellow employees. Access to the care covered by SB0460 will open transgender Marylanders to opportunities previously closed because of bias, allowing their talents to shine and their economic situations to improve. Embodying oneself fully, as these procedures allow our low-income transgender community members to do, makes all areas of life easier, especially employment.

When our community cannot access reliable employment or healthcare, our options for survival are limited. Many people turn to unregulated sources for hormones, which are cheaper on the black market than through pharmacies for people who are uninsured. Others engage in sex work as it is often the only field of employment where their trans identity is not a barrier, and for which they are compensated substantially above minimum wage.

The out-of-pocket cost of these medically necessary procedures is not just personal or individual for low-income transgender Marylanders; their burden is shared by the whole of our community. Every day, trans people fundraise on all manner of platforms to meet the cost of these critical healthcare interventions. Using social media, for instance, trans people pass the same $5 around to meet each other's medical fundraising goals. Imagine if their fundraising talent and accumulated capital could be harnessed and reinvested for other issues impacting trans people in this state, like establishing resources to address high rates of substance abuse in our community, tackling anti-LGBTQ+ street harassment, or providing food, housing, and clothing to other queer folks in need. Our community is weakened by the out-of-pocket costs of these medically necessary procedures, but it could truly thrive if low-income individuals' healthcare is covered more fully by this bill.

These services are federally reimbursable and are estimated to cost less than a half a percent of the state's Medicaid budget, and the cost saved on social and legal services as a result of Marylanders receiving this care reduces the net cost further. This legislation is thus a low-cost solution that improves the quality of life of the most marginalized within our community, based on the mainstream consensus of a broad swath of medical science and which mirrors policy already in place across our country.

For these reasons, FreeState Justice urges a favorable report on SB 0460

Jamie Grace Alexander

Policy Coordinator, FreeState Justice

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[2] "Passing means others see you as the gender that you identify as. For example, a transgender woman seen as a cisgender woman is "passing."" *Transgender and Nonbinary Identities*. Planned Parenthood. Web Link. Accessed Feb. 27, 2023.

HTPP Testimony Trans Health Equity Act SB 460- FAV

Uploaded by: Jessica Emerson

Position: FAV

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Testimony of the Human Trafficking Prevention Project

BILL NO:	Senate Bill 460
TITLE:	Maryland Medical Assistance Program – Gender-Affirming Treatment (Trans Health Equity Act)
COMMITTEE:	Finance
HEARING DATE:	February 28, 2023
POSITION:	**FAVORABLE**

Senate Bill 283 would expand Medicaid coverage to include lifesaving gender-affirming care for transgender Marylanders. The Human Trafficking Prevention Project at the University of Baltimore School of Law supports this bill because it will provide nonbinary, transgender, and gender-nonconforming Marylanders with the accessible, comprehensive, and medically necessary care they deserve, which, in turn, greatly reduces the stigma, violence, and exploitation they so commonly face.

Efforts at raising public awareness about the crime of human trafficking commonly ignores the impact that gender identity and gender presentation has on a person's vulnerability to trafficking. The reality is that nonbinary, transgender, and gender non-conforming people are made disproportionately more vulnerable to being trafficked because of the discrimination and isolation that they so often face, which commonly translates into the hallmarks of heightened trafficking risk including interpersonal violence, financial instability, homelessness, and drug use. One of the most common forms of discrimination that nonbinary, transgender, and gender non-conforming people face is the lack of access to gender-affirming healthcare.

According to Trans Maryland, a multi-racial, multi-gender community power building organization for Maryland's transgender community, the number of transgender Marylanders on Medicaid is only approximately 2000 people, and, given that gender transition is unique to each individual, not every transgender person on Medicaid will access these services, or any services at all. As they rightly point out, the small size of the community, combined with the urgency of the need to access this type of care, means that this is an easy gap to close.

Lack of access to gender-affirming care can be incredibly dangerous for transgender people, greatly impacting their access to housing, employment, and education, as well as their freedom to safely navigate social spaces. Experiences like these typically drive affected individuals further into isolation, which is why so many nonbinary, transgender, and gender non-conforming people are forced to exist on the margins of society where they face a far greater risk of violence and exploitation. The availability of gender-affirming healthcare ought to be commonplace here in Maryland, because for so many transgender Marylanders, this is truly a matter of life and death.

In recent years, Maryland has begun to show its support for *preventing* human trafficking and other forms of violence by addressing the societal challenges that make its citizens more vulnerable to exploitation. SB 460 would further this goal by reducing the stigma that nonbinary, transgender, and gender non-conforming persons face by providing them with gender-affirming, lifesaving healthcare. This will, in turn, affirm the humanity of these individuals, making them less vulnerable to the harms that so commonly precede a trafficking experience. Additionally, in a time of unprecedented and unsubstantiated attacks on the rights of transgender people, it is crucial that Maryland stand up and say conclusively that policies driven *or* denied by fear and intolerance have no place in our state. For these reasons, the Human Trafficking Prevention Project supports Senate Bill 460, and respectfully urges a favorable report.

Health Care for the Homeless - 2023 SB 460 FAV - T

Uploaded by: Joanna Diamond

Position: FAV

HEALTH CARE FOR THE HOMELESS TESTIMONY
IN SUPPORT OF
SB 460 – Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

Senate Finance Committee
February 28, 2023

Health Care for the Homeless strongly support SB 460, which would expand Medicaid coverage of lifesaving gender-affirming care. Instead of protecting the wellbeing of low-income Marylanders, our Medicaid program categorically denies dozens of gender-affirming services. SB 460 ensures that, among other things, Medicaid will provide medically necessary care based on up-to-date standards, prevents state officials from interfering with the patient-physician, and reduces sex-based discrimination by providing healthcare based on clinical need.

As a federal qualified health center, we seen firsthand that denial of gender-affirming care negatively impacts mental health and wellbeing[1] of our clients significantly. For Health Care for the Homeless, access to this medically necessary and life-saving care is an issue of fundamental human rights and must be made accessible for low-income Marylanders on Medicaid.[2]

Gender-affirming care is a matter of life and death

Without adequate medical care, trans Marylanders are exposed to job and housing discrimination, harassment and violence. Transgender and gender nonconforming persons face a tremendous amount of economic, social, and health vulnerabilities due to persistent stigma and discrimination.[3] As the trans community is historically underserved population, they face significant disparities in physical and behavioral health issues and barriers to care.

It is estimated that 20% of transgender individuals do not have secure housing and are inextricably linked to increased rates of poor health outcomes, including depression, anxiety, substance use, suicidality, and HIV.[4] For example, in the National Transgender Discrimination Survey, HIV rates of trans persons with a history of homelessness was 7.12%, compared to 1.97% of those who did not; and suicide and substance use rates were almost double compared to their housed trans counterparts.[5] **Make no mistake, for our clients, receiving gender-affirming care is a matter of life and death.**

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[1] Multiple major medical associations support comprehensive care for the trans community including the American Medical Association, the American Psychiatric Association, and American Academy of Pediatrics.
[2] https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Adults-US-Aug-2016.pdf
[3] See https://www.psychiatry.org/File Library/About-APA/Organization-Documents-Policies/Policies/Position-2018- Discrimination-Against-Transgender-and-Gender-Diverse-Individuals.pdf
[4] https://nhchc.org/wp-content/uploads/2019/08/Increasing-access-and-quality-of-care-for-TGNC_FINAL090816.pdf.
[5] Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. Injustice at every turn: a report of the National Transgender Discrimination Survey. Washington: National Center for the Transgender Equality and National Gay and Lesbian Task Force. http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf. Published 2011. Accessed July 12, 2016.

Within a system designed for cisgender individuals, high levels of individual and systematic oppression are at the root of many of these barriers. Individuals and systems often overlook, deny, and challenge experiences of trans persons and trans people are routinely discriminated against in areas such as employment, education, and health care. Research has also consistently shown that service access barriers contribute to these health disparities and to housing instability. Specifically, those barriers can range from reticence to disclose gender identity out of fear of rejection and compromising safety and mistrust of providers to lack of provider gender-affirming care knowledge and, notably, lack of insurance coverage and the high cost of primary and transition-related health services.

For these reasons, Marylanders pay for rising costs of discrimination through emergency room visits, hospitalization, mental health care, homelessness, joblessness and violence against the trans community.

Access to gender-affirming care is basic health care

As a primary care provider, we recognize that access to gender-affirming care is essential and basic health care for our clients. These services are especially important for trans individuals without homes as they may face additional challenges in their day to day life that may cause or exacerbate poor health conditions. This is the reason why at Health Care for the Homeless we strive to make a warm, welcoming and safe space for all members of the LGBTQ+ community and offer whole-person, trauma-informed health care. As a primary care provider, we provide hormone therapy, HIV/Hep C testing and counseling, and queer and LGBTQ+ affirming therapy.[6] And, importantly, in order for our trans clients to receive comprehensive care, we must be able to refer and they must be able to receive the full range of gender-affirming care. Unfortunately, Maryland is using 20-year-old guidelines for the needs of Maryland's trans community. In order for us to provide our clients with the best care possible, Medicaid's guidelines and coverage must be updated.

Client Stories from Health Care for the Homeless

Dr. Jamie Spitzer, Psychiatrist

As a psychiatrist I have seen firsthand the sometimes fatal repercussions when patients receive care that denies their gender identity.

I came to know Ms. S who was labeled "difficult" in the ER, because she advocated to be identified by her name and spoken to with the appropriate pronouns. She wanted the people responsible for her health to recognize the most fundamental aspects of her identity. She was in and out of the ER every few days either for medical complication or a nearly fatal suicide attempt. I once tried to count the number of ER visits in a 6-month time period, but I stopped at "more than 50." What was most harrowing looking at her medical course was not only that she could die from treatable medical conditions due mostly to a lack of engagement or respect, but that if she did not she would likely die from suicide. One day, I realized I hadn't seen her for a bit. While I would like to believe this was because of the care she received, I am fairly certain it is because of the care she did not receive.

Unfortunately, Ms. S story stands out because of the many failed opportunities to provide her the care she deserved. Gender nonbinary and transgender individuals experience more discrimination, victimization, poor mental health outcomes, and suicidality or self-harm than do cisgender men and women. Ms. S story demonstrates how poor access to medical resources and systemic discrimination play a large role in this inequity.

[6] We also know that health requires more than health care. That's why we offer these supportive services to LGBTQ+ community members: Support with name changes, letters for gender affirming surgeries. We can also help with getting ID, benefits and income assistance, a variety of support groups, securing housing and more.

Tyler Cornell, Lead Medical Provider

Unfortunately, trans people are at a significantly higher risk of violence in the community and human nature is often to make a quick judgment about people based on their external presentation. When someone has external features that don't fit within a societal norm, they stand out and people take notice.

One of my patients is a transgender male who is experiencing homelessness who has short hair, a beard, dresses in traditional male clothing, his changed his name, attends all of his medical appointments, and has been taking hormones for years to support his transition, but because of genetics, has a significant amount of breast tissue. He struggles to determine, multiple times a day, which public restroom to use, because he knows that on any day he could be the victim of violence in a male restroom because with one glance, someone could determine that he "doesn't belong."

Medically assisting patients with transition is to determine the appropriate and necessary interventions at each phase of their transition. When patients are denied access to insurance coverage for medically-approved treatment options, their physical and emotional health is at risk.

Client story of Von Cash

Von Cash has a movie reference for every occasion, wise words from his discipleship program and a homemade remedy for everything. He's never been happier. But, he had to wait 48 years to get there.

"When I was little, I asked my mom why I didn't look like my brother. She told me, 'you are a girl,' says Von. "I never saw that pretty girl, but there was always someone to shut me down."

Like many members of the transgender and gender non-conforming (TGNC) community, this reinforced shame kept Von from living fully as himself up until two years ago.

"In this country, we are raised to hate ourselves already, especially Black people. The system wants to keep us low so it can use us and I'm starting to understand that more. It never occurred to me not to be afraid until now," he says.

Seven years after first walking through our doors for insurance, medication and therapy, Von told his therapist that he wanted to start his medical transition from female to male. He connected with Lead Medical Provider Tyler Cornell, CRNP and started hormone replacement therapy (HRT) six months later.

"Providing HRT shouldn't be the gold standard of care, it should just be the standard," says Tyler. However, this is hardly the case. In Tyler's experience, gender-affirming care is learned on the job and taught by clients, instead of in standard medical training.

Shelters that welcome TGNC people are also far from the standard. Von has lived in a women's housing program for five years. Now that he is more open about his identity, he's unsure if his housing is secure and what alternatives he may have. TGNC youth who still rely on parents/caregivers for support can be at even higher risk of experiencing homelessness because families often reject or abuse them. And there aren't many places for them to turn.

Baltimore Safe Haven, an organization founded and run by Black trans women, is the only program in our city that offers shelter specifically for TGNC people. Most shelters do not acknowledge or respect the rights of TGNC people and are incredibly unsafe for them. This means they often sleep on the streets and are very likely to be targets of violence (see statistics).

Gender-affirming care is basic and essential health care. As such, it should be a full Medicaid benefit. We stand in strong support of SB 460 and we urge a favorable report on the bill.

Health Care for the Homeless is Maryland's leading provider of integrated health services and supportive housing for individuals and families experiencing homelessness. We work to prevent and end homelessness for vulnerable individuals and families by providing quality, integrated health care and promoting access to affordable housing and sustainable incomes through direct service, advocacy, and community engagement. We deliver integrated medical care, mental health services, state-certified addiction treatment, dental care, social services, and housing support services for over 10,000 Marylanders annually at sites in Baltimore City and Baltimore County. For more information, visit www.hchmd.org.

SB460.pdf
Uploaded by: John Ford
Position: FAV

Dear Members of the Senate Finance Committee,

I am a resident of **D46 and a professional mental health therapist (LCSW-C). I am testifying in support of "Trans Health Equity Act" (SB460).**

Gender affirming care has been shown, both by research and in my clinical experience, to reduce psychiatric hospitalizations and suicidal out in transgender youth and adults. I support gender-affirming care being available to individuals in need of it.

It is for that reason that I am encouraging you to vote **in support of SB460.**

Thank you for your time, service, and consideration.

Sincerely,
Laura Whitney

3301 Fleet St
Baltimore, MD 21224

SB 460_MD Center on Economic Policy_FAV.pdf
Uploaded by: Kali Schumitz
Position: FAV

FEBRUARY 28, 2023

Gender-Affirming Treatment is Essential Health Care

Position Statement Supporting Senate Bill 460

Given before the Senate Finance Committee

Every Marylander deserves to get the essential health care they need not just to survive, but to thrive. For transgender Marylanders, that essential health care includes gender-affirming treatments. **The Maryland Center on Economic Policy supports Senate Bill 460 because it will ensure low-income Marylanders enrolled in Medicaid can access the same types of gender-affirming treatment as those with private insurance.**

Maryland's Medicaid program currently uses outdated standards, developed 20 years ago, to govern decisions about the types of care available to low-income transgender people who rely on Medicaid to pay for their health care. SB 460 would enact updated standards that would allow more types of gender-affirming treatment to be covered through Medicaid. At least 9 other states, including Virginia, and Washington, D.C., already provide more robust care, and the services included in SB 460 are all eligible for federal reimbursement. Given the small number of transgender Marylanders enrolled in Medicaid, any impact on the state's share of Medicaid costs would be very minimal.

Ensuring more people can access gender-affirming care supports improved mental health and could reduce instances of workplace and housing discrimination that transgender people too often face. Because of chronic stress linked to discrimination, people who are transgender are up to three times more likely than the general population to have a mental health or substance use disorder[i]. That's why major medical associations including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics all consider comprehensive treatment for transgender people to be essential health care.

The 2015 U.S. Transgender Survey showed that transgender Marylanders face much higher levels of poverty and economic instability than others in the state[ii]:

- 9% of respondents were unemployed at the time of the survey, about double the statewide average at that time, and more than 1 in 5 reported incomes below the federal poverty level.
- 1 in 4 respondents reported experiencing various types of employment discrimination because of their gender identity or expression, such as being fired, not being hired, or being denied a promotion.
- Nearly 1 in 4 respondents also reported experiencing housing discrimination in the past year, such as being evicted or being denied a home or apartment, because of their gender identity or expression. 28% reported experiencing homelessness at some point in their lives.
- 31% refrained from seeing a medical provider due to affordability concerns.

It also found that 29% of respondents experienced at least one negative encounter with a healthcare provider due to being transgender. Unsurprisingly, more than 1 in 5 respondents refrained from seeking medical assistance for fear of mistreatment.

Moreover, research shows that providing gender-affirming care can make a great difference for transgender individuals. Associations with gender-affirming care include[iii][iv]:

- A 73% drop in suicidal ideation
- A 60% drop in depression
- Reduction in rates of HIV transmission
- Reduction in rates of drug use and overdose

Ensuring people can afford and received needed health care would be a significant step toward greater health and economic security for transgender Marylanders. **For these reasons, the Maryland Center on Economic Policy respectfully requests the Finance Committee to make a favorable report on Senate Bill 460.**

Equity Impact Analysis: Senate Bill 460

Bill Summary

SB 460 would require the Maryland Medical Assistance Program to cover gender-affirming treatment for transgender Marylanders. It would also prohibit the program from denying benefits unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the determination.

Background

Maryland's Medicaid program currently uses outdated standards, developed 20 years ago, to govern decisions about the types of care available to low-income transgender people who rely on Medicaid to pay for their health care. Private insurers are generally prohibited from denying coverage for gender-affirming treatment. SB 460 would enact updated standards that would allow more types of gender-affirming treatment to be covered through Medicaid. At least 9 other states, including Virginia and Washington, D.C., already provide more robust care, and the services included in SB 460 are all eligible for federal reimbursement.

Equity Implications

The 2015 U.S. Transgender Survey showed that transgender Marylanders face much higher levels of poverty and economic instability than others in the state:

- 9% of respondents were unemployed at the time of the survey, about double the statewide average at that time, and more than 1 in 5 reported incomes below the federal poverty level.
- 1 in 4 respondents reported experiencing various types of employment discrimination because of their gender identity or expression, such as being fired, not being hired, or being denied a promotion.
- Nearly 1 in 4 respondents also reported experiencing housing discrimination in the past year, such as being evicted or being denied a home or apartment, because of their gender identity or expression. 28% reported experiencing homelessness at some point in their lives.

Health equity means everyone has a fair and accessible opportunity to attain their highest level of health, especially for those who have been historically excluded from quality care. In Maryland, over half (54%) of transgender adults identify as a person of color. [v] Transgender people of color face even more pervasive challenges due to the combined impact of anti-transgender bias and racism. One national survey found that[vi]:

- Black transgender people had an extremely high unemployment rate at 26%, two times the rate of the overall transgender sample and four times the rate of the general population.
- 41%of Black respondents said they had experienced homelessness at some point in their lives, more than five times the rate of the general U.S. population.
- Black transgender people lived in extreme poverty with 34% reporting a household income of less than $10,000 per year. This is more than twice the rate for transgender people of all races (15%), four times the general Black population rate (9%), and eight times the general U.S. population rate (4%).

Impact

Senate Bill 460 will likely **improve racial, gender, and economic equity** in Maryland.

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[i]"Health Insurance Coverage for Gender-affirming Care of Transgender Patients", 2019. https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf

[ii] National Center for Transgender Equality, 2015 U.S. Transgender Survey: Maryland State Report. https://transequality.org/sites/default/files/USTS%20MD%20State%20Report.pdf

[iii] Tordoff, D.M., et al. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open, 5*(2). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423

[iv] Padula, W.V., et al. (2016). Societal implications of health insurance coverage for medically necessary services in the U.S. transgender population: A cost-effectiveness analysis. *Journal of General Internal Medicine, 31*(4), 394-401. SOI:10.1007/s11606-015-3529-6

[v] "How Many Adults and Youth Identify as Transgender in the United States?" (2022). https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/

[vi] "New Analysis Shows Startling Levels of Discrimination Against Black Transgender People," National LGBTQ Task Force. https://www.thetaskforce.org/new-analysis-shows-startling-levels-of-discrimination-against-black-transgender-people/

Testimony in support of SB0460.pdf
Uploaded by: Kristen Monthei
Position: FAV

Testimony in Support of SB 0460
Maryland Medical Assistance Program – Gender-Affirming Treatment
Trans Health Equity Act of 2023
Sedative Finance Committee
February 27, 2023

Kristen Monthei
Baltimore County, MD

Chair Griffith and Members of the Committee,

Thank you for the chance to testify in support of Senate Bill 0460.

I believe that SB 0460 is important because everyone deserves to live authentically, and it is only fair that individuals who need gender affirming care have access to it in order to achieve that authenticity.

I am the mother of a beautiful and vibrant trans-female teen daughter. I have watched her struggle with severe gender dysphoria which has led to feelings of low self-worth, anxiety, disassociation, suicidal ideation and depressive symptoms. Although we have always been an extremely supportive family, it wasn't until she started hormone therapy that we began to see how much of a difference it made in her confidence and self-perception. I believe it saved her life.

Our family has good medical insurance which allows us to provide the care she needs, but not everyone has that privilege. Transgender individuals are often at risk in so many areas and Medicaid is their only option. I want this to be available to my daughter, should she ever need it. This bill should be passed so that anyone needing gender affirming care can have the opportunity to live a safe, active, happy and healthy life.

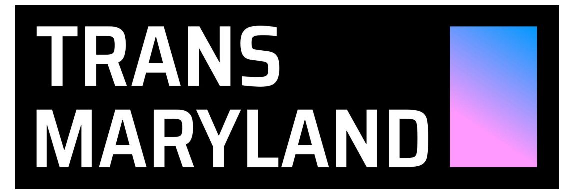
Please do what you can to support this vulnerable community, and give them the chance to live with the authenticity they deserve. I strongly urge you to support SB 0460.

Thank you for your consideration,

Kristen Monthei
407 Montemar Ave
Catonsville, MD 21228

Support SB 460 - Trans Maryland .pdf
Uploaded by: Lee Blinder
Position: FAV

Trans Maryland
1800 E Northern Parkway #66332
Baltimore MD 21239



Senate Bill #0460 Maryland Medical Assistance Program - Gender-Affirming Treatment
"Trans Health Equity Act"
Finance Committee
February 28, 2023
Position: Support

Greetings Chair Griffith, Vice Chair Klausmeier, and the esteemed members of the Senate Finance Committee. Trans Maryland is a multi-racial, multi-gender community power building organization for Maryland's trans community. Trans Maryland runs the state's largest name and gender marker change program, offering peer-to-peer guidance and financial assistance to Marylanders seeking a name and gender marker change. We also run the state's largest peer to peer connection space for Trans Marylanders. We represent thousands of transgender Marylanders who have detailed the barriers they face in accessing affirming medical care. The Trans Health Equity Act emerged from those conversations which highlighted to us that Maryland's current policy for transgender care is based on standards that are over 20 years out of date.

Many trans Marylanders experience gender euphoria as a result of accessing gender affirming care. We also witness the many barriers to that care, such as the 31 categorical exemptions listed in the Maryland Medicaid Gender Transition: Covered Service, Covered Criteria, Limitations and Exclusions bulletin from March 10, 2016. That bulletin is based on standards of care that were out of date at the time of issuance. Modernizing this care for Maryland's trans community is of the utmost importance. The gap between services accessible via Maryland Health Connection's paid plans, and the care available to transgender Marylanders on Medicaid is widening rapidly. Marylanders with paid plans through the Maryland Health Connection are able to access one standard of gender transition care through full coverage by insurance, while low-income trans Marylanders on Medicaid are completely excluded from the exact same care. The vulnerability of this community means this gap in services easily leads to a wave of other health disparities based on the social determinants of health for trans Marylanders.

The number of trans Marylanders on Medicaid is small, approximately 2000 people, and as gender transition is unique to each individual, we know that not every trans person on Maryland Medicaid will access these services, or even any services. The small size of the community, and the urgency of the need to access gender affirming care means this is an easy gap to close. Lack of access to gender affirming care can be dangerous, imperil access to housing, employment, education, and social spaces. While fiscal notes do not take into account these waves of additional impacts to both trans people and the state due to increased costs, those connections are unavoidable when looking at the overall well-being of Maryland's trans community. When we consider the financial realities of low-income trans Marylanders, being exempted from care that is accessible to those who have paid plans means a two-tier system is in play. The cost to the individual to be denied medical care that is covered and found to be medically necessary under paid plans through the Maryland Health Connection should be enough to change this policy, but do note that these procedures are also federally reimbursable.

Modernizing gender transition care through Maryland Medicaid is an easy fix, passing the Trans Health Equity Act is a financially sound decision, a moral and ethical imperative, and brings Maryland in line with the many other states who are leading in their coverage of this care. For these reasons, **we urge a favorable report on this Bill #** SB 0460.

For more information, contact Lee Blinder, Executive Director of Trans Maryland at
lee@transmaryland.org

SB460_MoCo_Frey_FAV.pdf
Uploaded by: Leslie Frey
Position: FAV

Montgomery County
Office of Intergovernmental Relations

ROCKVILLE: 240-777-6550 **ANNAPOLIS: 240-777-8270**

SB 460 **DATE: February 28, 2023**

SPONSOR: Senator M. Washington, *et al.*

ASSIGNED TO: Finance

CONTACT PERSON: Leslie Frey **(leslie.frey@montgomerycountymd.gov)**

POSITION: SUPPORT

Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

Senate Bill 460 expresses the intent of the General Assembly that Maryland Medical Assistance is required to provide gender-affirming treatment to all Medicaid recipients for whom gender-affirming treatment is medically necessary, including transgender, nonbinary, intersex, two spirit, and other gender diverse individuals. Under the bill, Medicaid may not exclude gender-affirming treatment, including revisions to prior gender-affirming treatment, on the basis that the treatment is a cosmetic service. The bill requires annual reporting from Medicaid Managed Care Organizations on location, provider name, and type of gender-affirming treatment provided and from the Maryland Department of Health regarding geographic access to gender-affirming treatment across the State.

Montgomery County joins the American Medical Association[1], the American College of Obstetricians and Gynecologists[2], the American Academy of Nursing[3], the American Psychiatric Association[4], along with many others across our State and the country in emphasizing the medical necessity of gender-affirming care. Senate Bill 460 will ensure that gender-affirming medical treatments are covered by Medicaid in a manner that is non-discriminatory and meets the critical health needs of approximately 2,000 Medicaid-enrolled transgender Marylanders. As stated by the American Academy of Nursing, removing discrimination from health care for gender diverse people is critical:

> The World Professional Association for Transgender Health Standards of Care views access to evidence-based health care as a right and barriers to access as discrimination. Discrimination negatively affects how individuals make decisions about accessing health care, thereby putting them at risk for short- and long-term adverse health outcomes.[5]

Montgomery County respectfully urges the committee to issue a favorable report on Senate Bill 460.

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[1] https://searchlf.amaassn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf

[2] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals

[3] https://www.nursingoutlook.org/article/S0029-6554(16)30120-8/fulltext

[4] https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Access-to-Care-for-Transgender-and-Gender-Diverse-Individuals.pdf

[5] https://www.nursingoutlook.org/article/S0029-6554(16)30120-8/fulltext (internal citations omitted).

THEA Written Testimony Senate.pdf
Uploaded by: Lily Pastor
Position: FAV

Senate Bill 460
Maryland Medical Assistance Program – Gender-Affirming Treatment
Trans Health Equity Act
February 14, 2023
Support

Dear Chair Griffith, Vice Chair Klausmeier, and members of the Finance Committee,

My name is Lily Amara Pastor; I am a nursing student at Anne Arundel Community College, a resident of District 40, and a 36-year-old transgender woman. This testimony is in support of SB460, the Trans Health Equity Act, which would ensure that Maryland Medicaid will provide comprehensive gender-affirming care. While I was the Outreach Director for Trans Maryland, I saw first-hand how many transgender individuals in the state lack access to gender-affirming care due to the high cost and relative impoverishment of transgender people in Maryland. This bill would greatly expand access to this lifesaving, scientifically-supported healthcare, improving the lives of many Marylanders and bringing Maryland in line with federal standards and internationally-recognized best practices. As a nursing student, I am learning more about the many barriers to quality healthcare experienced by marginalized populations and how bills like the Trans Health Equity Act help to address them. It is essential that lower income patients access necessary preventative and priority medical care.

Maryland and its residents will save on expensive care of future physical and mental health complications. Because these Medicaid costs are largely reimbursed by the federal government, the budget cost is minimal and, as is the case for many forms of preventative and priority healthcare, the short-term costs are eclipsed by the long-term savings. New York, Massechussettes, Virginia, and numerous other states have taken this step, helping to achieve a higher level of health equity in their state. According to a 2020 study from the Center for American Progress, 51% of transgender individuals have postponed or avoided medical care due to cost. Maryland can and should join other states in ensuring access to this essential, lifesaving care for as many of our residents as possible.

Comprehensive gender-affirming care has a thorough basis in research and is supported by myriad medical associations, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics. Access to gender-affirming care has enabled me to personally thrive, achieving a 4.0 GPA at Maryland's top-rated community college and acceptance into its nationally-renowned nursing program. I respectfully ask that the Finance committee return a favorable report on SB460 and help other transgender Marylanders thrive as I have.

Thank you,
Lily Amara Pastor

SB460_LuisaWayman_FAV
Uploaded by: Luisa Wayman
Position: FAV

I am writing in support of SB 460, the Trans Health Equity Act, to ensure that every trans person in the state of Maryland has access to gender affirming care. I have seen the necessity of gender affirming care to change and save lives, through my own life and those of many of my friends and loved ones. I have watched depressed, miserable wretches turn into vibrant, happy people, and I have done the same myself. I have also, sadly, seen trans people who were unable to access care, and watched them fall apart.

In the summer after I graduated college, I lived with a St. John's student named Augustine Stuart. Augustine struggled greatly through his freshman year, owing largely to his inability to access testosterone treatment. He was an intelligent, clever and creative thinker and artist; his art was once a constant presence in the college coffee shop. He could now be having a successful junior year were he not so burdened by gender dysphoria. Instead, he received four unsatisfactory don rags – the equivalent of failing a class at St. John's – and was not permitted to advance to sophomore year.

Over that summer, he was constantly suicidal and unable to hold a job. On two occasions, I directly intervened in his suicide attempts – once grabbing him as he tried to run into traffic, and later wrestling a knife from his hands. At one point I personally kept him on a nonstop 72 hour suicide watch. Eventually, as I and our other roommate were unable to continue to take care of him while ourselves working to cover both our expenses and his, he had to move home to his family in Colorado. He has not forgiven me for preventing his suicide, and I have heard nothing from him since – I hope that he is doing better.

This entire situation could have been avoided with the Trans Health Equity Act. Right now, Augustine could have been studying Locke, Baudelaire, Faraday and Lobachevski, surrounded by brilliant minds who he could both enrich and be enriched by. He could be well on his way to a promising career in academia. I could still have a friend, and St. John's could have a student who makes the campus a brighter place. On behalf of Augustine Stuart, I urge the Commission to pass SB 460, and contribute to human thriving in the state of Maryland.

SB0460 Gender Affirming Treatment_Trans Health Equ

Uploaded by: Margo Quinlan

Position: FAV

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Senate Bill 460 Maryland Medical Assistance Program - Gender-Affirming Treatment (Trans Health Equity Act)
Senate Finance Committee
February 28, 2023
Position: SUPPORT

The Mental Health Association of Maryland is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health, mental illness and substance use. MHAMD appreciates this opportunity to present testimony in support of Senate Bill 460.

SB 460 seeks to modernize the existing Maryland Department of Health policy on gender affirming care[i] by ensuring coverage is provided for all medically necessary gender-affirming care, using nondiscriminatory and current standards, and as "prescribed by a licensed health care provider for the treatment of a condition related to the individual's gender identity."[ii] The current policy was drafted using decades-old clinical standards,[iii] and this bill would simply bring Maryland's Medicaid program in line with the current clinical best practices. SB 460 recognizes the life-saving nature and medical necessity of gender affirming care for transgender (trans), non-binary, Two Spirit, intersex, and other gender diverse Marylanders.

Numerous studies indicate that transgender individuals are at particular risk of psychological distress and associated impairment, primarily from elevated exposure to stigma-related minority stress[iv] and from the stress associated with a lack of gender affirmation[v] (the accurate recognition and validation of one's gender identity). Minority stress is unique, socially based, and chronic, and may make trans and non-binary people more vulnerable to development of behavioral health concerns such as anxiety, depression, or substance use.[vi]

Due to this, many trans and non-binary people experience their transition related care at a unique intersection of somatic and mental healthcare needs. Access to gender affirming care has been shown to increase mental wellbeing and has been associated with a decrease in mental health treatment over time.[vii] It can lead to increased congruence with gender validation and reduction in the minority stress caused by discrimination and harassment. The World Professional Association for Transgender Health recommends consideration of transition related care for alleviating this significant gender-related stress.[viii]

Additionally, the vast majority of LGBTQ students (86.3%) report experiencing harassment or assault based on personal characteristics including sexual orientation and gender expression. LGBTQ students who reported more severe victimization regarding their sexual orientation or

For more information contact:
Margo Quinlan, Director of Youth & Older Adult Policy: 410-236-5488 / mquinlan@mhamd.org

gender expression report lower levels of self-esteem and higher levels of depression. For transgender youth in particular, over 50% of all transgender and nonbinary youth in the US report seriously considering suicide at some point in their lives.[ix] On the other hand, youth who had sought out and received hormone therapy were nearly 40% less likely to report recent depression and a past-year suicide attempt than those who wanted hormone treatment but could not receive it. Access to this care is a critical component to reducing the minority stress faced by this population, and there are disproportionately lower rates of access to hormone therapy for young people of color — especially Black youth — compared to white youth.[x]

Without adequate medical care, transgender Marylanders are exposed to job and housing discrimination, harassment, and interpersonal violence. The state ultimately pays for the rising costs of this discrimination through emergency room visits, hospitalizations, and over-reliance on mental health care, and is falling behind much of the nation as a result. SB 460 would bring Maryland in line with other states providing more robust care under their state Medicaid plans, including Virginia[xi], Alaska[xii], Colorado[xiii], Oregon[xiv], Massachusetts[xv], Connecticut[xvi], Washington State[xvii], California , New York[xix], and Washington DC[xx].

Maryland's transgender community includes over 22,000 individuals[xxi] and makes up only 0.5 % of the state's population. An estimated 6,000 transgender Marylanders are enrolled in Medicaid,[xxii] and not all of them would need to access all, or any, of the gender affirming care allowed under this bill. MHAMD expects this to be a relatively inexpensive change to the state Medicaid plan, yet one that would have tremendous impact in improving the health and mental wellbeing of our transgender communities. This care is life-saving, it is medically necessary, and it must be made accessible to all who need it. **For these reasons, we urge a favorable report on Senate Bill 460.**

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[i] Maryland Department of Health and Mental Hygiene. (March 10, 2016). *Managed Care Organizations Transmittal No. 110, Re: Gender Transition: Covered Services, Coverage Criteria, Limitations and Exclusions.* https://health.maryland.gov/mmcp/mcoupdates/documents/pt_37_16.pdf

[ii] Maryland General Assembly. (Regular Session, 2022). *Senate Bill 682 Maryland Medical Assistance Program - Gender-Affirming Treatment (Trans Health Equity Act of 2022).* *https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0682*

[iii] The Harry Benjamin International Gender Dysphoria Association. (February, 2001). *Standards Of Care for Gender Identity Disorders, Sixth Version.* https://www.cpath.ca/wp-content/uploads/2009/12/WPATHsocv6.pdf

[iv] Reisner SL, Poteat T, Keatley J, et al. (2016). *Global health burden and needs of transgender populations: a review.* Lancet 2016; 388:412–43. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7035595/

[v] Dhejne C, Van Vlerken R, Heylens G, et al. (2016). *Mental health and gender dysphoria: a review of the literature.* International Review of Psychiatry 2016; 28:44–57. https://pubmed.ncbi.nlm.nih.gov/26835611/

[vi] Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding.* Washington, DC: The National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK64806/

[vii] Branstrom, R., Pachankis, J. (October 3, 2019). *Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study.* American Journey of Psychiatry. https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2019.19010080
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[ix] GLSEN (2019). *The 2019 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation's Schools.* http://glsen.org/research/2019-national-school-climate-survey
[x] Green, A., DeCharnts, J., Price, M., Davis, C. (December 14, 2021). *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*. https://www.jahonline.org/article/S1054-139X(21)00568-1/fulltext
[xi] Virginia Department of Medical Assistance Services. *Gender Dysphoria Clinical Coverage Policy.* https://www.dmas.virginia.gov/media/3894/dmas-gender-dysphoria-provider-manual-supplement-10-5-2021.pdf
[xii] Alaska State Legislature, Admin Code 105.130. *Services requiring prior authorization.* http://www.legis.state.ak.us/basis/aac.asp#7.105.130
[xiii] Code of Colorado Regulations, Department of Health Care Policy and Financing. *Medical Assistance - Section 8.700: Federally Qualified Health Centers, Women's Health Services.* https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8091&fileName=10%20CCR%202505-10%208.700
[xiv] Oregon Health Authority, Health Evidence Review Commission. https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx
[xv] MassHealth. *Guidelines for Medical Necessity Determination for Gender-Affirming Surgery.* https://www.mass.gov/doc/gender-affirming-surgery/download
[xvi] Husky Health Connecticut, Provider Policies & Procedures. *Gender Affirmation Surgery.* https://www.huskyhealthct.org/providers/provider_postings/policies_procedures/Gender_Affirmation_Surgery.pdf
[xvii] Washington State Legislature, Washington apple health. *Gender affirming interventions for gender dysphoria.* https://apps.leg.wa.gov/wac/default.aspx?cite=182-531-1675
[xviii] State of California—Health and Human Services Agency
Department of Health Care Services. *Ensuring Access To Medi-Cal Services For Transgender Beneficiaries.* https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-013.pdf
[xix] New York State, Codes, Rules and Regulations. *Title: Section 505.2 - Physicians' services.* https://regs.health.ny.gov/volume-c-title-18/1262489358/section-5052-physicians-services
[xx] Washington DC Department of Health Care Finance. *Non-Discrimination in the District's State Medicaid Program Based on Gender Identity or Expression.* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/release_content/attachments/Policy%20%23%20OD-001-17_Gender%20Reassignment%20Surgery.pdf
[xxi] Williams Institute (June, 2016). *How Many Adults Identify as Transgender in the United States?* https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Adults-US-Aug-2016.pdf
[xxii] Williams Institute (December, 2022). *Medicaid Coverage for Gender-Affirming Care.* https://williamsinstitute.law.ucla.edu/wp-content/uploads/Medicaid-Gender-Care-Dec-2022.pdf

NASW Maryland - 2023 SB 460 FAV - Trans Health Equ

Uploaded by: Mary Beth DeMartino

Position: FAV

5750 Executive Drive, Suite 100, Baltimore, MD 21228
410.788.1066 » nasw-md.org

Senate Finance Committee

Senate Bill 460: Maryland Medical Assistance Program –
Gender-Affirming Treatment –
Trans Health Equity Act

February 28, 2023

*****Support*****

The National Association of Social Workers represents social workers across the State of Maryland. We are urging your support for *Senate Bill 460 – Maryland Medical Assistance Program – Gender-Affirming Treatment (Trans Health Equity Act)* which will enable gender-affirming medical care provided free of discriminatory practices.

Modernizing Maryland Medicaid's coverage of gender-affirming treatment to reflect current best practices is long overdue. By extending necessary care to our trans, non-binary, and gender nonconforming community we can make access to health care for all Marylanders more fair and equitable.

Transgender individuals unable to access the healthcare they need are at high risk for depression and other behavioral health maladies, and data reveals a suicide rate nine times the general population. The benefits and economic savings associated with gender affirming care far outweigh the long-term costs of untreated gender dysphoria.

Maryland is home to over 22,000 individuals who identify as transgender. We ask for a favorable report to assure access to Medicaid coverage for gender-affirming care, and reduce the human devastation of unmet medical needs.

For these reasons, we ask for a *favorable* report for Senate Bill 460.

Judith Schagrin, LCSW-C
Co-Chairperson, Legislative Committee

SB460 LOS 2023 Leg.docx.pdf
Uploaded by: MD Chesapake NAPNAP
Position: FAV

Support: SB 460 Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

2/24/2023

Maryland Senate
Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Dear Chair, Vice-Chair and Members of the Committee:

On behalf of the pediatric nurse practitioners (PNPs) and fellow pediatric-focused advanced practice registered nurses (APRNs) of the National Association of Pediatric Nurse Practitioners (NAPNAP) Chesapeake Chapter, I am writing to express our **Support for SB 460 Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act).**

We support the requirement for the Maryland Medical Assistance Program to provide medical necessary gender-affirming treatment as prescribed by a qualified medical provider. Gender affirming care includes hormone therapies, physical appearance alterations, voice alterations, fertility preservation, and surgeries. These treatments occur under the care of a licensed medical provider for the treatment of gender dysphoria. Under the Affordable Care Act, discrimination in healthcare on the basis of race, color, national origin, age, sex, or disability, is prohibited. For the estimated 2 million transgender individuals across the United States, gender-affirming care is an essential medical treatment and denial of this prescribed therapy could cause significant harm.

Transgender individuals experience disproportionately worse health outcomes than their peers. They are significantly more likely to receive harassment, discrimination, be the victim of physical or sexual assault, or have severe depression and poor mental health. Transgender adolescents and young adults are two times more likely to seriously consider and/or attempt suicide compared to cisgender LGBQ peers, which is inflated by the fact that LGBTQ youth in general are four times more likely to attempt suicide than non-LGBTQ peers. More than half of all transgender youth are estimated to have seriously consider attempting suicide in the past year. Gender affirming care is therefore lifesaving care. Studies have shown that gender-affirming care is linked to significant decreases in mental health disparities, with one study showing a 60% decrease in severe depression and 73% decrease in suicidal ideation.

Continuing to allow the Maryland Medical Assistance Programs denies these medically necessary treatments to the 25% of our state's population enrolled in the program, which could significantly impact our already evergrowing mental health crisis. For these reasons the Maryland Chesapeake Chapter of NAPNAP extends their **Support for SB 460 Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act).**

The pediatric advanced practice nurses of your state are grateful to you for your attention to these crucial issues. The members of Chesapeake Chapter of the National Association of Pediatric Nurse

Practitioners are committed to improving the health and advocating for Maryland's pediatric patients. If we can be of any further assistance, or if you have any questions, please do not hesitate to contact Lindsay J. Ward , the Chesapeake Chapter President at 410-507-3642 or lindsayjward@hotmail.com.

Sincerely,

Lindsay J. Ward

Lindsay J. Ward CRNP, RN, IBCLC, MSN, BSN
Certified Registered Nurse Practitioner- Pediatric Primary Care
International Board-Certified Lactation Consultant
National Association of Pediatric Nurse Practitioners (NAPNAP)
Chesapeake Chapter President

Evgenia Ogordova

Evgenia Ogordova-DNP
National Association of Pediatric Nurse Practitioners (NAPNAP)
Chesapeake Chapter Legislative Chair

MEnglish SB 460 Favorable.pdf
Uploaded by: Michael English
Position: FAV

SB 460 Trans Health Equity Act

Hearing before the Senate Finance Committee

Feb. 28, 2023 at 1:00 PM
Position: SUPPORT (FAV)

Hello, My name is Michael English, and I am writing to strongly support SB 460, the Trans Health Equity Act, which would require medicaid to cover a wide array of critically important gender affirming care.

While I will be somewhat vague to protect their privacy, something very important to me is trans, and she is fortunate enough to be able to afford multiple treatments that would be covered for those less fortunate under the Trans Health Equity Act. I have seen first hand the good these gender affirming treatments can do, and how much they can change someone's life. Unfortunately, many people, especially those in the trans community, do not have the resources to pay for such care.

This bill will do a tremendous amount of good and, frankly, I was disappointed and disturbed to see the way its predecessor was pulled before a floor vote after clearing committee, in an apparent acquiescence to a veto threat. A lot of trust was lost that day, and it won’t come back until the right thing is done. I, frankly, won’t be happy until there is a floor vote, and the bill passes, but that can’t happen without this initial step.

Governor Hogan is gone, and with him that excuse. People have already waited a year too long. Don't make them wait any longer. Give this bill a favorable report, move it forward out of committee, and make sure it gets a floor vote, and please vote in favor of it when that time comes.

Thank you

Mike English
Downtown Silver Spring

SB 460_Michele Levy_fav.pdf
Uploaded by: Michele Levy
Position: FAV

Testimony in Support of SB 460
Gender-Affirming Treatment
Trans Health Equity Act of 2023
Senate Finance Committee
February 28, 2023
SUPPORT

Dear Chair Griffith, Vice Chair Klausmeier, and members of the Senate Finance Committee,

My name is Michele Levy. I am a resident of District 43. I am submitting this testimony in support of SB460, the Trans Health Equity Act, which would expand Maryland Medicaid to cover lifesaving gender-affirming care.

More times than I can count, I have had the joy of celebrating and supporting transgender and gender non-conforming members of my community undergoing gender affirming medical treatment. These procedures have not been easy. Recovery is often grueling, challenging, and protracted. But these procedures have, in many instances, quite literally saved their lives.

Maryland has long recognized the insufficiencies in the federal Medicaid program. I am proud to live in a state whose Medicaid expansion has sought to provide critical healthcare to a broader swath of residents. Currently, Maryland is relying on 20-year old guidelines for the needs of Maryland's trans community, which is devastatingly outdated and puts us far beyond states like Virginia, Washington, D.C., and others offering more robust and relevant care.

Approximately 2,000 transgender Marylanders are enrolled in Medicaid. SB460 is a critical and cost-effective measure; services are federally reimbursable, and will only be used by a nominal percentage of Maryland's population. But beyond the financial impact, this bill would provide essential, life-saving care to low-income Marylanders on Medicaid. The ability to live authentically, and to access medically necessary care, should not be limited to those with private insurance.

I respectfully urge this committee to return a favorable report on SB460.

Michele Levy
D43

SB 460 - WLCMD - FAV.pdf
Uploaded by: Michelle Siri
Position: FAV

305 West Chesapeake Avenue, Suite 201 Towson, MD 21204
phone 410 321-8761 fax 410 321-0462 www.wlcmd.org

BILL NO.:	Senate Bill 460
TITLE:	Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)
COMMITTEE:	Finance
DATE:	February 28, 2023
POSITION:	**SUPPORT**

Senate Bill 460 aims to address rampant health outcome disparities within the Maryland Transgender communities by updating the Maryland Medical Assistance Program (Medicaid) and requiring it to cover medically necessary gender-affirming care. The Women's Law Center of Maryland supports SB 460 as it is a matter of equity and basic human dignity.

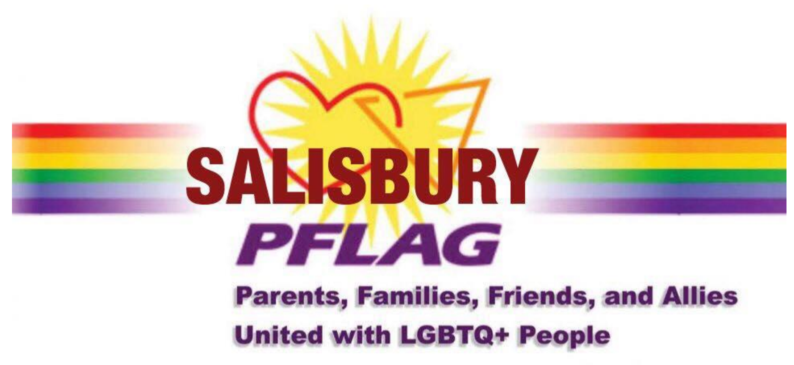
For over fifty years the Women's Law Center has been a leading voice in the fight for women's rights and gender equity. When we say women, that always includes transgender women, because transgender women are women. And as women, we all deserve the same access to physical safety, economic security, and bodily autonomy. Thus, the struggle for trans rights must be an integral part of our continued fight against systems of oppression. In short, our feminism must be intersectional if it is to succeed.

Regarding health care, in particular, it is a well-documented fact that marginalized communities experience widespread discrimination in health care settings. This is particularly acute for transgender communities and comes at great cost to the over 20,000 transgender Marylanders. Due to discriminatory and antiquated structures, transgender and gender non-conforming people must navigate a health care system that was not designed to support their unique medical needs, which in turn leaves many transgender individuals vulnerable to both physical and mental health complications. These gaps in our health care system lead to serious consequences and put the lives and health of transgender individuals at risk. HB283 would bridge those gaps and create meaningful access to critical health care services.

As such, the Women's Law Center of Maryland urges a favorable report on SB 460.

The Women's Law Center of Maryland is a private, non-profit, legal services organization that serves as a leading voice for justice and fairness for women. It advocates for the rights of women through legal assistance to individuals and strategic initiatives to achieve systemic change, working to ensure physical safety, economic security, and bodily autonomy for women in Maryland.

pflag_trans_health_equity.pdf
Uploaded by: Nicole Hollywood
Position: FAV



LEGISLATIVE **TESTIMONY**

Bill: **SB460/HB283 Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)**

Organization: PFLAG Salisbury Inc., PO Box 5107, Salisbury Maryland 21802

Submitted by: Nicole Hollywood, President of the Board

Position: **FAVORABLE**

SALISBURY PFLAG SUPPORTS THE TRANS HEALTH EQUITY ACT

I am submitting this testimony in FAVOR of SB460/HB283 on behalf of PFLAG Salisbury, the Salisbury, Maryland Chapter of PFLAG National.

LGBTQIA+ people experience a number of health disparities. They are at higher risk of certain conditions, have significantly less access to health care, and have worse health outcomes. These disparities come from a combination of homophobia and transphobia, a lack of access to affirming healthcare, misinformation, and inequities in our health care system.

Trans Maryland explains that the transgender community in Maryland "faces countless obstacles to obtaining the healthcare we need. We currently have a tiered system where some trans people with some insurances receive one level of care, while low-income trans Marylanders on Medicaid are denied countless gender affirming and life saving procedures."

Gender-affirming care, as defined by the World Health Organization, encompasses a range of social, psychological, behavioral, and medical interventions "designed to support and affirm an individual's gender identity" when it conflicts with the gender they were assigned at birth. The interventions help transgender and gender non-conforming individuals align various aspects of their lives — emotional, interpersonal, and biological — with their gender identity.

Transitioning is the process of progressing beyond ones gender assigned at birth to one's actual gender. Transitioning often includes social elements such as changing clothing, hair, names, and pronouns. It may include legal processes such as changing ones gender markers as well as one's legal name. It also may include gender-affirming medical treatments such as counseling, gender-affirming vocal care, laser hair removal, hormone blockers and/or replacement therapy, or various surgeries. These medical interventions are both necessary and life-affirming. More specifically, gender-affirming healthcare

practices have been shown in the research to result in lower rates of mental health issues, healthier self-esteem, and improve individual's overall quality of life.

According to the Human Rights Campaign, “Every credible medical organization, including the American Medical Association and the Academy of Pediatrics, supports age-appropriate, gender-affirming care for transgender and non-binary people. These doctors represent over 1.3 million doctors in the United States. Gender-affirming care has always existed and isn’t a new phenomenon.”

SB460/HB283 would require the Maryland Medical Assistance Program to provide gender-affirming treatment in a nondiscriminatory manner; requiring that the gender-affirming treatment be assessed according to nondiscriminatory criteria that are consistent with current clinical standards; prohibiting the issuance of an adverse benefit determination related to gender-affirming treatment unless a certain experienced health care provider has reviewed and confirmed the appropriateness of the determination; etc.

SB460/HB283 will help address gross inequities in Maryland’s current healthcare system that will greatly enhance the quality of life of thousands of transgender Marylanders. Because of this, PFLAG Salisbury Inc. supports SB460/HB283 and recommends a FAVORABLE report in committee.

SB460_FAV_SPACCASI.pdf
Uploaded by: Olivia Spaccasi
Position: FAV

OLIVIA SPACCASI
PUBLIC POLICY PROGRAM ASSOCIATE

AMERICAN CIVIL LIBERTIES UNION FOUNDATION OF MARYLAND

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Testimony for the Senate Finance Committee

February 28, 2023

SB 460 - Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

FAVORABLE

The ACLU of Maryland urges a favorable report on SB 460 which would require the Maryland Medical Assistance Program (Medicaid) to cover medically necessary gender affirming treatment.

The Maryland Medical Assistance Program currently fails to provide adequate coverage for medically necessary, gender affirming treatments for its 6,000 transgender beneficiaries. The list of treatments and surgeries that the program *does* cover is outdated and represents a fraction of the myriad ways in which gender dysphoria is remedied through medical and surgical care. Many of these more modern approaches are covered under private health insurance plans. As such, transgender beneficiaries are barred from accessing potentially lifesaving care due to their coverage status.

Gender affirming care can play an essential role in the mental, physical, and emotional wellbeing of transgender and nonbinary people. Numerous studies have shown how gender affirming care leads to improved mental health outcomes, particularly among youth.[1] According to a 2022 study of transgender individuals, gender affirming medical interventions were associated with lower odds of depression over 12 months.[2] Moreover, according to the American Medical Association, gender affirming care is linked to lower rates of suicide attempts and decreased substance use.[3] Given the disproportionately

---

[1] Columbia University Medical Center. (2022, March 30). Gender-affirming Care Saves Lives. Columbia University Department of Psychiatry. Retrieved from https://www.columbiapsychiatry.org/news/gender-affirming-care-saves-lives
[2] Tordoff, D. M., Wanta, J., & Collin, A. (2022, February 25). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. JAMA Network Open. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423
[3] American Medical Association. (n.d.). Advocating for the LGBTQ Community. American Medical Association. Retrieved from https://www.ama-assn.org/delivering-care/population-care/advocating-lgbtq-community

high rates of depression and suicide among transgender people, the impact of these medical interventions cannot be ignored. According to a 2022 study by the Trevor Project, 49% of transgender and non-binary youth in the Maryland seriously considered suicide in the past year.[4] The inability to access this medically necessary care only exacerbates the problem.

This bill will increase the standard of care and standard of living for transgender Marylanders, ensuring that access to essential care is not determined by gender identity, income, or employment status. For the foregoing reasons, we urge a favorable report on SB 460.

---

[4] The Trevor Project. (2022, December 15). 2022 National Survey on LGBTQ Youth Mental Health - Maryland. The Trevor Project. Retrieved February 24, 2023, from https://www.thetrevorproject.org/wp-content/uploads/2022/12/The-Trevor-Project-2022-National-Survey-on-LGBTQ-Youth-Mental-Health-by-State-Maryland.pdf

SB0460_FAV_MedChi, MDAAP, MACHC_MD Med. Ass. Prog.

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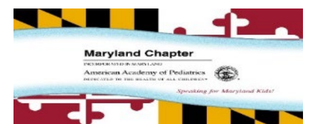
Position: FAV



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TO: The Honorable Melony Griffith, Chair
Members, Senate Finance Committee
The Honorable Mary Washington

FROM: Pamela Metz Kasemeyer
J. Steven Wise
Danna L. Kauffman
Andrew G. Vetter
Christine K. Krone
410-244-7000

DATE: February 28, 2023

RE: **SUPPORT** – Senate Bill 460 – *Maryland Medical Assistance Program – Gender-Affirming Treatment (Trans Health Equity Act)*

On behalf of the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, and the Mid-Atlantic Association of Community Health Centers, we submit this letter of **support** for Senate Bill 460.

Senate Bill 460 provides an important enhancement of Medicaid benefits to address gender-affirming treatment, provides clarification of what is considered gender-affirming treatment, and provides protections for the appropriate review of requested treatment to ensure that care is not unreasonably or inappropriately denied.

The legislation defines gender-affirming treatment as any medically necessary treatment consistent with current clinical standards of care prescribed by a licensed health care provider for the treatment of a condition related to the individual's gender identity. If enacted, Medicaid could not exclude gender-affirming treatment on the basis that the treatment is a cosmetic service and could not issue an adverse benefit determination denying or limiting access to gender-affirming treatment unless a health care provider with experience prescribing or delivering gender-affirming treatment had reviewed and confirmed the appropriateness of the adverse benefit determination.

In addition, Senate Bill 460 requires each Managed Care Organization (MCO) to submit to the Maryland Department of Health (MDH), a list of the name and location of each health care provider offering gender-affirming treatment with which the MCO has an active contract and the types of procedures provided by each provider. Annually, MDH must compile a report that includes the name and location of each health care provider offering gender-affirming treatment to Medicaid recipients; the MCOs that have active contracts with each health care provider; and the types of gender-affirming

treatment provided by each health care provider. The report must be posted on MDH's website to assist the public in accessing these medically necessary services.

Individuals that require gender-affirming treatment must often overcome the stigma, inherent discrimination, and often unfair assessment of the medical necessity of a required treatment. This treatment is most often provided by health care practitioners whose clinical practice focuses and/or specifically includes gender-affirming treatment. The statutory framework reflected in Senate Bill 460 will ensure the provision of medically necessary, clinically appropriate services reflective of recognized standards of care and provides a mechanism to ensure there are not intended or discriminatory adverse benefit determinations. Further, the bill will help enhance access to these services by identifying the health care practitioners who provide these services. A favorable report is requested.

MPA Testimony 2023 - Support - Senate Bill 460 - M

Uploaded by: Pat Savage

Position: FAV

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Senator Katherine Klausmeier, Vice Chair
Finance Committee
Miller Senate Office Building, 3 East
Annapolis, MD 21401

February 27, 2023

Bill: Senate Bill 460 – Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

Position: Support

Dear Chair Griffith, Vice Chair Klausmeier, and Members of the Committee:

The Maryland Psychological Association (MPA), which represents over 1,000 doctoral-level psychologists from throughout the state, is writing in **SUPPORT** of Senate Bill 460 – the Maryland Medical Assistance Program to provide gender-affirming treatment in a nondiscriminatory manner.

Supporting gender affirming care in a nondiscriminatory manner is, simply put, lifesaving. The attempted suicide rate for transgender individuals is at an astounding 41% with higher rates for those who have been victims of discrimination. Individuals pursuing gender affirming care should be entitled to care that is assessed and treated according to nondiscriminatory criteria that are consistent with current clinical/medical standards and prohibiting the issuance of an adverse benefit determination related to gender-affirming treatment unless a certain experienced health care provider has reviewed and confirmed the appropriateness of the determination. For these reasons, the Maryland Psychological Association asks for a **FAVORABLE** report on Senate Bill 460.

Thank you for considering our comments on SB 460. If we can provide any additional information or be of any assistance, please do not hesitate to contact the please do not hesitate to contact MPA's Legislative Chair, Dr. Pat Savage at mpalegislativecommittee@gmail.com.

Respectfully submitted,

Rebecca Resnik, Psy.D.
Rebecca Resnick, Psy.D.
President

R. Patrick Savage, Jr., Ph.D.
R. Patrick Savage, Jr., Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

SB460_FAV_Trans Health Equity Act_BHRC.pdf

Uploaded by: Rajani Gudlavalleti
Position: FAV

February 28, 2023

The Honorable Melony Griffith
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

Senate Bill 460 - Maryland Medical Assistance Program - Gender-Affirming Treatment (Trans Health Equity Act) - FAVORABLE

Dear Chair Griffith and Senate Finance Committee members,

Baltimore Harm Reduction Coalition (BHRC) is an advocacy organization that mobilizes community members for the health, dignity, and safety of people targeted by the war on drugs and anti- sex worker policies. As a certified Overdose Response Program, naloxone distributor, and syringe service program we have provided essential health care services across the state for years. For this reason and more we support SB460, the Trans Health Equity Act.

Maryland continues to rely on 20-year old standards of care to attempt to meet the needs of its transgender and gender diverse residents. In turn, our state categorically denies dozens of gender-affirming services, all of which are federally approved and reimbursable. Without access to these services we are pushing vulnerable trans and gender diverse Marylanders further into the margins by exposing them to more employment and housing discrimination, harassment, and interpersonal violence.

Increasing access to gender-affirming surgeries is a community harm reduction strategy and supported by public health research. Studies have shown that transgender and gender diverse people with a history of gender-affirming surgery have significantly lower rates of behavioral health concerns such as substance use, suicidal ideation,[1] and sharing non-sterile syringes needed for gender-affirming medical care.[2] Insurance is proven to be a significant barrier to accessing hygienic supplies and wrap-around health care services to address behavioral and physical health needs. Furthermore, studies and cost benefit analyses show that access to sterile supplies saves money, largely from averted HIV, hepatitis B, and hepatitis C infections.[3]

The healthcare community needs to eliminate access barriers and support harm reduction strategies. Gender-affirming surgeries should be made available for transgender and gender diverse

---

[1] Almazan AN, Keuroghlian AS. Association Between Gender-Affirming Surgeries and Mental Health Outcomes. JAMA Surg. 2021;156(7):611–618. doi:10.1001/jamasurg.2021.0952

[2] Jennifer L. Glick, Katherine M. Andrinopoulos, Katherine P. Theall, and Carl Kendall. Tiptoeing Around the System: Alternative Healthcare Navigation Among Gender Minorities in New Orleans. Transgender Health 2018 3:1, 118-126

[3] Australian Commonwealth Department of Health and Aging. Return on Investment in Needle and Syringe Programs in Australia.

people who seek them, and Maryland must remove barriers to gender-affirming surgery such as insurance exclusions for such care.

BHRC recently launched an MDH-approved free statewide mail-based syringe service program specifically for transgender, nonbinary, and gender diverse people who inject hormones for hormone replacement therapy (HRT). This program is meant to address a gap in syringe distribution specifically for the needs of transgender community members whose medical needs are not met by our current system. Our community members experience significant barriers from pharmacies and healthcare providers when attempting to receive health care supplies for life-affirming medication. These barriers are rooted in transphobic policies and practices.

It is time for Maryland to join a cohort of over 10 states and the District of Columbia who provide comprehensive, gender-affirming care under Medicaid. BHRC asks that the Senate Finance Committee give SB460 a favorable report.

For more information about Baltimore Harm Reduction Coalition or our position, please contact our Director of Mobilization, Rajani Gudlavalleti at rajani@baltimoreharmreduction.org

GAC Report 2.26.23.pdf
Uploaded by: Riley Roshong
Position: FAV

GENDER-AFFIRMATIVE CARE: A DATA-DRIVEN REVIEW OF RELEVANT ACADEMIC LITERATURE

Written By:

Riley Grace Roshong, Dual J.D./M.P.P. Candidate, University of Maryland

Justin Gibson, M.S., University of Kentucky

Elton Högklint, B.S. Candidate, University of Amsterdam

Scott Oatley, Ph.D. Candidate, University of Edinburgh

Presented on Monday, February 6, 2023 to:

Eric Luedtke, Chief Legislative Officer for the Moore-Miller Administration

Connor Shinn, Policy Advisor for Wes Moore, Governor of Maryland

Submitted on Friday, February 10, 2023 to:

The Maryland House Health & Government Operations Committee

And Submitted on Monday, February 27, 2023 to:

The Maryland Senate Finance Committee

To testify in favor (with amendment) for:

The Trans Health Equity Act (HB0283/SB0460)

Contact: rileygraceroshong@gmail.com

Last Updated: Sunday, February 26, 2023

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EXECUTIVE SUMMARY

A. Problem Statement

Gender-affirmative (GAC) care for transgender people has become a major focus of recent legislative efforts. Opponents to LGBT+ rights commonly focus on this as a culture war issue to argue that doctors are surgically mutilating children and that transgender people are mentally ill. While proponents of LGBT+ rights are often able to recognize that this is part-and-parcel for untrustworthy anti-LGBT+ propaganda, they often lack the resources to push back.

Part of this has to do with a lack of infrastructure. At the federal level of government, legislators can enlist the help of the Library of Congress and/or the Office of Government Accountability to weigh in on complicated political issues with authoritative academic literature. State-level governments often lack the infrastructure to call upon a similar entity to provide comprehensive and unbiased research on topics of interest. Consequently, state-level legislators often have to turn to interest groups to provide the information they need. Unfortunately, many of these groups are primarily motivated by an interest in furthering their missions–not necessarily by an interest in the truth–so much of their research is done by lobbyists who do not have training or backgrounds in academia.

This is why earlier in 2022, the Yale School of Medicine's Dean's Advisory Council on Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Affairs had to intervene. With so many states currently attempting (and sometimes succeeding) to restrict access to GAC based on rampant misinformation, the Yale School of Medicine created and submitted reports responding to some of the most blatant examples of misinformation, including the 2022 Opinion by Texas Attorney General Ken Paxton[1] and the 2022 Florida Medicaid Report.[2] While these are great summaries and responses to the most blatant misinformation on GAC, they are not great resources to advise states who want to *help* transgender people access GAC.

That is what this report seeks to do. By conducting: (1) a comprehensive legislative analysis that determined the primary arguments and themes that witnesses focused on in previous legislation, and (2) a subsequent review of the relevant academic literature and scientific evidence on those arguments, the following report summarizes the academic literature on the most relevant subjects related to GAC for transgender people. Using this information, we make recommendations for states who want to help this population.

---

[1] Susan Boulware et al., *Biased Science in Texas & Alabama*, Yale School of Medicine (2022), https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/biased-science/ (last visited Feb 9, 2023).

[2] Anne Alstott et al., *Flawed Medicaid Report in Florida*, Yale School of Medicine, https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida-medicaid/ (last visited Feb 9, 2023).

B. Summary of Legislative Analysis

GAC is a highly partisan issue. Republicans introduced nearly all the bills that would reduce access to GAC during the 2022 legislative session in majority-Republican legislatures. Conversely, Democrats introduced nearly all the bills that would increase access to GAC in majority-Democratic legislatures.

Legislators introduced 53 bills in 2022 that would either increase or decrease access to GAC. The majority of these bills (66%) sought to reduce access to GAC. But, only 5.7% of the bills that would decrease access to GAC were signed into law. Comparatively, the bills that would increase access to GAC were signed into law 16.5% more often, for a total of 22.2%.

Only 4.5% of witnesses who submitted written testimony in Maryland last year opposed expanding access to GAC. This is likely because Maryland has a supermajority-Democratic legislature, which may discourage opponents from testifying. We analyzed written testimony from a bill which took an opposite stance on the same issue in Ohio to better account for opponent views.

Within the data from Maryland and Ohio, it was 29.3% more common for medical or scientific experts to testify in favor of expanding access to GAC. But, it was 3.5% more common for witnesses who testified against expanding access to GAC to cite peer-reviewed sources or books from reputable publishers. This suggests that while it was more common for opponents to expanding access to GAC to cite peer-reviewed literature, it was less likely that those witnesses had the relevant expertise to fully understand and/or explain those sources. It was also more than twice as common for witnesses who either currently or formerly identified as transgender to testify in favor of expanding access to GAC.

The two subjects that proponents and opponents discussed in their written testimony the most overall were: (1) the Effects of Gender-Affirmative Care on Mental and Physical Health (which witnesses discussed the most overall, appearing in 84.7% of all the written testimony), and (2) the Modern Medical Standards for Gender-Affirmative Care (which witnesses discussed the second-most overall, appearing in 70.4% of all the written testimony). Otherwise, proponents and opponents tended to focus either minimally on similar subjects or on completely different subjects altogether.

Notably, the three main subjects that opponents focused on in their written testimony were: (1) the Capability of Transgender Youth to Provide Informed Consent (which was discussed in 90.0% of opponent testimony); (2) Satisfaction, Regret, & Reversibility of Gender-Affirmative Care (which was discussed in 86.7% of opponent testimony); and (3) Whether Being Trans is an Intrinsic Quality (which was discussed in 83.3% of opponent testimony). While opponents primarily focused on the application of GAC to transgender youth,

many of their arguments extend beyond youth to also apply to transgender adults. It is therefore reasonable to infer that many opponents of expanding access to GAC are ultimately interested in criminalizing access to all forms of GAC, regardless of age.

C. Summary of Literature Review

This report summarizes the current state of the academic literature on each subject that we identified. We summarize our findings below, which are best incorporated into either a bill and/or an executive order in the following format:

WHEREAS, Overall, the current academic literature on Gender-Affirmative Care (GAC) shows that: (1) GAC has very positive effects on the mental health of transgender people and successfully alleviates their gender dysphoria; (2) GAC has few or no negative effects on physical health; and (3) any side effects that do exist are typically offset by an overall higher quality of life.

WHEREAS, The World Professional Organization for Transgender Health (WPATH) Standards of Care (SoC) for the Health of Transgender and Gender Diverse People have been subject to rigorous peer review and widely used as the medical standards of care for transgender people for decades.

WHEREAS, GAC is medically-necessary healthcare because: (1) it is administered for the treatment of gender dysphoria or gender incongruence pursuant to the ICD-11; (2) it is administered consistent with the WPATH SoC; and (3) transgender patients who pursue GAC are assessed by medical professionals who meet the requirements set out by the WPATH SoC.

WHEREAS, Transgender people are often unable to access GAC due to: (1) costs, (2) lack of available providers, (3) lack of provider training, and (4) discrimination by providers.

WHEREAS, Overall, the current literature shows that: (1) not all forms of GAC are irreversible, and (2) that transgender people are generally satisfied with the GAC they receive. To the extent that GAC causes sterility, transgender people can still achieve reproduction by pursuing fertility cryopreservation before beginning GAC.

WHEREAS, GAC is also important to alleviate the minority stress faced by

transgender people as a highly stigmatized and discriminated minority, which can have a significant impact on other areas of their life such as reducing their risk of suicide and increasing their overall well-being.

WHEREAS, While transgender identity was historically regarded as a mental disease or defect, this is now out-of-date with current medical practice which regards transgender identity as an intrinsic quality, due in part to several factors: (1) the historic failure of Gender Identity Change Efforts (GICE), (2) the growing body of literature suggesting a biological basis for gender identity, and (3) the World Health Organization (WHO) now classifying gender dysphoria as a physical condition by recognizing that affirming transgender conceptions of one's body leads to the best health outcomes for transgender people.

WHEREAS, Medical intervention is not recommended under the WPATH SoC until adolescence (i.e., the beginning of puberty) and is only recommended for adolescents who–along with their parents or guardians–are able to demonstrate to a medical professional that they are capable of providing informed consent. Current academic literature demonstrates also that transgender adolescents are capable of providing informed consent to receive GAC.

WHEREAS, Current literature demonstrates that the costs associated with expanding access to GAC for state Medicaid programs are minimal.

WHEREAS, The quality of peer-reviewed evidence used to make recommendations on GAC is of comparable quality to evidence used to make other similar forms of healthcare recommendations.

WHEREAS, Off-label medications (such as puberty blockers) are already used by many medical professionals to safely and effectively treat children in a wide variety of medical practices.

WHEREAS, There is no consistent or credible basis for the argument opponents commonly make that there are high "desistance" rates of transgender youth identifying as cisgender later in life, and most current literature shows the opposite: that transgender youth who

strongly identify with the opposite sex earlier in life are very likely to continue identifying as transgender later in life.

WHEREAS, Pursuant to Section 1557 of the Affordable Care Act, failing to provide comprehensive GAC could result in HHS withholding federal funds, especially once the Biden Administration rule is finalized.

D. Summary of Recommendations

We recommend that an administration that wants to act on this information issue an executive order that accomplishes two things: (1) affirms that their state is safe for transgender people to move to and pursue GAC, and that transgender people who visit their state to receive GAC from states which criminalize that care–as well as in-state providers who serve them–will not be subject to criminal punishment; and (2) reaffirms and recognizes the current academic literature on GAC.

We also recommend signing legislation to bring state Medicaid coverage in-line with modern medical standards for GAC. This can be accomplished by signing legislation that either: (1) directs the state Department of Health (DoH) to promulgate a rule to expand coverage for GAC based on the current WPATH SoC; or (2) directly incorporates specific forms of GAC into state Medicaid coverage that are in-line with the current WPATH SoC. Proponents will tend to favor the latter option since there is concern that deferring to an agency may mean that not everything that is considered as medically necessary under WPATH will be covered under Medicaid. We prefer the former option because it gives a longer shelf life to any signed legislation since you can direct the DoH to promulgate a new rule whenever WPATH releases a new SoC, although these options are not mutually exclusive.

Finally, we would recommend the creation of a fund to increase the number of healthcare professionals that provide GAC. This fund would increase the number of healthcare professionals that provide GAC by funding two kinds of training through public-private partnerships: (1) training by qualified medical professionals so that interested clinics' practices are in-line with modern medical standards for GAC; and (2) training by LGBT+ community organizations on best practices for treating and interacting with transgender patients to help them feel affirmed and encourage them to seek medical care. We also may recommend pursuing legislation in the future which would reevaluate state law for when a transgender adolescent could pursue GAC when transphobic or otherwise unaccepting parents object to the provision of that care despite the recommendation(s) of healthcare professionals. This is something we wish to research and discuss more in a future version of this report.

I. GENDER-AFFIRMATIVE CARE, LEGISLATIVE ANALYSIS

A. Methods for Collecting Nationwide Data

Since legislative trackers are normally maintained by either one or a handful of employees, we used several of the most comprehensive LGBT+ legislative trackers to triangulate all the legislation that was introduced during the 2022 legislative session related to GAC. The legislative trackers we used include:

- The National Center for Transgender Equality (NCTE) State Action Center[3]
- The American Civil Liberties Union (ACLU) Legislative Tracker[4]
- The Freedom for All Americans LGBTQ Legislative Tracker[5]
- The Equality Federation State Legislation Tracker[6]

We looked through each legislative tracker and identified each bill that would either: (1) increase access to GAC (ex: through increasing state Medicaid coverage for GAC), or (2) decrease access to GAC (ex: through criminalizing some or all access to GAC). After identifying all the legislation that was introduced last year on this issue, we collected general data on each bill that included: (1) what state the bill was introduced in; (2) the majority party of the legislature that the bill was introduced in; (3) what the party(s) of the sponsor(s) of the bill was; (4) whether the bill would either expand or reduce access to GAC; (5) the bill's current status (which included: (a) whether the bill was passed by the legislature and signed by the governor into law, (b) whether the bill was passed by the legislature but is waiting to be signed by the governor, (c) whether the bill is still in committee, or (d) whether the bill is dead); and (6) whether the state legislature website has online records of written and/or testimony for that bill. This data can be accessed below, along with the other data we collected for our legislative analysis.[7]

B. Descriptive Statistics, Nationwide Data

Legislators introduced 53 bills during 2022 in state legislatures that would either expand or reduce access to GAC. 35 (or 66.0%) of these bills sought to reduce access to GAC. 18 (or 34.0%) of these bills sought to increase access to GAC.

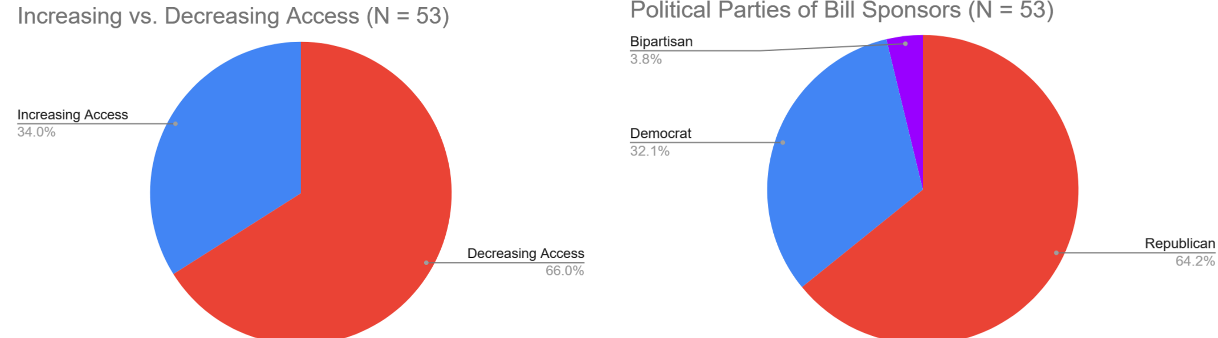
[3] State Action Center, National Center for Transgender Equality (2021), https://transequality.org/state-action-center (last visited Feb 9, 2023).

[4] Mapping Attacks on LGBTQ Rights in U.S. State Legislature, American Civil Liberties Union, https://www.aclu.org/legislative-attacks-on-lgbtq-rights (last visited Feb 9, 2023).

[5] Legislative Tracker, Freedom for All Americans, https://freedomforallamericans.org/legislative-tracker/ (last visited Feb 9, 2023).

[6] State Legislation, Equality Federation, https://www.equalityfederation.org/state-legislation (last visited Feb 9, 2023).

[7] Riley Roshong, Justin Gibson & Scott Oatley, *Gender-Affirmative Care 2022 Legislative Data*, Google Docs, https://docs.google.com/spreadsheets/d/18tPiFgOZ84cVlwSm02XaxBPYSivT_K7Kfa00Fh3t4Xc/edit?usp=sharing (last visited Feb 9, 2023).



Our nationwide data findings on final legislative outcomes are listed in Table 1. 43 (or 81.1%) of the 53 bills died. This includes 31 (or 88.6%) of the 35 bills that would have reduced access to GAC and 12 (or 66.7%) of the 18 bills that would have increased access to GAC.

6 (or 11.3%) of the 53 bills were signed by their state governor and passed into law. This includes 2 (or 5.7%) of the 35 bills that sought to reduce access to GAC (which were in Alabama (SB0184)[8] and Arizona (SB1138)) and 4 (or 22.2%) of the 18 bills that sought to increase access to GAC (which were in California (AB2521, SB0107, and SB0923) and Hawaii (SB2405)).

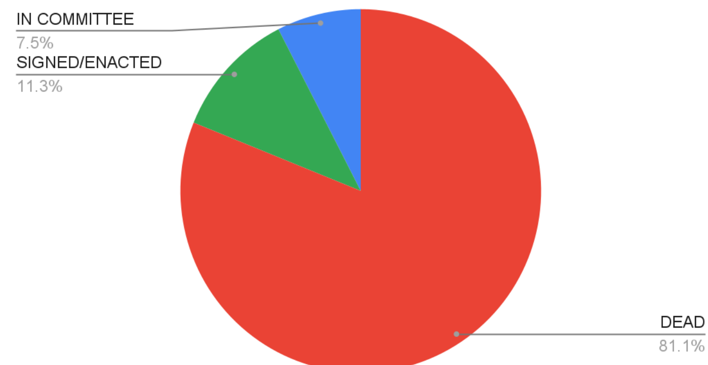
4 (or 7.5%) of the 53 bills are still in committee. This includes 2 (or 5.7%) of the 35 bills that sought to reduce access to GAC (which are in North Carolina (SB0514) and Ohio (HB0454)) and 2 (or 11.1%) of the 18 bills that sought to increase access to GAC (which are both in New Jersey (A3146/S1168 and S1494).

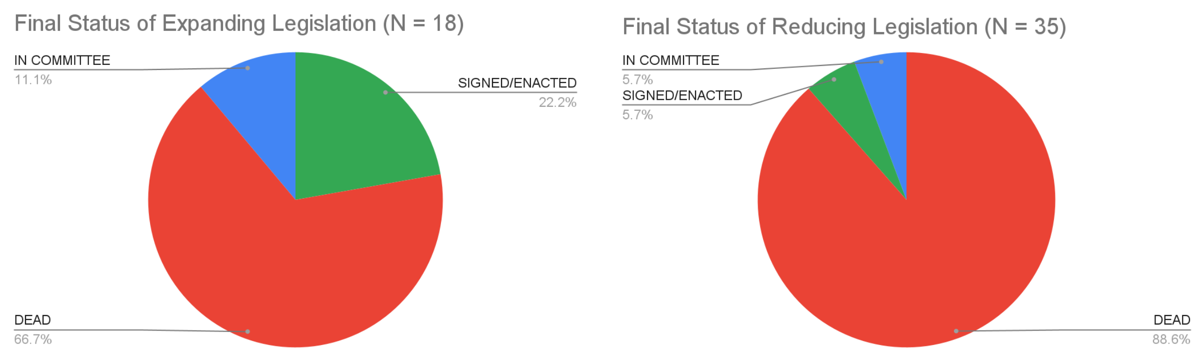
Table 1. Nationwide Legislative Data

Bill Status	Pro-GAC (N = 18)	Anti-GAC (N = 35)	Overall (N = 53)
Dead	12 (**66.7%**)	31 (**88.6%**)	43 (**81.1%**)
Signed Into Law	4 (**22.2%**)	2 (**5.7%**)	6 (**11.3%**)
Still In Committee	2 (**11.1%**)	2 (**5.7%**)	4 (**7.5%**)

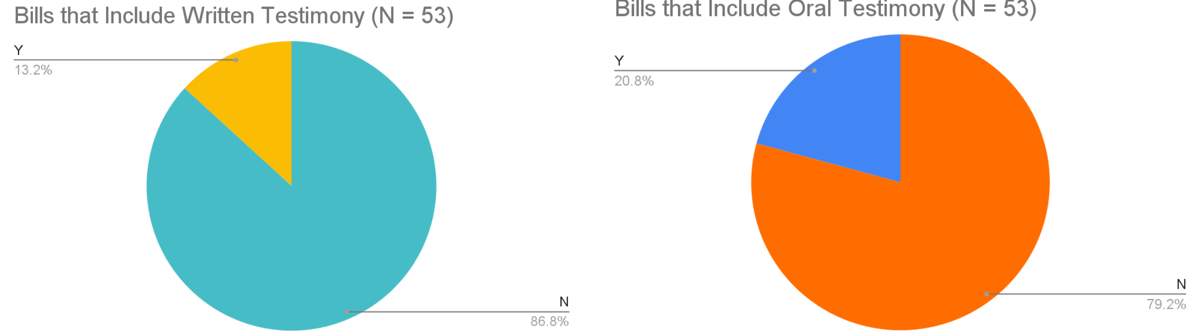
Color Categories: 0.01% - 30.0%; 30.01% - 60.00%; 60.01% - 99.99%

[8] A federal judge has blocked this law, arguing that there is a substantial likelihood that the law violates the Equal Protection Clause. *Eknes-Tucker et al. v. Marshall*, 2022 WL 1521889 (M.D. Ala. May 13, 2022).



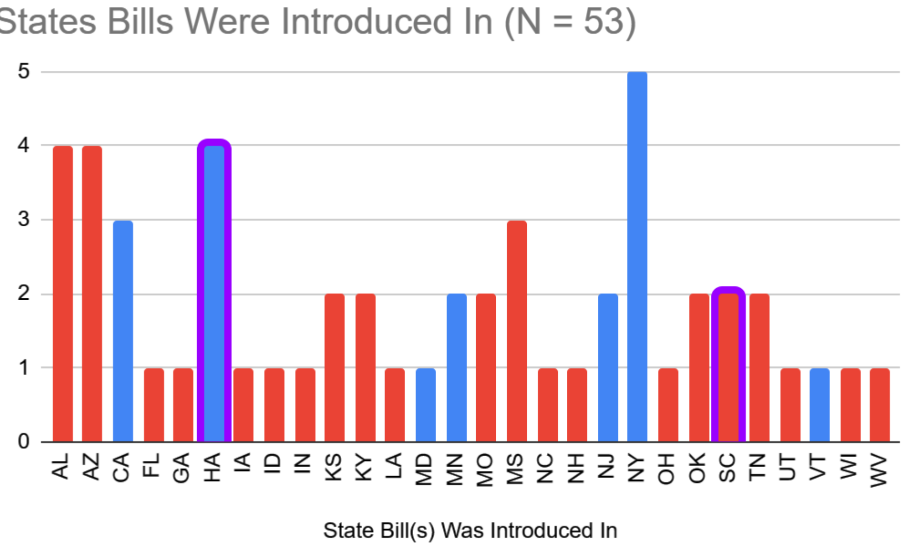


Only 7 (or 13.2%) of the 53 bills have online records of written testimony on their state legislature websites, and only 11 (or 20.8%) of the 53 bills have online records of oral testimony available on their state legislature websites. Of all 53 bills, only 6 (or 11.3%) have online records of both written and oral testimony available on their legislature websites. These bills were in three states: Maryland (HB0746/SB0682), Ohio (HB0454), and Hawaii (HB0285, HB2405, SB0752, and SB2835).



C. Discussion of Nationwide Data

All the bills that sought to reduce access to GAC were introduced in majority-Republican legislatures, whereas all of the bills that sought to increase access to GAC were introduced in majority-Democratic legislatures. Moreover, only one Democrat co-sponsored legislation that sought to reduce access to GAC (SC HB4047) and only one Republican co-sponsored legislation that sought to increase access to GAC (HA HB2405). This is represented in the graph below and tells us that this issue is highly partisan.



Despite the fact that all the legislation that sought to reduce access to gender-affirming care was introduced in majority-Republican legislatures, very few of those bills were signed into law. This tells us that–although every bill reducing access to GAC was introduced by a Republican–many Republicans do not agree with these policies. Comparatively, the bills that sought to increase access to GAC were signed into law 16.5% more often than those that sought to decrease access to GAC. This tells us that there has been more success convincing Democratic legislators to support increasing access to GAC (though they still need convincing).

Most records maintained on state legislature websites of their oral and/or written testimony for these bills are either poor or nonexistent. Fortunately, Maryland has some of the highest-quality records of both written and oral testimony on its bill from last year available on its state legislature website. This gives us a comprehensive source of data on the kinds of witnesses, evidence, and arguments presented to support expanding access to GAC. Unfortunately (for research purposes), there was very little testimony submitted by witnesses who did not support expanding access to GAC in Maryland (more specific data on this below). This means that the written testimony submitted in Maryland is insufficient to give us an

adequate understanding of the kinds of witnesses, evidence, and arguments that opponents make on this issue. The only legislation introduced during the past year that sought to reduce access to GAC and that has online records of both written and oral testimony available on its state legislature website is HB0454 from Ohio. For the purposes of this project, we will use the written testimony submitted in Ohio as a supplement so we can better account for the kinds of witnesses, evidence, and arguments that are cited by opponents to expanding access to GAC.

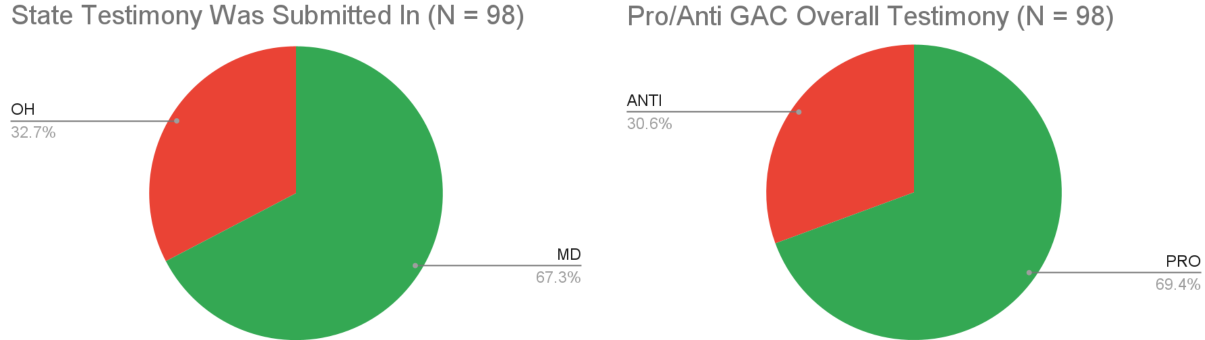
D. Descriptive Statistics, Written Testimony Data

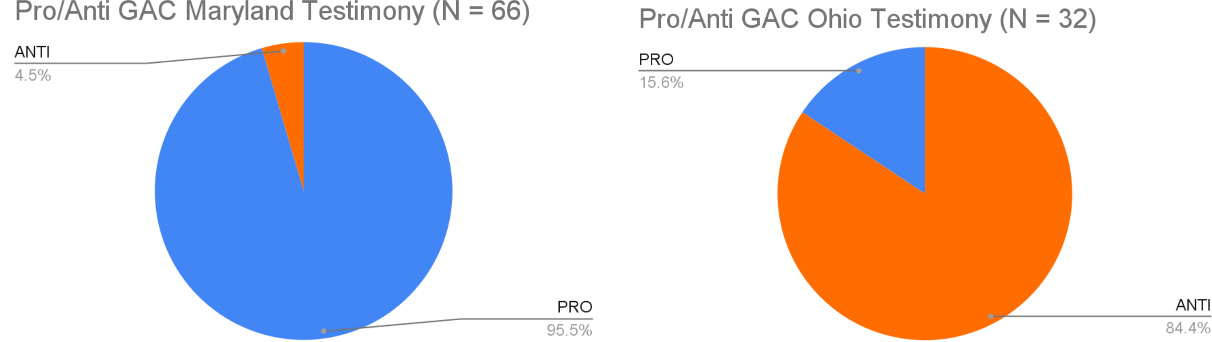
Our findings on the positions of witnesses who submitted written testimony in Maryland and Ohio on whether to increase or decrease access to GAC are reported below in Table 2. 98 witnesses submitted written testimony on the bills in Maryland and Ohio last year. 66 (or 67.3%) of those witnesses submitted testimony in Maryland and 32 (or 32.7%) of those witnesses submitted written testimony in Ohio. 63 (95.5%) of the 66 witnesses that submitted written testimony in Maryland testified in favor of expanding access to GAC and 3 (4.5%) of the 66 witnesses were not in favor. 27 (84.4%) of the 32 witnesses that submitted written testimony in Ohio testified in favor of reducing access to GAC and 5 (15.6%) of the 32 witnesses were not in favor.

Table 2. Written Testimony Position Data

Position	MD HB0746/SB0682 (N = 66) (**67.3%**)	OH HB0454 (N = 32) (**32.7%**)	Total (N = 98)
Pro-GAC	63 (**95.5%**)	5 (**15.6%**)	68 (**69.4%**)
Anti-GAC	3 (**4.5%**)	27 (**84.4%**)	30 (**30.6%**)

Color Categories: 0.01% - 30.0%; 30.01% - 60.00%; 60.01% - 99.99%





This means that the majority of witnesses in each state took opposite stances on GAC. The reasons for this are likely that: (1) the Maryland General Assembly is a supermajority Democratic body, whereas the Ohio State Legislature is a majority Republican body, and (2) witnesses were probably more inclined to submit testimony that aligned in substance with their personal positions on GAC.

Since this issue is highly partisan, witnesses who would not want to increase access to GAC may be discouraged from testifying in a majority-Democratic legislature, and vice-versa. This is important because it may suggest that at least some Maryland voters share some of the positions that are raised by the witnesses who testified in Ohio and that we may not see those positions represented in the written testimony that was submitted in Maryland because detractors were disincentivized from participating. This creates a substantial risk for populist political outsiders to potentially capitalize on a voting population that feels alienated from the current political establishment.

E. Expertise & Evidence, Qualitative Data Analysis

Our findings on the credibility of witnesses who submitted written testimony in Maryland and Ohio are reported below in Table 3. To collect this data, we created and utilized the following categories to measure how credible a witness's written testimony is in certain respects:

- **Medical/Scientific Expert**: If the witness in the testimony: (a) has a relevant medical or scientific degree, (b) has first-hand experience providing relevant medical treatment, or (c) is representing an organization that is explicitly medical or scientific in nature and that engages primarily in medical or scientific work.
- **Cited Peer-Reviewed Sources or Books from Reputable Publishers**: If the testimony includes citations to either: (a) peer-reviewed sources, or (b) books from reputable publishers.
- **Legal Expert**: If the witness in the testimony: (a) has a law degree, or (b) is representing an organization that is explicitly legal in nature and engages in primarily legal work.

- **Cited Legal Sources**: If the testimony includes explicit citations to: (a) statutes, (b) court decisions, (c) administrative law, (d) legislation, (e) legal briefs, or (f) law review articles.
- **Trans-Identified or Former Trans-Identified Witness**: If the testimony includes any indication that the witness has previously identified as transgender.
- **Cited Other Sources**: If the testimony includes any citations that are not included in the previous categories.

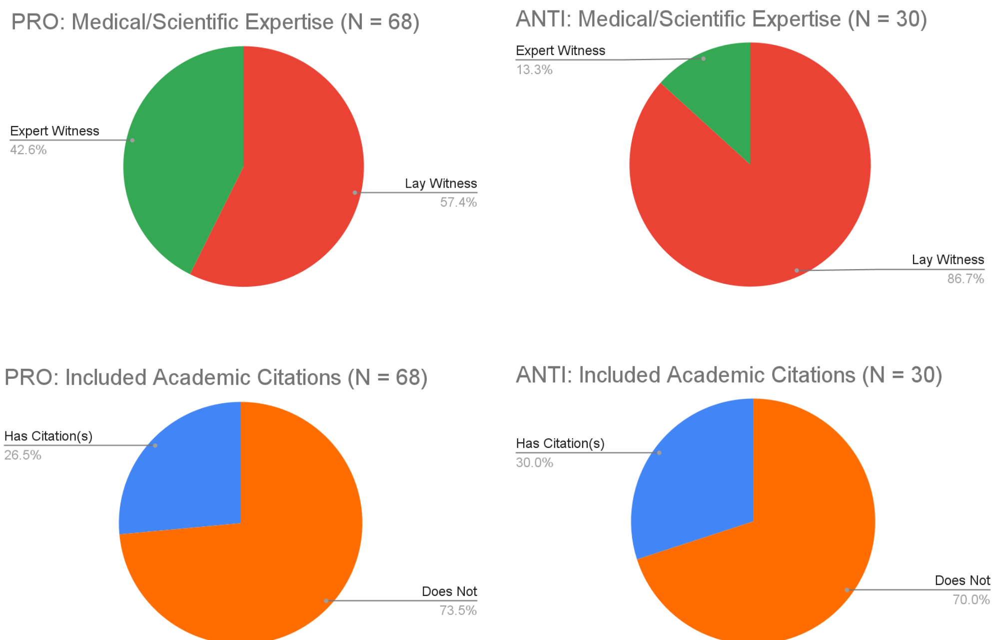
Table 3. Expertise & Evidence Data

Type of Data	Pro-GAC (N = 68)	Anti-GAC (N = 30)	Total (N = 98)
Medical/Scientific Expert	29 (**42.6%**)	4 (**13.3%**)	33 (**33.7%**)
Cited Peer-Reviewed Sources or Books from Reputable Publishers	18 (**26.5%**)	9 (**30.0%**)	27 (**27.6%**)
Legal Expert	7 (**10.3%**)	2 (**6.7%**)	9 (**9.2%**)
Cited Legal Sources	8 (**11.8%**)	5 (**16.7%**)	13 (**13.3%**)
Trans-Identified or Former Trans-Identified Witness	19 (**27.9%**)	4 (**13.3%**)	23 (**23.5%**)
Cited Other Sources	22 (**32.4%**)	11 (**36.7%**)	33 (**33.7%**)

Color Categories: 0.01% - 17.00%; 17.01% - 34.00%; 34.01% - 50.00%

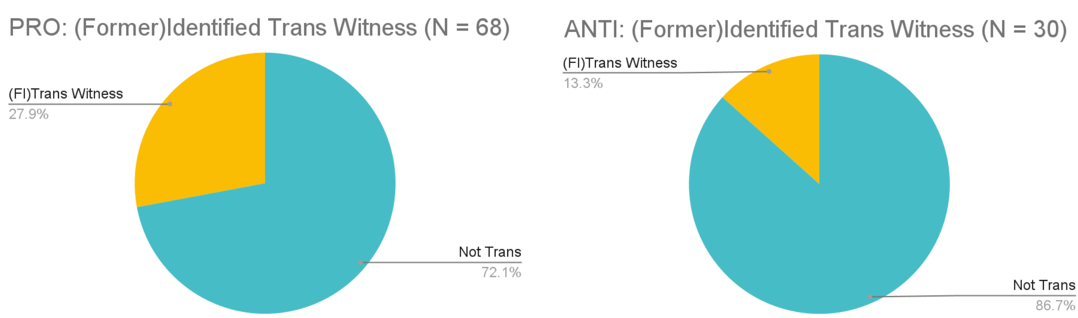
F. Discussion, Expertise & Evidence Qualitative Data Analysis

We found that it was 29.3% more common for medical or scientific experts to testify in favor of expanding access to GAC. But, it was 3.5% more common for witnesses who testified against expanding access to GAC to cite peer-reviewed articles or books from reputable publishers. This suggests that while it was slightly more common for witnesses who were against expanding access to GAC to cite peer-reviewed literature or books from reputable publishers, it was less likely that evidence was cited by witnesses with the requisite expertise to fully understand and explain those sources.



We also found that it was 3.6% more common for legal experts to testify in favor of expanding access to GAC. But, it was 4.9% more common for witnesses who testified against expanding access to GAC to cite legal sources. This similarly suggests that while it was more common for witnesses who were against expanding access to GAC to cite legal sources, it was less likely that evidence was cited by witnesses with the requisite expertise to fully understand and explain those sources.

Finally, we found that it was 14.6% more common for witnesses who either currently identified as transgender or formerly identified as transgender to testify in favor of expanding access to GAC. People who either currently or previously identified as transgender constituted 27.9% of all the witnesses who testified in favor of expanding access to GAC, which is more than double the 13.3% of the witnesses who either currently or previously identified as transgender who opposed expanding access to GAC. This is especially significant considering that this is the population of witnesses who are most directly affected by this issue.



G. Methods for Collecting Written Testimony Subject Matter Data

Riley Roshong and Justin Gibson collectively read through every piece of written testimony from MD HB0746/SB0682 and OH HB0454 and developed and utilized categories for determining whether certain language in written testimony was making an argument on a certain subject (ex: whether someone was making an argument on the effects of GAC on mental and physical health). Then, after one researcher read through the testimony and made an evaluation of whether certain testimony focused on certain subjects or not, the other would go through the same testimony to indicate whether they agreed with the initial assessment. If the other researcher did not agree with the initial assessment, they would mark it as such on the data sheet to indicate to whoever initially reviewed the testimony to review it again. If the initial researcher re-reviewed the data entry and still did not agree with the second researcher's assessment, then they marked to indicate that the two of them are in mutually-understood disagreement on that data entry. Lastly, both researchers discussed each mutually-understood disagreement on the data sheet to see if we could come to agreements on how to categorize the testimony data entries.

At the end of our qualitative analysis, both researchers only had mutually-understood disagreements on 4 data entries. The standard for inter-reviewer reliability is to agree on more than 70% of assessments, so we are meeting industry standards for internal validity. We also did not review data entries for when one of us believed that written testimony did not make an argument on a certain subject. This was for two reasons: (1) it saved us time, since this would otherwise have required each of us to read through the entirety of every piece of written testimony (compared to only reading the excerpts the initial researcher pulled from the testimony to justify their data entries), and (2) it would mean that our results are more cautious since there may be some data entries where we say that a certain witness did not make an argument on a certain subject when they either did or were trying to. This increases the certainty of our categorizations.

H. Qualitative Analysis & Results, Subject Matter

We created and utilized categories for the 18 subjects that witnesses made arguments on in their written testimony either in favor or against expanding access to GAC.[9] These subject matter categories are derived from the arguments that proponents and opponents primarily made on that subject and how often those subjects were discussed in proponent and opponent written testimony. Our findings are reported below, as well as in Tables 4 and 5. Results are organized below by how often witnesses discussed the subjects in written testimony overall:

[9] It should go without saying that these do not reflect the perspectives of the researchers on this project. These are meant to accurately capture the perspectives of the witnesses who testified on the bills we analyzed.

- **Effects of Gender-Affirmative Care on Mental and Physical Health** [**84.7%** | **1st Overall**]
    - **Pro-GAC** [**88.2%** | **1st**]: If GAC increases mental and/or physical well-being, then we should increase access on that basis.
    - **Anti-GAC** [**76.7%** | **4th**]: If GAC either does nothing or decreases mental and/or physical well-being, then we shouldn't increase access on that basis.

- **Modern Medical Standards for Gender-Affirmative Care** [**70.4%** | **2nd Overall**]
    - **Pro-GAC** [**70.6%** | **4th**]: If current Medicaid coverage for GAC is out of line with modern medical standards of care, then we should increase access on that basis to bring it into alignment.
    - **Anti-GAC** [**70.0%** | **5th**]: If current Medicaid coverage for GAC is out of line with modern medical standards of care, then we should not increase access on that basis because modern standards are bad/biased/etc. and we should reject them (ex: due to financial incentive).

- **Alleged Purpose(s) of Medicaid (Ex: Medical Necessity, Bodily Autonomy, etc.)** [**59.2%** | **3rd Overall**]
    - **Pro-GAC** [**79.4%** | **3rd**]: If covering GAC is in-line with at least one (alleged) purpose of Medicaid (ex: ensuring equitable access to medically-necessary healthcare, increasing bodily autonomy, etc.), then we should increase access to it on that basis.[10]
    - **Anti-GAC** [**13.3%** | **10th (TIE)**]: If covering GAC is not in-line with at least one (alleged) purpose of Medicaid (ex: ensuring access to medically-necessary healthcare, increasing bodily autonomy, etc.), then we should not increase access to it on that basis.

- **Cost & Similar Barriers to Gender-Affirmative Care** [**58.2%** | **4th Overall**]
    - **Pro-GAC** [**83.8%** | **2nd**]: If trans people cannot access GAC on their own due to cost or other similar barriers, then we should increase access to it on that basis.
    - **Anti-GAC** [**0.0%** | **18th**]: If trans people either can or should pay for GAC, then we should not increase access to it on that basis.

[10] The purpose of this language is to capture the fact that some witnesses seemed to assert different purposes of Medicaid coverage. For example, many witnesses discussed the importance of bodily autonomy in relation to expanding access to Medicaid. We will discuss this more in a later section.

- **Satisfaction, Regret, & Reversibility of Gender-Affirmative Care** [**44.9% | 5th Overall**]
    - **Pro-GAC** [**26.5% | 8th**]: If trans people are generally satisfied with GAC and/or the effects of GAC are generally reversible, then we should increase access to it on that basis.
    - **Anti-GAC** [**86.7% | 2nd**]: If trans people are generally unsatisfied with GAC or otherwise regret receiving that care and the effects of GAC are generally irreversible, then we should not increase access to it on that basis.

- **Minority Stress & Effects of Gender-Affirmative Care on How Trans People are Treated in Society** [**42.9% | 6th Overall**]
    - **Pro-GAC** [**57.4% | 5th**]: If GAC helps trans people to be treated better in society–which is relevant for healthcare purposes since it can alleviate minority stress that arises from discrimination–then we should increase access on that basis.
    - **Anti-GAC** [**10.0% | 13th**]: If GAC either doesn't impact how trans people are treated in society or makes them worse off, then we shouldn't increase access on that basis.

- **Other States/Health Insurance Policies on Gender-Affirmative Care** [**36.7% | 7th Overall**]
    - **Pro-GAC** [**45.6% | 6th**]: If other forms of health insurance cover types of GAC that we do not, then we should increase Medicaid coverage on that basis.
    - **Anti-GAC** [**16.7% | 9th**]: Either: (1) other forms of health insurance don't cover GAC, so we shouldn't increase Medicaid coverage on that basis, or (2) other forms of health insurance are wrong to cover it, so we shouldn't increase coverage on that basis.

- **Whether Being Trans is an Intrinsic Quality** [**32.7% | 8th Overall**]
    - **Pro-GAC** [**10.3% | 13th**]: If being trans is an intrinsic quality, we should increase access to GAC on that basis to make it easier for people to live as trans since it is impossible for them to be cis.
    - **Anti-GAC** [**83.3% | 3rd**]: If being trans is not an intrinsic quality–whether due to "social contagion," some other form of pathologization, or "grooming"–then not only is it unnecessary to expand access to GAC on that basis, but gender identity change efforts (GICE) are also justified.

- **Capability of Trans Youth to Provide Informed Consent** [**31.6% | 9th Overall**]
    - **Pro-GAC** [**5.9% | 14th**]: If trans youth are mentally capable of providing informed consent for certain forms of GAC, then we should increase access to it on that basis to the extent they can provide informed consent.
    - **Anti-GAC** [**90.0% | 1st**]: If trans youth are not mentally capable of providing informed consent for any forms of GAC, then we should not increase access to it on that basis.

- **Costs of Medicaid Expansion for the Government** [**29.6% | 10th Overall (TIE)**]
    - **Pro-GAC** [**39.7% | 7th**]: If covering GAC is affordable overall and/or worth the cost, then we should increase access to it on that basis.
    - **Anti-GAC** [**6.7% | 14th (TIE)**]: If covering GAC is expensive overall and/or not worth the cost, then we should not increase access to it on that basis.

- **Quality of Evidence Concerning Gender-Affirmative Care** [**29.6% | 10th Overall (TIE)**]
    - **Pro-GAC** [**17.6% | 11th**]: If the prevailing evidence on GAC is of high enough quality that we should be able to trust it, then we should rely on it to justify expanding access to GAC.
    - **Anti-GAC** [**56.7% | 6th**]: If the prevailing evidence on GAC is not high enough quality that we should be able to trust it, then we should not rely on it to justify expanding access to GAC because to do so would be "experimentation."

- **State Role in Overseeing the Wellbeing of Trans Youth** [**18.4% | 12th Overall**]
    - **Pro-GAC** [**13.2% | 12th**]: If either: (1) it is the role of the state to oversee the wellbeing of trans youth in the event that parents are incapable of acting in their best interest, or (2) if medical decisions should be left between patients and their doctors, then we should increase access to GAC on that basis.
    - **Anti-GAC** [**30.0% | 8th**]: If either: (1) it is not the role of the state to oversee the wellbeing of trans youth in the event that parents are incapable of acting in their best interests, or (2) the state should interfere between medical decisions between patients and doctors, then we should not increase access to GAC on that basis.

- **Position of the FDA** [**17.3% | 13th Overall**]
    - **Pro-GAC** [**19.1% | 9th (TIE)**]: If the FDA approves of GAC (and/or authorizes its reimbursement), then we should increase access to it on that basis.
    - **Anti-GAC** [**13.3% | 10th (TIE)**]: If the FDA does not approve of GAC (and/or does not authorize its reimbursement), then we should not increase access to it on that basis.

- **Coverage for Non-Binary Trans People** [**14.3% | 14th Overall (TIE)**]
    - **Pro-GAC** [**19.1% | 9th (TIE)**]: Current Medicaid coverage does not cover GAC for non-binary trans people, so we should increase access to GAC on that basis.
    - **Anti-GAC** [**3.3% | 16th (TIE)**]: Either: (1) only binary trans people are valid, so we should not increase access to include coverage for non-binary trans people on that basis; or (2) no trans people are valid–especially non-binary people–so we should not increase access to GAC at all on that basis.

- **Desistance & Detransition Rates of Transgender Youth** [**14.3% | 14th Overall (TIE)**]
    - **Pro-GAC** [**1.5% | 17th**]: If desistance and/or detransition rates of transgender youth are relatively low, then that should not be a basis to deny increasing access to permanent forms of GAC.
    - **Anti-GAC** [**43.3% | 7th**]: If desistance and/or detransition rates of transgender youth are relatively high, then that should be a basis to deny increasing access to permanent forms of GAC.

- **Federal & State Law Applications to Gender-Affirmative Care** [**6.1% | 16th Overall**]
    - **Pro-GAC** [**2.9% | 15th (TIE)**]: If it is legally permissible to expand access to GAC, then this should not be an objection to expanding access to it under Medicaid.
    - **Anti-GAC** [**13.3% | 10th (TIE)**]: If it is not legally permissible to expand access to GAC, then this should be an objection to expanding access to it under Medicaid.

- **Coverage for Cis People** [**4.1% | 17th Overall**]
    - **Pro-GAC** [**2.9% | 15th (TIE)**]: If forms of GAC are already covered under Medicaid for cis people, then we should increase access to that same care for trans people.
    - **Anti-GAC** [**6.7% | 14th (TIE)**]: If forms of GAC are not already covered under Medicaid for cis people, then we should not increase access to that same care for trans people.

- **Survey Data on the General Population** [**1.0% | 18th Overall**]
    - **Pro-GAC** [**0.0% | 18th**]: If survey data show that most people generally support expanding access to GAC, then we should increase access on that basis.
    - **Anti-GAC** [**3.3% | 16th (TIE)**]: If survey data shows that most people generally are either indifferent or do not support expanding access to GAC, then we should not increase access on that basis.

Table 4. Written Testimony Subject Matter Data

Subject Matter	Total & Rank (N = 98)	Pro-GAC (N = 68)	Anti-GAC (N = 30)
Effects of Gender-Affirmative Care on Mental & Physical Health	83 (**84.7%**)	60 (**88.2%**)	23 (**76.7%**)
Modern Medical Standards for Gender-Affirmative Care	69 (**70.4%**)	48 (**70.6%**)	21 (**70.0%**)
Alleged Purpose(s) of Medicaid (Ex: Medical Necessity, Bodily Autonomy, etc.)	58 (**59.2%**)	54 (**79.4%**)	4 (**13.3%**)
Cost & Similar Barriers to Gender-Affirmative Care	57 (**58.2%**)	57 (**83.8%**)	0 (**0.0%**)
Satisfaction, Regret, & Reversibility of Gender-Affirmative Care	44 (**44.9%**)	18 (**26.5%**)	26 (**86.7%**)
Minority Stress & Effects of Gender-Affirmative Care on How Trans People Are Treated in Society	42 (**42.9%**)	39 (**57.4%**)	3 (**10.0%**)
Other States/Health Insurance Policies on Gender-Affirmative Care	36 (**36.7%**)	31 (**45.6%**)	5 (**16.7%**)
Whether Being Trans is an Intrinsic Quality	32 (**32.7%**)	7 (**10.3%**)	25 (**83.3%**)
Capability of Trans Youth to Provide Informed Consent	31 (**31.6%**)	4 (**5.9%**)	27 (**90.0%**)
Cost of Medicaid Expansion for the Government	29 (**29.6%**)	27 (**39.7%**)	2 (**6.7%**)
Quality of Evidence Concerning Gender-Affirmative Care	29 (**29.6%**)	12 (**17.6%**)	17 (**56.7%**)
State Role in Overseeing the Wellbeing of Trans Youth	18 (**18.4%**)	9 (**13.2%**)	9 (**30.0%**)
Position of the FDA	17 (**17.3%**)	13 (**19.1%**)	4 (**13.3%**)
Coverage for Non-Binary Trans People	14 (**14.3%**)	13 (**19.1%**)	1 (**3.3%**)
Desistance & Detransition Rates of Transgender Youth	14 (**14.3%**)	1 (**1.5%**)	13 (**43.3%**)
Federal & State Law Applications to Gender-Affirmative Care	6 (**6.1%**)	2 (**2.9%**)	4 (**13.3%**)
Coverage for Cis People	4 (**4.1%**)	2 (**2.9%**)	2 (**6.7%**)
Survey Data on the General Population	1 (**1.0%**)	0 (**0.0%**)	1 (**3.3%**)

Color Categories: 0.00%; 0.01% - 30.0%; 30.01% - 60.00%; 60.01% - 99.99%

Table 5. Written Testimony Subject Matter Priority Ranking

Rank	Overall	Pro-GAC	Anti-GAC
1st	Effects of Gender-Affirmative Care on Mental & Physical Health (84.7%)	Effects of Gender-Affirmative Care on Mental & Physical Health (88.2%)	Capability of Trans Youth to Provide Informed Consent (90.0%)
2nd	Modern Medical Standards for Gender-Affirmative Care (70.4%)	Costs & Similar Barriers to Gender-Affirmative Care (83.8%)	Satisfaction, Regret, & Reversibility of Gender-Affirmative Care (86.7%)
3rd	Alleged Purpose(s) of Medicaid (Ex: Medical Necessity, Bodily Autonomy, etc.) (59.2%)	Alleged Purpose(s) of Medicaid (Ex: Medical Necessity, Bodily Autonomy, etc.) (79.4%)	Whether Being Trans is an Intrinsic Quality (83.3%)
4th	Costs & Similar Barriers to Gender-Affirmative Care (58.2%)	Modern Medical Standards for Gender-Affirmative Care (70.6%)	Effects of Gender-Affirmative Care on Mental & Physical Health (76.7%)
5th	Satisfaction, Regret, & Reversibility of Gender-Affirmative Care (44.9%)	Minority Stress & Effects of Gender-Affirmative Care on How Trans People Are Treated in Society (57.4%)	Modern Medical Standards for Gender-Affirmative Care (70.0%)
6th	Minority Stress & Effects of Gender-Affirmative Care on How Trans People Are Treated in Society (42.9%)	Other States/Health Insurance Policies on Gender-Affirmative Care (45.6%)	Quality of Evidence Concerning Gender-Affirmative Care (56.7%)
7th	Other States/Health Insurance Policies on Gender-Affirmative Care (36.7%)	Cost of Medicaid Expansion for the Government (39.7%)	Desistance & Detransition Rates of Transgender Youth (43.3%)
8th	Whether Being Trans is an Intrinsic Quality (32.7%)	Satisfaction, Regret, & Reversibility of Gender-Affirmative Care (26.5%)	State Role in Overseeing the Wellbeing of Trans Youth (30.0%)
9th	Capability of Trans Youth	Position of the FDA	Other States/Health

	to Provide Informed Consent (31.6%)	(19.1%) (**TIE, 9th**)	Insurance Policies on Gender-Affirmative Care (16.7%)
10th	Cost of Medicaid Expansion for the Government (29.6%) (**TIE, 10th**)	Coverage for Non-Binary Trans People (19.1%) (**TIE, 9th**)	Federal & State Law Applications to Gender-Affirmative Care (13.3%) (**TIE, 10th**)
11th	Quality of Evidence Concerning Gender-Affirmative Care (29.6%) (**TIE, 10th**)	Quality of Evidence Concerning Gender-Affirmative Care (17.6%)	Alleged Purpose(s) of Medicaid (Ex: Medical Necessity, Bodily Autonomy, etc.) (13.3%) (**TIE, 10th**)
12th	State Role in Overseeing the Wellbeing of Trans Youth (18.4%)	State Role in Overseeing the Wellbeing of Trans Youth (13.2%)	Position of the FDA (13.3%) (**TIE, 10th**)
13th	Position of the FDA (17.3%)	Whether Being Trans is an Intrinsic Quality (10.3%)	Minority Stress & Effects of Gender-Affirmative Care on How Trans People Are Treated in Society (10.0%)
14th	Coverage for Non-Binary Trans People (14.3%) (**TIE, 14th**)	Capability of Trans Youth to Provide Informed Consent (5.9%)	Cost of Medicaid Expansion for the Government (6.7%) (**TIE, 14th**)
15th	Desistance & Detransition Rates of Transgender Youth (14.3%) (**TIE, 14th**)	Federal & State Law Applications to Gender-Affirmative Care (2.9%) (**TIE, 15th**)	Coverage for Cis People (6.7%) (**TIE, 14th**)
16th	Federal & State Law Applications to Gender-Affirmative Care (6.1%)	Coverage for Cis People (2.9%) (**TIE, 15th**)	Coverage for Non-Binary Trans People (3.3%) (**TIE, 16th**)
17th	Coverage for Cis People (4.1%)	Desistance & Detransition Rates of Transgender Youth (1.5%)	Survey Data on the General Population (3.3%) (**TIE, 16th**)
18th	Survey Data on the General Population (1.0%)	Survey Data on the General Population (0.0%)	Costs & Similar Barriers to Gender-Affirmative Care (0.0%)

Color Categories: 0.00%; 0.01% - 30.0%; 30.01% - 60.00%; 60.01% - 99.99%

I. Discussion of Subject Matter Findings

Since 68% of the written testimony we analyzed was from Maryland, any subject that was discussed more than 68% of the time overall is likely especially important. Looking at Tables 4 and 5, the only two subjects discussed more than 68% of the time overall were: (1) the Effects of Gender-Affirmative Care on Mental and Physical Health (which was discussed the most overall, appearing in 84.7% of all written testimony), and (2) the Modern Medical Standards for Gender-Affirmative Care (which was discussed the second-most overall, appearing in 70.4% of all written testimony).

These are the only two subjects that were discussed extensively by both proponents and opponents of expanding access to GAC. The Effects of Gender-Affirmative Care on Mental and Physical Health were discussed in 88.2% of all proponent testimony (making it the most discussed subject in proponent testimony) and in 76.7% of all opponent testimony (making it the fourth-most discussed subject in opponent testimony). Similarly, the Modern Medical Standards for Gender-Affirmative Care were discussed in 70.6% of all proponent testimony (making it the fourth-most discussed subject in proponent testimony) and in 70.0% of all opponent testimony (making it the fifth-most discussed subject in opponent testimony).

Looking at Table 4, proponents and opponents of expanding access to GAC otherwise tended to focus minimally on similar subjects or on completely different subjects altogether. For example, we see in Table 5 that the second-most discussed subject in proponent testimony was Cost & Similar Barriers to Gender-Affirmative Care, which was discussed in 83.8% of all proponent testimony. Despite the fact this is such an important issue for proponents of GAC, we see in Tables 4 and 5 that this issue was discussed in none of the opponent testimony using our current coding structure.

On the other hand, we see in Table 5 that the third-most discussed subject in opponent testimony was Whether Being Trans is an Intrinsic Quality, which was discussed in 83.3% of all opposition testimony. Not only was this subject addressed in only 10.3% of all proponent testimony, but for many of the opposition witnesses, this was the main subject of their testimony. Many of the civilians (and several of the experts) who were not in favor of expanding access to GAC made their arguments primarily on the basis that trans identity ought to be pathologized and treated as a mental disease or defect. Furthermore, many of the arguments that opponents made on this subject focused on personal anecdotes or stories (ex: stories from detransitioners or parents of transgender children who disapproved of their childrens' actions).

This is an area where proponents would benefit from discussing the history of GAC, since it actually used to be the standard medical practice to pathologize trans identity and treat it as a mental disease or defect. Discussing why this is no longer standard practice (which has much to do with the failure of Gender Identity Change Efforts (GICE), commonly referred to as

conversion therapy) would directly address many of the arguments that are made by opponents which are currently going unaddressed. This will be the focus of this paper in a later section.

Lastly, one of the most significant takeaways from Table 5 is that the top three subjects opponents focused on in their testimony arguably lay out the core of the anti-GAC position. The top three subjects that opponents focused on were: (1) the Capability of Transgender Youth to Provide Informed Consent (which opponents discussed in 90.0% of their written testimony); (2) Satisfaction, Regret, & Reversibility of Gender-Affirmative Care (which opponents discussed in 86.7% of their written testimony); and (3) Whether Being Trans is an Intrinsic Quality (which opponents discussed in 83.3% of their written testimony). Based on this data, the core of their position can be laid out as follows:

(1) The State should not allow transgender youth to transition because they cannot provide adequate informed consent to receive GAC.
(2) Additionally, the State should not allow transgender people to transition generally because they are likely to regret receiving GAC, regardless of their age.
(3) Finally, the State should not affirm transgender identity at all because it is a mental disease or defect, rather than any intrinsic quality.

This is important because, while opponents focus the most on the application of GAC to transgender youth, it is clear that many of the arguments they are making apply beyond youth to also include transgender adults. This means that the main goal for many opponents is likely the full criminalization of GAC, regardless of how much they may try to shift this discussion to the potential impacts on children (as opponents to LGBT+ rights have done for decades). This is why it is important for states that are interested in helping the transgender population to also inform themselves on subjects relating to transgender youth. Even if they are mainly trying to increase access to GAC for transgender adults, opponents are very likely to raise objections based on potential applications to transgender youth. Similarly, states that are considering reducing access to GAC for *only* transgender youth should not only consider the relevant academic literature that we discuss below, but should also recognize that these efforts are likely going to lead to further attempts to criminalize access to GAC for transgender adults if the former legislative efforts prove to be successful.

This data is also relevant because it highlights the importance of this report. Despite these three subjects laying out the core of the anti-GAC position, very little pro-GAC testimony focused on these subjects at all. This helps to explain why pro-GAC legislators may run into difficulties responding to these arguments, since advocates and experts may not be providing them adequate support or advice. Conversely, opponents to GAC acting in good faith may feel that their arguments are not being heard or adequately responded to. This report aims to address these issues by informing proponents and opponents on the relevant academic literature on these and other subjects that both or either side focused on in their congressional testimony.

II. GENDER-AFFIRMATIVE CARE, REVIEW OF ACADEMIC LITERATURE

A. Methods for Reviewing Relevant Academic Literature

The purpose of this section is to review the relevant academic literature on each subject that we identified in our qualitative analysis of legislative testimony. For the purposes of this section, "academic literature" refers to: (1) peer-reviewed journal articles, and (2) books from reputable publishers. This is standard practice because–although these processes are not perfect–the process of peer review (and similar processes involved in seeking publication by a reputable publisher) are the best processes we have to: (1) protect against bias, and (2) guarantee a baseline level of academic rigor and credibility.

We used several methods for determining whether academic literature was relevant for the purposes of our analysis. First, we looked at every piece of academic literature that was cited in the written testimony we reviewed, since these would be the sources that legislators have had the greatest exposure to. Second, we looked at sources from relevant secondary sources. These included amicus briefs, public comments on proposed administrative rules, statements from credible academic and medical organizations, reports from credible nonprofits, and other secondary sources on the subjects discussed in the testimony we analyzed as time permitted. Third, after collecting this relevant academic literature through the two methods we described, we used the ResearchRabbit.ai program to identify any missing academic literature based on what we had already collected as time permitted. We discuss each subject below in the same priority ranking as observed in the written testimony overall.

For sections which required legal analysis, we looked at: (1) relevant statutes, (2) case law, and (3) regulations. We used a similar set of methods for determining whether legal sources were relevant for our analysis, such as looking at the legal sources that were cited in the testimony we reviewed and using secondary sources as time permitted.

B. Limitations for Reviewing Relevant Academic Literature

The primary purpose of this section is not to make new evaluations on existing academic literature, but rather to report on the state of the current literature as a whole. We make several evaluations as time permits on especially relevant literature, but doing this for every piece of relevant academic literature would increase the scope of this project beyond current capacity and time constraints. We plan on expanding our scope in future versions of this report.

There are also some subjects we were not able to address in this version of the report due to time constraints and lack of available literature. For example, witnesses did not cite much (if any) academic literature on Coverage for Cis People, Coverage for Non-Binary Trans People, and Survey Data on the General Population. Furthermore, subjects like Coverage for Non-Binary Trans People are primarily philosophical, so those are best addressed at a future date

when we can recruit researchers with the expertise and capacity to help with those subjects. We also did not address the State's Role in Overseeing the Wellbeing of Trans Youth in this version because it involves an intersection of philosophy and family law that we would need more time to research. Finally, we did not address Other States/Health Insurance Policies on Gender-Affirmative Care because, while there is a fair amount of secondary literature aggregating this information, there is very little peer-reviewed literature on the subject. In a future version of this report, we would like to aggregate this information with citations to primary sources and relevant state and federal law.[11]

We also did not address sources that were cited which are not subject to peer review or a comparable alternative. This is because to do so: (1) would increase the scope of this project far beyond what is practical, and (2) would require that we evaluate each of those sources for the influence of bias and the quality of their methods.[12] For this project, we report on differences in the relevant academic literature without making substantive evaluations unless in areas where the differences are so significant that it would be impractical for us to leave them unaddressed. We would like to discuss any unaddressed differences in relevant literature more in future versions of this report.

Lastly, the arguments we used for representing proponent and opponent views on each subject are based on our qualitative analysis of the written testimony. This means that they may not be perfect representations of how every proponent or opponent argued on each subject, since every witness will use slight variations of the same core arguments on each subject. Our characterizations of the arguments are our best attempts to aggregate and represent the arguments made by each side in the light most favorable to their position and which are the most internally-consistent.

C. Effects of Gender-Affirmative Care on Mental & Physical Health

This subject was discussed the most overall (84.7%) in the written testimony we analyzed. It was also the most-discussed subject in proponent testimony (88.2%) and the fourth-most discussed subject in opponent testimony (76.7%). Proponents argued that if GAC increases mental and/or physical well-being, then we should increase access on that basis. Opponents argued that if GAC either does nothing or decreases mental and/or physical well-being, then we shouldn't increase access on that basis.

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[11] In the meanwhile, this Williams Institute Report from 2022 is a relatively comprehensive accounting of what states' Medicaid programs cover GAC: Christy Mallory & William Tentindo, *MEDICAID COVERAGE FOR GENDER-AFFIRMING CARE*, (2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Medicaid-Gender-Care-Oct-2019.pdf.

[12] That being said, we include some citations to non-peer reviewed sources if they were especially relevant to discussing primary literature we discuss in this report (ex: if the author of a study had an interview to address any confusion about her findings).

The findings of most contemporary literature demonstrate that GAC has significant mental health benefits for transgender and gender diverse (TGD) people.[13] Gender affirming care such as cross-sex hormonal treatment has been shown to reduce gender dysphoria and symptoms of anxiety and dissociation,[14] as well as improve quality of life in both male-to-female and male-to-female individuals.[15] Longitudinal studies consistently report a positive association between hormonal treatment and improved mental health in general.[16] However, there is some difference between outcomes for female-to-male and male-to-female patients. The latter sees generally positive effects upon emotional functioning compared to mixed effects in the former.[17]

The general improvement in mental health of those that undergo GAC also translates to elements of suicidality.[18] Rates of lifetime prevalence of suicide attempts for transgender people vary from study to study, but the 2015 study by Perez-Brumer et al. found that for the U.S. population, the rate for attempted suicided for transgender people is estimated at 41% (compared to 9% for the general U.S. population).[19] The main predictive factors for this rate are internalized transphobia, ethnic minority status, and lower levels of educational attainment.[20] A 2022 12-month follow up study conducted by Tordoff et al. also found that individuals are at 73% lower odds of suicidality after starting on forms of GAC like puberty blockers and hormones.[21] Other studies like the 2014 study by de Vries et al. demonstrate after receiving hormone therapy, transgender young adult well-being was similar to or better than the general population.[22]

A meta-analysis of 28 studies concluded that there were positive mental health benefits from surgical gender affirmation.[23] As mentioned previously, the majority of this evidence is "low-quality," meaning that they are observational studies (as opposed to randomized control

[13] Anthony N. Almazan & Alex S. Keuroghlian, *Association Between Gender-Affirming Surgeries and Mental Health Outcomes*, 156 JAMA Surg 611 (2021); Rosalia Costa & Marco Colizzi, *The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review*, 12 NDT 1953 (2016); Amaya Perez-Brumer et al., *Individual- and Structural-Level Risk Factors for Suicide Attempts Among Transgender Adults*, 41 Behavioral Medicine 164 (2015).

[14] Mohammad Hassan Murad et al., *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes*, 72 Clin Endocrinol (Oxf) 214 (2010).

[15] Rosalia Costa & Marco Colizzi, *The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review*, 12 NDT 1953 (2016).

[16] *Id.*

[17] *Id.* at 1963.

[18] Amaya Perez-Brumer et al., *Individual- and Structural-Level Risk Factors for Suicide Attempts Among Transgender Adults*, 41 Behavioral Medicine 164 (2015).

[19] *Id.*

[20] *Id.* at 169.

[21] Diana M. Tordoff et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA Network Open e220978 (2022).

[22] Annelou L. C. de Vries et al., *Young adult psychological outcome after puberty suppression and gender reassignment*, 134 Pediatrics 696 (2014).

[23] Mohammad Hassan Murad et al., *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes*, 72 Clin Endocrinol (Oxf) 214 (2010).

trials). This is not necessarily an issue and is discussed more at-length later in this report. Almazan and Keuroghlian conducted a 2021 study with higher-quality data that re-affirms much of the existing consensus on mental health outcomes: TGD people who pursue at least one form of gender-affirming surgeries were 42% less likely to experience psychological distress than the control group of those that want gender-affirming surgeries but have not undergone any such surgeries.[24]

Several studies have been conducted to look into the long term follow ups of gender affirming care and mental and physical health outcomes. For example, a 2015 study by Ruppin and Pfafflin followed 71 trans people over 10-24 years (with a mean of 13.8 years) after sex reassignment surgery and reported that, in the long term, they saw a reduction in gender dysphoria.[25] Echoing this, a 2010 study by Johansson et al. reported that all 60 participants in their 5 year follow up did not regret receiving gender affirming care and that over 90% were stable or improved in respect to their work situation, partner relations, and sex life.[26]

The main study cited by opponents to argue that GAC has a negative relationship with mental health for transgender people is the 2015 study by Dhejne et al., "Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden."[27] Often referred to as the "Sweden study," opponents cite this to argue that receiving gender-affirmative surgery increases the risk of suicide for transgender people. This misrepresents the findings of the study, which compared post-gender-affirmation transgender individuals with cisgender individuals from the general population, as opposed to transgender individuals who did not receive gender-affirming care.[28] This is why the study's author explicitly cautions that it is impossible to conclude from this data that gender-affirming procedures were a causative factor in suicidality for transgender individuals:

> It is therefore important to note that the current study is only informative with respect to [transgender] persons' health after sex reassignment; *no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism*. In other words, the results should not be interpreted such as sex reassignment per se increases morbidity and mortality. Things might have been even worse without sex reassignment.[29]

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[24] Anthony N. Almazan & Alex S. Keuroghlian, *Association Between Gender-Affirming Surgeries and Mental Health Outcomes*, 156 JAMA Surg 611 (2021).

[25] Ulrike Ruppin & Friedemann Pfäfflin, *Long-Term Follow-Up of Adults with Gender Identity Disorder*, 44 Arch Sex Behav 1321 (2015).

[26] Annika Johansson et al., *A Five-Year Follow-Up Study of Swedish Adults with Gender Identity Disorder*, 39 Arch Sex Behav 1429 (2010).

[27] Cecilia Dhejne et al., *Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden*, 6 PLoS One e16885 (2011).

[28] *Id.*

[29] *Id.* at 7.

Rather, the study shows only that transgender adults were more likely to experience suicidal ideation/attempts and risky behavior when compared to the general population in Sweden between 1973 and 2003.[30] Furthermore, the Dhejne study is not generalizable to a modern population. During the study period, Swedish law required that individuals seeking gender-affirming surgery need to be sterilized.[31] The presence of this law alone might account for the higher risk of suicide attempts and risky behavior in the transgender population compared to the cisgender population at the time.

In addition to discussing the implications that GAC has for mental health, it is also important to discuss their implications for the physical health of TGD people. The relevant literature on the impacts of GAC on physical health can be divided into three areas: (1) cardiovascular disease, (2) pubertal suppression, and (3) bone density.

The transgender population is found to have a higher reported history of myocardial infarction (heart attack) in comparison to the cisgender population, except for transgender women compared with cisgender men.[32] Increases in ischemic stroke rates among transfeminine persons are also not consistent with those observed in cisgender women, demonstrating a need to identify and closely study vascular side effects of cross-sex estrogen.[33]

One of the most politically controversial elements of GAC is the notion of pubertal suppression in TGD youth. Gonadotropin releasing hormone analogues (GnRHa) are used to delay irreversible body changes during an unwanted puberty for transgender adolescents. When implemented during the youth phase, other more invasive surgeries can sometimes be avoided (ex: mastectomies).[34] There is no evidence that the use of GnRHa's has any effect on negative psychological function.[35] While preliminary evidence suggests pubertal suppression improves mental health, there is little to no evidence to suggest this treatment impacts neurodevelopment.[36] Also, while certain studies[37] have raised important questions that need to be studied further, there is little to no evidence to suggest that these questions are anything more than that.

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[30] *Id.*

[31] Rebecca Nelson, *Transgender People in Sweden No Longer Face Forced Sterilization*, Time, Jan. 2013, https://newsfeed.time.com/2013/01/14/transgender-people-in-sweden-no-longer-face-forced-sterilization/ (last visited Feb 9, 2023).

[32] Talal Alzahrani et al., *Cardiovascular Disease Risk Factors and Myocardial Infarction in the Transgender Population*, 12 Circ Cardiovasc Qual Outcomes e005597 (2019).

[33] Darios Getahun et al., *Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, 169 Ann Intern Med 205 (2018).

[34] Tim C. van de Grift et al., *Timing of Puberty Suppression and Surgical Options for Transgender Youth*, 146 Pediatrics e20193653 (2020).

[35] Polly Carmichael et al., *Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK*, 16 PLOS ONE e0243894 (2021).

[36] Diane Chen et al., *Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth*, 5 Transgend Health 246, 247 (2020).

[37] Peggy T. Cohen-Kettenis et al., *Puberty Suppression in a Gender-Dysphoric Adolescent: A 22-Year Follow-Up*, 40 Arch Sex Behav 843 (2011).

There are reported side-effects from using GnRHa's, with one 2012 study by Gallagher et al. showing 80% of patients reporting side effects lasting less than 6 months.[38] Despite these side effects (some of which include memory loss, insomnia, and hot flashes) two thirds of people in the study would recommend it to others.[39] Another 2021 study by Luo et al. found that implantable GnRHa's provide a 97.1% satisfaction rate (though 39.8% of patients described challenges about affordability and insurance denials).[40] Finally, A 2010 long-term study by Magiakou et al. on the effects of GnRHa's on final height (FH), body mass index (BMI), body composition, bone mineral density (BMD), and ovarian function on 92 female patients with central precocious puberty (with 33 patients presented at a median age of 7.92 years) and with final evaluation carried out in all 92 subjects at a median age of 17.98 years found that patients treated in childhood with GnRHa's have normal BMI, BMD, body composition, and ovarian function in early adulthood.[41]

The existing literature also shows that transgender adolescents experience positive mental health benefits from using puberty blockers.[42] For example, a 2020 study by Turban et al. analyzed survey data from 89 transgender adults who had access to puberty blockers during adolescence and from more than 3,400 transgender adults who did not and found that those who received puberty blocking hormone treatment had lower odds of lifetime suicidal ideation than those who wanted puberty blocking treatment but did not receive it, even after adjusting for demographic variables and level of family support.[43] Furthermore, approximately nine in ten transgender adults who wanted puberty blocking treatment but did not receive it reported lifetime suicidal ideation.[44] Another example is the 2020 study by van der Miesen et al. comparing transgender adolescents before and after receiving pubertal suppression with cisgender adolescents of similar ages from the general population.[45] The study found that transgender adolescents showed poorer psychological well-being before treatment, but then showed similar or better psychological functioning compared with cisgender peers from the general population

[38] Jenny Sadler Gallagher et al., *Long-Term Effects of Gonadotropin-Releasing Hormone Agonists and Add-Back in Adolescent Endometriosis*, 31 J Pediatr Adolesc Gynecol 376 (2018).

[39] *Id.*

[40] Xiaoping Luo et al., *Long‑term efficacy and safety of gonadotropin‑releasing hormone analog treatment in children with idiopathic central precocious puberty: A systematic review and meta‑analysis*, 94 Clin Endocrinol (Oxf) 786 (2021).

[41] Maria Alexandra Magiakou et al., *The Efficacy and Safety of Gonadotropin-Releasing Hormone Analog Treatment in Childhood and Adolescence: A Single Center, Long-Term Follow-Up Study*, 95 The Journal of Clinical Endocrinology & Metabolism 109 (2010).

[42] *See also* Christal Achille et al., *Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results*, 2020 International Journal of Pediatric Endocrinology 8 (2020).

[43] Jack L. Turban et al., *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, 145 Pediatrics e20191725 (2020).

[44] *Id.*

[45] Anna I. R. van der Miesen et al., *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared With Cisgender General Population Peers*, 66 Journal of Adolescent Health 699 (2020).

after beginning pubertal suppression.[46]

Overall, in their 2008 article, Giordano argues in favor of pubertal suppression for transgender adolescents: "suspension of puberty is not only not unethical: if it is likely to improve the child's quality of life and even save his or her life, then it is indeed unethical to defer treatment."[47] The Amsterdam Gender Identity Clinic–one of the only centers that has treated a sufficient number of adolescents to assess effects of treatment–recommends the use of GnRHa's as an appropriate intervention.[48] The World Professional Association for Transgender Health (WPATH) concurs with this, arguing that GnRHa's should be used to suspend puberty for transgender adolescents.[49]

Another common theme underpinning the effects of GAC on physical health is a focus on bone health and density in transgender patients. A 2022 study by Giacomelli and Meriggiola found that prior to gender-affirming hormone treatment, transgender women tend to have lower bone mineral density (BMD) than cisgender men.[50] In their 2020 article, Lee et al. argues this is due to external factors (ex: such as less physical activity compared to cisgender counterparts).[51] There is some evidence that the use of GnRHa's in adolescents may also cause lower bone density,[52] though the addition of gender affirming hormone treatment helps alleviate this issue.[53] Echoing this, the 1999 article by Heger et al. finds that while bone density may be impacted, the usage of GnRHa is associated with normal body proportions.[54] The 2021 article by Navabi et al. concurs, finding that while GnRHa's are negatively associated with bone mineral density, adolescent subjects' body fat distribution was consistent with their affirmed gender, evidence of increased fractures or changes in BMI score has not been substantiated thus far, and that Vitamin D supplements can alleviate these issues.[55]

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[46] *Id.*

[47] S. Giordano, *Lives in a chiaroscuro. Should we suspend the puberty of children with gender identity disorder?*, 34 Journal of Medical Ethics 580 (2008).

[48] Baudewijntje P. C. Kreukels & Peggy T. Cohen-Kettenis, *Puberty suppression in gender identity disorder: the Amsterdam experience*, 7 Nat Rev Endocrinol 466 (2011).

[49] Simone Mahfouda et al., *Puberty suppression in transgender children and adolescents*, 5 The Lancet Diabetes & Endocrinology 816 (2017).

[50] Giulia Giacomelli & Maria Cristina Meriggiola, *Bone health in transgender people: a narrative review*, 13 Therapeutic Advances in Endocrinology 20420188221099344 (2022).

[51] Janet Y Lee et al., *Low Bone Mineral Density in Early Pubertal Transgender/Gender Diverse Youth: Findings From the Trans Youth Care Study*, 4 Journal of the Endocrine Society bvaa065 (2020).

[52] Daniel Klink et al., *Bone mass in young adulthood following gonadotropin-releasing hormone analog treatment and cross-sex hormone treatment in adolescents with gender dysphoria*, 100 J Clin Endocrinol Metab E270 (2015).

[53] Giulia Giacomelli & Maria Cristina Meriggiola, *Bone health in transgender people: a narrative review*, 13 Therapeutic Advances in Endocrinology 20420188221099344 (2022).

[54] S. Heger, C. J. Partsch & W. G. Sippell, *Long-term outcome after depot gonadotropin-releasing hormone agonist treatment of central precocious puberty: final height, body proportions, body composition, bone mineral density, and reproductive function*, 84 J Clin Endocrinol Metab 4583 (1999).

[55] Behdad Navabi et al., *Pubertal Suppression, Bone Mass, and Body Composition in Youth With Gender Dysphoria*, 148 Pediatrics e2020039339 (2021). *See also* Sebastian E. E. Schagen et al., *Bone Development in*

Finally, there is no evidence that supports the view that there is an adverse impact of hormone therapy on cognitive function.[56] A 2020 study by Carmichael et al. also evaluated the effects of GnRHa's on 44 transgender adolescents with follow up at 12 months, 24 months, and 36 months found that there were no changes in psychological function in adolescents who underwent puberty suppression.[57]

This information is especially useful because in addition to seeing this subject come up in written testimony, it also came up in the oral testimony on MD HB0746/SB0682. During a hearing on the bill in front of the Maryland House Health and Government Operations Committee, Delegate Heather Bagnall (D-33C) asked what are the mental and physical health outcomes for transgender people who receive GAC.[58] The best available evidence tells us that overall: (1) GAC has very positive effects on the mental health of transgender people and has shown to alleviate their gender dysphoria; (2) GAC has few or no negative effects on physical health; and (3) any side effects that do exist are typically offset by an overall higher quality of life.

D. Modern Medical Standards for Gender-Affirmative Care

This subject was discussed the second-most overall (70.4%) in the written testimony we analyzed. It was also the fourth-most discussed subject in proponent testimony (70.6%) and the fifth-most discussed subject in opponent testimony (70.0%). Proponents argued that if current Medicaid coverage for GAC is out of line with modern medical standards of care, then we should increase access on that basis to bring it into alignment. Opponents argued that if current Medicaid coverage for GAC is out of line with modern medical standards of care, then we should not increase access on that basis because modern standards are bad/biased/etc. and we should reject them (ex: due to financial incentive).

The modern medical standards for gender-affirmative medical care are: (1) the World Professional Organization for Transgender Health (WPATH) Standards of Care (SoC) for the Health of Transgender and Gender Diverse People, Version 8;[59] and (2) the Endocrine Society

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Transgender Adolescents Treated With GnRH Analogues and Subsequent Gender-Affirming Hormones, 105 J Clin Endocrinol Metab dgaa604 (2020).

[56] Maria A. Karalexi et al., *Gender-affirming hormone treatment and cognitive function in transgender young adults: a systematic review and meta-analysis*, 119 Psychoneuroendocrinology 104721 (2020).

[57] Polly Carmichael et al., *Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK*, 16 PLOS ONE e0243894 (2021).

[58] HGO 3.2.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/bb1c84fe3b9e4dcd8f1c81d9c6251b8c1d (last visited Feb 9, 2023).

[59] E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 International Journal of Transgender Health S1 (2022).

Clinical Practice Guidelines.[60] Here, we will primarily consider the WPATH SoC, which have been used by clinicians for decades. WPATH issued its initial guidelines in 1979 and has updated them in 1980, 1981, 1990, 1998, 2001, and 2012. The current version incorporated systematic literature reviews and ample opportunities for peer review and revision. For the purposes of this report, the relevant guidelines can be broken down into three areas: (1) adults (people above the legal age of majority), (2) adolescents (youth who have begun puberty), and (3) children (youth who have not begun puberty).

Under Section 5.1 of the WPATH SoC Version 8, it is recommended that healthcare professionals assessing transgender and gender diverse adults for physical treatments:

(a) are licensed by their statutory body and hold, at minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution;
(b) are competent using the latest edition of the World Health Organization's International Classification of Diseases (ICD)[61] for countries requiring diagnosis for access to care (and to make efforts to utilize the latest ICD in countries that have not implemented the latest ICD as soon as practicable);
(c) are able to identify co-existing mental health or other psychological concerns and distinguish these from gender dysphoria, incongruence, and diversity;
(d) are able to assess capacity to consent for treatment;
(e) have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity; and
(f) undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.[62]

Under Section 5.3, it is recommended that all healthcare professionals assessing transgender and gender diverse adults for gender-affirming medical and surgical treatment:

(a) only recommend gender-affirming medical treatment requested by a transgender person when the experience of gender incongruence is marked and sustained;
(b) ensure fulfillment of diagnostic criteria prior to initiating gender-affirming treatments in regions where a diagnosis is necessary to access health care;
(c) identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments;

[60] Wylie C Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline*, 102 The Journal of Clinical Endocrinology & Metabolism 3869 (2017).
[61] ICD-11, World Health Organization, https://icd.who.int/en (last visited Feb 9, 2023).
[62] E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 International Journal of Transgender Health S1, S32 (2022).

(d) ensure that any mental health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment;
(e) ensure that any physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment;
(f) assess the capacity to consent for the specific physical treatment prior to the initiation of this treatment; and
(g) assess the capacity of the transgender or gender diverse adult to understand the effect of gender-affirming treatment on reproduction and explore reproductive options with the individual prior to the initiation of gender-affirming treatment.[63]

Under Section 5.6, it is recommended that healthcare professionals assessing transgender and gender diverse adults seeking gonadectomy (i.e., the surgical removal of either testes or ovaries) consider a minimum of six months of hormone therapy as appropriate before recommending irreversible surgical intervention (unless hormones are not clinically indicated for the individual).[64] Then, under Section 5.5, it is recommended that transgender and gender diverse adults who fulfill the criteria for gender-affirming medical and surgical treatment require a single opinion for the initiation of this treatment from a professional who has competencies in the assessment of transgender and gender diverse people pursuing gender-related medical and surgical treatment.[65]

Under Section 6.1, it is recommended that healthcare professionals working with gender diverse adolescents:

(a) are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution;
(b) receive theoretical and evidence-based training and develop expertise in general child, adolescent, and family mental health across the development spectrum;
(c) receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity/consent, and possess general knowledge of gender diversity across the life span;
(d) receive training and have expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents; and
(e) continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.[66]

[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.* at S48.

Additionally, under Section 6.10, it is recommended that healthcare professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to initiating treatment, of the potential effects it could have on reproductive capacity (including potential loss of fertility).[67] It is also recommended to discuss available options to preserve fertility within the context of the youth's stage of pubertal development.[68]

Under Section 6.11, it is recommended that when gender-affirming medical or surgical treatments are indicated for adolescents, that healthcare professionals working with transgender and gender diverse adolescents should involve parents and/or guardians in the assessment and treatment process (unless their involvement is determined to be harmful to the adolescent or not feasible). Under Section 6.12, health care professionals assessing transgender and gender diverse adolescents should *only* recommend gender-affirming medical or surgical treatments requested by the patient when:

(a) the adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 for countries requiring diagnosis for access to care (and to make efforts to utilize the latest ICD in countries that have not implemented the latest ICD as soon as practicable);
(b) the experience of gender diversity/incongruence is marked and sustained over time;
(c) the adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
(d) the adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed;
(e) the adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility (as well that these have been discussed in the context of the adolescent's current stage of pubertal development);
(f) for the purposes of receiving pubertal suppression, the adolescent has reached tanner stage 2 of puberty; and
(g) for the purposes of considering gender-affirming surgery (including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery), the adolescent has had at least 12 months of gender-affirming hormone therapy prior or longer (unless hormone therapy is either not desired or is medically contraindicated).[69]

Importantly, this *does* mean that adolescents can pursue gender-affirming surgery if they meet the above criteria under the current standards. This is a significant departure from the previous WPATH SoC Version 7, which only permitted adolescents to begin partially-reversible

[67] *Id.*
[68] *Id.*
[69] *Id.*

hormone therapy at the age of majority and irreversible surgeries at 18 or older (except for chest "masculinizing" mastectomy, which had an age minimum of 16 years).[70] Of these factors, the one that opponents will likely focus on the most is the ability for transgender adolescents to provide informed consent. This is discussed in a later section of this report.

Comparatively, no medical interventions are recommended for pre-pubertal children. Under Sections 7.13 and 7.14, it is recommended that professionals discuss the potential benefits and risks of a social transition with families who are considering it, and to otherwise provide support to children to continue to explore their gender throughout their pre-pubescent years regardless of social transition.[71] Under Sections 7.1-7.4, it is recommended that healthcare professionals working with gender diverse children receive several kinds of training:

(a) training and expertise in gender development and gender diversity in children and possess a general knowledge of gender diversity across the life span;
(b) theoretical and evidence-based training and develop expertise in general child and family mental health across the developmental spectrum;
(c) training and expertise in autism spectrum disorders and other neurodiversity or collaborate with an expert with relevant expertise when working with autistic/neurodivergent, gender diverse children; and
(d) continuing education related to gender diverse children and families.[72]

Under Appendix E,[73] these are the specific gender-affirming surgical procedures that are deemed as medically-necessary, in addition to the use of puberty blockers and hormonal treatment:

Table 6. Facial Surgery

Brow	Brow reduction
	Brow augmentation
	Brow Lift
Hairline advancement and/or hair transplant	
Facelift/mid-face lift (following alteration of the underlying skeletal structures)	Platysmaplasty

[70] E. Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 International Journal of Transgenderism 165 (2012).
[71] E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 International Journal of Transgender Health S1, S69 (2022).
[72] *Id.*
[73] *Id.* at S260.

Blepharoplasty	Lipofilling
Rhinoplasty (+/- fillers)	
Cheek	Implant
	Lipofilling
Lip	Upper lip shortening
	Lip augmentation (includes autologous and non-autologous)
Lower jaw	Reduction of mandibular angle
	Augmentation
Chin reshaping	Osteoplastic
	Alloplastic (implant-based)
Chondrolaryngoplasty	Vocal cord surgery

Table 7. Breast/Chest Surgery

Mastectomy	Mastectomy with nipple-areola preservation/reconstruction as determined medically necessary for the specific patient
	Mastectomy without nipple-areola preservation/reconstruction as determined medically necessary for the specific patient
Liposuction	
Breast reconstruction (augmentation)	Implant and/or tissue expander
	Autologous (includes flap-based and lipofilling)

Table 8. Genital Surgery

Phalloplasty (with/without scrotoplasty)	With/without urethral lengthening
	With/without prosthesis (penile and/or testicular)

	With/without colpectomy/colpocleisis
Metoidioplasty (with/without scrotoplasty)	With/without urethral lengthening
	With/without prosthesis (penile and/or testicular)
	With/without colpectomy/colpocleisis
Vaginoplasty (inversion, peritoneal, intestinal)	May include retention of penis and/or testicle
Vulvoplasty	May include procedures described as "flat front"

Table 9. Gonadectomy

Orchiectomy	
Hysterectomy and/or salpingo-oophorectomy	

Table 10. Body Contouring

Liposuction	
Lipofilling	
Implants	Pectoral, hip, gluteal, calf
Monsplasty/mons reduction	

Table 11. Additional Procedures

Hair removal: Hair removal from the face, body, and genital areas for gender affirmation or as part of a preoperative preparation process. (see statement 15.14 regarding hair removal)	Electrolysis
	Laser epilation
Tattoo (i.e., nipple-areola)	
Uterine transplantation	
Penile transplantation	

It is important to note that the WPATH SoC Version 8 also specifies that this list is non-exhaustive.[74] This is due to the continuing development of technology and understanding in this field, which allows for additional treatments that are not listed. This is also important due to the often lengthy time periods between WPATH SoC versions, during which new evolutions in understanding and treatment may occur. The WPATH SoC also specifies that "the criteria put forth in this document for gender affirming interventions are clinical guidelines; individual health care professionals and programs, in consultation with the TGD person, may modify them" due to the particular circumstances of individual cases.[75]

The reasons these standards are trustworthy is because they: (1) have been subject to a rigorous process of peer-review, (2) incorporate systematic literature reviews, and (3) have been used as the medical standards for GAC for decades.[76] For people who want further information about their methods, WPATH publishes its methodology for public review on its website.[77] As stated previously, while the process is not perfect, subjecting a publication for peer review is the best process we have to: (1) protect against bias, and (2) guarantee a baseline level of academic rigor and credibility. Unless opponents are able to present more substantial evidence or methodological critique to suggest that the standards are not credible, they have not met their burden of proof to suggest that the modern standards should not be trusted.

This information is especially useful because in addition to seeing this subject come up in written testimony, it also came up in the oral testimony on MD HB0746/SB0682. During a hearing on the bill in front of the Maryland House Health and Government Operations Committee, Delegate Lisa M. Belcastro (D-11) asked how parents play a role in the decisions to provide GAC to transgender youth.[78] During another bill hearing in front of the same committee, Chairwoman Joseline A. Pena-Melnyk (D-21) asked whether receiving this care requires a diagnosis or recommendation by a doctor or medical professional, similar to the diagnosis of any other condition in accordance with modern medical standards.[79] Finally, during a hearing on the

[74] *Id.*

[75] *Id.* at S256.

[76] Anne Alstott et al., *Flawed Medicaid Report in Florida*, Yale School of Medicine (2022), https://medicine.yale.edu/lgbtqi/research/gender-affirming-care/florida-medicaid/ (last visited Feb 9, 2023) ("These longstanding clinical practice guidelines have been used by clinicians for decades. WPATH issued its initial guidelines in 1979 and updated them in 1980, 1981, 1990, 1998, 2001, and 2012. The eighth version remains in process, and it incorporates systematic literature reviews and ample opportunities for peer review and revision.").

[77] Methodology for the Development of SOC8, World Professional Association for Transgender Health, https://www.wpath.org/soc8/Methodology (last visited Feb 9, 2023).

[78] HGO 3.2.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/bb1c84fe3b9e4dcd8f1c81d9c6251b8c1d (last visited Feb 9, 2023).

[79] HGO 3.24.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/184a5876f7c94cc3a4a8b7924bea84821d (last visited Feb 9, 2023).

bill in front of the Maryland Senate Finance Committee, Senator Justin Ready (R-5) asked what are the criteria for doctors to provide GAC.[80]

The information in this section responds to all of these questions. Under Section 6.11 of the latest WPATH guidelines, it is recommended that healthcare professionals working with transgender and gender diverse adolescents should involve parents and/or guardians in the assessment and treatment process (unless their involvement is determined to be harmful to the adolescent or not feasible). Under Sections 5.1 and 6.1, it is recommended that healthcare professionals assessing transgender and gender diverse adults for physical treatments are licensed by their statutory body and hold, at minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution, and that healthcare professionals working with gender diverse adolescents meet the same criteria as well as hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution. Finally, patients who are pursuing GAC must satisfy the requirements set out in Sections 5.3, 5.6, 6.10, 6.11, and 6.12 of the WPATH guidelines. Importantly, these guidelines require that medical professionals: (a) only recommend gender-affirming medical treatment requested by a transgender person when the experience of gender incongruence is marked and sustained; (b) identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments; (c) ensure that any mental or physical health conditions that could negatively impact treatment outcomes are assessed, with risk and benefits discussed; (d) assess the capacity to consent for the specific physical treatment prior to initiating this treatment; and (e) assess the capacity of the patient to understand the effects this treatment may have on their fertility.

E. Alleged Purpose(s) of Medicaid (Ex: Medical Necessity, Bodily Autonomy, etc.)

This subject was discussed the third-most overall (59.2%) in the written testimony we analyzed. It was also the third-most discussed subject in proponent testimony (79.4%) and the tenth-most discussed subject in opponent testimony (13.3%, TIE). Proponents argued that if covering GAC is in-line with at least one (alleged) purpose of Medicaid (ex: ensuring equitable access to medically-necessary healthcare, increasing bodily autonomy, etc.), then we should increase access to it on that basis. Opponents argued that if covering GAC is not in-line with at least one (alleged) purpose of Medicaid, then we should not increase access to it on that basis.

The likely reason why people argued that GAC was in-line with different alleged purposes of Medicaid is that the federal Medicaid statute is actually silent on the actual definition of "medical necessity." The baseline requirements set out under federal law for state Medicaid Programs are: (1) the Availability Provision, which requires states to provide medical assistance

[80] FIN 2.22.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/2b38ee8906b54042a2ec5d051930b2901d (last visited Feb 9, 2023).

to all categorically needy individuals in sufficient "amount, duration, and scope"; and (2) the Comparability Provision, which requires assistance to be provided equally among individuals within beneficiary groups.[81] We will address these more in a later section.

Beyond those requirements, Medicaid regulations allow states to place appropriate limits on a service based on criteria such as medical necessity, but does not define what that means.[82] That being said, one of the main Congressional intents of the federal Medicaid program was to leave the decision of whether to cover a particular treatment as medically necessary to a patient's treating physician:

> The Committee's bill provides that the *physician* is to be the key figure in determining utilization of health services and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs, and treatments, and determine the length of stay.[83]

Consistent with this, several federal courts have focused on the involvement of physicians when looking at whether certain forms of healthcare ought to be considered as medically necessary.[84] Furthermore, the Supreme Court has implied, but not held, that the Medicaid Act requires states to provide medically necessary care.[85]

Maryland law defines medical necessity as:

(a) directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
(b) consistent with current accepted standards of good medical practice;
(c) the most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
(d) not primarily for the convenience of the consumer, family, or provider.[86]

Although Maryland law is silent on the involvement of a medical professional, it does define medically necessary care as "consistent with current accepted standards of good medical

[81] 42 C.F.R. § 440.230.
[82] 42 C.F.R. § 440.230(d).
[83] S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C.A.N. 1943, 1986.
[84] *See Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980) (recognizing that "the decision of whether or not certain treatment or a particular type of treatment is 'medically necessary' rests with the individual recipient's physician and not with clerical personnel or government officials"); *Hope Med. Group for Women v. Edwards*, 860 F. Supp. 1149, 1151 (E.D. La. 1994) (holding that "[e]ach state's Medicaid plan must cover those mandatory covered services which an individual patient's physician certifies as 'medically necessary.'"); Preterm v. Dukakis, 591 F.2d 121 (1st Cir. 1979) (describing two levels of judgment as to medical necessity: macrodecisions of the legislature that only certain services are covered and micro-decisions of a physician that a patient needs a covered service).
[85] *See Beal v. Doe*, 432 U.S. 438, 444, 97 S. Ct. 2366, 53 L. Ed. 2d 464 (1977) ("[S]erious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage.").
[86] COMAR 10.09.02.01(11).

practice." The modern medical standards for GAC are the WPATH SoC, which are discussed in the previous section. The WPATH SoC sets out requirements for healthcare professionals who treat transgender patients and recommends that GAC be administered based on their assessments.

While medical necessity is not necessarily the main consideration for whether healthcare qualifies for coverage under Medicaid, it is one of the main factors that people consider generally and is one of the main considerations under Maryland law. We also see this in the 2022 Maryland Medical Assistance Program Professional Services Provider Manual, which says on page 16 that one of the main considerations for whether to cover surgical procedures is whether that procedure is considered medically necessary.[87]

Generally, the main factors we look at in determining whether certain healthcare is medically necessary are:

(1) whether that care is directly related to the treatment of an illness, injury, disability, or health condition;
(2) whether that care is consistent with modern medical standards; and
(3) whether that care is determined to be medically necessary by a relevant medical professional.

GAC that is administered consistent with the WPATH SoC is medically necessary under these criteria. The WPATH SoC are widely regarded as the modern medical standards for the care of transgender people and have been used by clinicians for decades. The WPATH SoC recommends that transgender people who are seeking GAC be assessed by a qualified medical professional with relevant experience in that field of practice. Finally, GAC is administered for the treatment of gender dysphoria or gender incongruence under the ICD-11.

This information is especially useful because in addition to seeing this subject come up in written testimony, it also came up in the oral testimony on MD HB0746/SB0682. During hearings on the bill in front of the Maryland House Health and Government Operations Committee and the Senate Finance Committee, Former Delegate Sid A. Saab (R-33) and Senator Justin Ready (R-11) asked about why the procedures in this bill are considered medically necessary when they believed many of them seemed to be cosmetic.[88] Additionally, during the same hearing in front of the Maryland House Health and Government Operations Committee,

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[87] Professional Services Provider Manual, Maryland Medical Assistance Program (2022), https://health.maryland.gov/mmcp/Documents/Professional%20Services%20Provider%20Manual%202022%20web.pdf (last visited Feb 9, 2023).

[88] HGO 3.2.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/bb1c84fe3b9e4dcd8f1c81d9c6251b8c1d (last visited Feb 9, 2023); FIN 2.22.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/2b38ee8906b54042a2ec5d051930b2901d (last visited Feb 9, 2023).

Delegate Terri L. Hill (D-12A) and Former Vice-Chair (now current Chair) Joseline A. Peña-Melnyk (D-21) asked about whether the determination of medical necessity is made on a case-by-case basis by a medical professional.[89] The reason why these forms of healthcare are medically necessary is because they satisfy the conventional criteria we look at for evaluating medical necessity: (1) they are administered for the treatment of a health condition (gender dysphoria or gender incongruence under the ICD-11); (2) they are consistent with modern medical standards (the WPATH SoC); and (3) transgender patients are assessed on a case-by-case basis by medical professionals who satisfy the WPATH requirements.

While we address the importance of medical necessity in this section, we do not address the importance of bodily autonomy in terms of determining Medicaid coverage. As stated previously, federal law gives states wide latitude to set their own parameters for how they set their Medicaid coverage. Although bodily autonomy is not referenced in the 2022 Maryland Medical Assistance Program Professional Services Provider Manual,[90] we would like to investigate the importance of bodily autonomy and other asserted purposes for making these determinations in a future version of this report.

F. Costs & Similar Barriers to Gender-Affirmative Care

This subject was discussed the fourth-most overall (58.2%) in the written testimony we analyzed. It was also the second-most discussed subject in proponent testimony (83.8%) and was not discussed at all in opponent testimony. Proponents argued that if trans people cannot access GAC on their own due to cost or other similar barriers, then we should increase access to it on that basis. Although opponents did not discuss this subject in their written testimony, the opposing argument would be: if trans people either can or should pay for GAC, then we should not increase access to it on that basis.[91]

Transgender people have historically and currently face significant barriers to accessing medically-necessary GAC that are not faced as much by cisgender people.[92] Four of the main barriers are: (1) cost, (2) lack of available providers, (3) lack of provider training, and (4)

[89] HGO 3.2.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/bb1c84fe3b9e4dcd8f1c81d9c6251b8c1d (last visited Feb 9, 2023).

[90] Professional Services Provider Manual, Maryland Medical Assistance Program (2022), https://health.maryland.gov/mmcp/Documents/Professional%20Services%20Provider%20Manual%202022%20web.pdf (last visited Feb 9, 2023).

[91] One argument we did not code for that may fall under this category is whether opponents believed that there are not currently significant barriers to accessing GAC. It is possible that some opponents made this argument and were not captured in our qualitative analysis. This is because grouping this argument with this subject occurred to us well after we finished our qualitative analysis. We would like to re-review the testimony to focus on how often opponents made this argument in future versions of this report.

[92] Alexandra Terris-Feldman et al., *How Accessible Is Genital Gender-Affirming Surgery for Transgender Patients With Commercial and Public Health Insurance in the United States? Results of a Patient-Modeled Search for Services and a Survey of Providers*, 8 Sex Med 664 (2020).

discrimination by providers.

Many providers currently exclude forms of GAC that are considered to be medically-necessary by modern medical standards because they classify them as "cosmetic." One example is facial feminization/masculinization surgery. Since facial feminization/ masculinization surgery is often not covered under insurance, many transgender people are cost-prohibited from accessing this kind of healthcare since it is often very costly.[93] Other forms of GAC are also often cost-prohibited when transgender people have to travel out of state to receive that care since they have to pay for additional expenses.[94] This is relevant since transgender people often have to travel out of state to receive procedures such as vaginoplasty or phalloplasty.[95] Transgender people are also often unable to afford certain forms of care like fertility preservation because, while such treatments are often covered for cisgender people, insurance often does not cover it for transgender people pursuing GAC.[96]

Transgender people are also prevented from accessing GAC due to a lack of existing and accessible providers. A 2020 study by Terris-Feldman et al. found that even for transgender people who qualify for insurance coverage for genital gender-affirming surgery, access is still significantly limited by the small number of current providers and their uneven geographic distribution across the United States.[97] A 2016 study by White Hughto et al. also showed that certain demographic factors (such as being older, trans feminine, Native American, multiracial or being another racial/ethnic minority, and having low income) are positively associated with refusal by care providers.[98] Adjusting for demographic factors found that variation was observed across the U.S., with transgender people in Southern and Western states being at increased risk of experiencing refusal by care providers.[99] Adjusting for state-level factors also found that the percentage of the state population voting Republican was positively associated with providers refusing care to transgender people.[100]

Additionally, even if transgender people can access providers who are willing to treat them, they often encounter issues where providers have not been provided adequate training on

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[93] lex Dubov & Liana Fraenkel, *Facial Feminization Surgery: The Ethics of Gatekeeping in Transgender Health*, 18 Am J Bioeth 3 (2018).

[94] Jae Downing et al., *Spending and Out-of-Pocket Costs for Genital Gender-Affirming Surgery in the US*, 157 JAMA Surgery 799 (2022).

[95] *Id.*

[96] Shira Baram et al., *Fertility preservation for transgender adolescents and young adults: a systematic review*, 25 Hum Reprod Update 694 (2019).

[97] Alexandra Terris-Feldman et al., *How Accessible Is Genital Gender-Affirming Surgery for Transgender Patients With Commercial and Public Health Insurance in the United States? Results of a Patient-Modeled Search for Services and a Survey of Providers*, 8 Sex Med 664 (2020).

[98] Jaclyn M. White Hughto et al., *Geographic and Individual Differences in Healthcare Access for U.S. Transgender Adults: A Multilevel Analysis*, 3 LGBT Health 424 (2016).

[99] *Id.*

[100] *Id.*

GAC. Non-exhaustive anecdotal evidence demonstrates that clinicians may fail to provide cancer screenings and counseling to transgender people based on misconceptions about a patient's anatomy.[101] Additionally, a 2017 study by Davidge-Pitts et al. found that in a survey of 411 practicing endocrinological clinicians, almost 80% had treated transgender patients, but 80.6% had never received training on providing care to transgender patients (although 77.1% reported being either very or somewhat confident in terms of definitions and 64.8% reported being very or somewhat confident in prescribing hormones).[102]

Finally, transgender people are often unable to access medically-necessary gender-affirmative healthcare due to discrimination in healthcare settings. For example, a 2016 longitudinal study by Macapagal et al. that used questionnaire results from 206 LGBTQ adults from 2012 to 2013 found that, "while most participants did not report having negative experiences in healthcare settings related to their LGBTQ identity, transgender patients were more likely to delay care and report negative effects of disclosure[, such as discrimination, invalidation, or harassment,] to their provider compared with cisgender patients."[103] Another study by Casey et al. in 2019 based on a national, probability-based survey, found that 18% of LGBT+ people reported having avoided pursuing medically-necessary healthcare due to perceived discrimination.[104] Furthermore, a 2015 study by Kattari et al. found that transgender and gender-nonconforming people of color experience higher levels of antitransgender discrimination in many healthcare settings.[105]

These barriers prevent transgender people from alleviating their gender dysphoria or presenting in their desired gender roles and leads to problems throughout their lives.[106] This relates to issues of minority stress, which are discussed at-length in another section. Compounding this issue is the fact that experiencing discrimination in healthcare settings can cause LGBT+ people to be hypervigilant and expect to be treated negatively for seeking treatment, which can discourage them from seeking necessary care beyond the aforementioned

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[101] Joshua Sterling & Maurice M. Garcia, *Cancer screening in the transgender population: a review of current guidelines, best practices, and a proposed care model*, 9 Transl Androl Urol 2771 (2020).

[102] Caroline Davidge-Pitts et al., *Transgender Health in Endocrinology: Current Status of Endocrinology Fellowship Programs and Practicing Clinicians*, 102 The Journal of Clinical Endocrinology & Metabolism 1286 (2017).

[103] Kathryn Macapagal, Ramona Bhatia & George J. Greene, *Differences in Healthcare Access, Use, and Experiences Within a Community Sample of Racially Diverse Lesbian, Gay, Bisexual, Transgender, and Questioning Emerging Adults*, 3 LGBT Health 434 (2016).

[104] Logan S. Casey et al., *Discrimination in the United States: Experiences of lesbian, gay, bisexual, transgender, and queer Americans*, 54 Health Services Research 1454 (2019).

[105] Shanna K. Kattari et al., *Racial and Ethnic Differences in Experiences of Discrimination in Accessing Health Services Among Transgender People in the United States*, 16 International Journal of Transgenderism 68 (2015).

[106] Henriette A. Delemarre-van de Waal & Peggy T. Cohen-Kettenis, *Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects*, 155 European Journal of Endocrinology S131 (2006).

issues and can lead them to consider unsafe alternatives.[107] Consequently, these systemic barriers in accessing medically-necessary healthcare for the transgender community results in transgender people being more likely to report that their health is fair or poor than cisgender people.[108]

G. Satisfaction, Regret, & Reversibility of Gender-Affirmative Care

This subject was discussed the fifth-most overall (44.9%) in the written testimony we analyzed. It was also the eighth-most discussed subject in proponent testimony (26.5%) and was the second-most discussed subject in opponent testimony (86.7%). Proponents argued that if trans people are generally satisfied with GAC and/or the effects of GAC are generally reversible, then we should increase access to it on that basis. Opponents argued that if trans people are generally unsatisfied with GAC or otherwise regret receiving that care and the effects of GAC are generally irreversible, then we should not increase access to it on that basis.

There is a wide body of literature that explores satisfaction and regret with different forms of GAC. This literature can be broken down into three areas: (1) puberty blockers, (2) hormone therapy, and (3) surgery.

The existing literature shows that transgender adolescents are generally satisfied with using puberty blockers. For example, a 2021 study by Carmichael et al. of adolescents with gender dysphoria who were treated with gonadotropin releasing hormone analogues (GnRHa's, or "puberty blockers") showed that overall participant experience of changes on GnRHa treatment was positive.[109] Another 2020 study by Brik et al. showed that among 143 transgender adolescents who were receiving GnRHa's, 127 (or 87%) of them started gender-affirming hormones after a median of 0.8 years.[110] Only nine (or 6% of) adolescents discontinued GnRHa's, and only five (or 3.5%) of whom no longer wished to receive gender-affirming treatment.[111] A similar 2022 study by van der Loos et al. using data from the Amsterdam Cohort of Gender Dysphoria (ACOG) found that 98% of people who started gender-affirming medical treatment in adolescence (with a median age of 14.1 years for people assigned male at birth and 16.0 years for those assigned female at birth) continued to use gender-affirming hormones at

[107] Ilan H. Meyer, *Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence*, 129 Psychological Bulletin 674 (2003); Jennifer L. Glick et al., *"Tiptoeing Around the System": Alternative Healthcare Navigation Among Gender Minorities in New Orleans*, 3 Transgend Health 118 (2018).

[108] Ethan C. Cicero et al., *The health status of transgender and gender nonbinary adults in the United States*, 15 PLOS ONE e0228765 (2020); Jaimie F. Veale et al., *The mental health of Canadian transgender youth compared with the Canadian population*, 60 J Adolesc Health 44 (2017).

[109] Polly Carmichael et al., *Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK*, 16 PLOS ONE e0243894 (2021).

[110] Tessa Brik et al., *Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*, 49 Arch Sex Behav 2611 (2020).

[111] *Id.*

follow-up (with a median age of 20.2 years for people assigned male at birth and 19.2 years for those assigned female at birth).[112]

The existing literature also shows that transgender patients are generally satisfied with hormone therapy.[113] For example, a 2021 study by Grannis et al. evaluating the effects of testosterone treatment on transmasculine adolescents who had spent an average of 13 months on hormone replacement therapy, found that testosterone treatment was associated with greater body satisfaction.[114] Another 2021 study by Nieder et al. using data from a clinical cohort sample of 75 adolescents and young adults diagnosed with gender dysphoria showed that patients who underwent hormone treatment showed overall high satisfaction with the treatment they received.[115] No adolescents in this sample regretted undergoing treatment at follow-up, which occurred on average of 2 years after treatment.[116] Another 2020 study by Kuper et al. that specifically collected data on and controlled for psychotherapy and use of psychiatric medications found that gender-affirming hormone therapy not only improved symptoms of depression and anxiety, but that it made significant improvements in alleviating adolescents' body-related stress.[117] Finally, a 2017 study by van de Grift et al. of 201 transgender patients who applied for gender-affirming interventions from 2007 to 2009 found that hormone-based interventions were associated with improvements in body satisfaction.[118]

Lastly, a wide body of existing literature shows that transgender patients are generally satisfied with surgical outcomes and rarely experience regret with gender-affirming surgery.[119]

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[112] Maria Anna Theodora Catharina van der Loos et al., *Continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence: a cohort study in the Netherlands*, 6 The Lancet Child & Adolescent Health 869 (2022).

[113] *See also* Carla Pelusi et al., *Effects of three different testosterone formulations in female-to-male transsexual persons*, 11 J Sex Med 3002 (2014); Mohammad Hassan Murad et al., *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes*, 72 Clin Endocrinol (Oxf) 214 (2010).

[114] Connor Grannis et al., *Testosterone treatment, internalizing symptoms, and body image dissatisfaction in transgender boys*, 132 Psychoneuroendocrinology 105358 (2021).

[115] T. O. Nieder et al., *Individual Treatment Progress Predicts Satisfaction With Transition-Related Care for Youth With Gender Dysphoria: A Prospective Clinical Cohort Study*, 18 The Journal of Sexual Medicine 632 (2021).

[116] *Id.*

[117] Laura E. Kuper et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145 Pediatrics e20193006 (2020).

[118] Tim C. van de Grift et al., *Effects of Medical Interventions on Gender Dysphoria and Body Image: A Follow-Up Study*, 79 Psychosom Med 815 (2017).

[119] *See also* Mehrdad Eftekhar Ardebili et al., *Quality of life in people with transsexuality after surgery: a systematic review and meta-analysis*, 18 Health and Quality of Life Outcomes 264 (2020); Sara Danker et al., *Abstract: A Survey Study of Surgeons' Experience with Regret and/or Reversal of Gender-Confirmation Surgeries*, 6 Plast Reconstr Surg Glob Open 189 (2018); Johanna Olson-Kennedy et al., *Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts*, 172 JAMA Pediatrics 431 (2018); Chantal M. Wiepjes et al., *The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets*, 15 J Sex Med 582 (2018); Tim C. van de Grift et al., *Effects of Medical Interventions on Gender Dysphoria and Body Image: A Follow-Up Study*, 79 Psychosom Med 815 (2017); Jochen Hess et al., *Satisfaction With Male-to-Female Gender Reassignment Surgery*, 111 Dtsch Arztebl

For example, a 2022 study by Tang et al. evaluating the satisfaction and regret of adolescents who received gender-affirming mastectomies found that of 209 patients with a median age of 16 (range of 12-17), only two patients (0.95%) had documented postoperative regret (but did not undergo reversal surgery at follow-up of three and seven years postoperatively).[120] A 2021 systematic review and meta analysis of regret after gender-affirmation surgery by Bustos et al. found that regret was only expressed by one percent or fewer of transgender patients who underwent gender-affirming surgery.[121] The aforementioned 2021 study by Nieder et al. also found that adolescents and young adults who underwent gender-affirming surgery showed overall high satisfaction with the treatment they received.[122] Another 2020 study by Morrison et al. evaluating the quality of life of 66 transgender women after receiving facial feminization surgery showed that mean satisfaction at follow-up was excellent and patients achieved significantly-more feminine appearances.[123] Lastly, a 2014 study by Dhejne et al. looking at incidence and prevalence of applications in Sweden for legal and surgical sex reassignment over a 50 year period between 1960 and 2010 found that only 2.2% of applicants filed for regret applications and that there was a significant decline in regrets over the time period.[124] While the data from this study is older, it is useful because (1) it shows that regret associated with gender-affirming surgery has declined over time as surgical techniques have improved, and (2) it is authored by the same researcher as the "Sweden study" that many opponents cite (incorrectly) to argue that gender-affirmative surgery increases the risk of suicidality of trans people who

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Int 795 (2014); Annika Johansson et al., *A Five-Year Follow-Up Study of Swedish Adults with Gender Identity Disorder*, 39 Arch Sex Behav 1429 (2010); Tiffiny A. Ainsworth & Jeffrey H. Spiegel, *Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery*, 19 Qual Life Res 1019 (2010); Mohammad Hassan Murad et al., *Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes*, 72 Clin Endocrinol (Oxf) 214 (2010); Luk Gijs & Anne Brewaeys, *Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges*, 18 Annual Review of Sex Research 178 (2007); Yolanda L. S. Smith et al., *Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals*, 35 Psychol Med 89 (2005); Anne A. Lawrence, *Factors Associated with Satisfaction or Regret Following Male-to-Female Sex Reassignment Surgery*, 32 Arch Sex Behav 299 (2003); M. Landén et al., *Factors predictive of regret in sex reassignment*, 97 Acta Psychiatrica Scandinavica 284 (1998); P. T. Cohen-Kettenis & S. H. van Goozen, *Sex reassignment of adolescent transsexuals: a follow-up study*, 36 J Am Acad Child Adolesc Psychiatry 263 (1997); Richard Green & Davis T. Fleming, *Transsexual Surgery Follow-Up: Status in the 1990s*, 1 Annual Review of Sex Research 163 (1990). *But see* Annette Kuhn et al., *Quality of life 15 years after sex reassignment surgery for transsexualism*, 92 Fertility and Sterility 1685 (2009).

[120] Annie Tang et al., *Gender-Affirming Mastectomy Trends and Surgical Outcomes in Adolescents*, 88 Ann Plast Surg S325 (2022).

[121] Valeria P. Bustos et al., *Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence*, 9 Plast Reconstr Surg Glob Open e3477 (2021).

[122] T. O. Nieder et al., *Individual Treatment Progress Predicts Satisfaction With Transition-Related Care for Youth With Gender Dysphoria: A Prospective Clinical Cohort Study*, 18 The Journal of Sexual Medicine 632 (2021).

[123] Shane D. Morrison et al., *Prospective Quality-of-Life Outcomes after Facial Feminization Surgery: An International Multicenter Study*, 145 Plastic and Reconstructive Surgery 1499 (2020).

[124] Cecilia Dhejne et al., *An analysis of all applications for sex reassignment surgery in Sweden, 1960-2010: prevalence, incidence, and regrets*, 43 Arch Sex Behav 1535 (2014).

receive it.[125] We discuss this study more in an earlier section.

One of the major reasons why it is important whether transgender people are generally satisfied or unsatisfied with the care they receive is because some (but not all) forms of GAC are irreversible. Opponents focus on this to argue that if GAC is likely to lead to regret, then we should not allow transgender people to pursue forms of GAC if that care is not reversible. Opponents mainly focus on the potential impact(s) that GAC can have on reproductive capacity. If the care is reversible, then if someone does regret receiving that care, then they can undo whatever changes it causes, so possible regret becomes a weaker objection to increasing access to that care.

Possible regret is also a weaker argument if we are talking about providing care to adults above the age of majority. Provided that they are capable of providing informed consent to whatever risks are associated with an irreversible procedure, the fact that adults may come to regret going through an irreversible procedure is not enough by itself to criminalize that procedure. Adults can currently get any design tattooed anywhere on their body. The fact that some people may come to regret getting certain tattoos does not mean that tattoos should be illegal.[126] When we are talking about reversibility of GAC as an area of concern, we are mainly talking about the application to transgender adolescents. This is because the State has a unique legal interest in "protecting the physical and psychological wellbeing of minors."[127]

The existing literature shows that puberty blockers do not impact reproductive capacity.[128] For example, a 2022 study by de Nie et al. showed that transfeminine patients who were treated with GnRHa's starting at the onset of pubertal development were shown to have normal-appearing, immature sperm-producing cells in the testes, suggesting that those individuals retained fertility potential.[129] There is also a long history of puberty blockers being used to safely treat cisgender adolescents with central precocious puberty (CPP).[130] For example,

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[125] Cecilia Dhejne et al., *Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden*, 6 PLoS One e16885 (2011).

[126] Granted, this is more concerned with arguing against the criminalization of permanent forms of GAC rather than arguing affirmatively for its coverage under Medicaid. We would like to explore other forms of healthcare with relatively permanent effects that could result in regret which are covered under Medicaid in a future version of this report.

[127] *Sable Communications of Cal., Inc. v. FCC*, 492 U.S. 115, 126 (1989).

[128] *See also* Kanthi Bangalore Krishna et al., *Use of Gonadotropin-Releasing Hormone Analogs in Children: Update by an International Consortium*, 91 HRP 357 (2019); Maria Alexandra Magiakou et al., *The Efficacy and Safety of Gonadotropin-Releasing Hormone Analog Treatment in Childhood and Adolescence: A Single Center, Long-Term Follow-Up Study*, 95 The Journal of Clinical Endocrinology & Metabolism 109 (2010). *But see* Philip J. Cheng et al., *Fertility concerns of the transgender patient*, 8 Transl Androl Urol 209 (2019).

[129] I. de Nie et al., *Histological study on the influence of puberty suppression and hormonal treatment on developing germ cells in transgender women*, 37 Hum Reprod 297 (2022).

[130] *See also* E. Kirk Neely et al., *Leuprolide acetate 1-month depot for central precocious puberty: hormonal suppression and recovery*, 2010 Int J Pediatr Endocrinol 398639 (2010); Anna Pasquino et al., *Long-Term Observation of 87 Girls with Idiopathic Central Precocious Puberty Treated with Gonadotropin-Releasing Hormone*

a long-term 2018 study by Gallagher et al. of 51 female adolescents with surgically confirmed endometriosis found that there were no abnormalities in reproductive function after GnRHa discontinuation.[131] A 2014 literature review by Thorton et al. also found that published reports on puberty suppression in adolescents with central precocious puberty (CPP) confirm the reversibility of puberty suppression after cessation of GnHRa therapy, with no significant differences being found between adolescents who received GnHRa therapy compared to those that didn't.[132]

The existing literature also shows that transfeminine patients are capable of achieving reproductive capacity after starting estrogen therapy (although results vary) and that transmasculine patients often still have normal reproductive capacity after starting testosterone therapy.[133] For example, the aforementioned 2022 study by de Nie et al. found that while neither the cessation of hormone replacement therapy nor the length of the hormone replacement therapy before testing affected the presence of germ cells or their maturation stage, 88.3% of patients who were treated with testosterone suppression therapies had normal-appearing, immature sperm-producing cells in the testes, again suggesting that those individuals retained fertility potential.[134] A 2017 literature review by Schneider et al. also reported that three publications described a marked reduction in the spermatogenic level in all transfeminine hormone replacement therapy patients examined, but eight other publications reported inconsistent results.[135] Concerning transmasculine patients, a 2019 study by Leung et al. found that of 26 transgender men who had already initiated testosterone therapy, seven had fresh or frozen oocyte

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Analogs: Impact on Adult Height, Body Mass Index, Bone Mineral Content, and Reproductive Function, 93 The Journal of clinical endocrinology and metabolism 190 (2008); Sabine Heger et al., *Long-term GnRH agonist treatment for female central precocious puberty does not impair reproductive function*, 254–255 Molecular and Cellular Endocrinology 217 (2006); S. Heger, C. J. Partsch & W. G. Sippell, *Long-term outcome after depot gonadotropin-releasing hormone agonist treatment of central precocious puberty: final height, body proportions, body composition, bone mineral density, and reproductive function*, 84 J Clin Endocrinol Metab 4583 (1999); P. P. Feuillan et al., *Reproductive axis after discontinuation of gonadotropin-releasing hormone analog treatment of girls with precocious puberty: long term follow-up comparing girls with hypothalamic hamartoma to those with idiopathic precocious puberty*, 84 J Clin Endocrinol Metab 44 (1999); N. Jay et al., *Ovulation and menstrual function of adolescent girls with central precocious puberty after therapy with gonadotropin-releasing hormone agonists*, 75 J Clin Endocrinol Metab 890 (1992).

[131] Jenny Sadler Gallagher et al., *Long-Term Effects of Gonadotropin-Releasing Hormone Agonists and Add-Back in Adolescent Endometriosis*, 31 J Pediatr Adolesc Gynecol 376 (2018).

[132] Paul Thornton et al., *Review of outcomes after cessation of gonadotropin-releasing hormone agonist treatment of girls with precocious puberty*, 11 Pediatr Endocrinol Rev 306 (2014).

[133] *See also* Jenna Gale et al., *Oocyte cryopreservation in a transgender man on long-term testosterone therapy: a case report*, 2 F S Rep 249 (2021); Florian Schneider et al., *Testicular Functions and Clinical Characterization of Patients with Gender Dysphoria (GD) Undergoing Sex Reassignment Surgery (SRS)*, 12 J Sex Med 2190 (2015); Sumer Allensworth Wallace, Kiara L. Blough & Laxmi A. Kondapalli, *Fertility preservation in the transgender patient: expanding oncofertility care beyond cancer*, 30 Gynecol Endocrinol 868 (2014). *But see* Philip J. Cheng et al., *Fertility concerns of the transgender patient*, 8 Transl Androl Urol 209 (2019).

[134] I. de Nie et al., *Histological study on the influence of puberty suppression and hormonal treatment on developing germ cells in transgender women*, 37 Hum Reprod 297 (2022).

[135] F. Schneider et al., *Andrology of male-to-female transsexuals: influence of cross-sex hormone therapy on testicular function*, 5 Andrology 873 (2017).

transfers, with all achieving live births.[136] Another 2014 study by Light et al. found that 25 out of 41 (or 61% of) transgender men were using testosterone before beginning pregnancy and that 88% of the oocytes (n=36) came from the patients' own ovaries.[137]

There is little academic literature on the effects of gender-affirming surgery on the fertility of transgender patients, likely because it is undisputed that hysterectomy and oophorectomy in transgender men and orchiectomy in transgender women results in permanent sterility.[138] That being said, transgender patients can still pursue fertility cryopreservation before gender-affirming hormonal therapy or surgery and therefore have a biological child through a surrogate or a sexually intimate partner.[139]

Opponents have also argued that puberty blockers cause other forms of irreversible damage to adolescents, such as decreasing bone density or inhibiting regular puberty development if discontinued. The existing literature suggests that while there is some basis for this concern, it is relatively minimal.[140] For example, the aforementioned 2018 study by Gallagher et al. found that while bone mineral density decreases through GnRHa treatment, it recovers to normal after discontinuation.[141] The aforementioned 2014 study by Thorton et al. also found that GnRHA therapy "does not appear to induce polycystic ovary syndrome or have long-term negative repercussions on either bone mineral density or body composition."[142] Furthermore, a 2010 study by Neely et al. of 55 cisgender adolescents found that after several years of puberty suppression, all patients achieved a pubertal hormonal response within one year

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[136] Angela Leung et al., *Assisted reproductive technology outcomes in female-to-male transgender patients compared with cisgender patients: a new frontier in reproductive medicine*, 112 Fertil Steril 858 (2019).

[137] Alexis D. Light et al., *Transgender men who experienced pregnancy after female-to-male gender transitioning*, 124 Obstet Gynecol 1120 (2014).

[138] Philip J. Cheng et al., *Fertility concerns of the transgender patient*, 8 Transl Androl Urol 209 (2019).

[139] Susan Maxwell et al., *Pregnancy Outcomes After Fertility Preservation in Transgender Men*, 129 Obstet Gynecol 1031 (2017); F. Schneider et al., *Andrology of male-to-female transsexuals: influence of cross-sex hormone therapy on testicular function*, 5 Andrology 873 (2017).

[140] *See also* Silvano Bertelloni & Dick Mul, *Treatment of central precocious puberty by GnRH analogs: long-term outcome in men*, 10 Asian J Androl 525 (2008); Anna Pasquino et al., *Long-Term Observation of 87 Girls with Idiopathic Central Precocious Puberty Treated with Gonadotropin-Releasing Hormone Analogs: Impact on Adult Height, Body Mass Index, Bone Mineral Content, and Reproductive Function*, 93 The Journal of clinical endocrinology and metabolism 190 (2008); S. Heger, C. J. Partsch & W. G. Sippell, *Long-term outcome after depot gonadotropin-releasing hormone agonist treatment of central precocious puberty: final height, body proportions, body composition, bone mineral density, and reproductive function*, 84 J Clin Endocrinol Metab 4583 (1999); P. K. Manasco et al., *Resumption of puberty after long term luteinizing hormone-releasing hormone agonist treatment of central precocious puberty*, 67 J Clin Endocrinol Metab 368 (1988). *But see* Xiaoping Luo et al., *Long‐term efficacy and safety of gonadotropin‐releasing hormone analog treatment in children with idiopathic central precocious puberty: A systematic review and meta‐analysis*, 94 Clin Endocrinol (Oxf) 786 (2021).

[141] Jenny Sadler Gallagher et al., *Long-Term Effects of Gonadotropin-Releasing Hormone Agonists and Add-Back in Adolescent Endometriosis*, 31 J Pediatr Adolesc Gynecol 376 (2018). See also S. Bertelloni et al., *Final height, gonadal function and bone mineral density of adolescent males with central precocious puberty after therapy with gonadotropin-releasing hormone analogues*, 159 Eur J Pediatr 369 (2000).

[142] Paul Thornton et al., *Review of outcomes after cessation of gonadotropin-releasing hormone agonist treatment of girls with precocious puberty*, 11 Pediatr Endocrinol Rev 306 (2014).

after discontinuing puberty suppression and no impairment of reproductive function was observed in adulthood.[143]

Lastly, it should be noted that while opponents argue that using puberty blockers can cause irreversible damage to transgender adolescents, the primary reason that transgender adolescents are prescribed puberty blockers is in order to prevent the irreversible changes that are brought on by an incorrect puberty, meaning that "watchful waiting" is not a neutral option.[144] Instead, what puberty suppression does is give transgender adolescents additional time for gender exploration without the pressure of ongoing pubertal development.[145] Furthermore, puberty suppression also makes follow up care–such as hormone replacement therapy–more effective, as well as reduces the need for certain surgical interventions such as facial feminisation surgery.

Not only are transgender adolescents overwhelmingly satisfied with using puberty blockers, and not only are their effects reversible if one discontinues their use, but they are specifically used to prevent irreversible harm to transgender adolescents by giving them more time to consider their gender and work with professionals regarding what medical steps to take in the future.

This information is especially useful because in addition to seeing this subject come up in written testimony, it came up in oral testimony on MD HB0746/SB0682. During a hearing in front of the Maryland Senate Finance Committee, Senator Justin Ready (R-5) asked whether puberty blockers are reversible.[146] The best available evidence suggests that they are reversible, which is why they are recommended by medical organizations to be used to delay the onset of an irreversible puberty.

H. Minority Stress & Effects of Gender-Affirmative Care on How Trans People are Treated in Society

This subject was discussed the sixth-most overall (42.9%) in the written testimony we analyzed. It was also the fifth-most discussed subject in proponent testimony (57.4%) and the thirteenth-most discussed subject in opponent testimony (10.0%). Proponents argued that if GAC helps trans people to be treated better in society–which is relevant for healthcare purposes since it can alleviate minority stress that arises from discrimination–then we should increase

[143] E. Kirk Neely et al., *Leuprolide acetate 1-month depot for central precocious puberty: hormonal suppression and recovery*, 2010 Int J Pediatr Endocrinol 398639 (2010).

[144] Stephen M. Rosenthal, *Challenges in the care of transgender and gender-diverse youth: an endocrinologist's view*, 17 Nat Rev Endocrinol 581 (2021).

[145] Stephen M. Rosenthal, *Transgender youth: current concepts*, 21 Ann Pediatr Endocrinol Metab 185 (2016); Wylie C. Hembree, *Management of juvenile gender dysphoria*, 20 Curr Opin Endocrinol Diabetes Obes 559 (2013).

[146] FIN 2.22.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/2b38ee8906b54042a2ec5d051930b2901d (last visited Feb 9, 2023).

access on that basis. Opponents argued that if GAC either doesn't impact how trans people are treated in society or makes them worse off, then we shouldn't increase access on that basis.

LGBT+ people are frequently discriminated against in the United States. A 2019 study using national probability-based survey data by Casey et al. found that experiences of interpersonal discrimination were common for LGBT+ adults.[147] Specifically, they found that 57% of LGBT+ adults reported being called slurs, 53% reported being victims of microaggressions, 51% reported being victims of sexual harassment, 51% reported being victims of physical violence, and 34% reported being harassed regarding bathroom use.[148] LGBT+ racial and ethnic minorities also reported a higher likelihood of experiencing discrimination than white LGBT+ people when applying for jobs, when trying to vote or participate in politics, and interacting with the legal system.[149]

There is also specific literature looking at the discrimination that transgender people in particular face in the United States. A 2009 study by Rebecca L. Stozer reviewed the three primary sources of data in the United States for discerning the rates and types of violence that transgender people face: (1) self-report surveys and needs assessments, (2) hot-line call and social service records, and (3) police reports.[150] Stozer found that "[a]ll three sources indicate that violence against transgender people starts early in life, that transgender people are at risk for multiple types and incidences of violence, and that this threat lasts throughout their lives[,]" as well as that transgender people are at a "particularly high risk for sexual violence."[151]

GAC is important not only to alleviate gender dysphoria (which we discussed earlier in this report), but also so that transgender people can integrate into society and "pass" as the gender they identify with. Several examples include subcutaneous mastectomies and facial feminization or masculinization surgery. These surgical interventions can often have a greater practical significance in a patient's daily life than reconstruction of their genitals because they influence all of their interactions with other people.[152]

This is especially relevant in the discussion of pubertal suppression for transgender adolescents because suffering from gender dysphoria without being able to stop the development of unwanted secondary sex characteristics also usually leads to problems throughout their

[147] Logan S. Casey et al., *Discrimination in the United States: Experiences of lesbian, gay, bisexual, transgender, and queer Americans*, 54 Health Services Research 1454 (2019).
[148] *Id.*
[149] *Id.*
[150] Rebecca L. Stotzer, *Violence against transgender people: A review of United States data*, 14 Aggression and Violent Behavior 170 (2009).
[151] *Id.*
[152] Randi Ettner, Stan Monstrey & A. Evan Eyler, Principles of transgender medicine and surgery (2007), http://catdir.loc.gov/catdir/toc/ecip0711/2007007362.html (last visited Dec 14, 2022).

lives.[153] To support this, a 2018 study by Rider et al. found that transgender and gender nonconforming youth "whose gender presentation was *perceived* as very congruent with their birth-assigned sex were less likely to report poorer health and long-term mental health problems compared with those with other gender presentations."[154]

This has important implications for healthcare because there is a wide body of literature demonstrating that gender-related bias, victimization, criminalization, and forced-gender conformity experienced by transgender people commonly causes minority stress.[155] This is where the stress associated with experiencing mistreatment on the basis of belonging to a class of people can result in heightened psychological distress, compromised overall wellbeing, and disparities across various contexts.[156] This is important because many opponents argue that behavioral health disorders cause gender dysphoria when it is well-established that the opposite is true: that being transgender tends to lead to mental health concerns because of the social stress and discrimination of being transgender in a society that is strongly cisnormative and

[153] Henriette A. Delemarre-van de Waal & Peggy T. Cohen-Kettenis, *Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects*, 155 European Journal of Endocrinology S131 (2006).

[154] G. Nicole Rider et al., *Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study*, 141 Pediatrics e20171683 (2018).

[155] Michael L. Hendricks & Rylan J. Testa, *A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model.*, 43 Professional Psychology: Research and Practice 460 (20120813); Stephen T. Russell et al., *Adolescent Health and Harassment Based on Discriminatory Bias*, 102 Am J Public Health 493 (2012); Walter Bockting et al., *Adult development and quality of life of transgender and gender nonconforming people*, 23 Curr Opin Endocrinol Diabetes Obes 188 (2016); Russell B. Toomey et al., *Gender-nonconforming lesbian, gay, bisexual, and transgender youth: School victimization and young adult psychosocial adjustment*, 1 Psychology of Sexual Orientation and Gender Diversity 71 (2013); Sari L. Reisner et al., *Global Health Burden and Needs of Transgender Populations: A Review*, 388 Lancet 412 (2016); Lore M. Dickey et al., *Health disparities in the transgender community: Exploring differences in insurance coverage*, 3 Psychology of Sexual Orientation and Gender Diversity 275 (2016); Kevin L. Nadal, Avy Skolnik & Yinglee Wong, *Interpersonal and Systemic Microaggressions Toward Transgender People: Implications for Counseling*, 6 Journal of LGBT Issues in Counseling 55 (2012); Ilan H. Meyer, *Resilience in the study of minority stress and health of sexual and gender minorities*, 2 Psychology of Sexual Orientation and Gender Diversity 209 (2015); Ilan H. Meyer, Sharon Schwartz & David M. Frost, *Social patterning of stress and coping: Does disadvantaged social statuses confer more stress and fewer coping resources?*, 67 Social Science & Medicine 368 (2008); Walter O. Bockting et al., *Stigma, Mental Health, and Resilience in an Online Sample of the US Transgender Population*, 103 Am J Public Health 943 (2013); Jack L. Turban et al., *Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes*, 69 Journal of Adolescent Health 991 (2021); Sari L. Reisner et al., *Psychiatric Diagnoses and Comorbidities in a Diverse, Multicity Cohort of Young Transgender Women: Baseline Findings From Project LifeSkills*, 170 JAMA Pediatrics 481 (2016). *See also* Vickie M. Mays & Susan D. Cochran, *Mental Health Correlates of Perceived Discrimination Among Lesbian, Gay, and Bisexual Adults in the United States*, 91 Am J Public Health 1869 (2001); I. H. Meyer, *Minority stress and mental health in gay men*, 36 J Health Soc Behav 38 (1995); Mark L. Hatzenbuehler, Susan Nolen-Hoeksema & Sarah J. Erickson, *Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: Results from a prospective study of bereaved gay men*, 27 Health Psychology 455 (2008); Mark L. Hatzenbuehler, *Structural Stigma and the Health of Lesbian, Gay, and Bisexual Populations*, 23 Current Directions in Psychological Science 127 (2014).

[156] *Id.*

transphobic.[157] According to the American Academy of Pediatrics, this is also why gender affirmation among adolescents with gender dysphoria helps them lead healthier lives:

> Gender affirmation among adolescents with gender dysphoria often reduces the emphasis on gender in their lives, allowing them to attend to other developmental tasks to attend to other developmental tasks, such as academic success, relationship building, and future-oriented planning.[158]

This is especially important because minority stress has been shown to be one of the primary predictors of suicidality in transgender people. According to a 2016 study by Klein and Golub, 42.3% of respondents from the National Transgender Discrimination Survey (6,456 participants overall and 3,458 respondents who provided complete data on study variables) reported a suicide attempt in their lifetime and 26.3% reported misusing drugs or alcohol to cope with transgender-related discrimination.[159] After controlling for age, race/ethnicity, sex assigned at birth, binary gender identity, income, education, and employment status, family rejection was associated with increased risk of both behaviors and risks increased significantly with increasing levels of family rejection.[160]

Several other studies also show that minority stress is a strong predictor of suicidality in transgender people.[161] For example, a 2018 study by Zeluf et al. of 796 transgender people from an online survey in Sweden found that 37% of respondents reported having seriously considered suicide during the previous 12 months and 32% had ever attempted suicide.[162] Within this study, offensive treatment during the previous three months and lifetime exposure to trans-related violence were significantly-associated with suicidality.[163] Another example is a 2017 study by

[157] Rylan J. Testa et al., *Development of the Gender Minority Stress and Resilience Measure*, 2 Psychology of Sexual Orientation and Gender Diversity 65 (2015).

[158] Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics e20182162 (2018).

[159] Augustus Klein & Sarit A. Golub, *Family Rejection as a Predictor of Suicide Attempts and Substance Misuse Among Transgender and Gender Nonconforming Adults*, 3 LGBT Health 193 (2016). This statistic has sometimes been used to suggest that GAC does not help reduce the risk of suicide for transgender people. This is a misrepresentation of this statistic, because even if transgender people pursued GAC and it did reduce their risk of suicide, they may still have answered "Yes" to the question since it asked about whether they had *ever* reported a suicide attempt in their lifetime. The exact question posed was "Have you ever attempted suicide?" with dichotomized responses of Yes/No.

[160] *Id.*

[161] *See also* Arnold H. Grossman, Jung Yeon Park & Stephen T. Russell, *Transgender Youth and Suicidal Behaviors: Applying the Interpersonal Psychological Theory of Suicide*, 20 J Gay Lesbian Ment Health 329 (2016); Sari L. Reisner et al., *Psychiatric Diagnoses and Comorbidities in a Diverse, Multicity Cohort of Young Transgender Women: Baseline Findings From Project LifeSkills*, 170 JAMA Pediatrics 481 (2016).

[162] Galit Zeluf et al., *Targeted Victimization and Suicidality Among Trans People: A Web-Based Survey*, 5 LGBT Health 180 (2018).

[163] *Id.*

Trujillo et al. of 78 transgender participants as part of a national online survey.[164] A series of simultaneous multiple regressions found that discrimination was a positive predictor of poor mental health symptoms and suicidal ideation.[165] This study also found that discrimination predicted suicidal ideation most strongly when participants had low social support from a significant other (in comparison to moderate or high support).[166] Another example is a 2015 study by Perez-Brumer et al. which found that lower levels of state-level structural stigma (including aggregated public opinion toward homosexuality) was associated with fewer lifetime suicide attempts among trans people.[167] Finally, a 2016 meta analysis by Virupaksha et al. found that while the suicide attempt rate among transgender persons ranged from 32% to 50% across countries, the main contributing factors were gender-based victimization, discrimination, bullying, violence, being rejected (by family, friends, and community), harassment (by intimate partners, family members, police, and the public), discrimination, and mistreatment within healthcare systems.[168]

This literature demonstrates that it is not true that transgender identification itself is what leads to higher rates of suicidality for transgender people, but rather that the main cause is the discrimination that transgender people experience on the basis of their transgender identity. Therefore, increasing access to GAC is important for healthcare purposes in order to alleviate the minority stress common in transgender people that arises from being members of a vulnerable and highly stigmatized group.

This information is especially useful because in addition to seeing this subject come up in written testimony, it also came up in the oral testimony on MD HB0746/SB0682. During a hearing on the bill in front of the Maryland House Health and Government Operations Committee, Senator Mary Washington (D-43) discussed how the discussion on GAC is similar to the history of dental care insofar as how it used to be considered "cosmetic," but is now considered medically-necessary care because dental care addresses many comorbidities.[169] Not only does GAC alleviate gender dysphoria, but it can also address issues like minority stress. Both of these effects improve the overall quality of life for transgender patients, which can help address other comorbidities in their lives.

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[164] Michael A. Trujillo et al., *The buffering role of social support on the associations among discrimination, mental health, and suicidality in a transgender sample*, 18 Int J Transgend 39 (2017).

[165] *Id.*

[166] *Id.*

[167] Amaya Perez-Brumer et al., *Individual- and Structural-Level Risk Factors for Suicide Attempts Among Transgender Adults*, 41 Behavioral Medicine 164 (2015).

[168] H. G. Virupaksha, Daliboyina Muralidhar & Jayashree Ramakrishna, *Suicide and Suicidal Behavior among Transgender Persons*, 38 Indian J Psychol Med 505 (2016).

[169] HGO 3.24.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/184a5876f7c94cc3a4a8b7924bea84821d (last visited Feb 9, 2023).

I. Whether Being Trans is an Intrinsic Quality

This subject was discussed the eighth-most overall (32.7%) in the written testimony we analyzed. It was also the thirteenth-most discussed subject in proponent testimony (10.3%) and the third-most discussed subject in opponent testimony (83.3%). Proponents argued that if being trans is an intrinsic quality, we should increase access to GAC on that basis to make it easier for people to live as trans since it is impossible for them to be cis. Opponents argued that if being trans is not an intrinsic quality–whether due to "social contagion," some other form of pathologization, or "grooming"–then not only is it unnecessary to expand access to GAC on that basis, but gender identity change efforts are also justified.

The 20th century onwards is dominated by three particular terms: transvestite, transexual, and transgender. The term transvestite was coined in 1910 by Magnus Hirschfield to mean: "the urge to present and conduct oneself in the outer raiment of the sex to which a person does not belong-as regards the visible sexual organs."[170] In contemporary contexts, the term transvestite has fallen out of fashion and the term "cross-dresser" is more commonly used to describe people dressing and presenting as the opposite sex typically for short term periods. The term transvestite does not fully cover modern conceptualizations of trans identity, the main reason being since it fails to recognize the innateness of the desire to change one's body to better suit how they believe it ought to be in respect to biological sex. Concepts related to cross-dressing are thus less to do with modern notions of transness and more related to aspects of queerness and activities such as drag.

It was the work of Hirschfield that led in 1919 to the opening of the Institut fur Sexualwissenschaft in Berlin that led pioneering work in the study of trans identity. Much of the research, practices, and data collected was destroyed in 1933 with it being burned to the ground by the Nazi seizure of power–the famous pictures of book burnings in Germany were actually the books and research related to this institute. Following the war, trans related studies began to increase once more, however the sexological approach of Hirschfield et al. was rapidly replaced with the forensic psychology approach to trans studies. This became the era of psychiatrization of transness, whereby there was an increased desire to pathologize trans identity and treat it as an illness. This is where the second term of the century was coined: transexual. The term itself developed out of Hirschfeld's successful gender reassignment surgeries of the 1920s where he coined the term "transexualismus," whereby David Oliver Caudwell introduced the English term "transexual" in 1950.[171] This is also the first documentation of the belief that those that are

[170] Farah Naz Khan, *A History of Transgender and Gender Diverse Health Care: From Medical Mistreatment to Gender-Affirmative Health Care*, *in* Transgender and Gender Diverse Health Care: The Fenway Guide (Alex S. Keuroghlian, Jennifer Potter, & Sari L. Reisner eds., 2022), accessmedicine.mhmedical.com/content.aspx?aid=1184175720 (last visited Jan 8, 2023).

[171] Joanne Meyerowitz, How Sex Changed: A History of Transsexuality in the United States (New Ed edition ed. 2004).

transexual held a desire to change their physiological sex and was coupled with the (now debunked) Freudian based beliefs that transsexualism was connected to an over-familiarity of a boy with their mother or a girl with their father.[172] Nevertheless, the concept of transsexualism was connected to an idea that medical intervention was a requirement to be sought out.

The term "transgender" was coined in 1965 by John Oliven.[173] As a concept, it encompassed a more holistic approach that did not demand of every person a specific, uniform surgical route. Some transgender people undergo as much gender affirming care and surgeries as possible; others undergo some, and others still undergo none. This is reflected in recent estimates that only around 20-40 percent of transgender individuals seek gender affirming surgery (though these estimates are based on convenience samples).[174]

Modern Gender Critical (otherwise known as Trans Exclusionary Radical Feminist) views and beliefs stem from a rejection of contemporary science post-1965 related to the adoption of modern terms such as "transgender" and instead focus upon pre-1965 science that worked within a psychiatric and primarily pathological model to recognize trans identity as an "illness" that should be cured.

One of the most recent examples of this is the novel "rapid-onset gender dysphoria" (ROGD) pathology proposed by Lisa Littman in her paper originally titled: "Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports."[175] This theory, based only on surveying parents from antitransgender websites who had become aware that their child was transgender after the child reached adolescence, proposed that adolescents who identified as transgender did not do so due to any innate sense of gender identity, but due primarily to peer influence.[176]

This article has come under serious methodological critique since it was published, such that the publishing journal required Littman to republish the article with a new title and substantial correction.[177] This is an unusual step that is taken only when a panel of experts, in retrospect, recognized that it would be unscientific to allow the originally published findings to

[172] *Id.*

[173] Dana Jennett Bevan Ph.D, The Psychobiology of Transsexualism and Transgenderism: A New View Based on Scientific Evidence: A New View Based on Scientific Evidence (2014).

[174] Joseph K. Canner et al., *Temporal Trends in Gender-Affirming Surgery Among Transgender Patients in the United States*, 153 JAMA Surgery 609, 610 (2018).

[175] Lisa Littman, *Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports*, 13 PLoS ONE e0202330 (2018).

[176] *Id.*

[177] Lisa Littman, *Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria*, 13 PLOS ONE e0202330 (2018). *See also* Arjee Javellana Restar, *Methodological Critique of Littman's (2018) Parental-Respondents Accounts of "Rapid-Onset Gender Dysphoria,"* 49 Arch Sex Behav 61 (2020).

stand.[178] The corrected version of the study, titled "Parent reports of adolescents and young adults perceived to show signs of rapid onset gender dysphoria," more strongly conveys that this was a study of parent perceptions rather than youth behavior or development.[179] Accompanying this corrected version of Littman's article was a public apology in which the journal's editor-in-chief stated:

> I would also like to apologize in particular to the trans and gender variant community for oversights that occurred during the original assessment of the study. . . . [The corrected article] now provides a better context of the work, as a report of parental observations, but not a clinically validated phenomenon or a diagnostic guideline.[180]

Additionally, recent studies have found no evidence of a new type of gender dysphoria driven by social media or social contagion. For example, a 2022 study by Bauer et al. analyzing 173 youth presenting to a Canadian gender clinic found no correlations between teens who had more recently begun identifying as transgender and online support/engagement from their peers for their gender identity.[181] On the contrary, the study found that teens with more recent awareness of being transgender were not significantly more likely to have gender-supportive online friends, general support from online friends or transgender friends, or gender support from parents.[182]

This is a primary example why attempts to pathologize trans identity as a mental disease or defect that ought to be cured have not held up to scientific scrutiny. Another example is the historical failure of gender identity change efforts (GICE). Several studies demonstrate that not only are GICE almost never successful at actually changing one's perception of their own gender or sexuality, but they often worsen mental health issues for LGBT+ people. For example, a 2020 study by Turban et al. of 27,715 survey respondents found that "lifetime and childhood exposure to GICE are associated with adverse mental health outcomes in adulthood[,]" including higher odds of lifetime suicide attempts.[183] Another example is a 2020 study by Green et al. that used a large online sample of LGBT+ young people to find that those who reported experiencing GICE were more than twice as likely to report having attempted suicide and having multiple suicide attempts as those who did not experience change efforts.[184] It is for these and similar reasons that

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[178] *Id.*

[179] *Id.*

[180] Juanita Baker, *Correcting the scientific record on gender incongruence – and an apology*, EveryONE (2019), https://everyone.plos.org/2019/03/19/correcting-the-scientific-record-and-an-apology/ (last visited Feb 9, 2023).

[181] Greta R. Bauer et al., *Do Clinical Data from Transgender Adolescents Support the Phenomenon of "Rapid Onset Gender Dysphoria"?*, 243 J Pediatr 224 (2022).

[182] *Id.*

[183] Jack L. Turban et al., *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, 77 JAMA Psychiatry 68 (2020).

[184] Amy E. Green et al., *Self-Reported Conversion Efforts and Suicidality Among US LGBTQ Youths and Young Adults, 2018*, 110 Am J Public Health 1221 (2020).

it is the modern medical consensus that GICE do not work because gender identity and sexual orientation are innate aspects of one's identity:

> We reiterate the prevailing science confirming that variations in sexual orientation and gender identity represent normal expressions of human diversity and cannot be changed at will. We affirm the contemporary scientific agreement that being lesbian, gay, bisexual, or transgender (LGBT) is not a mental illness or disorder and should not be pathologized.[185]

Additionally, there is a substantial body of literature demonstrating there is a durable biological element to gender identity.[186] In addition to the aforementioned literature on the failure of GICE, there is also literature demonstrating: (a) identical twins (who share the exact same genetic background) are more likely to both experience transgender identity as compared to fraternal (non-identical) twins;[187] (b) among individuals with XX chromosomes, rates of male gender identity are higher for those exposed to higher levels of androgens *in utero* compared to those without such exposure, and individuals with XY chromosomes with complete androgen insensitivity syndrome typically have female gender identity;[188] and (c) there are associations of certain brain scan or staining patterns with gender identity rather than external genitalia or chromosomes.[189]

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[185] Declaration on the Impropriety and Dangers of Sexual Orientation and Gender Identity Change Efforts, http://assets2.hrc.org/files/assets/resources/National_Orgs_Letter_in_Support_of_Legislative_Efforts_to_End_Conversion_Therapy.pdf?_ga=2.127699982.246403592.1558460063-2112112692.1535393527 (last visited Feb 9, 2023).

[186] Aruna Saraswat, Jamie D. Weinand & Joshua D. Safer, *Evidence supporting the biologic nature of gender identity*, 21 Endocr Pract 199 (2015); Stephen M. Rosenthal, *Approach to the Patient: Transgender Youth: Endocrine Considerations*, 99 The Journal of Clinical Endocrinology & Metabolism 4379 (2014). *See also* Hillary B. Nguyen et al., *What has sex got to do with it? The role of hormones in the transgender brain*, 44 Neuropsychopharmacol 22 (2019); C. E. Roselli, *Neurobiology of gender identity and sexual orientation*, 30 J Neuroendocrinol e12562 (2018); Tinca J. C. Polderman et al., *The Biological Contributions to Gender Identity and Gender Diversity: Bringing Data to the Table*, 48 Behav Genet 95 (2018); Elke Stefanie Smith et al., *The transsexual brain – A review of findings on the neural basis of transsexualism*, 59 Neuroscience & Biobehavioral Reviews 251 (2015). *But see* Michael V. Lombardo et al., *Fetal Testosterone Influences Sexually Dimorphic Gray Matter in the Human Brain*, 32 J. Neurosci. 674 (2012); E. Santarnecchi et al., *Intrinsic Cerebral Connectivity Analysis in an Untreated Female-to-Male Transsexual Subject: A First Attempt Using Resting-State fMRI*, 96 NEN 188 (2012); H. Berglund et al., *Male-to-Female Transsexuals Show Sex-Atypical Hypothalamus Activation When Smelling Odorous Steroids*, 18 Cerebral Cortex 1900 (2008); Meredith L. Chivers & J. Michael Bailey, *Sexual Orientation of Female-to-Male Transsexuals: A Comparison of Homosexual and Nonhomosexual Types*, 29 Arch Sex Behav 259 (2000).

[187] Gunter Heylens et al., *Gender identity disorder in twins: a review of the case report literature*, 9 J Sex Med 751 (2012).

[188] Arianne B. Dessens, Froukje M. E. Slijper & Stenvert L. S. Drop, *Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia*, 34 Arch Sex Behav 389 (2005).

[189] Aruna Saraswat, Jamie D. Weinand & Joshua D. Safer, *Evidence supporting the biologic nature of gender identity*, 21 Endocr Pract 199 (2015); Stephen M. Rosenthal, *Approach to the Patient: Transgender Youth: Endocrine Considerations*, 99 The Journal of Clinical Endocrinology & Metabolism 4379 (2014).

Because trans identity is now predominantly conceptualized as an innate quality, the World Health Organization (WHO) categorizes gender dysphoria as a physical condition in the International Classification of Diseases 11th Revision (ICD-11).[190] Consequently, the treatment of gender dysphoria is different from the treatment of mental conditions since the form of treatment that leads to the best outcomes for patients overall is to *affirm* the beliefs of the patient about their own body (as opposed to trying to correct or change those beliefs).

This information is especially useful because in addition to seeing this subject come up in written testimony, it also came up in the oral testimony on MD HB0746/SB0682. During a hearing on the bill in front of the Maryland Senate Finance Committee, Senator Justin Ready (R-5) argued that providing this kind of care sounds like transgender people are "conforming to a gender stereotype" that is more reflective of sex stereotypes than any innate sense of self.[191] Not only is there a wide body of evidence demonstrating a durable biological element to gender identity, but due to the historic failure of gender identity change efforts (GICE), it is the academic consensus that sexual orientation and gender identity are innate aspects of one's self that cannot be changed at will. Transgender people would likely pursue GAC regardless of how much they are affected by social issues such as sex stereotypes.

J. Capability of Trans Youth to Provide Informed Consent

This subject was discussed the ninth-most overall (31.6%) in the written testimony we analyzed. It was also the fourteenth-most discussed subject in proponent testimony (5.9%) and the most discussed subject in opponent testimony (90.0%). Proponents argued that if trans youth are mentally capable of providing informed consent for certain forms of GAC, then we should increase access to it on that basis to the extent they can provide informed consent. Opponents argued that if trans youth are not mentally capable of providing informed consent for any forms of GAC, then we should not increase access to it on that basis.

The WPATH SoC recommends only non-physical interventions for prepubertal children suffering from gender dysphoria.[192] For example, for the treatment of prepubertal children, the WPATH SoC provides for mental healthcare, support for the children and their family, and social transition (which is entirely reversible; ex: wearing clothing and using a name that is consistent with a child's stated gender identity).[193] The WPATH SoC does not recommend any physical

[190] ICD-11, World Health Organization, https://icd.who.int/en (last visited Feb 9, 2023).

[191] FIN 2.22.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/2b38ee8906b54042a2ec5d051930b2901d (last visited Feb 9, 2023).

[192] E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 International Journal of Transgender Health S1, S69 (2022); Wylie C Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline*, 102 The Journal of Clinical Endocrinology & Metabolism 3869 (2017).

[193] *Id.*

interventions (such as medications or surgery) for prepubertal children with gender dysphoria.[194] This is relevant because opponents commonly argue that irreversible gender-affirmative surgeries (specifically genital surgeries) are currently being carried out on children.

Under the WPATH SoC Version 8, gender-affirming medical interventions are only recommended after transgender youth begin adolescence.[195] The specific criteria to qualify for medical interventions are discussed in the earlier section on the modern medical standards for gender-affirming care. Here, we discuss the academic literature evaluating youth awareness of their gender or sexuality and their assessed capability to provide informed consent to receive GAC.

Gender identity is common to all people, is developed in early childhood, and is thought to be firmly established in most people–transgender or not–by age four.[196] Furthermore, there is long standing evidence that some LGBT+ children become aware of their atypical gender or sexual orientation by early adolescence.[197] For example, a 2015 study by Olson et al. found that "transgender children clearly viewed themselves in terms of their expressed gender and showed preferences for their expressed gender, with response patterns mirroring those of two cisgender (nontransgender) control groups."[198] This provided evidence that "early in development, transgender youth are statistically indistinguishable from cisgender children of the same gender identity," meaning that "they showed a clear preference for peers and objects endorsed by peers who shared their expressed gender, an explicit and implicit identity that aligned with their expressed gender, and a strong implicit preference for their expressed gender."[199] That being said, some children and adolescents may experience a long period of questioning their sexual orientation or gender identity, which can cause them to experience stress, confusion, fluidity, or complexity in their feelings and social identities.[200]

Several studies have evaluated the capability of adolescents to provide informed consent to receive GAC. For example, a 2021 study by Vrouenraets et al. found that 89.2% of the transgender adolescents they evaluated were assessed competent to consent for starting puberty blockers when evaluated by the MacArthur Competence Assessment Tool for Treatment

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[194] *Id.*

[195] *Id.* at S48.

[196] Edward L. Schor, Caring for Your School Age Child: Ages 5-12 (Revised edition ed. 1999); Kenneth J. Zucker, *Gender identity development and issues*, 13 Child and Adolescent Psychiatric Clinics 551 (2004); Principles of transgender medicine and surgery, (Randi Ettner, Stan Monstrey, & Eli Coleman eds., Second edition ed. 2016).

[197] Richard R. Troiden, *Homosexual identity development*, 9 Journal of Adolescent Health Care 105 (1988).

[198] Kristina R. Olson, Aidan C. Key & Nicholas R. Eaton, *Gender Cognition in Transgender Children*, 26 Psychol Sci 467 (2015).

[199] *Id.*

[200] Gary Remafedi et al., *Demography of Sexual Orientation in Adolescents*, 89 Pediatrics 714 (1992); Principles of transgender medicine and surgery, (Randi Ettner, Stan Monstrey, & Eli Coleman eds., Second edition ed. 2016); Gary Hollander, *Questioning Youths: Challenges to Working with Youths Forming Identities*, 29 School Psychology Review 173 (2000).

(MacCAT-T), and 93.2% were found to be when using clinicians' assessments.[201] The MacCAT-T has also been shown to effectively evaluate treatment decision-making capacity in children and adolescents when they have severe mental disorders.[202] Another 2021 study by Clark and Virani using a qualitative content analysis of interviews with trans youth, parents, and healthcare providers found that "trans youth demonstrated the understandings and abilities characteristic of the capacity to consent to hormone therapy and that they did consent to hormone therapy with positive outcomes."[203] With guidance from mental health providers, parents, and physicians, adolescents can competently participate in a process that helps them explore their identity and make nuanced decisions about the benefits and risks of GAC.[204]

This information is especially useful because in addition to seeing this subject come up in written testimony, it also came up in the oral testimony on MD HB0746/SB0682. During a hearing on the bill in front of the Maryland House Health and Government Operations Committee, former Delegate Lisa M. Belcastro (D-11) asked what the importance this bill has for transgender children, as well as how parents play a role in these medical decisions.[205] Not only is it recommended that parents are involved in medical decisions involving their transgender children, but also: (a) medical interventions are only recommended for adolescents who have begun puberty; (b) the purpose of this care is to give adolescents more time to consider whether to pursue a full medical transition without having to worry about the threat of an irreversible puberty; and (c) recent evidence suggests that, with guidance from parents and medical professionals, transgender adolescents can competently make decisions on whether to receive GAC.

K. Costs of Medicaid Expansion for the Government

This subject was discussed the tenth-most overall (29.6%, TIE) in the written testimony we analyzed. It was also the seventh-most discussed subject in proponent testimony (39.7%) and the fourteenth-most discussed subject in opponent testimony (6.7%, TIE). Proponents argued that if covering GAC is affordable overall and/or worth the cost, then we should increase access

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[201] Lieke J. J. J. Vrouenraets et al., *Assessing Medical Decision-Making Competence in Transgender Youth*, 148 Pediatrics e2020049643 (2021).

[202] Gabriele Mandarelli et al., *Treatment Decision-Making Capacity in Children and Adolescents Hospitalized for an Acute Mental Disorder: The Role of Cognitive Functioning and Psychiatric Symptoms*, 27 Journal of Child and Adolescent Psychopharmacology 462 (2017).

[203] Beth A. Clark & Alice Virani, *"This Wasn't a Split-Second Decision": An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy*, 18 J Bioeth Inq 151 (2021).

[204] Megan S. O'Brien et al., *Critical Issues for Psychiatric Medication Shared Decision Making with Youth and Families*, 92 Families in Society 310 (2011); Lieke Josephina Jeanne Johanna Vrouenraets et al., *Dealing with Moral Challenges in Treatment of Transgender Children and Adolescents: Evaluating the Role of Moral Case Deliberation*, 49 Arch Sex Behav 2619 (2020); Beth A. Clark & Alice Virani, *"This Wasn't a Split-Second Decision": An Empirical Ethical Analysis of Transgender Youth Capacity, Rights, and Authority to Consent to Hormone Therapy*, 18 J Bioeth Inq 151 (2021).

[205] HGO 3.2.2022 Bill Hearing, Maryland General Assembly, https://mgahouse.maryland.gov/mga/Play/bb1c84fe3b9e4dcd8f1c81d9c6251b8c1d (last visited Feb 9, 2023).

to it on that basis. Opponents argued that if covering GAC is expensive overall and/or not worth the cost, then we should not increase access to it on that basis.

A 2016 study by Padula et al. evaluating the cost-effectiveness of insurance coverage for gender-affirmative healthcare (specifically including hormone replacement therapy, mastectomy, abdominoplasty, hysterectomy, genital reconstruction, and other related services) determined the incremental cost-effectiveness ratio (ICER) of covering these services to be less than $8,000 per quality-adjusted life year (QALY) gained over a ten-year period.[206] This is far below the standard "willingness to pay" threshold of $100,000 per QALY.[207]

Additionally, not all transgender patients who seek care at gender clinics receive medical interventions. For example, a 2018 study by Wiepjes et al. showed that, while the number of people with gender identity issues seeking professional help has increased dramatically in recent decades, the percentage of those patients who have actually started hormone therapy within five years after their first visit has decreased over time, with almost 90% of patients seeking that care in 1980 and only 65% of patients seeking that care in 2010.[208]

Lastly, eliminating barriers to GAC could have positive downstream economic effects. By increasing access to GAC, this can help alleviate minority stress and other comorbidities that arise from untreated gender dysphoria, which can decrease costs for medical care for transgender people in other areas.[209]

L. Quality of Evidence Concerning Gender-Affirmative Care

This subject was discussed the tenth-most overall (29.6%, TIE) in the written testimony we analyzed. It was also the eleventh-most discussed subject in proponent testimony (17.6%) and the sixth-most discussed subject in opponent testimony (56.7%). Proponents argued that if the prevailing evidence on GAC is of high enough quality that we should be able to trust it, then we should rely on it to justify expanding access to GAC. Opponents argued that if the prevailing evidence on GAC is not high enough quality that we should be able to trust it, then we should not rely on it to justify expanding access to GAC because to do so would be "experimentation."

The internationally-recognized standards for evaluating the quality of medical literature for purposes of making healthcare recommendations are the Grading of Recommendations

[206] William V. Padula, Shiona Heru & Jonathan D. Campbell, *Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis*, 31 J GEN INTERN MED 394 (2016).

[207] David Cameron, Jasper Ubels & Fredrik Norström, *On what basis are medical cost-effectiveness thresholds set? Clashing opinions and an absence of data: a systematic review*, 11 Glob Health Action 1447828 (2018).

[208] Chantal M. Wiepjes et al., *The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets*, 15 J Sex Med 582 (2018).

[209] Kellan E. Baker, *The Future of Transgender Coverage*, 376 N Engl J Med 1801 (2017).

Assessment, Development, and Evaluation (GRADE) guidelines.[210] Using this system, opponents have criticized the prevailing literature on the efficacy of GAC to argue that it should not be relied upon to expand access to GAC (and even that it should be banned) since it is predominantly "low-quality" under the GRADE guidelines.

This is misleading, because the terms "low-quality" and "high-quality" under the GRADE guidelines are highly technical terms of art. Generally, only randomized controlled trials (RCTs) are coded as "high-quality" evidence according to the GRADE guidelines.[211] A randomized controlled trial is a study that randomly divides patients into a control group that receives no treatment and a test group that receives the treatment. In contrast, most of the medical studies on GAC consist of observational studies, which record information about patients in a real-world setting (ex: a cohort of patients seen at a clinic). Under the GRADE criteria, observational studies are coded as "low-quality."[212]

The term "low-quality" does not mean that the underlying studies in a set of recommendations are poorly-conducted or unreliable. The GRADE guidelines specifically note that they should *not* be used to dismiss observational studies or to give absolute priority to RCTs:

> Although higher quality evidence is more likely to be associated with stronger recommendations than lower quality evidence, a particular level of quality does not imply a particular strength of recommendations. *Sometimes, low or very low quality evidence can lead to a strong recommendation.*[213]

It is therefore incorrect to assert that the absence of RCTs from a body of medical literature means that it cannot be relied upon to make consensus recommendations. Instead, the GRADE criteria requires that researchers evaluate the design and conduct of specific observational studies and to do so with an awareness of the clinical context.[214]

The main reason why consensus recommendations may be based primarily, or in large part, on observational studies is that there are ethical and/or practical limitations to conducting RCTs to evaluate gender-affirming treatment. For example, the standard practice that children

[210] Gordon Guyatt et al., *GRADE guidelines: 1. Introduction—GRADE evidence profiles and summary of findings tables*, 64 Journal of Clinical Epidemiology 383 (2011); Gordon H. Guyatt et al., *GRADE: an emerging consensus on rating quality of evidence and strength of recommendations*, 336 BMJ 924 (2008).

[211] Howard Balshem et al., *GRADE guidelines: 3. Rating the quality of evidence*, 64 J Clin Epidemiol 401 (2011).

[212] *Id.*

[213] *Id.* at 141.

[214] Howard Balshem et al., *GRADE guidelines: 3. Rating the quality of evidence*, 64 J Clin Epidemiol 401 (2011). ("[W] e caution against a mechanistic approach toward the application of the criteria for rating the quality of the evidence up or down.... Fundamentally, the assessment of evidence quality is a subjective process, and GRADE should not be seen as obviating the need for or minimizing the importance of judgment or as suggesting that quality can be objectively determined").

should not be given aspirin for fevers is based on observational studies that showed an association between aspirin treatment during viral illnesses and the development of Reye's syndrome (a rapid and progressive disease of neurological dysfunction that can be fatal). Conducting "higher-quality" studies on this issue would necessitate violating ethical principles since it would require giving aspirin to children and risk exposing them to serious harm.[215] In this case, conducting an RCT on the effectiveness of GAC would require denying medically-necessary treatment to transgender people.

Many consensus recommendations for surgical procedures are also based on "low-quality" evidence since it can be impossible to randomly assign test subjects to categories without their knowing. For example, the main body of literature on minimally invasive gallbladder surgery consists of mainly observational studies.[216] Here, it would be impossible to provide a "placebo" surgery for testing the effectiveness of genital-related surgery and other forms of gender-affirmative surgery.

The fact of the matter is that clinical practice guidelines are often supported only by "low-quality" (but respected) observational studies. For example, the famous Framingham Heart Study was an observational study that provided the framework for clinical practice guidelines that support the use of statins, a cholesterol-lowering drug that is effective in preventing cardiovascular death and is currently prescribed to 28% of all adults over the age of 40.[217] In 2013, the American College of Cardiology and the American Heart Association issued updated clinical practice guidelines on the treatment of cholesterol to reduce heart disease risk in adults based not only on RCTs, but also on many observational studies that would technically be ranked as "low-quality" under the GRADE guidelines.[218] The authors of the Cholesterol Guidelines are very careful to grade their evidence (like the Endocrine Society and WPATH authors), but they base their recommendations on a holistic evaluation of the existing evidence, as opposed to a mechanical assessment of technical quality of existing evidence.[219]

M. Position of the FDA

This subject was discussed the thirteenth-most overall (17.3%) in the written testimony we analyzed. It was also the ninth-most discussed subject in proponent testimony (19.1%, TIE) and the tenth-most discussed subject in opponent testimony (13.3%, TIE). Proponents argued

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[215] Howard Balshem et al., *GRADE guidelines: 3. Rating the quality of evidence*, 64 J Clin Epidemiol 401, 403 (2011).

[216] *Id.*

[217] Neil J. Stone et al., *2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines*, 129 Circulation S1 (2014).

[218] *Id.*

[219] Syed S. Mahmood et al., *The Framingham Heart Study and the epidemiology of cardiovascular disease: a historical perspective*, 383 Lancet 999 (2014).

that if the FDA approves of GAC (and/or authorizes its reimbursement), then we should increase access to it on that basis. Opponents argued that if the FDA does not approve of GAC (and/or does not authorize its reimbursement), then we should not increase access to it on that basis.

The main reason why this argument is relevant is because opponents attempt to cast doubt on the scientific evidence supporting gender affirming hormone medications by noting that the FDA has not approved puberty blockers to treat gender dysphoria (and it is therefore "off-label" use). This is misleading because the term "off-label" has a very specific and narrow meaning in medicine, namely: use of a certain drug is "off-label" if the FDA has not approved a particular use of a particular medication for a particular population.[220] The "off-label" use of medications for children is quite common, and often necessary since an "overwhelming number of drugs" have no FDA-approved instructions for use in pediatric settings due to limits imposed by burdensome and expensive regulatory processes.[221] This is why the American Academy of Pediatrics approves of "off-label" use of drugs:

> The purpose of off-label use is to benefit the individual patient. Practitioners use their professional judgment to determine these uses. *As such, the term "off-label" does not imply an improper, illegal, contraindicated, or investigational use.* Therapeutic decision making must always rely on the best available evidence and the importance of the benefit for the individual patient.[222]

One example of common off-label medication use is the use of steroids for croup, which helps toddlers get through severe, potentially airway-obstructing illnesses safely.[223] Ondanstetron (Zofran) is used off-label with children to treat nausea and vomiting to prevent fluid loss since children are particularly vulnerable to dehydration. Ketamine and fentanyl are used off-label for pain relief (for example, to manage chronic pain in palliative care and in patients with cancer, but is used on-label in anesthesia).[224] In neonatal medicine, off-label medications are often used to treat the smallest and most fragile babies.[225] Pantoprazole (a

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[220] COMMITTEE ON DRUGS et al., *Off-Label Use of Drugs in Children*, 133 Pediatrics 563 (2014).

[221] COMMITTEE ON DRUGS et al., *Off-Label Use of Drugs in Children*, 133 Pediatrics 563 (2014); H. Christine Allen et al., *Off-Label Medication use in Children, More Common than We Think: A Systematic Review of the Literature*, 111 J Okla State Med Assoc 776 (2018); Lenneke Schrier et al., *Off-label use of medicines in neonates, infants, children, and adolescents: a joint policy statement by the European Academy of Paediatrics and the European society for Developmental Perinatal and Pediatric Pharmacology*, 179 Eur J Pediatr 839 (2020).

[222] COMMITTEE ON DRUGS et al., *Off-Label Use of Drugs in Children*, 133 Pediatrics 563 (2014); Katelyn Yackey et al., *Off-label Medication Prescribing Patterns in Pediatrics: An Update*, 9 Hosp Pediatr 186 (2019); Lenneke Schrier et al., *Off-label use of medicines in neonates, infants, children, and adolescents: a joint policy statement by the European Academy of Paediatrics and the European society for Developmental Perinatal and Pediatric Pharmacology*, 179 Eur J Pediatr 839 (2020).

[223] Katelyn Yackey et al., *Off-label Medication Prescribing Patterns in Pediatrics: An Update*, 9 Hospital Pediatrics 186, 192 (2019). *See also* COMMITTEE ON DRUGS et al., *Off-Label Use of Drugs in Children*, 133 Pediatrics 563 (2014).

[224] *Id.*

[225] *Id.* at 190.

proton pump inhibitor (PPI) used in general pediatric care to treat acid reflux) is used off-label in neonates with gastroesophageal reflux disease to help infants gain adequate weight in the first four-to-six months of life if they do not respond to traditional first-line treatments.[226] Selective Serotonin Reuptake Inhibitors (SSRIs) are used off-label to treat major depressive disorder and generalized anxiety in adolescents.[227] Combined hormonal contraceptives or progesterone-only contraceptive methods are used off-label to treat heavy menstrual bleeding, premenstrual dysphoric disorder, and polycystic ovarian syndrome (but is used on-label for contraception).[228] Finally, clonidine is used off-label for anxiety, insomnia, and post-traumatic stress disorder (PTSD) (but is used on-label for attention deficit hyperactivity disorder (ADHD)).[229]

As we can see, "off-label" does not mean that a certain medication's use is experimental or unsafe. Off-label drug use is so common in pediatrics that off-label drugs are prescribed in over 20% of patient visits.[230] A 2021 study by Back et al. found that at least one medication was prescribed off-label in 28% of visits to children's hospitals in which medication was prescribed, and this rate increased to 75% of treatments in inpatient pediatric cardiac care.[231] Many medications are commonly used "off-label" to safely and effectively treat children and adolescents for a wide variety of purposes.

N. Desistance & Detransition Rates of Transgender Youth

This subject was discussed the fourteenth-most overall (14.3%, TIE) in the written testimony we analyzed. It was also the seventeenth-most discussed subject in proponent testimony (1.5%) and the seventh-most discussed subject in opponent testimony (43.3%). Proponents argued that if desistance and/or detransition rates of transgender youth are relatively low, then that should not be a basis to deny increasing access to permanent forms of GAC. Opponents argued that if desistance and/or detransition rates of transgender youth are relatively high, then that should be a basis to deny increasing access to permanent forms of gender-affirmative GAC.

"Desistance" rates are commonly brought up by opponents to argue that most children who identify as transgender "desist" from their transgender identification later in life, with the

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[226] *Id.* at 191.

[227] Boris Birmaher & David Brent, *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorders*, 46 Journal of the American Academy of Child & Adolescent Psychiatry 1503 (2007).

[228] Divya Hoon et al., *Trends in Off-Label Drug Use in Ambulatory Settings: 2006-2015*, 144 Pediatrics e20190896 (2019).

[229] Rama Yasaei & Abdolreza Saadabadi, *Clonidine*, *in* StatPearls (2022), http://www.ncbi.nlm.nih.gov/books/NBK459124/ (last visited Nov 2, 2022).

[230] COMMITTEE ON DRUGS et al., *Off-Label Use of Drugs in Children*, 133 Pediatrics 563 (2014); Divya Hoon et al., *Trends in Off-Label Drug Use in Ambulatory Settings: 2006-2015*, 144 Pediatrics e20190896 (2019).

[231] Julia Back et al., *Evidence of support used for drug treatments in pediatric cardiology*, 4 Health Sci Rep e288 (2021).

most commonly cited number being 85%. However, it is often unclear or contradictory what this "85% desistance rate" is referring to. Some opponents use this term to refer to minors who previously identified as transgender who "resolved" those feelings and identified with their gender assigned at birth. Others use the same or similar statistics to refer to minors who "grow out of" a diagnosis of gender dysphoria.

As a point of clarification, a "trans-identification" and a medical diagnosis are not the same. A child can identify as transgender without a diagnosis of gender dysphoria. However, regardless of which definition of "desistance" is put forth, the ways that opponents present peer-reviewed evidence to support this claim is misleading at best. At worst, their misuse may lead to many believing (incorrectly) that transgender children are simply going through a phase and will be harmed by affirmative intervention when they would have otherwise had a happier life without it.

The five most common primary sources cited to obtain an average "desistance" rate are: (1) Drummond et al., 2008;[232] (2) Singh, 2012 and/or Singh et al., 2021;[233] (3) Steensma et al., 2011;[234] (4) Steensma et al., 2013;[235] and (5) Wallien & Cohen-Kettenis, 2008.[236] These studies were conducted with samples of gender-nonconforming children in two different clinics in Canada and the Netherlands.[237] [238]

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[232] Kelley D. Drummond et al., *A follow-up study of girls with gender identity disorder*, 44 Dev Psychol 34 (2008).

[233] Devita Singh, Susan J. Bradley & Kenneth J. Zucker, *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Front Psychiatry 632784 (2021); Devita Singh, Susan J. Bradley & Kenneth J. Zucker, *A Follow-Up Study of Boys With Gender Identity Disorder*, Mar. 29, 2021, https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full (last visited Oct 18, 2022) (Note: the 2012 source is a doctoral dissertation that was the basis for the 2021 publication; they are both referring to the same data).

[234] Thomas D. Steensma et al., *Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study*, 16 Clin Child Psychol Psychiatry 499 (2011).

[235] Thomas D. Steensma et al., *Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study*, 52 J Am Acad Child Adolesc Psychiatry 582 (2013).

[236] Madeleine S. C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual outcome of gender-dysphoric children*, 47 J Am Acad Child Adolesc Psychiatry 1413 (2008).

[237] Other sources that are sometimes referenced include: Richard Green, The Sissy Boy Syndrome: The Development of Homosexuality (1987), https://www.jstor.org/stable/j.ctt1ww3v4c (last visited Oct 18, 2022); Robert J. Kosky, *Gender-disordered children: does inpatient treatment help?*, 146 Medical Journal of Australia 565 (1987); Charles W. Davenport, *A follow-up study of 10 feminine boys*, 15 Arch Sex Behav 511 (1986); Bernard Zuger, *Early Effeminate Behavior in Boys: Outcome and Significance for Homosexuality*, 172 The Journal of Nervous and Mental Disease 90 (1984); John Money & Anthony J. Russo, *Homosexual Outcome of Discordant Gender Identity/Role in Childhood: Longitudinal Follow-Up1*, 4 Journal of Pediatric Psychology 29 (1979); Bernard Zuger, *Effeminate behavior present in boys from childhood: Ten additional years of follow-up*, 19 Comprehensive Psychiatry 363 (1978); Phil S. Lebovitz, *Feminine Behavior in Boys: Aspects of Its Outcome*, 128 AJP 1283 (1972); and Harry Bakwin, *DEVIANT GENDER-ROLE BEHAVIOR IN CHILDREN: RELATION TO HOMOSEXUALITY*, 41 Pediatrics 620 (1968). However, these older studies come from a different era where the primary research concern was to prevent homosexuality or transsexualism in effeminate boys, rather than to study the persistence of transgender identities or gender dysphoria.

[238] As a further point of clarification, "desist" is also sometimes used synonymously with "detransition." However, "detransition" typically refers to the reversal of medical procedures associated with gender transition,

All five of these papers utilized data collected before the introduction of "gender dysphoria" into the fifth addition of the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM) in 2013:

> *Gender dysphoria* refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.[239]

The previous diagnosis, "gender identity disorder of childhood" (GIDC), was overly broad and did not require a desire or insistence that one is "the other sex" to meet the threshold for diagnosis.[240] The diagnostic criteria included a preference "for wearing only stereotypical masculine clothing," "preferences for cross-sex roles in make-believe play," "[an] intense desire to participate in the stereotypical games and pastimes of the other sex," and "strong preferences for playmates of the other sex."[241] In their 2008 study referenced above, Wallien and Cohen-Kettenis discussed how this could have meant that they were inappropriately counting many children as "desisters," meaning that the percentage of actual desisters would have been much lower than what they found:

> Some critics have expressed concerns that the DSM criteria may not adequately differentiate children with GID from children who show healthy gender nonconforming behavior and that, as a consequence, children who should not be classified as having a psychiatric disorder would be treated. . . . [W]e believe that the percentage of desisters could be much lower than it is now.[242]

Beyond this inadequate diagnosis, there are other problems with using the five aforementioned studies to make claims about the prevalence of "desistance." The 2021 study by Singh et al. reports a desistance rate of 87.8% in a study of 139 boys from the mean years of

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rather than the cessation of an identity or diagnosis more commonly associated with transgender youth. These sources are more concerned with the latter. While their use in estimating desistance rates will be critiqued shortly, it would be inaccurate to claim these are studies of "detransitioning" youth.

[239] American Psychiatric Association, Diagnostic And Statistical Manual Of Mental Disorders, Fifth Edition (2013), https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425787 (last visited Oct 20, 2022).

[240] Julia Temple Newhook et al., *A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children*, 19 International Journal of Transgenderism 212 (2018).

[241] American Psychological Association, *Diagnostic and Statistical Manual of Mental Disorders, 3rd ed., revised (DSM-III-R)*, 145 AJP 1301 (1988); American Psychological Association, *Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV)*, 152 AJP 1228 (1995).

[242] Madeleine S. C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual outcome of gender-dysphoric children*, 47 J Am Acad Child Adolesc Psychiatry 1413 (2008).

1989 at the start and 2002 at follow up.[243] However, 51 (36.7%) of all the boys were subthreshold for the DSM-III, III-R, or IV criteria for gender identity disorder.[244] Yet, 46 of those 51 youths were classified as "desisters."[245] This begs the question: what did they desist from?

The 2008 study by Drummond et al. of 25 girls using data collected from 1975 to 2004 has an identical issue.[246] Ten of the girls in the study (or 40% of the participants) were subthreshold for a GID diagnosis, and yet nine of them were still classified as "desisters."[247] The 2013 study by Steensma et al., which followed 127 adolescents from 2008 to the follow-up in 2012, found a desistance rate of 63%.[248] Yet, once again, 47 (37%) of all these adolescents were subthreshold for a DSM-IV-TR diagnosis of GID.[249] Of those 47 subthreshold adolescents, 44 were still classified as "desisters."[250] Lastly, 35% of the "desisters" in the 2008 study by Wallien and Cohen-Kettenis did not receive a full GID diagnosis as children.[251]

Compounding these issues is the fact that the term "desister" often lacks an explicit definition in these studies, and the implicit definition is often contradictory. The 2012 dissertation by Singh states that "[s]tudies have generally found that not all boys with GID persist in having GID through adulthood and, in fact, the majority desist[,]"[252] which implies that "desisting" refers to no longer having a diagnosis of GID. However, as previously discussed, individuals who never received a GID diagnosis are often categorized as "desisters" in these studies. Likewise, the 2008 study by Drummond et al. begins its abstract by saying "[t]his study provided information on the natural histories of 25 girls with gender identity disorder (GID)" before informing us that 10 of said girls were not ever diagnosed with GID.[253] According to Dr. Kenneth Zucker, a prolific researcher in the field of gender and sexuality, the terms "persistence" and "desistance" originate from his stumbling across the terms in a paper reporting on the rates

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[243] Devita Singh, Susan J. Bradley & Kenneth J. Zucker, *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Front Psychiatry 632784 (2021) (Note: the 2012 source is a doctoral dissertation that was the basis for the 2021 publication; they are both referring to the same data).

[244] *Id.*

[245] *Id.*

[246] Kelley D. Drummond et al., *A follow-up study of girls with gender identity disorder*, 44 Dev Psychol 34 (2008).

[247] *Id.*

[248] Thomas D. Steensma et al., *Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study*, 52 J Am Acad Child Adolesc Psychiatry 582 (2013).

[249] *Id.*

[250] *Id.*

[251] Madeleine S. C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual outcome of gender-dysphoric children*, 47 J Am Acad Child Adolesc Psychiatry 1413 (2008).

[252] Devita Singh, Susan J. Bradley & Kenneth J. Zucker, *A Follow-Up Study of Boys With Gender Identity Disorder*, Mar. 29, 2021, https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full (last visited Oct 18, 2022).

[253] Kelley D. Drummond et al., *A follow-up study of girls with gender identity disorder*, 44 Dev Psychol 34 (2008).

of persistence and desistance of oppositional defiant disorder: "*At the time, the terms sounded pretty cool to me. . . .*"[254] It seems that the terms were borrowed from research on behavioral disorders without much justification or formal adaptation to research on gender identity, especially after the APA evolution for GIDC to GDC diagnoses.

That being said, the 2011 and 2013 studies by Steensma et al. included subthreshold children in their research because these studies were not designed to find *rates* of persistence or desistance, but rather to find *reasons* for persistence or desistance. Steensma has gone on record stating that this study was not designed to find desistance rates, and that "[p]roviding these [desistance] numbers will only lead to wrong conclusions."[255]

Furthermore, the studies commonly cited by opponents also suffer severely from issues of external validity. As stated earlier, the five commonly-cited studies by opponents used data collected from only two clinics: one in Toronto, Canada and one in the Netherlands. Many of the children in the Toronto studies[256] were enrolled in a treatment program that sought to "lower the odds" that they would grow up to be transgender.[257] Dr. Kenneth Zucker wrote the following about the clinic's approach: "*[I]n our clinic, treatment is recommended to reduce the likelihood of GID persistence*."[258] This clinic was closed in 2015 after an external report concluded that their corrective model was contrary to currently recognized professional norms.[259] While the Netherlands clinic[260] did not discourage children from exploring their gender expression, it did discourage children from socially transitioning prior to puberty.[261]

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[254] Kenneth J. Zucker, *The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al. (2018)*, 19 International Journal of Transgenderism 231 (2018).

[255] Jon Brooks, *The Controversial Research on "Desistance" in Transgender Youth*, KQED (2018), https://www.kqed.org/futureofyou/441784/the-controversial-research-on-desistance-in-transgender-youth (last visited Feb 9, 2023).

[256] Devita Singh, Susan J. Bradley & Kenneth J. Zucker, *A Follow-Up Study of Boys With Gender Identity Disorder*, 12 Front Psychiatry 632784 (2021); Kelley D. Drummond et al., *A follow-up study of girls with gender identity disorder*, 44 Dev Psychol 34 (2008).

[257] Julia Temple Newhook et al., *A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children*, 19 International Journal of Transgenderism 212 (2018).

[258] Kenneth J. Zucker et al., *A Developmental, Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder*, 59 Journal of Homosexuality 369, 393 (2012).

[259] Suzanne Zinck & Antonio Pingnatiello, *External Review of the Gender Identity Clinic of the Child, Youth and Family Services in the Underserved Populations Program at the Centre for Addiction and Mental Health*, (2015), https://www.transadvocate.com/wp-content/uploads/GIC-Review-26Nov2015-TA1.pdf (last visited Feb 9, 2023).

[260] Thomas D. Steensma et al., *Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study*, 16 Clin Child Psychol Psychiatry 499 (2011); Madeleine S. C. Wallien & Peggy T. Cohen-Kettenis, *Psychosexual outcome of gender-dysphoric children*, 47 J Am Acad Child Adolesc Psychiatry 1413 (2008).

[261] Julia Temple Newhook et al., *A critical commentary on follow-up studies and "desistance" theories about transgender and gender-nonconforming children*, 19 International Journal of Transgenderism 212 (2018).

In short, due to a lack of consistent definitions for "desistance," overly-inclusive criteria for an inadequate and outdated diagnosis that is often not even met by all "desisters," and other significant issues identified with the literature commonly cited by opponents, it is unlikely that the 85% desistance statistic is an accurate reflection of modern practices. This is especially misleading when given to the general public as proof that "transgender children are most likely going through a phase." One recent 2022 study by Olson et al. looked specifically at rates of persistence of gender self-identification.[262] Of 317 youth who initially identified as transgender, 94% identified as binary transgender five years later.[263] Only 2.5% identified as cisgender, and 3.5% identified as nonbinary, something that was rarely reported in previous studies that focused on GICD.[264] In fact, in the 2011 study by Steensma et al., a self-identified bigender patient was classified as a desister because they did not want to seek medical intervention,[265] further demonstrating that "desistance" in the studies cited by opponents do not always accompany an identification with one's gender assigned at birth.

This is not to say that all or even most children with a "proper" diagnosis of gender dysphoria or self-identification as transgender will persist with that identity into adulthood and/or desire medical intervention. However, without proper definitions of variables across (or at the very least within) studies, this data cannot be credibly cited to argue that we should not expand access to GAC. It also bears mentioning that, as noted previously in the "Satisfaction, Regret, & Reversibility of Gender-Affirmative Care" section of this report, any form of gender affirming care that these "desistors" had received prior to "desisting," such as social transition and puberty blockers, are completely reversible.

O. Federal & State Law Applications to Gender-Affirmative Care

This subject was discussed the sixteenth-most overall (6.1%) in the written testimony we analyzed. It was also the fifteenth-most discussed subject in proponent testimony (2.9%, TIE) and the tenth-most discussed subject in opponent testimony (13.3%, TIE). Proponents argued that if it is legally permissible to expand access to GAC (or if current laws would require it), then this should not be an objection to expanding access to it under Medicaid. Opponents argued that if it is not legally permissible to expand access to GAC, then this should be an objection to expanding access to it under Medicaid.

The primary federal statute to consider is Section 1557 of the Affordable Care Act (ACA), which states in relevant part: "an individual shall not . . . be excluded from participation

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[262] Kristina R. Olson et al., *Gender Identity 5 Years After Social Transition*, 150 Pediatrics e2021056082 (2022).
[263] *Id.*
[264] *Id.*
[265] Thomas D. Steensma et al., *Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study*, 16 Clin Child Psychol Psychiatry 499 (2011).

in, be denied the benefits of, or be subjected to discrimination under, any health program or activity [on the basis of sex]."[266]

The United States Department of Health and Human Services (HHS) has taken regulatory action throughout the past several administrations to interpret Section 1557 with respect to how they believe it protects transgender people. In 2016, HHS issued several regulatory provisions that interpreted Section 1557 to prohibit discrimination based on gender identity.[267] Although these provisions were removed in 2020 under the Trump Administration, the Biden Administration's proposed rule interpreting Section 1557 of the ACA would reinstate the prohibitions against discrimination on the basis of gender identity.[268] Under the Biden Administration, HHS argued in their announcement[269] that this is consistent with the Supreme Court's recent ruling in *Bostock v. Clayton County*, where the Court concluded that employers violated Title VII of the Civil Rights Act of 1964 when they fired a long-time employee shortly after the employee revealed that she was transgender.[270] Here, the Court ruled that it was impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual on the basis of sex.[271] Consequently, failing to cover GAC could result in the HHS withholding federal funds since it could constitute discrimination on the basis of sex, especially once this rule is finalized.

There are also several courts who have held that the statutory language of Section 1557 prohibits discrimination based on gender identity as a form of sex discrimination pursuant to the same rationale that the Court set out in *Bostock*. For example, a federal district court in Wisconsin held in 2019 that the state's ban on Medicaid coverage for GAC violated Section 1557 because the state engaged in "a straight forward case of sex discrimination" by covering certain procedures for people whose sex matched their gender identity, but not for those whose sex and gender identity did not match.[272] That court also held that discrimination against transgender individuals is by its nature discrimination based on sex and sex stereotypes,[273] and they even came to that conclusion a year before the Court came to the same conclusion in *Bostock*. Another federal district court in West Virginia held in 2022 that their state's ban on GAC violated the Affordable Care Act, following the reasoning of the Court's analysis in *Bostock*.[274]

[266] 42 U.S.C.S. § 18116 (citing 20 U.S.C.S. § 1681).
[267] 42 C.F.R. §§ 440.262, 438.206(c)(2), 438.3(d)(4) (2018).
[268] 87 F.R. 47824 (proposed Aug. 4, 2022).
[269] Office for Civil Rights (OCR), *HHS Announces Proposed Rule to Strengthen Nondiscrimination in Health Care*, HHS.gov (2022), https://www.hhs.gov/about/news/2022/07/25/hhs-announces-proposed-rule-to-strengthen-nondiscrimination-in-health-care.html (last visited Feb 9, 2023).
[270] *Bostock v. Clayton Cty.*, 140 S. Ct. 1731 (2020).
[271] *Id.*
[272] *Flack v. Wis. Dep't. of Health Servs.*, 328 F. Supp. 3d 931, 947-48 (W.D. Wis. 2018).
[273] *Id.* at 948-51.
[274] *Fain v. Crouch*, _ F. Supp. 3d _, 2022 WL 3051015 (S.D. W. Va. 2022). That being said, other courts have held that discrimination based on gender identity is not a form of sex discrimination prohibited by Section 1557 of

The other federal statute to consider is the Medicaid Act, which was discussed in an earlier section of this report. As mentioned previously, the baseline requirements set out under federal law for state Medicaid programs are: (1) the Availability Provision, which requires that states provide medical assistance to all categorically needy individuals; and (2) the Comparability Provision, which requires that assistance must be provided equally among individuals within beneficiary groups.[275]

Some federal courts have interpreted these provisions to require states to provide GAC to transgender Medicaid beneficiaries. For example, a federal district court in New York held in 2016 that the state's blanket ban on Medicaid coverage for some gender-affirmative surgeries violated the Availability Provision by barring coverage for treatments that could be medically necessary for transgender beneficiaries.[276] That same court also held that the ban violated the Comparability Provision by covering treatments that were excluded by their state's ban for individuals with diagnoses other than gender dysphoria.[277] Federal courts in Wisconsin and West Virginia have also held that state bans on GAC violated the Availability and Comparability provisions for similar reasons.[278]

It is also possible that the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution supports access to GAC under state Medicaid programs. However, there are cases currently pending on this issue, so this is an area that we would like to take up further in a future version of this report.

There are several Maryland state regulations and laws which may apply as well. For example, Maryland regulation requires that "[a] [Managed Care Organization] shall provide medically necessary gender reassignment surgery and other somatic specialty care for members with gender identity disorder."[279] Maryland law also states that government units and employees may not discriminate on the basis of sex.[280]

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the ACA. *See Franciscan All., Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016); Office for Civil Rights, *Fact Sheet: HHS Proposes to Revise ACA Section 1557 Rule*, U.S. Dep't Health & Hum. Servs. (May 24, 2019), https://www.hhs.gov/sites/default/files/factsheet-section-1557.pdf (noting the District Court of North Dakota enjoined the application of the Final Rule to two plaintiffs because the court concluded *Franciscan Alliance* was persuasive).

[275] 42 U.S.C. §§ 1396a(a)(10)(A)–(B) (2018).

[276] *Cruz v. Zucker*, 195 F. Supp. 3d 554, 570, 576 (S.D.N.Y. 2016).

[277] *Id.* at 576. *See also Davis v. Shah*, 821 F.3d 231, 258 (2d Cir. 2016) ("[The Comparability Provision] prohibits discrimination among individuals with the same medical needs stemming from different medical conditions.").

[278] *Flack v. Wisc. Dept' of Health Servs.*, No. 18-cv-309-wmc (W.D. Wisc. Aug. 16, 2019); *Fain v. Crouch*, _ F. Supp. 3d _, 2022 WL 3051015 (S.D. W. Va. 2022).

[279] COMAR 10.67.06.26-3.

[280] Md. Code, State Government, § 20-901.

Opponents seem to focus on two main arguments concerning the legality of providing GAC: (1) whether GAC is experimental in nature,[281] and (2) the role of the State in limiting children's ability to make life-altering decisions. The former argument comes from the idea that the State has a "significant role to play in regulating the medical profession"[282] and that the State's authority to regulate the medical field is even stronger "in areas where there is medical and scientific uncertainty."[283] The latter argument is based on the State's interest in "protecting the physical and psychological wellbeing of minors"[284] and how the State will often limit the ability for children to make life-altering decisions since they often lack the "experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them."[285]

Both of these arguments are primarily evidentiary in nature and are addressed in previous sections of this report. To reiterate, GAC is *not* experimental in nature. This is why the Federal District Court for the Eastern District of Arkansas recognized that the use of gender-affirming interventions as specified under modern medical standards is supported by all mainstream pediatric organizations, representing thousands of accredited physicians across multiple disciplines.[286] Furthermore, there are several studies demonstrating that transgender adolescents are capable of providing informed consent with the help of parents and trained physicians. This was discussed in an earlier section of this report.

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[281] *Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 697, 711 (D.C. Cir. 2007) (finding no "right to procure and use experimental drugs that is deeply rooted in our Nation's history and traditions" including requests by "terminally ill patients" to obtain "experimental drugs that have passed limited safety trials but have not been proven safe and effective")."

[282] *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007).

[283] *Id.* at 163; *see also Kansas v. Hendricks*, 521 U.S. 346, 360 n.3 (1997) ("[I]t is precisely where such disagreement exists that legislatures have been afforded the widest latitude in drafting such statutes.")

[284] *Sable Communications of Cal., Inc. v. FCC*, 492 U.S. 115, 126 (1989).

[285] *Bellotti v. Baird*, 443 U.S. 622, 635 (1979).

[286] *Brandt v. Rutledge*, 551 F. Supp. 3d 882 (E.D. Ark. 2021).

LEAD AUTHOR ACKNOWLEDGEMENTS

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Elton Högklint: Thank you for providing substantive feedback on the penultimate draft of the report, for your help preparing for our final presentations, and for your substantial help preparing the report to be made public.

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A DATA-DRIVEN POLICY GUIDE TO

GENDER-AFFIRMATIVE CARE

AUTHORS

Riley Grace Roshong, Justin Gibson

Elton Högklint, Scott Oatley

We conducted a qualitative analysis of all the written testimony for two bills on Gender-Affirmative Care (GAC) submitted in 2022: HB0746/SB0682 in Maryland (which sought to increase access to GAC), and HB0454 in Ohio (which sought to decrease access to GAC) to determine what subjects witnesses focused on and how often. Then, we reviewed and summarized the relevant academic literature on most subjects we identified. These are the findings on eight of our top subjects.

Overall	Pro	Anti
1st 84.7%	1st 88.2%	4th 76.7%

Effects of Gender-Affirmative Care on Mental & Physical Health

Overall, the current academic literature on Gender-Affirmative Care (GAC) shows that: (1) GAC has very positive effects on the mental health of transgender people and successfully alleviates their gender dysphoria; (2) GAC has few or no negative effects on physical health; and (3) any side effects that do exist are typically offset by an overall higher quality of life.

Overall	Pro	Anti
2nd 70.4%	4th 70.6%	5th 70.0%

Modern Medical Standards for Gender-Affirmative Care

The World Professional Organization for Transgender Health (WPATH) Standards of Care (SoC) for the Health of Transgender and Gender Diverse People have been subject to rigorous peer review and widely used as the medical standards of care for transgender people for decades.

Overall	Pro	Anti
3rd 59.2%	3rd 79.4%	11th 13.3%

Alleged Purpose(s) of Medicaid (Ex: Medical Necessity & Bodily Autonomy)

GAC is medically-necessary healthcare because: (1) it is administered for the treatment of gender dysphoria or gender incongruence pursuant to the ICD-11; (2) it is administered consistent with the WPATH SoC; and (3) transgender patients who pursue GAC are assessed by medical professionals who meet the requirements set out by the WPATH SoC.

Overall	Pro	Anti
4th 58.2%	2nd 83.3%	18th 0.0%

Cost & Similar Barriers to Gender-Affirmative Care

Transgender people are often unable to access GAC due to: (1) costs, (2) lack of available providers, (3) lack of provider training, and (4) discrimination by providers.

Overall	Pro	Anti
5th 44.9%	8th 26.5%	2nd 86.7%

Satisfaction, Regret, & Reversibility of Gender-Affirmative Care

Overall, the current literature shows that: (1) not all forms of GAC are irreversible, and (2) that transgender people are generally satisfied with the GAC they receive. To the extent that GAC causes sterility, transgender people can still achieve reproduction by pursuing fertility cryopreservation before beginning GAC.

Overall	Pro	Anti
6th 42.9%	5th 57.4%	13th 10.0%

Minority Stress & Effects of Gender-Affirmative Care on How Trans People Are Treated in Society

GAC is also important to alleviate the minority stress faced by transgender people as a highly stigmatized and discriminated minority, which can have a significant impact on other areas of their life such as reducing their risk of suicide and increasing their overall well-being.

Overall	Pro	Anti
8th 32.7%	13th 10.3%	3rd 83.3%

Whether Being Trans is an Intrinsic Quality

While transgender identity was historically regarded as a mental disease or defect, this is now out-of-date with current practice which regards transgender identity as an intrinsic quality, due in part to several factors: (1) the historic failure of Gender Identity Change Efforts (GICE); (2) the growing body of literature suggesting a biological basis for gender identity; and (3) the World Health Organization (WHO) now classifying gender dysphoria as a physical condition by recognizing that affirming transgender conceptions of one's body is what leads to the best health outcomes for transgender people.

Overall	Pro	Anti
9th 31.6%	14th 5.9%	1st 90.0%

Capability of Trans Youth to Provide Informed Consent

Medical intervention is not recommended under the WPATH SoC until adolescence (i.e., the beginning of puberty) and is only recommended for adolescents who–along with their parents or guardians–are able to demonstrate to a medical professional that they are capable of providing informed consent. Current academic literature also demonstrates that transgender adolescents are capable of providing informed consent to receive GAC.

Our full report–with all sections, citations, and recommendations–is available in the Witness List for HB0283 (2023) on the Maryland General Assembly website. Contact Riley Grace Roshong at rileygraceroshong@gmail.com for consultation or media inquiries.

GAC Report One Pager 2.26.23.pdf
Uploaded by: Riley Roshong
Position: FAV

A DATA-DRIVEN POLICY GUIDE TO

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Overall	Pro	Anti
1st 84.7%	**1st** 88.2%	**4th** 76.7%
2nd 70.4%	**4th** 70.6%	**5th** 70.0%
3rd 59.2%	**3rd** 79.4%	**11th** 13.3%
4th 58.2%	**2nd** 83.3%	**18th** 0.0%
5th 44.9%	**8th** 26.5%	**2nd** 86.7%
6th 42.9%	**5th** 57.4%	**13th** 10.0%
8th 32.7%	**13th** 10.3%	**3rd** 83.3%
9th 31.6%	**14th** 5.9%	**1st** 90.0%

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Transgender people are often unable to access GAC due to: (1) costs, (2) lack of available providers, (3) lack of provider training, and (4) discrimination by providers.

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Our full report–with all sections, citations, and recommendations–is available in the Witness List for HB0283 (2023) on the Maryland General Assembly website. Contact Riley Grace Roshong at rileygraceroshong@gmail.com for consultation or media inquiries.

2023 ACNM SB 460 Senate Side FWA.pdf
Uploaded by: Robyn Elliott
Position: FAV

Committee:	**Senate Finance Committee**
Bill number:	**SB 460 - Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)**
Hearing Date:	**February 28, 2023**
Position:	**Support with Amendments**

The Maryland Affiliate of the American College of Nurse Midwives (ACNM) supports *Senate Bill 460 - Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)*. The bill would update coverage policies for gender-affirming care under the Maryland Medicaid Program.

In a position statement, our national organization stated that, "ACNM supports efforts to provide transgender and gender non-binary (TGNB) people with access to safe, comprehensive, culturally-responsive, and respectful health care." [i] Gender-affirming care is health care, and insurance plans, whether public or private, should provide equitable coverage. Coverage is particularly essential for gender-affirming care, as the TGNB community faces many other challenges, such as employment discrimination, a high risk of violent assault, and high rates of serious behavioral health issues, including suicide. Gender-affirming care is both life-changing and life-saving.

We request consideration of two amendments:

1) On page 2 in line 30, insert "OR CERTIFIED" after "LICENSED".

   Explanation: Advanced practice registered nurses (APRNs), including nurse-midwives, are certified rather than licensed. APRNs do provide gender-affirming care.

2) On page 4 in lines 31-33 and page 5 in lines 1 through 17, the bill requires the Department of Health to publish a list of practitioners who provide gender-affirming care. We strongly support more resources to connect individuals to gender-affirming care. However, we are very concerned that a listing of practitioners could compromise the safety of gender-affirming practitioners. As a result, some practitioners may be dissuaded from offering gender-affirming care because of the safety risks. We would be pleased to work with

stakeholders and the Department to determine alternative language that supports creating resources for connecting people to gender affirming care.

We ask for a favorable report with the amendments we have suggested. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

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[i] https://www.midwife.org/acnm/files/acnmlibrarydata/uploadfilename/000000000326/ACNM--PS--Care%20for%20TGNB%20People-%20Final_1.pdf

2023 LCPCM SB 460 Senate Side FAV.pdf
Uploaded by: Robyn Elliott
Position: FAV

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 460**

Title: **Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)**

Hearing Date: **February 28, 2023**

Position: **Support**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) supports *Senate Bill 460 – Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)*. The bill would modernize Maryland Medicaid's coverage of gender-affirming treatment to reflect current best practices.

Maryland Medicaid currently excludes many gender-affirming services from coverage because the services are considered "cosmetic." There is a growing recognition among experts that these service denials "reflect a long history of labeling medical care for transgender people as unnecessary, unproven, and unworthy of payment[.]"[i] This bill recognizes that many services sometimes considered "cosmetic" are medically necessary for transgender patients. In addition to addressing symptoms of gender dysphoria, treatments to align outward appearance with a patient's gender identity can decrease the risk of experiencing discrimination and violence.[ii]

By modernizing our state's Medicaid program, we will ensure that more patients can access all medically necessary gender-affirming care. We as for a favorable report. If we can provide any additional information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

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[i] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6549509/#R1
[ii] https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf

2023 MCHS SB 460 Senate Side FAV.pdf
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Position: FAV

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill: **Senate Bill 460 – Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)**

Hearing Date: **February 28, 2023**

Position: **Support**

Maryland Community Health System strongly supports *Senate Bill 460 – Maryland Medical Assistance Program - Gender-Affirming Treatment (Trans Health Equity Act)*. The bill ensures that Medicaid covers all medically necessary gender-affirming care.

Maryland Community Health System is a network of federally qualified health centers committed to providing services to the underserved, which includes individuals who need gender-affirming care. Maryland Medicaid does currently cover gender-affirming care but many services are excluded.[i] The justification for these exclusions is often that they excluded services are "cosmetic." However, there is a growing recognition in the medical community that often the "demarcation between 'necessity' and 'cosmetic' in transgender…is in direct opposition to the scientific community's understanding of gender dysphoria and professional guidelines for transgender health."[ii] This bill recognizes that for many transgender patients certain services that are traditionally considered "cosmetic" such as hair alterations or facial surgery are actually medically necessary in order to address gender dysphoria. Passing HB 283 will ensure that Maryland Medicaid's coverage of gender-affirming care reflects current best practices for caring for transgender patients.

We ask for a favorable report, and we stand ready to assist the Committee in every way possible in this endeavor. If we can be helpful in any way, please let us know by contacting Robyn Elliott at relliott@policypartners.net.

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[i] https://mmcp.health.maryland.gov/mcoupdates/documents/pt_37_16.pdf
[ii] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6549509/#R1

2023 MNA SB 460 Senate Side FAV.pdf

Uploaded by: Robyn Elliott

Position: FAV

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 460 - Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)**

Hearing Date: **February 28, 2023**

Position: **Support**

The Maryland Nurses Association (MNA) supports *Senate Bill 460 – Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)*. The bill ensures that Medicaid covers all medically necessary gender-affirming care.

MNA works to promote healthcare consumer safety, access to care, education, and self-determination, which includes supporting individuals in gender-affirming care. Maryland Medicaid does currently cover gender-affirming care but many services are excluded.[i] The justification for these exclusions is often that they excluded services are "cosmetic." However, there is a growing recognition in the medical community that often the "demarcation between 'necessity' and 'cosmetic' in transgender…is in direct opposition to the scientific community's understanding of gender dysphoria and professional guidelines for transgender health."[ii] This bill recognizes that for many transgender patients certain services that are traditionally considered "cosmetic" such as hair alterations or facial surgery are actually medically necessary in order to address gender dysphoria.

Passing this bill will ensure that Maryland Medicaid's coverage of gender-affirming care reflects current best practices for caring for transgender patients. We ask for a favorable report. If we can provide any additional information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

[i] https://mmcp.health.maryland.gov/mcoupdates/documents/pt_37_16.pdf
[ii] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6549509/#R1

2023 Moveable Feast SB 460 Senate Side FAV.pdf

Uploaded by: Robyn Elliott

Position: FAV

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 460 - Maryland Medical Assistance Program – Gender– Affirming Treatment (Trans Health Equity Act)**

Hearing Date: **February 28, 2023**

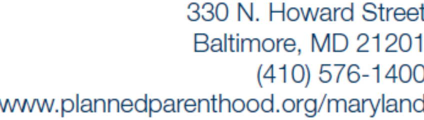
Position: **Support**

Moveable Feast strongly supports *Senate Bill 460 - Maryland Medical Assistance Program - Gender-Affirming Treatment (Trans Health Equity Act).* Our mission is to improve the health and quality of life of people with serious illnesses through nutritional counseling and medically-tailored meals.

We provide services to many members of the LGBTQ community and have seen the importance of gender-affirming treatment. Maryland Medicaid currently excludes many gender-affirming services from coverage, claiming they are "cosmetic." However, we know how important having one's outward appearance match one's gender identity is in addressing symptoms of gender dysphoria. This bill will end the antiquated restrictions and ensure that more transgender Marylanders can access needed care.

We urge a favorable report on this legislation in order to modernize our Medicaid program. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net.

2023 PPM SB 460 Senate Side FAV.pdf
Uploaded by: Robyn Elliott
Position: FAV



Planned Parenthood of Maryland

Committee: **House Health and Government Operations Committee**

Bill Number: **House Bill 1148 - Behavioral Health Care – Treatment and Access**

Hearing Date: **February 28, 2023**

Position: **Support**

Planned Parenthood of Maryland supports *House Bill 1148 – Behavioral Health Care – Treatment and Access*. The bill, while mostly about behavioral health, includes telethealth provisions regard reimbursement for all health care services. The bill extends two provisions of SB 3/HB 123 which are set to sunset at the end of June 2023: 1) reimbursement for audio-only services; and 2) reimbursement parity for telehealth services. It is critical that Maryland continue these policies to ensure the health care system can meet the needs of patients for somatic, behavioral health, and dental care.

A recent report from the Maryland Health Care Commission observed that the telehealth use during the pandemic "demonstrated the utility of telehealth and the potential of telehealth to address disparities in access to care."[i] In reproductive health, telehealth has been critical in supporting access to a wide range of services including birth control, abortion, and prevention of HIV.

We ask for a favorable report. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

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[i] https://mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/hit_tlth_study_recommendations.pdf

SB 460_Disability Rights Marland_fav.pdf
Uploaded by: Sam Williamson
Position: FAV

Empowerment. Integration. Equality.

1500 Union Ave., Suite 2000, Baltimore, MD 21211
Phone: 410-727-6352 | Fax: 410-727-6389
www.DisabilityRightsMD.org

SUPPORT – SB 460
Maryland Medical Assistance Program – Gender-Affirming Treatment
Trans Health Equity Act
Senate Finance Committee
February 28, 2023

Chair Griffith and Members of the Committee,

Thank you for the opportunity to provide written testimony in support of Senate Bill 460, on behalf of Disability Rights Maryland (DRM). DRM is a legal nonprofit and Maryland's federally designated Protection & Advocacy agency. DRM is dedicated to advancing the civil rights of people with disabilities.

Maryland's Medicaid program currently fails to cover the full range of medically necessary, gender-affirming healthcare. Every major medical organization has endorsed the medical necessity of this care, including the American Medical Association and the World Health Organization.[1]

By withholding necessary coverage, Maryland is deepening a crisis among a community that already faces disparate health burdens. Strikingly, 39% of transgender individuals have one or more disabilities, compared to 15% of the general population.[2] It is no surprise that failing to provide adequate treatment for a medical condition, such as gender dysphoria, leads to significant long-term health consequences.

Providing full coverage for gender-affirming care is also legally required. Multiple federal courts have found that states violated nondiscrimination provisions in the Affordable Care Act when they withheld coverage for gender-affirming care.[3] Likewise, federal Medicaid regulations require providing coverage in sufficient "amount, duration, and scope" and coverage must be comparable across beneficiary groups. By targeting specific procedures for exclusion when they are prescribed for gender dysphoria, Maryland Medicaid is violating Medicaid regulations.[4]

DRM urges the Committee to follow medical best practices and issue a favorable report on SB 460. Thank you for your consideration. Please contact Sam Williamson at 410-727-6352 or SamW@DisabilityRightsMd.org with any questions.

---

[1] *AMA fights to protect health care for transgender patients*, American Medical Association, https://www.ama-assn.org/health-care-advocacy/advocacy-update/march-26-2021-state-advocacy-update; Virginia Macdonald, *et al.*, *The World Health Organization's work and recommendations for improving the health of trans and gender diverse people*, 25 J. of International AID Society S5 (2022), https://onlinelibrary.wiley.com/doi/10.1002/jia2.26004.

[2] Health Disparities at the Intersection of Disability and Gender Identity: A Framework and Literature Review, Disability Rights Education & Defense Fund (July 2018) at 2, https://dredf.org/wp-content/uploads/2018/07/Health-Disparities-at-the-Intersection-of-Disability-and-Gender-Identity.pdf.

[3] *Fain v. Crouch*, – F. Supp. 3d –, 2022 WL 3051015, *12 (S.D. W. Va. 2022); *Cruz v. Zucker*, 195 F. Supp. 3d 554, 581 (S.D.N.Y. 2016); *Flack v. Wisconsin Dep't of Health Servs.*, 395 F. Supp. 3d 1001, 1015 (W.D. Wis. 2019).

[4] *See Fain*, 2022 WL 3051015, *13-14; *Cruz*, 195 F. Supp. 3d at 577; *Flack*, 395 F. Supp. 3d at 1019.

SB460_SponsorAmendment
Uploaded by: Senator Mary Washington
Position: FAV

SB0460/783027/1

AMENDMENTS PREPARED BY THE DEPT. OF LEGISLATIVE SERVICES

27 FEB 23
14:30:22

BY: Senator M. Washington
(To be offered in the Finance Committee)

AMENDMENT TO SENATE BILL 460
(First Reading File Bill)

On page 4, in line 33, after "**INCLUDES**" insert "**, FOR EACH HEALTH CARE PROVIDER OFFERING GENDER–AFFIRMING TREATMENT WITH WHICH THE MANAGED CARE ORGANIZATION HAS AN ACTIVE CONTRACT AND THAT CONSENTS TO THE INCLUSION**".

On page 5, in line 1, strike "**EACH**" and substitute "**THE**"; strike beginning with "**OFFERING**" in line 2 down through "**CONTRACT**" in line 3; in line 3, strike "**AND**"; in line 5, strike "**EACH**" and substitute "**THE**"; in the same line, after "**PROVIDER**" insert "**; AND**

(III) WHETHER THE HEALTH CARE PROVIDER CONSENTS TO BEING PUBLICLY LISTED AS PART OF THE DEPARTMENT'S ANNUAL REPORT REQUIRED UNDER PARAGRAPH (2) OF THIS SUBSECTION";

in line 9, after "**INCLUDE**" insert "**, FOR EACH HEALTH CARE PROVIDER OFFERING GENDER–AFFIRMING TREATMENT TO PROGRAM RECIPIENTS AND WHOSE CONSENT TO THE INCLUSION IS INDICATED IN A REPORT SUBMITTED UNDER PARAGRAPH (1) OF THIS SUBSECTION**"; in line 10, strike "**EACH**" and substitute "**THE**"; in line 11, strike "**OFFERING GENDER–AFFIRMING TREATMENT TO PROGRAM RECIPIENTS**"; and in lines 13 and 15, in each instance, strike "**EACH**" and substitute "**THE**".

To___THEA Support Letter (1).pdf
Uploaded by: Sharon Blugis
Position: FAV

Senate Bill 460
Maryland Medical Assistance Program – Gender-Affirming Treatment
Trans Health Equity Act
February 28, 2023
Support

Dear Chair Griffith, Vice Chair Klausmeier, and members of the Senate Finance Committee,

Pro-Choice Maryland is submitting this testimony in support of SB460, the Maryland Medical Assistance Program – Gender-Affirming Treatment Trans Health Equity Act, which would expand Maryland Medicaid to cover lifesaving gender-affirming care. Maryland has long been a safe haven for people seeking care that isn't available in their own states. In continuing to be a haven state, we must protect the people who are on the front lines of offering both abortion care and gender-affirming care without equivocation. Pro-Choice Maryland fully supports the autonomy and protection of trans people and their care providers.

We respectfully urge this committee to return a favorable report on SB460.

Sincerely,

Sharon Blugis
Interim Executive Director
Pro-choice Maryland

SB 460_ Gender Affirming Treatment (TransHealthEqu

Uploaded by: Stacey Jefferson
Position: FAV

February 28, 2023

Senate Finance Committee
TESTIMONY IN SUPPORT

SB 460 Maryland Medical Assistance Program-Gender-Affirming Treatment
(Trans Health Equity Act)

Behavioral Health System Baltimore (BHSB) is a nonprofit organization that serves as the local behavioral health authority (LBHA) for Baltimore City. BHSB works to increase access to a full range of quality behavioral health (mental health and substance use) services and advocates for innovative approaches to prevention, early intervention, treatment and recovery for individuals, families, and communities. **Baltimore City represents nearly 35 percent of the public behavioral health system in Maryland, serving over 77,000 people with mental illness and substance use disorders (collectively referred to as "behavioral health") annually.**

Behavioral Health System Baltimore supports SB 460- Maryland Medical Assistance Program- Gender-Affirming Treatment (Trans Health Equity Act) This bill requires the Maryland Medical Assistance Program provide gender-affirming treatment and prohibiting them from an adverse benefit determination related to gender-affirming treatment unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed or confirmed the appropriateness of the determination.

BHSB supports SB 460 as it will allow equitable access to vital health care services for transgender people. Research shows that access to gender-affirming medical care is linked to better mental health outcomes. A 2020 study of transgender adults 18 and older found that access to gender affirming care during adolescence was associated with a lower risk of suicidality. It also found that approximately nine out of ten transgender adults who wanted gender affirming care during adolescence but didn't receive it experienced suicidal ideation at some point in their lifetime. [1]

Current Maryland Medicaid policies create barriers to accessing adequate medical care for trans Marylanders. Without adequate medical care they are exposed to discrimination, harassment, and interpersonal violence. This can also lead to negative behavioral health outcomes. An American Psychological Association report shows the impact of discrimination on adults can lead to a state of heightened vigilance and changes in behavior, which can trigger stress responses. This toxic stress has a negative impact on both physical and mental health. [2]We must continue to protect our most vulnerable Marylanders. **As such, BHSB urges the Senate Finance Committee to support SB 460**

[1] Yurcaba, Jo. *Trans Youth with Access to Early Medical Care Have Access to Better Mental Health Outcomes.* Very Well Mind: Mental Health News, 2020

[2] Schreiber, Katherine. *Why Transgender People Experience More Mental Health Issues*. Psychology Today, 2016.

SB 460_MD Center on Economic Policy_FAV.pdf
Uploaded by: Stacey Jefferson
Position: FAV

FEBRUARY 28, 2023

Gender-Affirming Treatment is Essential Health Care

Position Statement Supporting Senate Bill 460

Given before the Senate Finance Committee

Every Marylander deserves to get the essential health care they need not just to survive, but to thrive. For transgender Marylanders, that essential health care includes gender-affirming treatments. **The Maryland Center on Economic Policy supports Senate Bill 460 because it will ensure low-income Marylanders enrolled in Medicaid can access the same types of gender-affirming treatment as those with private insurance.**

Maryland's Medicaid program currently uses outdated standards, developed 20 years ago, to govern decisions about the types of care available to low-income transgender people who rely on Medicaid to pay for their health care. SB 460 would enact updated standards that would allow more types of gender-affirming treatment to be covered through Medicaid. At least 9 other states, including Virginia, and Washington, D.C., already provide more robust care, and the services included in SB 460 are all eligible for federal reimbursement. Given the small number of transgender Marylanders enrolled in Medicaid, any impact on the state's share of Medicaid costs would be very minimal.

Ensuring more people can access gender-affirming care supports improved mental health and could reduce instances of workplace and housing discrimination that transgender people too often face. Because of chronic stress linked to discrimination, people who are transgender are up to three times more likely than the general population to have a mental health or substance use disorder[i]. That's why major medical associations including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics all consider comprehensive treatment for transgender people to be essential health care.

The 2015 U.S. Transgender Survey showed that transgender Marylanders face much higher levels of poverty and economic instability than others in the state[ii]:

- 9% of respondents were unemployed at the time of the survey, about double the statewide average at that time, and more than 1 in 5 reported incomes below the federal poverty level.
- 1 in 4 respondents reported experiencing various types of employment discrimination because of their gender identity or expression, such as being fired, not being hired, or being denied a promotion.
- Nearly 1 in 4 respondents also reported experiencing housing discrimination in the past year, such as being evicted or being denied a home or apartment, because of their gender identity or expression. 28% reported experiencing homelessness at some point in their lives.
- 31% refrained from seeing a medical provider due to affordability concerns.

It also found that 29% of respondents experienced at least one negative encounter with a healthcare provider due to being transgender. Unsurprisingly, more than 1 in 5 respondents refrained from seeking medical assistance for fear of mistreatment.

Moreover, research shows that providing gender-affirming care can make a great difference for transgender individuals. Associations with gender-affirming care include[iii][iv]:

- A 73% drop in suicidal ideation
- A 60% drop in depression
- Reduction in rates of HIV transmission
- Reduction in rates of drug use and overdose

Ensuring people can afford and received needed health care would be a significant step toward greater health and economic security for transgender Marylanders. **For these reasons, the Maryland Center on Economic Policy respectfully requests the Finance Committee to make a favorable report on Senate Bill 460.**

Equity Impact Analysis: Senate Bill 460

Bill Summary

SB 460 would require the Maryland Medical Assistance Program to cover gender-affirming treatment for transgender Marylanders. It would also prohibit the program from denying benefits unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the determination.

Background

Maryland's Medicaid program currently uses outdated standards, developed 20 years ago, to govern decisions about the types of care available to low-income transgender people who rely on Medicaid to pay for their health care. Private insurers are generally prohibited from denying coverage for gender-affirming treatment. SB 460 would enact updated standards that would allow more types of gender-affirming treatment to be covered through Medicaid. At least 9 other states, including Virginia and Washington, D.C., already provide more robust care, and the services included in SB 460 are all eligible for federal reimbursement.

Equity Implications

The 2015 U.S. Transgender Survey showed that transgender Marylanders face much higher levels of poverty and economic instability than others in the state:

- 9% of respondents were unemployed at the time of the survey, about double the statewide average at that time, and more than 1 in 5 reported incomes below the federal poverty level.
- 1 in 4 respondents reported experiencing various types of employment discrimination because of their gender identity or expression, such as being fired, not being hired, or being denied a promotion.
- Nearly 1 in 4 respondents also reported experiencing housing discrimination in the past year, such as being evicted or being denied a home or apartment, because of their gender identity or expression. 28% reported experiencing homelessness at some point in their lives.

Health equity means everyone has a fair and accessible opportunity to attain their highest level of health, especially for those who have been historically excluded from quality care. In Maryland, over half (54%) of transgender adults identify as a person of color. [v] Transgender people of color face even more pervasive challenges due to the combined impact of anti-transgender bias and racism. One national survey found that[vi]:

- Black transgender people had an extremely high unemployment rate at 26%, two times the rate of the overall transgender sample and four times the rate of the general population.
- 41%of Black respondents said they had experienced homelessness at some point in their lives, more than five times the rate of the general U.S. population.
- Black transgender people lived in extreme poverty with 34% reporting a household income of less than $10,000 per year. This is more than twice the rate for transgender people of all races (15%), four times the general Black population rate (9%), and eight times the general U.S. population rate (4%).

Impact

Senate Bill 460 will likely **improve racial, gender, and economic equity** in Maryland.

---

[i]"Health Insurance Coverage for Gender-affirming Care of Transgender Patients", 2019. https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf

[ii] National Center for Transgender Equality, 2015 U.S. Transgender Survey: Maryland State Report. https://transequality.org/sites/default/files/USTS%20MD%20State%20Report.pdf

[iii] Tordoff, D.M., et al. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open, 5*(2). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423

[iv] Padula, W.V., et al. (2016). Societal implications of health insurance coverage for medically necessary services in the U.S. transgender population: A cost-effectiveness analysis. *Journal of General Internal Medicine, 31*(4), 394-401. SOI:10.1007/s11606-015-3529-6

[v] "How Many Adults and Youth Identify as Transgender in the United States?" (2022). https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/

[vi] "New Analysis Shows Startling Levels of Discrimination Against Black Transgender People," National LGBTQ Task Force. https://www.thetaskforce.org/new-analysis-shows-startling-levels-of-discrimination-against-black-transgender-people/

SB460_FAV_MCHI.pdf
Uploaded by: Stephanie Klapper
Position: FAV

TESTIMONY IN SUPPORT OF SENATE BILL 460
Trans Health Equity Act
Before the Senate Finance Committee
By Stephanie Klapper, Deputy Director Maryland Citizens' Health Initiative, Inc.
February 28, 2023

Chair Griffith, Vice Chair Klausmeier, and Members of the Senate Finance Committee, thank you for this opportunity to testify in support of Senate Bill 460. Special thank you to Senator Mary Washington for being the lead sponsor for the bill. I am submitting this testimony on behalf of our individual organization, Maryland Citizens' Health Initiative, Inc., as we have not reviewed this legislation with the full Maryland Health Care for All! Coalition. Our mission is to ensure that all Marylanders have access to quality affordable health care coverage. This bill ensures that the Maryland Medical Assistance Program will provide gender-affirming treatment in a nondiscriminatory manner. Currently Marylanders with private health coverage through Maryland Health Connection are able to access gender transition care that Marylanders enrolled in Medicaid cannot. The vulnerability of this community means this gap in services results in other health inequities based on the social determinants of health for trans Marylanders. Gender-affirming care has been shown to dramatically increase mental health and wellbeing, and multiple major medical associations support comprehensive care for the trans community including the American Medical Association and American Academy of Pediatrics. I urge the Committee to pass SB 460.

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SB460 Testimony Tina Jones.pdf
Uploaded by: Tina Jones
Position: FAV

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Tina Grace Jones (she/her)
Deputy Executive Director
tjones@freestate-justice.org

The Honorable Melony G. Griffith, Chair
Senate Finance Committee
Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401
February 26, 2023

Testimony of FreeState Justice

IN SUPPORT OF SENATE BILL 460

To the Honorable Chair Griffith, Vice Chair Klausmeier, esteemed committee members:

My name is Tina Jones and I serve as the Deputy Executive Director for FreeState Justice, Maryland's lesbian, gay, bisexual, transgender, and queer (LGBTQ+) civil rights advocacy organization. I also am the co-founder of the Delmarva Pride Center and the founder and facilitator of Delmarva Gender Expression Movement (GEM) a transgender support group on the Eastern Shore. I stand before you today as a transgender woman who knows firsthand the importance of providing the medical services covered by the Trans Health Equity Act.

Living without the ability to be myself for most of my life took an emotional and physical toll on me. I was depressed, I drank too much. I engaged in unsafe behaviors. I was unable to be there for my family in the way I should have been. Even with years of therapy I saw myself as less than a person. Eventually I attempted suicide.

I was hospitalized and spent another 15+ years in therapy. Things only changed when I accepted myself. But personal acceptance was not enough. I needed to physically change..

I was lucky. I had good insurance. I was able to get the surgeries I needed. I will never forget waking up from surgery, looking down and crying. But I still needed more. Because I waited until later in life, I had a deep voice, facial hair, and male pattern baldness. I continued to suffer trauma at the hands of strangers. I was shunned. I was labeled a pedophile and groomer. I received death threats.

Those things changed when I was able to address my voice, my beard, and my hair. I am extremely fortunate. I was able to pay for those things. Today I am a proud, confident woman because of the wonderful care I received.. Those procedures saved my life.

We live in the greatest nation in the world yet we struggle with saving the lives of those who are different. We often use cost as the reason for not doing the right thing. We struggled with funding HIV research in the 80's when thousands of people were dying. We have struggled with providing services to people of color throughout our history.

None of us deserves to be forced to live a life of trauma, bias, harm and possible death because of who we are. None of us should be forced to forgo life saving medical care because we cannot afford it. We are all human, we all matter. Please, show your support for our community. Please issue a favorable report on SB 460.

Thank you,

Tina Grace Jones (she/her)
Deputy Executive Director

Alexa Rodriguez THEA Testimony FWA.pdf
Uploaded by: Brige Dumais
Position: FWA

HB283: Trans Health Equity Act of 2023

Position: Favorable with Sponsor Amendments

My name is Alexa Rodriguez, I am the Director of Trans Latinx DMV. Our mission is to advocate for the needs that specifically affect the Trans-Latinx community and strategize ways to improve the community's quality of life in our region. I'm also a member of 1199SEIU United Healthcare Workers E, the largest healthcare workers union in the country, with over 10,000 members in Maryland/DC. I support the Trans Health Equity Act, and we urge the Committee to issue a **favorable** report, **including sponsor amendments**. This bill will allow low-income transgender patients to access lifesaving, medically necessary gender affirming healthcare (GAC).

I'm a transgender patient and a provider of gender affirming healthcare. As a provider I see a lot of people like me- people living with HIV, trans folks who are immigrants and many of them undocumented – struggling to access GAC that is medically necessary and ultimately life-saving. I hear so many stories from trans patients who can't afford GAC that break my heart. As a trans care provider, I know how to treat my community because I am part of that community – so I can confidently say from personal and professional experience that GAC is medically necessary.

Many trans women who have not received GAC have so called "masculine" features like a strong forehead that present in our faces, so people tend to see us as different, which puts us at risk of discrimination and violence. Trans people, especially Black & Brown transgender women, are disproportionately targets of violent attacks at the hands of people who hate us simply because we are transgender. When we are able to get GAC, we are less "noticeably trans" to people who seek to harm us, so GAC allows us to move through the world more safely.

I medically transitioned when I was 25 years old. Because I didn't have access to hormone treatments when I was younger, I developed "masculine" features, so I needed GAC to live as my true self. Adults like me who transition later in life often need GAC for feminization of the forehead or jawline, hair removal, voice training and more. When I first started working at Whitman Walker and I was working with trans patients from Virginia. Virginia didn't have GAC like what I and my patients needed classified as a medical necessity. A year ago, Virginia changed their policy and now GAC is covered by Medicaid. Since then, I have seen the health and well-being of my transgender patients from Virginia improve drastically. I want my transgender patients who live in Maryland to have that same access to care and a better life. <u>If Virginia can do this, so can (and should) Maryland!</u>

I support Delegate Anne Kaiser's amendment to require consent from healthcare providers to have our names listed on a public directory. This amendment as it is important for the safety of healthcare workers. Please vote **YES** on this life saving legislation and amendment to expand access to healthcare for transgender Marylanders.

In Unity,
Alexa Rodriguez

Andrea Speedie THEA Testimony FWA.pdf
Uploaded by: Brige Dumais
Position: FWA

Trans Health Equity Act of 2023
Position: Favorable with Sponsor Amendments

Chair Peña-Melnyk and Members of the Health & Government Operations Committee,

My name is Dr. Andrea Speedie, I am a Family Medicine Physician at Chase Brexton Health Care, and a member of 1199SEIU United Healthcare Workers East. We are the largest healthcare workers union in the country, with over 10,000 members in Maryland and Washington DC. Our union supports HB283 – the Trans Health Equity Act, and we urge the Committee to issue a **favorable** report, including **sponsor amendments**. This legislation will allow low-income transgender patients to access lifesaving, medically necessary gender affirming healthcare.

HB 283 is essential to the work that we do as physicians for our transgender patients. It will codify the care that we currently provide and assure a peace of mind to a group who faces sometimes life-threatening vulnerabilities within the public and private sphere. And at this time, a vulnerability that extends to their basic right of access to healthcare. As a legislature you can provide this peace of mind that assures people that their lives are valuable, that the care that they receive is valued, respected and guaranteed.

I don't feel that it is necessary for legislatures to understand the care that we give, to understand how providing for someone's mental and physical health, offering them a pathway to reconciling their identities, can save their lives. I think it is necessary that you to trust us. We are the same people you trust with your needs, your children's, your parents'. Trust that the care we provide to transgender people is critical to their wellbeing and long-term health outcomes and that the decisions we make, like all healthcare decisions, are best made between the provider and patient.

I'm afraid that I cannot give you one patient's story because I am overwhelmed the the lives of the thousands of patients we serve. But please know that this is some of the most impactful work I do as a Family Physician and I thank you for ensuring I can continue to do it.

I support Delegate Anne Kaiser's amendment to require consent from healthcare providers to have our names listed on a public directory of providers who specialize in gender-affirming healthcare, rather than mandating all providers be listed as the current bill draft requires. I urge the Committee to adopt this amendment as it helps to ensure accuracy in the listing and is important for the safety of healthcare workers and their families. Please vote **YES** on this life saving legislation to expand access to healthcare for transgender Marylanders.

In Unity,

Andrea Speedie, MD, *speedieandrea@gmail.com*

Brige Dumais THEA Testimony FWA.pdf
Uploaded by: Brige Dumais
Position: FWA

HB283: Trans Health Equity Act of 2023
Maryland Medical Assistance Program – Gender-Affirming Treatment
Position: Favorable with Sponsor Amendments

Chair Peña-Melnyk and Members of the Health & Government Operations Committee,

My name is Brige Dumais and my pronouns are they/them. I am the Political Coordinator with 1199SEIU United Healthcare Workers East, the largest healthcare workers union in the nation. We represent 10,000 members who work in hospitals and Long-Term Care facilities across Maryland/DC. Hundreds of our members work at LGBTQ community health centers that provide gender affirming healthcare (GAC), including Chase Brexton in Maryland and Whitman Walker in DC; and we represent union members who are Trans & Queer. Our union supports HB283: the Trans Health Equity Act to require the Maryland Medical Assistance Program to cover medically necessary gender-affirming treatment. We urge the committee to issue a **favorable** report including the **sponsor amendment**.

Transgender people are more likely to live in poverty than our cisgender counterparts, so there is a gap in the ability of low-income transgender people in Maryland to access affordable GAC. Transgender Marylanders are currently being forced to navigate an unjust, tiered healthcare system where certain **medially necessary** GAC is not covered through Medicaid. Transgender patients' ability to have health insurance that covers GAC should not be based on their employer's willingness to provide health insurance in the first place, and certainly should not be subject to any employer's potential biases against transgender people that would cause the employer to deliberately not provide insurance plans that cover GAC. **The medical necessity of GAC, like any other healthcare, should be a decision made between a patient and their healthcare provider.**

GAC is lifesaving healthcare. Access to GAC improves the overall quality of life for transgender people by drastically reducing the risk of depression and suicide, being targeted by anti-trans violence, and other types of discrimination and stigmatization that trans people face.

1199SEIU supports Delegate Anne Kaiser's amendment to require consent from healthcare providers to have our names listed on a public directory. This amendment as it is important for the safety of healthcare workers. Please vote **YES** on this life saving legislation and amendment to expand access to healthcare for transgender Marylanders.

In Unity,

Brige Dumais, Political Coordinator
1199SEIU United Healthcare Workers E.
brigette.dumais@1199.org

Claudia Martinez THEA Testimony FWA.pdf
Uploaded by: Brige Dumais
Position: FWA

Trans Health Equity Act of 2023
Maryland Medical Assistance Program – Gender-Affirming Treatment
Position: Favorable with Sponsor Amendments

Chair Peña-Melnyk and Members of the Health & Government Operations Committee,

My name is Claudia Martinez. I am a [TITLE] at Whitman Walker, and a member of 1199SEIU United Healthcare Workers East. We are the largest healthcare workers union in the country, with over 10,000 members in Maryland and Washington DC. Our union supports HB283 – the Trans Health Equity Act, and we urge the Committee to issue a **favorable** report, including **sponsor amendments**. This legislation will allow low-income transgender patients to access lifesaving, medically necessary gender affirming healthcare.

Access to gender affirming healthcare (GAC) for transgender patients is life changing for the better. Too many trans people end up dead when we are not living our authentic life as the gender we truly are. There are very high rates of depression and suicide, as well as being the targets of violence, in the transgender community – this is made even worse when transgender people can't afford GAC. Passing HB283 can help prevent these hardships. It will literally save lives.

I support Delegate Anne Kaiser's amendment to require consent from healthcare providers to have our names listed on a public directory of providers who specialize in gender-affirming healthcare, rather than mandating all providers be listed as the current bill draft requires. I urge the Committee to adopt this amendment as it is important for the safety of healthcare workers.

Transgender people are taxpayers too, so we deserve to get the healthcare we need through Medicaid that we help pay for. We demand to be treated with dignity and respect. Please vote **YES** on this life saving legislation to expand access to healthcare for transgender Marylanders.

In Unity,

Claudia Martinez
dmvcmartinez@gmail.com

Daniel Mendoza THEA Testimony FWA.pdf
Uploaded by: Brige Dumais
Position: FWA

Trans Health Equity Act of 2023
Maryland Medical Assistance Program – Gender-Affirming Treatment
Position: Favorable with Sponsor Amendments

Chair Peña-Melnyk and Members of the Health & Government Operations Committee,

My name is Daniel Mendoza, I am a Trans Rights Activist, and a member of 1199SEIU United Healthcare Workers East. We are the largest healthcare workers union in the country, with over 10,000 members in Maryland and Washington DC. Our union supports HB283 – the Trans Health Equity Act, and we urge the Committee to issue a **favorable** report, including **sponsor amendments**. This legislation will allow low-income transgender patients to access lifesaving, medically necessary gender affirming healthcare.

HB 283 is important because as a Trans person who had my own gender affirming surgery and care covered by my employer's coverage, I know many who do not have that luxury. These friends and community members continue to fight for their life saving care to be covered as often times the difference between being able to see yourself reflected back in the mirror or not is life or death. Passing this bill would not only save lives of many Marylanders, but it would also improve that quality of life.

I support Delegate Anne Kaiser's amendment to require consent from healthcare providers to have our names listed on a public directory of providers who specialize in gender-affirming healthcare, rather than mandating all providers be listed as the current bill draft requires. I urge the Committee to adopt this amendment as it is important for the safety of healthcare workers.

Please vote **YES** on this life saving legislation to expand access to healthcare for transgender Marylanders.

In Unity,

Daniel Mendoza
Daniel.mendoza@1199.org

Diego Contreras THEA Testimony FWA.pdf
Uploaded by: Brige Dumais
Position: FWA

Trans Health Equity Act of 2023
Maryland Medical Assistance Program – Gender-Affirming Treatment
Position: Favorable with Sponsor Amendments

Chair Peña-Melnyk and Members of the Health & Government Operations Committee,

My name is Diego Contreras, I am a Social Work Case Manager at Chase Brexton Health Care, and a member of 1199SEIU United Healthcare Workers East. We are the largest healthcare workers union in the country, with over 10,000 members in Maryland and Washington DC. Our union supports HB283 – the Trans Health Equity Act, and we urge the Committee to issue a **favorable** report, including **sponsor amendments**. This legislation will allow low-income transgender patients to access lifesaving, medically necessary gender affirming healthcare.

HB 283 is important because it recognizes something that should have been recognized a long time ago, that no matter your gender identity you are entitled to gender-affirming care. In my personal journey, I have benefited from my insurance covering gender-affirming care. Gender-affirming therapists helped me better understand my gender identity questions and feelings. Gender-affirming medical providers helped me understand my options. And gender-affirming health and mental health organizations helped me to connect with other people dealing with gender identity needs so that we could help each other through this journey. But I was only able to do this because I had private insurance. I would hope that someone who is in a situation where they cannot afford private insurance could also receive these services that help to reduce the anxiety and depression that one can experience from not addressing one's gender identity needs.

As a healthcare worker I was able to witness the benefits in people of having gender-affirming care be covered by Medicaid. When I worked at Whitman-Walker Health, a community health organization that provides gender-affirming care to the Washington DC metro area it was great to see how our patients who lived in DC and sought gender-affirming care were able to get that care through DC Medicaid because Washington, DC had already recognized the importance of this type of care. I also saw my coworkers' lives transformed by the type of gender-affirming care that they were able to receive, which helped them continue to provide great care for the community we served. This is why I think it is only right that you vote Yes on this life saving legislation to finally stop the denial of gender-affirming care of transgender Marylanders.

Additionally, I support Delegate Anne Kaiser's amendment to require consent from healthcare providers to have our names listed on a public directory of providers who specialize in gender-affirming healthcare, rather than mandating all providers be listed as the current bill draft requires. I urge the Committee to adopt this amendment as it is important for the safety of healthcare workers.

In Unity,
Diego Contreras, diego.a.contreras@outlook.com

Jess Freidman THEA Testimony FWA.pdf
Uploaded by: Brige Dumais
Position: FWA

Trans Health Equity Act of 2023
Maryland Medical Assistance Program – Gender-Affirming Treatment
Position: Favorable with Sponsor Amendments

Chair Peña-Melnyk and Members of the Health & Government Operations Committee,

My name is Jessica Friedman, I am a Family Physician at Chase Brexton Health Care in Baltimore, MD, and a member of 1199SEIU United Healthcare Workers East. We are the largest healthcare workers union in the country, with over 10,000 members in Maryland and Washington DC. Our union supports HB283 – the Trans Health Equity Act, and we urge the Committee to issue a favorable report, including sponsor amendments. This legislation will allow low-income transgender patients to access lifesaving, medically necessary gender affirming healthcare.

I provide gender affirming hormone therapy to transgender and gender diverse adults with gender dysphoria at Chase Brexton. Gender dysphoria is a medical diagnosis that describes the distress someone experiences related to the mismatch between their biological sex and their gender identity. For many of my patients, the hormones and surgeries already covered by Maryland Medicaid address their gender dysphoria. However, I have patients whose primary sources of distress are their facial features, hair growth patterns, or voice pitch; there are medical therapies and procedures available to address these issues for patients with commercial insurance, however my patients with Medicaid are unable to afford and access them. These treatments and therapies are not cosmetic, but rather a necessary part of providing gender affirming medical care. It is inequitable and unjust that low-income Marylanders cannot access them, and the Trans Health Equity act will remedy this.

I support Delegate Anne Kaiser's amendment to require consent from healthcare providers to have our names listed on a public directory of providers who specialize in gender-affirming healthcare, rather than mandating all providers be listed as the current bill draft requires. I urge the Committee to adopt this amendment as it is important for the safety of healthcare workers.
Please vote YES on this life saving legislation to expand access to healthcare for transgender Marylanders.

In Unity,
Jessica Friedman, MD, MPH
jessica.l.friedman@gmail.com

Joyce Jackson THEA Testimony FWA.pdf
Uploaded by: Brige Dumais
Position: FWA

Trans Health Equity Act of 2023
Maryland Medical Assistance Program – Gender-Affirming Treatment
Position: Favorable with Sponsor Amendments

Chair Peña-Melnyk and Members of the Health & Government Operations Committee,

My name is Joyce Jackson, I am a Senior Medical Assistant & Medical Administrator at Whitman Walker, and a member of 1199SEIU United Healthcare Workers East. We are the largest healthcare workers union in the country, with over 10,000 members in Maryland/DC. Our union supports HB283 – the Trans Health Equity Act, and we urge the Committee to issue a **favorable** report, including **sponsor amendments**. This legislation will allow low-income transgender patients to access lifesaving, medically necessary gender affirming healthcare (GAC).

The clinic where I work provides GAC. Without GAC, many of my transgender patients experience depression and isolation that lowers their quality of life. Transgender Marylanders want to be who they recognize themselves to be and to be able to live in the body they are comfortable living in no matter their financial status. Without passing the Trans Health Equity Act, the mental health of transgender Marylanders who need GAC but can't afford it will suffer. When my patients do get access to GAC, I see such a positive change in them. Their mental health and self-esteem improve drastically. That is why GAC is medically necessary.

My late brother was transgender. Back in the 70's, he did not have access to GAC at all. I wish he had the ability to get the GAC and be able to live in the body he wanted. This is one of the reasons I fight so fiercely on behalf of my transgender patients and the entire low-income transgender people of Maryland. I have a big heart and I believe *everyone*, no matter their gender or sexual orientation, deserves access to high quality, affordable healthcare.

I support Delegate Anne Kaiser's amendment to require consent from healthcare providers to have our names listed on a public directory of providers who specialize in gender-affirming healthcare, rather than mandating all providers be listed as the current bill draft requires. I urge the Committee to adopt this amendment as it is important for the safety of healthcare workers.

There should be no difference in access to healthcare through Medicaid for transgender patients in the DMV. Virginia Medicaid covers GAC and Washington DC Medicaid covers GAC, so Maryland needs to catch up and cover all GAC through Medicaid too! Please vote **YES** on this life saving legislation to expand access to healthcare for transgender Marylanders.

In Unity,
Joyce Jackson, Ladyjaye1@hotmail.com

Lauren Reichard THEA TestimonyFWA.pdf

Uploaded by: Brige Dumais

Position: FWA

Trans Health Equity Act of 2023
Maryland Medical Assistance Program – Gender-Affirming Treatment
Position: Favorable with Sponsor Amendments

Chair Peña-Melnyk and Members of the Health & Government Operations Committee,

My name is Lauren Reichard. I am a Registered Nurse in an Intensive Care Unit in Maryland, and I'm a member of 1199SEIU United Healthcare Workers East. We are the largest healthcare workers union in the country, with over 10,000 members in Maryland and Washington DC. Our union supports HB283 – the Trans Health Equity Act, and we urge the Committee to issue a **favorable** report, including **sponsor amendments**. This legislation will allow low-income transgender patients to access lifesaving, gender affirming healthcare.

As an RN, I want to be very clear that gender affirming healthcare (GAC) is medically necessary. Without GAC, transgender people experience both psychological and biological distress. Transgender people who "look" transgender face a lot of stigma that is traumatizing and damaging to their mental health. Furthermore, trans patients are less likely to seek healthcare for physical conditions like wounds and preventable illnesses -- I have had multiple patients who were transgender women that delayed coming to the hospital because they feared being stigmatized. If they had had access to affordable GAC, they may have been more confident in seeking medical treatment much sooner.

Passing the Trans Health Equity Act will of course improve access to healthcare for transgender patients by making GAC more affordable. It will also expand access because when GAC is covered by Medicaid, more medical providers will be willing to provide GAC to low-income transgender patients because the provider does not risk being stuck with the cost if a patient is not able to afford to pay their bill.

I support Delegate Anne Kaiser's amendment to require consent from healthcare providers to have our names listed on a public directory of providers who specialize in gender-affirming healthcare, rather than mandating all providers be listed as the current bill draft requires. I urge the Committee to adopt this amendment as it is important for the safety of healthcare workers.

In Maryland there is a consensus that healthcare decisions should be made between a patient and their medical provider when it comes to reproductive healthcare. That same logic applies to allowing us medical providers to determine with our patients that GAC is medically necessary. GAC helps trans people be able to live their lives as their true selves, and that liberating feeling improves overall quality of life. Please vote **YES** on this life saving legislation to expand access to healthcare for transgender Marylanders.

In Unity,
Lauren Reichard, RN
lereichard@gmail.com

Rachel Renee Smith THEA Testimony FWA.pdf
Uploaded by: Brige Dumais
Position: FWA

Trans Health Equity Act of 2023
Maryland Medical Assistance Program – Gender-Affirming Treatment
Position: Favorable with Sponsor Amendments

Chair Peña-Melnyk and Members of the Health & Government Operations Committee,

My name is Rachel Renee Smith I am a Behavioral Health Therapist and a member of 1199SEIU United Healthcare Workers East. We are the largest healthcare workers union in the country, with over 10,000 members in Maryland and Washington DC. Our union supports HB283 – the Trans Health Equity Act, and we urge the Committee to issue a **favorable** report, including **sponsor amendments**. This legislation will allow low-income transgender patients to access lifesaving, medically necessary gender affirming healthcare.

HB 283 is important because it will increase safety, health, and wellness for transgender people who rely on these health insurances, especially transgender feminine people of color who are more likely to suffer the effects of discrimination and negative social determinants of health outcomes due to lack of access to medically necessary health care. This bill will open access to so many who have otherwise been suffering. Many of the patients I work with have been negatively impacted by the absence of the equity that this bill is offering to bring.

I support Delegate Anne Kaiser's amendment to require consent from healthcare providers to have our names listed on a public directory of providers who specialize in gender-affirming healthcare, rather than mandating all providers be listed as the current bill draft requires. I urge the Committee to adopt this amendment as it is important for the safety of healthcare workers.

Please vote **YES** on this life saving legislation to expand access to healthcare for transgender Marylanders.

In Unity,

Rachel Rene Smith
turbones@gmail.com

SB0460 Testimony of Devon Ojeda on behalf of NCTE

Uploaded by: Devon Ojeda

Position: FWA

Dr. Devon Ojeda (They/He)
Senior National Organizer
dojeda@transequality.org

February 27, 2023

The Honorable Melony Griffith
Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

Testimony of the National Center for Transgender Equality Action Fund

In SUPPORT WITH AMENDMENTS of

SB0460: Trans Health Equity Act

To the Honorable Chair Griffith, Vice Chair Klausmeier, and esteemed members of the Senate Finance Committee:

The National Center for Transgender Equality Action Fund ("NCTE Action Fund") is a 501(c)(4) non-profit political advocacy organization affiliated with the National Center for Transgender Equality ("NCTE"). Founded in 2003, the NCTE works to improve the lives of the nearly two million transgender people in the United States and their families through sound public policy, public education, and groundbreaking research. NCTE has worked with countless health and human service providers as well as local, state, and federal agencies on policies to ensure equal access to vital health and human services. The NCTE Action Fund, launched in 2017, builds power for transgender people, our families, and our allies – to make our collective voice heard – so that together, we can change the landscape in this country to fully support transgender equality.

The NCTE Action Fund writes today in support of Senate Bill 460, which would expand access to medically-necessary, live-saving care for transgender Marylanders who receive healthcare through the state's Medicaid system. Due to recent attacks on providers of gender-affirming care across the country, however, we request that the reporting requirements in part D of the bill be amended so as to eliminate the risk that the well-intentioned report could be used to target care providers.

In addition, NCTE Action Fund is also submitting statements of 66 Marylanders in support of SB460. These statements, which were collected through a comment portal hosted by EveryAction and NCTE Action Fund, are attached as Appendix 1.

While Maryland is in the majority of states whose Medicaid programs explicitly include coverage for transition-related healthcare, it is fast becoming an outlier in the limitations that state places on just what transgender Marylanders on Medicaid are able to get covered. Under the March 2016 Managed Care Organizations Transmittal No. 110, which established coverage requirements for transition-related surgeries under Maryland's Medicaid program, over two dozen procedures or care related to procedures were excluded from coverage, including hair removal (a common prerequisite for a variety of surgical procedures), voice therapy, and even many surgical revisions or multi-stage surgeries. For example, coverage of multi-stage phalloplasties is expressly prohibited under the guidelines, ignoring both medical realities and the needs of specific patients.

While most state Medicaid regulations do not expressly outline the specific transition-related procedures that are excluded from coverage, a number of states do specifically provide that coverage will be provided for care currently excluded by Maryland, including California (hair removal, facial gender affirmation surgery), Colorado (hair removal, revision surgeries), Connecticut (hair removal, facial gender affirmation surgery, revision surgery), Hawaii (tracheal shave, hair removal, facial gender affirmation surgery, vocal therapy, vocal surgery),

Massachusetts (hair removal, facial gender affirmation surgery), Oregon (hair removal, facial gender affirmation surgery, revision surgery), Washington (hair removal, facial gender affirmation surgery, revision surgery), and the District of Columbia (tracheal shave, facial gender affirmation surgery). While Maryland's MCO Transmittal may have seemed a reasonable compromise when it was issued in March 2016, the state is fast falling behind our peer states in this area.

MCO Transmittal 110 also likely violates federal non-discrimination laws under Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of sex (including sexual orientation and transgender status) in programs receiving federal funds for healthcare. With additional regulations enforcing Section 1557 expected to go into force this year, Maryland's Medicaid system is at risk of an investigation or even enforcement action by the federal government if it does not bring coverage for transition-related care into line with federal requirements.

Even were Maryland's Medicaid policy not in contravention of federal law and out of step with our sibling states, the ongoing national moral panic around transition-related healthcare makes legislative all the more critical. Across the country, we have seen legislative and administrative attacks on transition-related care, whether in the form of stripping insurance coverage for care, threatening the medical licenses of physicians who provide care, or creating criminal penalties for medical providers or even family members who facilitate access to care. In this atmosphere, it is more crucial than ever for Maryland to encode access to transition-related care for transgender Marylanders, both to ensure that such care is not casually stripped away in the future and to send a message to transgender people across the country that they are deserving of human dignity.

But while the National Center for Transgender Equality Action Fund strongly supports Senate Bill 460, we believe that amendments are necessary to part D of the bill, which would require the Department of Health to compile and publish an annual report listing the names and locations of physicians and clinics providing transition-related care. While the initial intent of this reporting requirement – to ensure transgender Marylanders knew where they could seek care – was laudatory, political realities over the year since the prior version of HB283 was first introduced have made clear the report required under part D would likely put medical providers at risk of harassment, violence, and potentially death. Since August 2022, we have seen targeted attacks on providers of transition-related care, including Boston Children's Hospital, Vanderbilt University Medical Center, the Children's Hospital of Pittsburgh, the University of Wisconsin Health, and at least 20 other hospitals across multiple states. Given this reality, the NCTE Action Fund asks that part D of the bill be either significantly amended or removed.

I thank you for your time and urge a favorable report with amendment of Senate Bill 460.

Sincerely,

Dr. Devon Ojeda
Senior National Organizer
National Center for Transgender Equality Action Fund
dojeda@transequality.org

Appendix 1

#	Name	Testimony
1	Levitt, Howard	I support bill SB460. The federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics.
2	McMillan, Melody	I am writing this today in support of Bill SB460. As a Trans Woman currently residing in Maryland and going through the local healthcare system, I've seen first hand that these benefits and protections need to be put in place.
3	Schweitzer, Jillian	I absolutely support SB460. Gender affirming care has proven to reduce harm and improve the quality of life among those in need of the care. And every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics. Even the federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Please help Maryland be a safe care state!
4	Yadon, Hailey	My name is Hailey, and I'm writing to support SB460, to provide trans health equity for all Marylanders. As a 26 year old trans woman, I can personally attest that gender-affirming care is essential to the life and well-being of transgender people. Starting gender-affirming hormone therapy was the single greatest improvement to my mental and physical wellbeing I have ever experienced, and without it I would not be a healthy, happy, or functioning person today. This is not just my opinion; every major medical association recognizes gender-affirming care as medically necessary, and section 1557 of the Affordable Care Act describes it as an 'essential health benefit.' But there are many barriers to accessing this care in Maryland, especially for those without the financial means to afford private health insurance or pay out of pocket. SB460 will provide an enormous health benefit to one of the most vulnerable populations in Maryland, at very little cost. It deserves the support of every member of our legislature.
5	Entwistle, Jin	I should not be alive. My name is Jin, and I have had roughly 7 attempts at suicide. All of them have been related to my gender. Clearly, I'm not very good at killing myself- I'm thankful for that, now that I've been able to get help. Prior to my treatment with gender affirming healthcare, I struggled daily with severe depression. It felt like a cruel, satanic joke; I had to wake up in a body that felt so foreign, so fundamentally wrong, I couldn't force myself to even get out of bed. I couldn't force myself to be perceived, to be seen, to have anybody else know what my body was. I dressed only in large, baggy clothes, often wearing one outfit for weeks to months at a time. I didn't take care of myself, didn't eat or shower. There was just no point. Everything I did, when I did anything at all, felt hollow and numb. Pointless. Useless. I just wanted to stop having to wake up. Looking back at my life, there

		were extremely clear signs I've been trans since I was as little as 6. Some of them are so blatant I can't help but laugh; I recall an instance in middle school we were learning about eunuchs in history class. I cringed, and my classmate told me I couldn't feel anything because I wasn't a boy. I recall not understanding, and simply being baffled. I never thought anything else of it. My dysphoria manifested as an extreme form of depression, ranging from feeling extremely numb to having the overwhelming, debilitating urge to mutilate myself. To pick, prod, cut, to shape my body the way it would feel right by any means necessary. More often than not, I would stare at the mirror with a needle and thread and fantasize about how it would feel to finally look right. To feel right in my own body. It wasn't about weight, or influence, or anything but a deep, intuitive knowledge that who I was born as was wrong on the most basic level. I got better. Almost 6 months ago now, I finally began my medical transition. I fought so, so hard just to be able to feel hope again. Hope that things could be better for me. That things could change. I fought against my family, who reacted so poorly when I came out that I was forced back into the closet for over a decade. I fought against old white men or grimacing middle aged women who would take one look at me and decide that THEY knew me and my past and feelings better than I knew myself. I fought against myself. I fought against what my parents had drilled into me, my intense self-hate, my very core of being so angry and miserable and broken that I could never just feel okay. I went about it in an extremely dangerous way, before now. Nobody would help me, so I had to do it myself. I had no choice. I would be dead if I didn't. My ribs are bent and grooved, my skin scarred, and I'll never be able to breathe right again. I had to make binders myself because I was alone. I'll take that over being dead any day. I'm still not fully there. I still suffer on a daily basis, still make morbid jokes and still fuss with being able to feel okay. If I don't laugh about how I feel, I'll have to acknowledge that it's true. I've been fully medicated for over 5 years now, and no amount of anti-depressants or therapy has been able to change my gender dysphoria. It's not a joke. It's not a phase, or a trend. I can wake up in the mornings, get dressed, make myself meals and take care of myself because I've finally been allowed access to HRT. I'm on the path to becoming a lawyer in a year or two, and I'm a force to be reckoned with in and out of the classroom. Not only am I alive today because of gender affirming care, but I can finally start living to my full potential. This summer, I'll have surgery. I look forward to it with all my heart and soul. It's so hard to believe it's real, it's finally real, it's happening. Then, and only then, can I truly be fully at peace. My story serves as a guide for all who come after me, for all those who can't yet live comfortably in their own body. It speaks for itself about why this healthcare is vital to transgender individuals of all ages across the spectrum. Trans rights are under attack right now, with GAHC being outlawed and bills being passed in various states forcing people to either resort to their own means to do things or lay down and die. These are real, human lives at stake here. Trans rights ARE human rights.

6	Stewart, Cassandra	I am Cassandra, a 33-year-old transgender woman. I cannot overstate the positive effects that gender-affirming care has had on my life. I have so much more energy than I had before, and I use that energy to improve myself and help those around me. I can focus more. I can motivate myself more. It's not surprising—gender affirming care is a huge part of what lets trans people enjoy their bodies and themselves. I have been incredibly lucky to have private insurance that covers my HRT (albeit with repeated prior authorizations for refills) and savings to cover hair removal that simply isn't covered by my insurance. I am also lucky to have been able to access that gender-affirming care within months of realizing who I am. I cannot imagine the pain of crossing the hurdles of coming out to yourself, and then to those in your life and the world at large, and then simply being unable to afford the care you need. I support SB460 with my whole heart.
7	Marcus, Lisa	My son (assigned female at birth) came out as transgender at age 14. He was depressed and suicidal due to gender dysphoria. If he had not received gender-affirming care, including hormone therapy and a double mastectomy, I don't know if he would have survived to adulthood. He is now 24 and thriving, majoring in forestry in college and planning to work for the forest service. We were fortunate to be able to afford care for him at a time when our private health insurance did not cover trans care. Every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics. Trans kids and adults can thrive with the help of affirming health care. I'm part of an online support group for parents of trans kids, and every day I see testimony from parents in states where their kids can no longer get health care, even if they can afford it. Parents who are leaving their homes and jobs to move to states like MD where their kids have the same right to medical care that other kids do. It's not acceptable to deprive people of health care because of their gender. Please support SB460 and protect trans Marylanders. Thank you from a concerned mom.
8	Brown, Cydney	I'm a trans genderqueer person who navigates the medical system regularly to receive hormones and ultimately support my overall wellness. Having access to equitable care is very important to me and I think all trans folks should have accessible, affordable, and equitable healthcare access. The federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics. I support SB460 because I believe that gender affirming care is critical to trans community not just for physical wellness, but holistic wellness.

9	Gillelan, Sarah	SB460 would profoundly improve the lives of trans Marylanders and Americans, especially during a time of amplified hatred and violence coming from our own government. My partner, who is trans, has been taking hormones for 3 years, and he has never been more joyous and self-loving than he is now. I want to see all people who need this life-affirming care find that joy. I, myself, have opted to avoid gender-affirming care in the past because I was on Medicaid, and I knew the hurdles to get past to get coverage would be close to impossible. Those hurdles would come only after finding a PCP or GYN who would be willing to treat me, and among the ones who would may still need guidance on how to do it. This bill would make it easier for the socially and economically marginalized transgender people of Maryland to access what may be the most important medical care of their lives.
10	Evers, Tamara	I am writing in support of Bill SB460. This bill is important for families like mine. The federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics.
11	Mahoney, Eirnin	I am in support of bill SB460 because gender-affirming care dramatically changed my life for the better. Before I was able to start taking testosterone, I was really uncomfortable with the way my body and face looked, and the way my voice sounded. I felt disconnected from myself when I looked in the mirror, and it was painful for me to listen to any recordings of my voice. I loved performing in musical theater, but I couldn't really tell if my singing was good or not because I hated the sound of my voice so much. Then, I went on testosterone. Over the course of some months, my voice dropped, and I became proud of the way I sounded when I sang. My body and face shape changed, and I felt excited to look at myself in the mirror, rather than uncomfortable. And I finally grew facial hair, which I had been wishing for ever since I was a young teen. Now, I am taking steps towards getting top surgery, and the prospect of having that procedure in the next year or two makes me feel very excited. I often daydream about how handsome I'll look after surgery, and how I'll take my shirt off at the beach and feel the wind on my bare back and chest. Bill SB460 will make sure that every trans person on Medicaid in Maryland has access to these same life-changing opportunities. I have been lucky enough to access care using private insurance, but many trans people don't have that same privilege. There are more than just anecdotes to support this bill; the federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics.

12	Pillalamarri, Khiyali	Greetings. I strongly support SB460. Gender-affirming healthcare quite literally saves lives. As an LGBTQ teen with a lot of trans friends, I have seen it drastically improve the lives, health, and well-being of people I love. Moreover, it is a right to be able to seek the healthcare that you want and need. As such, it should be easy to access and to pay for -- which, too often, it isn't. Remove this barrier. The federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics. It is important that people be able to seek medically necessary care. Thank you.
13	torres, Cher	We all bleed the same and we all feel sad and happy and lonley and everything. Inside, god made us all the same.
14	Haaga, Candice	Dear Maryland Senators: I write as the parent of a trans adult daughter whom we love dearly. I support SB460 as a major step of humane progress in reducing health care inequities for Maryland transgender people on Medicaid who need Gender-Affirming health care. This is a small population, as only about 6,000 transgender Marylanders are enrolled in Medicaid. But this care can be life-saving, and -- - The federal government has named Gender-Affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. - Every major medical association agrees that Gender-Affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics. I've watched our adult trans daughter's journey over the years to get Gender-Affirming care, and it is simply out of reach financially for most people if not covered by health insurance. No one seeks gender-affirming care lightly, only out of deep need to live safely & with dignity as who they really are. Gender Dysphoria is a significant factor in the higher suicide rates for transgender folks, & so appropriate Gender-Affirming health care can literally be life-saving. The quality health care my daughter has received & continues to receive has helped her immensely to feel safer & much better mood & morale, so she can use more of her energy to live her life fully. I am deeply grateful for the health insurance coverage she was able to access (Medicaid in another state at one point) after she aged out of our family health insurance. SB460 will be Cost-Effective: - These Gender-Affirming services are federally reimbursable and cost only 0.005% of our Medicaid budget. - Maryland will save costs from reduced long-term physical and mental health complications, such as an 84% reduction in suicide attempts. - This medically necessary, life-saving care must be accessible for low-income Marylanders on Medicaid, just as it is under many private insurance plans. THANK YOU for supporting SB460 to insure that low-income transgender people can receive Gender-Affirming health care! Trans rights are human rights.

15	HERRMANN, ALEXANDER	I've since moved to another state, but I lived in MD until May of 2021. During part of that time, I was on Medicaid due to unemployment. I am a transgender man, and I needed gender affirming care in the form of hormones (Testosterone) and 'top surgery' (double mastectomy). I was very grateful to receive the care I needed, but all transgender people need this care, and I urge you to pass this bill. Thank you.
16	Hill, Kai	As a trans individual on government support. It is vital to provide essential care, benefits, and support for ALL individuals. There are larger issues to tend to than whether or not certain humans can have rights. It's 2023 and people need to get ober the fear of differences. If this country is to flourish, then everyone needs to be united. Rights, benefits, and support for all humans in the country.
17	Horvath, Diane	I am writing in strong support of SB460: Trans Health Equity Act. As a physician who provides reproductive healthcare, I have witnessed the difference it makes when people are able to access the care that best meets their needs. Reams of evidence show that gender affirming care saves lives, and it should be available to all people who need it, no matter their insurance payor. I am proud to live and work in Maryland, and I chose to move here in part because this state values the health and safety of women, LGBTQ+ folks, youth, and people with disabilities. I urge you to support this bill and affirm our state's commitment to the trans and gender-diverse community who are counting on us to stand up to the rising tide of anti-trans hatred that is consuming the dialogue in so many other states. I know Maryland can do better. Best regards, Diane Horvath, MD, MPH, FACOG Medical director, Partners in Abortion Care
18	Howes, Hilary	I'm a 67 year old transsexual that transitioned in when I was 40. I'm a 22 year resident of Maryland active in civic and non-profit community and have served on the board of Gender Rights Maryland. I want to urge you in the strongest terms to pass SB460. Though we make up only .5% of the population the federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Due to years of research and clinical studies every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics. Though I transitioned at 40 and have lived my life as a woman everyday since then I had to wait until I was 60 years old to get gender confirmation surgery due to a mandate by DC law and my coverage from my employer. It was years of work to get through the system of paperwork, psychological evaluation, electrolysis on my donor flesh, and logistics of time off and caregiving to pull it off. It made a dramatic difference to my psychological condition and functioning in society. For 20 years I was managing my gender dysphoria with the hormones and dressing within my gender role but after surgery I was able to feel complete and function fully as a woman without fear in public restrooms, locker rooms, pools and beaches. In my experience it is critical to even those of us in our senior years that may be covered by Medicare and Medicaid. Please consider the very minor expense of this

		bill a valuable investment in mental health and productivity of our population.
19	Wray, Tanner	I am writing to express my support for SB460. The federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Gender-affirming care should be covered. Every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics. Thank you for considering making this important change.
20	Debus-Lopez, Karl	Dear Senators, Please support Bill SB460: Maryland Medical Assistance Program-Gender-Affirming Treatment. This bill brings Maryland into compliance with federal legal guidelines, ensures MD Medicaid offers comprehensive healthcare coverage to the transgender community in compliance with internationally recognized, best medical practices, and reduces the significant health inequities faced by Maryland's transgender community. Maryland's transgender community makes up only 0.5% of the state's population. Only around 6,000 transgender Marylanders are enrolled in Medicaid. This low-cost, high-impact legislation will dramatically increase mental well-being, reduce suicidality, and save lives. Thank you so much for your support of this bill. Sincerely, Karl Debus-Lopez
21	Ragogna, Dan	Gender-affirming care literally saves lives. Period. It is just as necessary to have as any other healthcare out there for people who need it. As a trans non-binary person who has been fortunate enough to receive such care, I cannot stress enough how much of a difference was made compared to when I did not have it. I was born in and lived in Georgia for most of my life. Acquiring GAC there was and remains so difficult. Someone like me would have to jump through so many (discriminatory) hoops to receive such care. I didn't even bother until I moved to Maryland in 2021 where I knew there were far more facilities offering GAC with far fewer hoops if any. My mental health improved significantly when I started receiving GAC. My quality of life is so much better compared to when I lived in Georgia, in a state where the LGBTQ community struggles so much more with finding safe, trustworthy, affordable health facilities. Please pass this bill. You will save children, teenagers, adults. Thank you.

22	Lee, Simone	I Support the SB460 Bill, to be presented for the Senate Hearing by Feb 25th, and may be able to lend my testimony towards the cause if called upon. I'm a mature Trans Women, who has relegated herself to break stereotypes, walls & misconceptions. They only way we can do so is to be ambassadors towards our cause of being represented, accepted and treated for our particular need via the healthcare system per Section 1557 of the Affordable Care Act My Personal Story: As one who has been Transgender or Trans in some form since well before the terminology existed, I can attest to my challenges, turmoil & sometimes dark, deep hopelessness in seeking to find/express my 'Authentic Self.' My journey has brought me to a point, where I can only live one way; the way I seek to express myself. An expression which most family, friends, work/business associates (I'm self-employed) neither understand nor accept. I've been taking HRT since the Fall, in an effort to correct my incongruent feelings/mind, with my body. I'm on a journey they call 'Transition'... one which I have effectively denied, repressed/suppressed since I had feelings of expressing myself in a feminine expression/manner. In the coming months, I will seek additional therapy and treatments to better align my mindset/feelings, with my physical body. This will be a time-consuming, expensive process. However, it will be one which may allow me to at last live my last years true, bringing a sense of relief to a life which has been perpetually in conflict, perpetually at battle. A battle to life up to the expectations of everyone else, except the wishes/desires of myself. Perhaps the struggle of the Trans Women, represents a deeper struggle for most of us. We mostly grow up in the shadows of parents, siblings, school-mates and friends who dictate implicit, unspoken manner. Perhaps if more of us, whether Trans or not, could one day listen to themselves, present as they feel, as they think, as they are without judgement, fear or risk of being ostracized, disowned, or unloved. I always fall back upon Oscar Wilde's wonderful quote 'Be yourself, everyone else is already taken.' It not only represents how Trans people would like to be accepted, but perhaps the rest of us who have different expressions would like to live. peace, love & light ~ Simone Lee
23	Lind, Paige	Gender affirming care should absolutely be covered. Regardless of your personal feeling on gender, please think of the lives it could save. So many need this just to feel comfortable in their own skin. Consider yourself lucky if you never had to live a moment in a body you don't identify with. Even if you don't understand or are unable to relate, it's 100% real for others. Thank you

24	Drapez, Jamy	To deny quality, protected, and standardized transgender health care that only stands to save lives and improve the livelihood of Maryland residents is an act of violence. As a nonbinary person, new parent, and licensed psychotherapist, I live and witness firsthand the resoundingly positive impact access to quality health care has on an individual, a family, and a community. Trans lives as young as 12 years old are lost to suicide upon being denied life-saving health care that is able to support them in affirming their identity, that ripples to providing their families and communities fact-based education and regulated resources to strengthen their bond as they welcome their transgender member into living as their full selves. Transgender folx that live, work, and play in the state of Maryland range in age, ethnicity, religion, creed, socioeconomic background, and even in public service. With my privilege, I am able to afford private healthcare and am fortunate to have care team of medical professionals that not only treat me with the highest standards of care, but I know are trained and have access to resources supporting a trans-identified patient. Dignity and quality care should not be a luxury. Competent and comprehensive medical aid should not be held hostage behind a paywall. To not pass SB460 is to send a message that the state of Maryland is comfortable profiting off people's labor, taxes, and tourism and not responding in kind to provide for their healthcare needs as one would expect of our elected governance. To not pass SB460 retains the root message: if we can deny people care because they are transgender, we can deny any group of people care based on their identity. As a Maryland resident, I hope to see the passage of SB460 as a sign my state agrees to uphold their duty in providing basic human rights for all Marylanders.
25	mchenry, sylis	I support bill SB460 and having gender affirming care to the fullest extent. I began my transition on July 26th 2017 and administered my first shot August 04, 2017. The day I went to be cleared by the doctors and therapist to being hormones was the day former president Trump released a tweet that he was going to ban transgender service members from entering the military and also continuing to serve in the military. I currently am serving in the military and have been since November 2011. This put a lot of questions in my mind as to whether I should still continue to go through with it especially because my military career could also be on the line. I decided to go through with it and seek gender affirming care that still to this day has saved my life. I still serve this country to this day and will continue to for as long as possible. Having access to gender affirming care for anyone who may need it and wants to pursue transitioning is something that shouldn't be a question. If you want to have plastic surgery because you have body dysmorphia you have access to it, if you suffer from ED, you have access to those avenues. It's all care that is a basic human right. Gender affirming care saves hundreds every day and allows those suffering with their gender identity to pursue avenues to find out what best suits them and their desire to medically or non-medically transition. When you wake up each day hating yourself and your body and it is a constant battle to feel comfortable in your own skin it's something I'd never wish upon anyone. Being a trans man and being so open about my transition has not only saved my life but has allowed others to feel

		comfortable to come to me with questions about seeking their own paths to transition. I have been very open about my transition and I know everyone has their opinions about those who do but especially being in the military where it is such a new thing and something that can happen now it has helped me educate thousands of people and a lot of them have come around with how they feel about it because they based their opinions off something they didn't know anything about or what the media or religion portrayed us to be. When you look at yourself in the mirror and don't know who you are and hate the person staring back at you to now looking gin the mirror and being able to smile and see the person you always should have been because of the gender affirming care I have been pleased to receive it has changed my life for the better. I wouldn't change anything about my transition. It has showed me truly who is there for me and who isn't and has made a lot of my friends more like family now then my own flesh and blood. By taking away gender affirming care you limit the abilities of those seeking such care and open doors to negative things to begin to happen. We just want to be happy and to be able to live our lives as the most authentic version of ourselves and to be happy and proud of who we are. We shouldn't be limited on what care we can receive and should be able to be ourselves. I believe that having access to gender affirming care saves lives and will grealty improve the mental well being of transgender individuals and non binary people greatly as i know it helped me in more ways i can ever begin to put into words. The military has opened doors for me through my life as well as my transition has and i dont ever take thatfor granted not even for a moment. I will continue to share this fight to make sure that gender affirming care is accessible for everyone as well as their ability to serve this country if they so choose because I don't think anyone should take our rights away when it comes to getting the care, we so desperately need to be who we always should have been as well as having the care that not only improves mental well-being but also saves lives. Everyone deserves a chance to fight for their rights as a person and I will continue to do so with my brothers and sisters. I will gladly speak openly on this topic till my last dying breath so that those who come after us have all the access to any form of care they may need and not have to go through all the channels different states and finding care. At the end of the day this fight isn't just for us know it's for those coming after us and making sure they are taken care of more than we ever were.

Appendix 1

26	Phin, Vanessa	I am writing in support of SB460. I am a transmasculine nonbinary parent, and one of my children is a trans girl. I am in my 40s, and have seen a lot change in the trans community of late. I've seen hormone therapy as settled science begin to be questioned for political gain. I've seen trans girls flee states in which they're old enough to have a rapist's baby but not old enough to transition. I've seen many trans friends lose their lives to suicide or violence, some murdered by their own parents. I've seen my daughter harassed in school--and that's *before* puberty. I can't imagine what her life would be like if she couldn't hormonally transition to the gender she is and have to endure a puberty that is WRONG for her and lead to worse harassment, only to have costlier surgeries later to correct for it. So many trans kids don't have supportive parents or live below the poverty line--many are in foster care. My spouse, a professor, has seen parents kick their young adult kids out of the home while they attend college because they are trans. To access medical care is a tiny, TINY portion of aid in an otherwise extremely difficult life. WhenI was diagnosed with myalgic encephalomyelitis, testosterone was open to me without any of the anti-science nonsense that accompanies using it for young trans men. Menopausal women can also get testosterone without bunk science interference. Gender-affirming care is healthy, scientific, and supported by every major medical association in the U.S., including the American Academy of Pediatrics. Please help us by supporting funding for gender-affirming care as medically necessary. Pass SB460.
27	Powell, Bridget	I'm almost 39 years old and I only realized I was transgender in March of 2021. I've been on HRT for a year and a half now and the mental weight that has been lifted in that time is staggering. I'm lucky. I work for the state, I have a stable job, I have excellent health insurance through the state of Maryland for which I am incredibly thankful. This should be extended to anyone on Medicaid. The idea that Medicaid doesn't cover something as fundamental as 'You are in the correct body now' is absolutely horrifying. Last month, because of a scheduling issue, I couldn't get in to see my physician and get a refill on my estradiol (estrogen). I had to ration it at two-thirds the prescribed dose for almost two weeks so that I could have some each day. For two weeks I felt panicked, like my world was fundamentally wrong. No matter what I did, my anxiety was double what it normally is. For just two weeks on a partial dose that happened to me. Can you imagine what it's like for us when we can't get anything? The anxiety, the depression, and all of the things that accompany those mental states? Are you able to put yourselves in our shoes, to be able to say 'I understand the terror inherent in denying basic care' and still not approve this? How could any rational, caring individual look out and say 'I understand all of this but I still refuse to help you because it might cost a dollar per month per resident'? Less than three cents a day. You find more than that on the sidewalk in a few minutes just walking around. You save more than that just by turning out the lights at night. You can find this money. You can help these people. Nothing compares to waking up in the morning and being able to look yourself in the eyes. I realized that less than two years ago. By agreeing to help these people in need, you can get that same rush transgender people

		get from realizing they're in the correct body. Do the right thing. Pass SB 460.
28	Parker, Tanya	I have worked for many years at a community clinic that provides gender affirming health care and I can attest to the fact that it is truly life saving health care. Gender dysphoria can be extremely challenging, and it's vital to support transpeople in being their authentic selves for them to be healthy and happy members of society. Everyone should be able to access gender affirming care, no matter their insurance status and income. I strongly urge you to support SB460.
29	Johnson, Michaela	My two grandchildren -- one gay, one trans -- can access the health care they need. Transgender health care is essential for physical and emotional well being. I want all trans people, young and old, to get the care that is available to my family. I support SB460, to keep Maryland in the forefront as a state that cares for all its people.
30	Benson, Anne	I support SB460. As the mother of a transgender teen I understand how critical this is. Gender affirming healthcare saves lives. It is crucial to those who need it and should be accessible. Thank you Anne Benson
31	AlJunaidi, Norah	Gender affirming care is life saving. As an SLP who serves transgender individuals of all ages for voice therapy, I know how much it means to them. To deny access to this care by not covering it with insurance is inhumane and unconstitutional. Transgender people are often already struggling financially and have to prioritize their care in their budget to be able to live comfortably and happily in their identity. We need to change that.
32	Rhodes, Ellery	As a transgender citizen of Maryland, I have experienced firsthand the impact that accessible and affordable gender affirming care can have as well as how detrimental a lack of trans-conscious medical care can be. Numerous federal and privately funded research projects have shown that the transgender community is several times more likely to self-harm, attempt suicide, suffer from mental health issues, struggle with substance abuse and eating disorder issues, and have limited access to healthcare and the basic necessities to live in the US. As someone who is currently on the Maryland Medicaid program and has been forced to fight for basic medical care and withstand innumerable cases of mistreatment because of my gender identity, it is vital that Maryland passes bill SB460. Any improvement to transgender health service access and affordability is a step towards supporting our transgender community and ensuring equal and compassionate care for all.
33	Franco, Anderson	I believe gender affirming care is a basic human right and denying that to those who need it amounts to enabling their deaths. Discrimination of this kind is truly unacceptable and abhorrent. I speak on behalf of my friend Erin who worries about her own future due to restrictions on the care that she needs.
34	Dasta, Frank	I know multiple trans women, one of whom lives with me in MD and the other lives in Delaware. The gender affirming care available in DE has been life changing for one friend, and it would be nice if the other friend could benefit from having the same level of care in Maryland. This bill would be a wonderful step in securing what should be a right.

35	Messinger, Colin	I support SB460. Make sure Marylanders get the medical care they need - that includes gender-affirming care!
36	Cook, Corey	Having low cost options for trans health care would not only provide benefits to one of the most at risk groups of people in the US, but also prevent medical accidents from those who have to use DIY kits as alternatives. As someone who is trans and who has financial problems, this would be a life changing option. It would allow me to be myself. The person I felt I've always wanted to be. So many states have folded due to mob mentality pushed from greatly uninformed sources. Please don't let Maryland be one of those. I am in Ohio. Almost daily, LGBTQA+ rights are pushed aside for intimidation and segregation. Don't let Maryland become one of those places.
37	McLaurin, Thomas	Every single trans person I've met is so much happier after transitioning. Medical care for the trans community is not only gender affirming, but life affirming. SB460 only stands to save lives and increase joy in the world. To oppose it is villainous.
38	Conner, Joseph	There is no reason that gender-affirming care should not be covered by Medicaid. Beyond the fact that it's been named and upheld as an essential health benefit under the Affordable Care Act in Federal District Courts, it is vital for the mental and physical health of trans people within Maryland. It needs to be affordable to all who wish to get it. I actually have two trans friends in Maryland, who to date have struggled financially to receive gender-affirming care, and would hope that this SB460 is passed as soon as possible, for their sakes, and for all the others struggling with this.
39	Judice, Tristan	Healthcare for a serverely marginalized group at a low cost is a no-brainer decision
40	Burnett, Glenn	Bill SB 460 is an important piece of legislation which would ensure coverage of gender affirming care for trans Marylanders using Medicaid for insurance. This would improve trans people's lives in the state in a huge way. Those with Medicaid would be able to afford care which would improve the quality of their lives which is not accessible to them now. This care is not optional. Trans people need access to gender affirming care so they can feel more like who they are on the inside. Denying them this care for finance reasons is ignorant and beat and transphobic at worst. Maryland should do the right thing and pass this bill. During a time so many other states are moving are regressing on trans right, we have an opportunity to become a beacon of hope for those seeking to live a life as their true selves
41	Aimable, Rick	Transgender people are real, human people who deserve affordable health care and treatments. Many people who I know, who I talk to, who I look up to are transgender, or have transgender friends who they value dearly. Gender-affirming care is an imperative health benefit, and I support the SB460 bill.
42	Connolly, Michael	Gender-affirming care is proven health care. It saves lives, increases quality of life, and is broadly supported. Trans rights are human rights.
43	Vermeer, Isaac	Gender affirming care accessibility will increase the mental health for those who need it, and in turn save lives.
44	Rodri, Lian	man idk I think trans people just want to live
45	TYX, O	this thing is so much bigger than me and there are people who need the help more than most

46	Toomey, Lauren	Practices that fall under gender affirming health care are medical practices used for non trans people as well. They are important for saving Trans lives but they are also important for many more people. Hormone treatment is used for a variety of life saving reasons outside of transitioning.
47	Seymour, Ian	I wholly support the bill SB460, as gender-affirming care is a vital necessity that should not be denied for those with lower income. The federal government has named gender-affirming care as an essential health benefit protected under Section 1557 of the Affordable Care Act, which has been upheld in federal district courts across the country, and has been back by the Centers for Medicare & Medicaid Services. Every major medical association agrees gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics. On top of gender-affirming care being important for the people's well-being, allowing it to be covered will also significantly save costs from reduced long-term health complications, including a reduction in suicide attempts as high as 84 percent.
48	Chrobak, Pawel	While I do not have a story relating to being transgender, I believe that the gender-affirming care should be covered as this will help make those who want to be their real selves come out easier. Being transgender in the US today is tough because of the hearsay from Republicans and other transphobic people, they are simply harmless and only want to be themselves. I support the SB460 bill.
49	Woods, Joseph	To deny a person who they are inside is cruel and evil.
50	madore, alexander	trans people exist and deserve to continue to exist.
51	Tait, Nick	I support bill SB460! The federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Along with this, every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics.
52	Kendra, Joseph	I support affordable gender affirming care for my friends and for all trans people in Maryland. In a time of increasing coordinated attacks on this group of people, I ask that the state of Maryland do the right thing and protect their access to healthcare.
53	I, Anna	Gender affirming care is legitimate healthcare. Physical and mental health of non-binary and transgender people will improve dramatically when given the opportunity to undergo affirming surgery and/or therapy
54	Huggins, Quasson	The federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics. Not enshrining 'Gender Affirming Care' in all of it's forms----- something so accessible to cisgender citizens but so elusive for NON-

		cisgendered people would be detrimental to the freedoms of non-cisgendered and a serious failure in the protection of Marylands' queer population
55	Young, Tyler	I support this bill and want the trans community to have the same rights and protections as everybody else. I have several trans friends and I want their lives to improve; just do the right thing!
56	Christian, Daniel	I'm not signing this for myself, I'm signing this for my trans friends and family who deserve better than being denied the medical care they need.
57	Viens, Alden	Everyone should be given the right to choose however they identify, and with the use of gender-affirming care, that can be a reality. As someone who has been on HRT for a few years, I can attest that such a thing has greatly improved my life in terms of mood and self-care. That is why I support this bill, SB460.
58	Shinto, Hamilton	The federal government has named gender-affirming care as an 'essential health benefit' protected under Section 1557 of the Affordable Care Act. This has been upheld in federal district courts and is backed by the Centers for Medicare & Medicaid Services. Every major medical association agrees that gender-affirming care is medically necessary, including the American Medical Association, the American Psychiatric Association, and the American Academy of Pediatrics.
59	Brown, Cenauru	I'm transgender, specifically Male to Female, and after years of dodging the 'Am I trans?' question that was constantly on my mind no matter how much I tried to push it aside, I reached a breaking point where I couldn't deny it anymore and finally accepted it. I have not been coerced, my parents aren't happy about it and have brought up numerous and untrue reasons for why they don't think I'm trans. Nevertheless, I applied to the closest Planned Parenthood for an HRT appointment, and under Informed Consent, I was able to book an appointment 2 weeks later. In no way did I just get handed meds, I had to fill out lots of paperwork, had to make it extremely clear that I understand the changes I will experience, and after a few hours of this, plus alot of personal discussion with my doctor about my life experiences with my difficulty over my gender identity and birth sex, gave me a prescription for HRT meds to start my transition journey later that very day. It's been a year and a half since then, and transitioning has changed my life. I was previously very apathetic about life and didn't really care about who I am. But now, my gender identity is a source of happiness, I've made lots of friends with other trans people and those who accept us, I have a WONDERFUL girlfriend (who is also trans), and in general I am a much more cheerful and happy person now, and have grown into my own personality that I brings me joy to express, rather than the apathetic, miserable person I used to be. Gender-affirming care not only saves lives for many, but also enriches our lives, and allows us to embrace our true feelings and live as our true selves. I support gender-affirming care, and I support SB460.
60	Timlen, Joshua	Gender affirming care saves lives and has a lower regret rate than many other life saving surgeries. Everyone deserves the gender affirming care they need.

61	Duncan, Joshua	People always puts down another group just for being different is sicking. Everyone should have equal access no mater who they are.
62	Davis, Zachary	Gender affirming care is as necessary to a transgender person's health and wellbeing as all other forms of healthcare, and is a human right. In the form of both hormonal treatments and surgical treatments, it has provided enormous relief and healing to a great many of my transgender friends. All of them remark that it has increased their quality of life and happiness, and helped them live the happy and long lives they have wanted to for so long. Thus I can only support SB460 and the benefits it extends to all of Maryland's transgender community.
63	Williams, Brittany	February 24, 2023 The Honorable Senator Melony G. Griffith Chairperson, Senate Finance Committee Maryland Senate 11 Bladen Street Annapolis, Maryland 21401 Re: SUPPORT for SB 460, the Trans Health Equity Act Dear Senator Griffith and Members of the Senate Finance Committee: As Vice President of American Atheists, a trans citizen of Maryland, and on behalf of our approximately 1,100 constituents in Maryland, I write in support of SB 460. This bill would provide coverage for gender-affirming care under the Maryland Medical Assistance Program (Medicaid) to trans Marylanders. This bill will address systemic discrimination against trans people and help ensure access to necessary health care in Maryland. We urge the swift passage of this bill. American Atheists is a national civil rights organization that works to achieve religious equality for all Americans by protecting what Thomas Jefferson called the "wall of separation" between government and religion created by the First Amendment. We strive to create an environment where atheism and atheists are accepted as members of our nation's communities and where casual bigotry against our community is seen as abhorrent and unacceptable. We promote understanding of atheists through education, outreach, and community-building and work to end the stigma associated with being an atheist in America. As advocates for the health, safety, and well-being of all Americans, American Atheists objects to efforts to subordinate the health and safety of all to the religious beliefs of a few. Medical experts have established that gender affirming care is safe, clinically appropriate, and medically necessary for many individuals that experience gender dysphoria. Further, legitimate medical professional associations, such as the American Academy of Pediatrics, the American Medical Association, and the American Psychiatric Association, have long supported this care. SB 460 would expand access to this well-founded and necessary care. There is overwhelming evidence demonstrating the positive impacts of gender-affirming medical care for those who need it. In fact, several studies have established that receiving care, such as hormone-replacement therapy, has significantly improved the mental and social health of trans people. In a study of 47 trans youth who received appropriate hormone treatment, these youth were 60% less likely to report depression and 73% less likely to report suffering from suicidal thoughts. In contrast, another relevant study showed that 83% of those who did not receive gender-affirming care experienced suicidal ideation and or engaged in self-harm. This is only a fraction of the robust research supporting

		gender-affirming care and confirming that it is medically necessary health care. If passed, this bill will provide life-saving care to vulnerable trans people and help mitigate barriers that still exist to their health care. For example: 23% of trans and gender non-conforming people who informed health care providers of their gender identity were denied service altogether. Due to discrimination and disrespect, nearly 30% of trans and gender non-conforming people postponed or avoided medical treatment when they were sick or injured. Similarly, 33% of gender non-conforming and trans people did not seek needed preventative care. Trans people already face significant stigma, and they are at higher risk for mental and physical harm as the result of not being able to access gender-affirming care. The vulnerable deserve to feel safe and supported by their state, and SB 460 does just that. American Atheists strongly urges you to pass SB 460 to provide Medical Assistance Program coverage for gender-affirming care. Every patient, regardless of gender or gender identity deserves to receive adequate and medically necessary health care. This low-cost, high-impact legislation will dramatically increase mental well-being, reduce suicidality, and save lives. If you have any questions regarding American Atheists' support for SB 460, please contact me at agill@atheists.org. Sincerely, Alison Gill, Esq. Vice President, Legal & Policy American Atheists
64	Perino, Auden	My name is Auden, I use they/them pronouns. I have been a Maryland resident for over 20 years, and I am an openly transgender civil rights attorney. I am fortunate to have health insurance that covers gender-affirming care--and I know personally how devastating and harmful it is to lose access to that care. It is deeply wrong that in Maryland, some of our most vulnerable residents, many of them LGBTQI+ people of color, are subjected to second-class benefits based on the state's viewpoint that transgender healthcare is optional, too expensive, or simply disfavored because of deeply rooted biases and stigma targeting transgender people. Maryland must enact SB460--it is the right thing to do, and also necessary under federal law for insurance programs like MD Medicaid to provide essential benefits under the Affordable Care Act without discrimination based on sex. (As the Supreme Court has held in Bostock v. Clayton County, discrimination based on sexual orientation or gender identity cannot occur without unlawful discrimination based on sex or sex stereotypes.) Although not every transgender or nonbinary person experiences gender dysphoria, gender affirming care is a life-sustaining and life-saving necessity for many of us living with gender dysphoria. Denying medically necessary care that is supported by every major medical association--representing millions of doctors worldwide--is a cruel status quo that directly causes wide reaching harms to the 6,000 people on Maryland Medicaid who may need gender affirming care. Our state has no legitimate interest in forcing people to conform to sex stereotypes (saying we must perform the gender assigned to us at birth) through an arbitrary and cruel carve-out in our Medicaid program coverage. Right now, religious extremists and white nationalists are collaborating across the U.S. to divide our community and undermine the gains that have been made for LGBTQI+ justice by demonizing transgender

		people, especially our youth, with a special focus on baseless fearmongering against gender affirming healthcare that is safe, proven effective, and supported by every major medical association. In my community we have a saying: no Pride for some of us without liberation for all of us. This bill is your chance to stand with the LGBTQI+ community, take meaningful action to defend transgender people against the wave of coordinated, authoritarian attacks we are facing nationwide, and to offer a liberation from suffering to people on Maryland Medicaid who desperately need and unquestionably deserve access to all medically necessary healthcare. Thank you.
65	DelloIoio, Richard	Trans rights
66	Lugo, Dawn	I have trans friends that would benefit from this

10 - X - SB 460 - FIN - MDH - LOSWA.pdf
Uploaded by: State of Maryland (MD)
Position: FWA

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 28, 2023

The Honorable Melony Griffith
Chair, Senate Finance Committee
3 East Senate Office Building
Annapolis, MD 21401-1991

Re: SB 460 – Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act) – Letter of Support with Amendments

Dear Chair Griffith and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of support with amendments for Senate Bill (SB) 283 – Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act). The Moore-Miller Administration is committed to the wellbeing of Maryland's LGBTQ+ population. In Maryland and across the nation, LGBTQ+ individuals face adversity at higher levels than many other communities. This adversity is felt in all intersections of life, including health care. MDH supports this bill's efforts to improve access to health care for our LGBTQ+ community by expanding gender–affirming treatments for transgender, nonbinary, intersex, two spirit, and other gender diverse individuals that are enrolled in Medicaid.

MDH appreciated the opportunity to discuss SB 460 with the bill sponsor and stakeholders prior to the bill hearing. MDH notes that in this discussion we shared that, pursuant to 42 CFR § 440.230, MDH can establish utilization control procedures, such as prior authorization, to ensure services are rendered in compliance with medical necessity criteria.[1] Medical necessity criteria are established based on evidentiary standards related to recognized treatment guidelines.[2] Review of requests for coverage and appeals for compliance with these standards are conducted by clinicians.

SB 460 will incorporate medical necessity criteria into state statute. Medical necessity criteria are important to the day-to-day administration of benefits covered by the Medical Assistance Program. These criteria are not static. Instead, medical necessity criteria evolve constantly to reflect changes in best evidence-based practices and the latest research. The flexibility to make changes to these criteria through sub regulatory guidance is critical for the operations of MDH.

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1 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-B/section-440.230

2 Guidelines include Interqual, UpToDate, Hayes, or Milliman Criteria, and may also be informed by opinions from governing Medical Specialty Boards from each of the subspecialties, as well as other MDH agencies. With respect to off-label drugs, COMAR 10.09.03.06B requires that the off-label use must be documented in and supported by the latest edition of the American Hospital Formulary Service Drug Information, the Thompson Micromedex Drugdex, or the United States Pharmacopeia

Including these criteria in statute will necessitate new legislation each time a change is needed. Specifically, the bill will prohibit MDH from issuing an adverse benefit determination denying or limiting access to gender-affirming treatment unless a health care provider with experience prescribing or delivering gender-affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination. It is also unclear whether a sufficient network of providers will exist to permit independent, unbiased reviews, while ensuring inter-rater reliability and consistency of decision making.

To address this item, MDH proposes the attached amendment which will allow the Medical Assistance Program to continue to have flexibility to make any necessary updates through sub regulatory guidance. This will ensure that updates are timely and are based on current health care research and best practices.

If you would like to discuss this further, please do not hesitate to contact Megan Peters, Acting Director of Governmental Affairs at megan.peters@maryland.gov or (410) 260-3190.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

AMENDMENTS TO SENATE BILL 460

(First Reading File Bill)

On page 1, in line 8, strike beginning with “prohibiting” down through “determination;” in line 11, inclusive.

On page 4, strike in their entirety the lines beginning with line 30 down through line 2 on page 5.

SB 460 Written Testimony 28 February 2023.pdf
Uploaded by: Amy Waychoff
Position: UNF

SB 460

Senate Finance Committee

Unfavorable

Amy Waychoff

Montgomery County, LD 18

I am writing in opposition to SB 460, “Maryland Medical Assistance Program — Gender Affirming Treatment (Transgender Health Equity Act)” for the following reasons:

- Maryland Medicaid already covers a long list of gender-affirming treatments for those over the age of 18, including hormone replacement therapy and gender reassignment surgery.
- The proposed bill does not specify any age restrictions, so teenagers whose brains are not developed enough to make life-altering decisions would be allowed to undergo radical surgeries and hormone treatments.
- “Gender-affirmation” approaches ignore other co-morbidities, such as depression and anxiety. Many also suffer from adversity or traumatic childhood events. For decades, “watchful waiting” and/or psychotherapy successfully addressed children’s gender dysphoria. In up to 88% of these situations, the child’s gender dysphoria resolved by puberty.*
- The fact that sex is imprinted on the every cell in a person’s body and cannot change. Therefore, the NIH requires its 80,000 research grant applicants to account for sex as a biological variable in all animal and human studies. Men and women respond differently to medications and have differing susceptibilities to illnesses, including heart disease, cancer, depression and anxiety.
- In 2019, a transgender man admitted to an emergency room with severe abdominal pain was assessed as a man, therefore missing the fact that “he” was actually a woman in late-stage labor. The result was the stillbirth of a human child that might have been saved but for the hospital staff conforming to gender identity politics. Imagine the anguish felt by the staff who made that mistake.
- Most of the treatments proposed in the bill are of a cosmetic nature and would add a large expense to the Maryland taxpayer. According to the bill’s Fiscal and Policy Note, cost estimates per person could exceed $50,000.
- One of the benefits in the bill would be coverage for fertility preservation, which are not covered by Medicaid even for cancer patients. Passage of the bill would most likely lead to large numbers of residents lobbying for fertility preservation for any reason, further increasing costs to the Maryland taxpayer.

For all of these reasons, I ask for an unfavorable report on this bill. Thank you.

*Singh, D., Bradley, S.J., & Zucker, K.J. (2021). A Follow-Up Study of Boys With Gender Identity Disorder. *Frontiers in psychiatry.*

sb0460.pdf
Uploaded by: Brian Caine
Position: UNF

SB0460
Brian Caine
Position: Unfavorable

Today I am writing to express my opposition to Senate Bill 460.

Senate Bill 460 intends to extend medical assistance coverage to "gender affirming treatments" that are deemed "medically necessary" in a "nondiscriminatory manner".

I object to it on the basis that it labels anything that could be related to gender "medically necessary", it is inherently discriminatory, and it makes several vulnerable groups targets of an unscrupulous medical industry at the expense of their wellbeing.

1. Anything related to gender is "medically necessary"

The proposed bill radically labels any whim of a transgender individual as "medically necessary gender affirming care".

At the very least, it specifically lays out hair removal, voice therapy, chest/ab procedures (usually breast implants and targeted liposuction, "ab sculpting"), buttocks (so "brazilian butt lifts" should be covered) and voice training.

The bill includes a provision that these procedures cannot be denied on the basis that they're cosmetic.

The bill also includes a provision that the burden of proof is on the state to establish that something isn't medically necessary.

The state can only challenge a procedure on the advice of a clinician with experience prescribing such procedures.

This means access to these procedures is entirely up to the whim of individuals financially and professionally invested in the very lucrative gender affirming medical industry. Any growth is beneficial to them.

Let's be honest: none of these are medically necessary. We all know this. I think the sponsors realize this. It's silly to claim that they are necessary. Talk to your neighbors, your friends and your family, they'll agree.

For example, no one in Maryland thinks breast implants are medically necessary solely on the basis of the psychological distress over having small breasts.

That's ridiculous and frankly, it's offensive on basic feminist principles.

2. This proposal is inherently discriminatory

The bill includes an interesting loophole that I don't believe the sponsors considered.

The criteria for qualifying for these procedures is that they be related to a condition related to an individual's gender identity. This casts far wider of a net than I think the sponsors probably intended.

The thing to keep in mind is, it's not only trans individuals who experience distress with their gender identity. In this bill, non-binary individuals, two-spirit and other "gender diverse individuals" are included by name.

But what about cis women? Women and girls have crises of femininity too. If we all have a gender identity, then probably the most common psychological conditions relating to gender identity occur in cis women. Cis women can feel they aren't womanly enough or feminine enough. Teenaged girls develop eating disorders over their body image in the context of a gender identity as a girl attaining womanhood.

In order to be internally consistent, this law would need to extend coverage for breast implants and butt lifts to cis women who do not feel fulfilled in their gender identity too.

I'm proud to say that Maryland has a very good track record with broad equal rights policies. We take that seriously here. So if we're extending medical coverage on the basis of gender identity issues to one demographic, there will absolutely be lawsuits if we do not extend that to anyone who has gender identity issues, including girls with self image issues.

And you can't say they don't have a point. A woman is having a crisis of femininity because of her small breast. Legally and ethically, does it matter if she's cis or trans?

I suspect that the sponsors did not intend this coverage to be interpreted that way, but either way, I don't think this would be very popular with your average Marylander.

3. Medical industry preying on vulnerable people; "the money"

In 2021, the US sex reassignment surgery market was valued at $1.9 billion in 2021 and is expected to expand at a rate of 11.23% from 2022 to 2030 to $4.9 billion.

And this doesn't even cover most of the procedures proposed in this bill.

Ultimately, the medical industry is, well, an industry. Their goal is to profit. On its own, that should be fine, as long as there are checks and balances from other involved parties.

Insurance companies or state insurance programs are the big counterweight. In their drive to save money, they try to challenge proposed treatments as "not medically necessary". As mentioned above though, this proposed bill will completely neuter the state's ability to challenge any of these treatments.

Unfortunately it will be the most vulnerable Marylanders who suffer from this.

3.1 Children

As an example, children are extremely valuable patients to the gender treatment industry.

Children with gender identity issues, if they avoid medicalization, they usually desist from any trans identities naturally, around 86% of the time.

However, when confused children are given puberty blockers (guaranteed by this bill) and then led into a cross-sex hormone regimen rarely detransition. There's a significant "sunk cost" mindset going on here, where they feel that all the adults (who are supposed to be trusted) have been telling them something about them for their whole life. How can children be expected to challenge adults on such a serious topic?

More than 90% of trans surgeries are double mastectomies (breast removal) performed on teenage girls.

Often male children go on to be castrated, right around their 18th birthday, and at which point, they are unable to produce their own hormones. Without lifelong hormone treatments, they will lose bone density and develop osteoporosis.

Every time this happens, the medical industry gets a new patient for life.

It is clearly not in the medical industry's financial interest to question any of these narratives. As long as the cultural zeitgeist keeps presenting trans identity as a solution to very normal adolescent problems, parents will keep bringing kids into gender clinics, and the gender clinics will keep wanting to "explore the child's identity" with puberty blockers. Cha-ching!

European countries, when presented with the evidence against this, have been quickly rolling back their adolescent gender programs, declaring many of them operational failures. Case in point: Finland.

Only the US continues at this breakneck speed, and that's entirely because of the commercialized medical industry here.

In fact, Johns Hopkins University sent out an email to all its staff gleefully promoting this bill. They were like sharks with blood in the water.

There’s a very good Daily Caller article on their public stance:

https://dailycaller.com/2023/02/15/johns-hopkins-medicare-transgender-cosmetic-surgeries/

3.2 Intersex children

This is a strange one, because the proposed bill seems to misunderstand what intersex is. Intersex is not an identity, but it's a set of generally unrelated medical issues that affect sex development.

The modern term is DSD (disorder/difference of sexual development).

All DSDs are sex specific. Everyone with a DSD is either male or female with a kind of hormonal or chromosomal issue.

They do not generally have gender identity issues more often than the general population.

However, they are still aggressively targeted by the medical industry for unnecessary procedures.

DSD advocacy organizations almost universally argue that children with DSDs deserve a say in their medical treatments. Historically, many doctors tried to "correct" DSD-related genital conditions and often left them with horrible scarring and poor genital function.

The doctors are coming from a good place. They want to get the surgeries over with while the child is an infant and there are less complications. However surgery was (and still is) crude and had serious side effects on sexual function, among other issues.

DSD advocates now suggest that all medical/surgical corrections be restricted solely to medically necessary ones. Cosmetic procedures should be put off until the child is old enough to participate in the consent process about their body.

On the other hand, not all doctors are very scrupulous in this area.

There's all kinds of procedures, medical implants and drugs they can sell to well-meaning, but overwhelmed parents of children with DSDs "for the greater good" or "so they don't have to grow up with shame".

In the past, this included clitoridectomies for girls with atypical genitalia. Nowadays, this can include testicular implants for infants.

Times change, but the greed of the medical industry seems to be growing. And in this case, at the expense of children with DSDs.

Please don't hand them the keys to the castle.

4. Finally

Ultimately, this is a very sketchy bill. It really only serves to enrich the medical industry, using public money, at the expense of the mental and physical wellbeing of Marylanders.

2023 SB0460- Kijesky-OPPOSED.pdf
Uploaded by: Crystal Kijesky
Position: UNF

Crystal Kijesky
11980 Provident Drive
LaPlata, MD 20646

SB0460– OPPOSED

I am against proposed bill SB0460 and ask that you give it an unfavorable report.

SB0460 proposes to "affirm" and use "inclusive" language regarding persons who believe they were born the wrong gender.

Though I am heartily moved by the suffering of people who believe they were born the incorrect gender, I do not believe the prescription for their suffering should be to block nature.

Science, and a little background of history, shows that there are people who are effected with gender dysphoria. A medical condition that requires treatment. Not in the form of puberty blockers and mastectomies in the prime of their developmental growth.

I did grow up a "tom-boy." I climbed trees, got dirty, and liked "boy" things. Never once was it ever presented to me by the adults surrounding me, that I was born into the wrong gender. The extremes that we have gone to so that children and teens, we are still developmentally immature, can make such life-altering decisions, is mind blowing.

I have three children. I have always taught them that we live in reality. When they were little, in the imaginative stage, I would play-along that they were horses or puppies. But when we ate, or had bedtime, we would always know that we were humans. Boys and girls who brush our teeth and need sleep in a human bed. This may sound silly to state in my testimony, but this is what we adults need to teach to our young people who are suffering with this confusion.

A few scholarly articles are linked below. I do hope you take the time to read them and realize helping someone isn't always affirming what they want to be, but what they are. This is when reality and true help can be obtained.

Doctors Have Failed Them, Say Those Who Regret Transitioning (webmd.com)
Debate Heats Up on How Best to Treat Gender-Questioning Kids (medscape.com)

Home | SEGM

Sharp Increase in Incidence of Gender Dysphoria in Children and Young People

Historically, the small numbers of children presenting with gender dysphoria were primarily prepubescent males. In recent years, there has been a sharp increase in referrals of adolescents, and particularly adolescent females, to gender clinics. Many do not have a significant history of childhood gender dysphoria and a number suffer from comorbid mental health issues and neurodevelopmental conditions such as autism (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD). The reasons for these changes are understudied and remain poorly understood.

Childhood-onset gender dysphoria has been shown to have a high rate of natural resolution, with 61-98% of children reidentifying with their biological sex during puberty. The research into the course of gender dysphoria desistance among the cohort presenting with adolescent-onset gender dysphoria is still in its infancy, due to the novelty of this presentation. However, recent research from the UK clinic population suggests that 10-12% of youth may be detransitioning within 16 months to 5 years of initiating medical interventions, with an additional 20-22% discontinuing treatments for a range of reasons. The researchers noted that the detransition rate found in the recently-presenting population raises critical questions about the phenomenon of "overdiagnosis, overtreatment, or iatrogenic harm as found in other medical fields."

Studies | SEGM

A huge variety of info. Please take the time to visit the studies pages.

▼ C. Health risks of medical and surgical affirmation

- ▶ Bone health complications
- ▶ Cardiovascular complications
- ▶ Endocrine complications
- ▶ Fertility complications
- ▶ Other biomedical risks and uncertanties

▼ D. Desistence, detransition and regret

- ▶ Adolescent-onset gender dysphoria
- ▶ Childhood-onset gender dysphoria
- ▶ Mature adult transitioners

I urge you to please issue an unfavorable report on SB0460.

Sincerely,
Crystal Kijesky
LaPlata, MD

Unfavorable SB 460 .pdf
Uploaded by: Daniela D’Orazio
Position: UNF

Dear Education, Energy and Environment and Finance Committee Members,

As a Maryland Constituent, I am asking you to Oppose SB 460.

When I was a teen girl I wanted to be a boy, thank God such bill and opportunities to change my sex didn’t exist as it was just a short phase of my life that I grew out of it.

Please oppose SB 460.

Thank you,

Daniela DOrazio

Oppose SB460.pdf
Uploaded by: Ekaterina Smirnova
Position: UNF

SB460 - Medicaid-paid transgender care – why I oppose SB460

Dear Sir/Madam, please make a note of my concerns regarding bill SB460

Since there is no upper age limit for receiving this care, minors can make their own decisions or can be persuaded to do so by medical professionals who have a financial stake in such procedures.

There is no charge or program coverage for mental health counseling or a need assessment.

These operations are exceedingly expensive, and taxpayer money is used to pay for them.

Thank you

Ekaterina Smirnova

SB460.pdf
Uploaded by: Eleanor Jones
Position: UNF

Opposition to SB460 – Maryland Medical Assistance Program – Gender Affirming Treatment

I am writing in opposition to SB460 primarily because government has no business influencing children regarding a highly controversial political ideology. Furthermore, I do not want my tax funds involved in what likely will be an extremely invasive and unnecessary surgery on a minor which could lead to health complications as well as severe emotional issues when this child becomes an adult.

There is evidence now being made public that demonstrates how children were convinced by adults who were supposed to be their care providers that they were “in the wrong body.” Now, these young adults realize that they were not trapped in the wrong body and they seek to try to reverse the damage (de-transitioning) that has been done via surgery or hormones. In most cases, the damage cannot be done. It is even more unconscionable that this bill specifically targets underprivileged children for it’s science experiment.

In closing, I will ask you, have you forgotten what occurred during the Tuskegee Experiment? Apparently you have. For forty years, the U.S. Public Health Service with the CDC, experimented on Black men to study syphilis. The CDC even admits now that informed consent was not obtained by the male participants (https://www.cdc.gov/tuskegee/timeline.htm). These men were also not treated for syphilis and were only told that they were being studied for “bad blood.” More than one hundred of these men died as a result of the irresponsibility, callousness and recklessness of the government. Today, this study is recognized for one of the most egregious violations of human treatment and lack of ethical standards in medicine. The political transgender ideology stands to repeat this human travesty. This ideology is not rooted in biological science. It is a business where the medical community profits off of human misery and emotional issues by convincing children and young adults that they are trapped in the wrong gender. What’s worse, when these patients realize years later that they were lied to by those in a position of trust, and there is no hope of reversing the damage done.

OUR KIDS ARE NOT A GOVERNMENT EXPERIMENT.

Eleanor Jones
Carroll County

Oppose SB 460.pdf
Uploaded by: Gala Meyerovich
Position: UNF

From: **Gala Meyerovich** gala_meyerovich@hotmail.com
Subject: Oppose SB 460
Date: February 27, 2023 at 2:11 PM
To: mary.washington@senate.state.md.us, malcolm.augustine@senate.state.md.us, sarah.elfreth@senate.state.md.us, brian.feldman@senate.state.md.us, guy.guzzone@senate.state.md.us, shelly.hettleman@senate.state.md.us, nancy.king@senate.state.md.us, Ben.Kramer@senate.state.md.us, clarence.lam@senate.state.md.us, will.smith@senate.state.md.us, jeff.waldstreicher@senate.state.md.us, craig.zucker@senate.state.md.us, arthur.ellis@senate.state.md.us

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Dear Senators,

I strongly oppose SB 460 for the following reasons:

- The bill allows for abuse of taxpayer funds, since it does not do not include review of the amount spent on such procedures, independent review of the necessity of procedures, or any evaluation of benefit versus risks.
- This procedures are not reversible. There is NO AGE LIMIT in this bill!!! Gender-affirming treatments are suitable only for adults and only after substantial mental health or psychological evaluation.
- Since the bill requires the Medical Assistance Program to cover all costs, schools and doctors may influence and coerce children to undergo such procedures. Even providers who have financial interest in such procedures may be able to recommend them to vulnerable children.
- The bill talks about medical necessity but does not describe whether the program covers the cost of evaluating the medical necessity.
- Some school systems allow recommending such treatments to children and hiding it from parents. Expenses covered by a state program completely excludes parents from the evaluation and decision making process, which is absolutely ENACCEPTABLE.

Sincerely,
Gala Meyerovich
A resident of Montgomery County, MD
240-672-3274

pjmedia-com-news-and-politics-tyler-o-neil-2019-05
Uploaded by: Jessica Helms
Position: UNF

NEWS & POLITICS

Transgender Tragedy: This Baby Died Because the Mother's Medical Records Listed Her as Male

BY **TYLER O'NEIL** 10:54 AM ON MAY 16, 2019

This week, *The New England Journal of Medicine* published a bizarre story. A “transgender man” entered a hospital with severe abdominal pains. Because she was identified as a man, the doctors naturally did not think to treat her for labor and delivery, so she tragically lost the baby. Rather than emphasizing the danger of placing gender identity over biological sex, both the journal and *The Washington Post* made the absurd claim that the hospital should not have ruled out pregnancy for a man.

“He was rightly classified as a man” in the medical records and

appears masculine, Dr. Daphna Stroumsa at the University of Michigan-Ann Arbor, wrote in the journal article. “But that classification threw us off from considering his actual medical needs.”

“The point is not what’s happened to this particular individual but this is an example of what happened to transgender people interacting with the health care system,” she added.

The Washington Post’s Marilynn Marchione argued that this case should make doctors aware of the “blurred lines” in medicine. Citing the journal article, she claimed that the case “points to larger issues about assigning labels or making assumptions in a society increasingly confronting gender variations in sports, entertainment and government. In medicine, there’s a similar danger of missing diseases such as sickle cell and cystic fibrosis that largely affect specific racial groups, the authors wrote.”

Yet this conclusion is forced at best, and merely serves to blind people to the truth of the story.

The 32-year-old woman was not identified, but the journal noted that she told the nurse she was transgender at the emergency room. The record listed her as male. She hadn’t had a period in several years and had been taking testosterone, which decreases ovulation and menstruation. She quit taking the hormone after she lost health insurance.

The mother had taken a home pregnancy test and it came out positive. She also had wet herself, a possible sign of ruptured membranes and labor. A nurse ordered a pregnancy test but considered her stable and her problems non-urgent.

Hours later, a doctor evaluated her and confirmed pregnancy. They took an ultrasound and found clear signs of fetal heart activity, but part of the umbilical cord had slipped into the birth canal. Doctors prepared to do an emergency c-section, but the baby's heartbeat stopped in the operating room.

The Washington Post reported these words, "Moments later, the man delivered a stillborn baby."

Tellingly, the authors wrote that if a clearly identified woman had shown up with similar systems, the woman "would almost surely have been triaged and evaluated more urgently for pregnancy-related problems." In other words, the confusion of transgender identity prevented the doctors from giving this mother the care she needed.

The toxic doublespeak of transgender identity runs throughout the journal article and the *Washington Post* story. Marchione actually defined "transgender men" as people "who are considered female at birth but who identify as male" and wrote that they "may or may not be using masculinizing hormones or have had surgical alterations, such as womb removal."

This kind of explanation is clear gaslighting. From the moment of conception, human beings are either female (two "X" chromosomes) or male (one "X" and one "Y"). Some people have intersex conditions, where their reproductive organs do not develop normally and many of them are sterile. This is not a "third sex," however, as human reproduction involves one male and one female.

When a reproductively-healthy biological female identifies as a man, that does not *make her a man*. Unless she undergoes surgeries that

sterilize her, she can still get pregnant.

Yet the embrace of transgender identity in medicine and in journalism has led people to make absurd statements, such as claiming that “men” have female sex organs and that “men” can get pregnant and deliver babies. This is lunacy.

To be clear, some people have a serious condition of experiencing severe discomfort from persistently identifying with the gender opposite their biological sex (gender dysphoria). These struggles deserve sympathy, but it is entirely wrongheaded to embrace a false transgender identity in the name of helping these people.

This is akin to telling a teenage girl who struggles with anorexia (thinking she is fat when she is really thin) that she is truly fat and should starve herself. Whatever the anorexic girl’s “fat identity,” the fact is that she needs food to survive, and attempts to starve herself are unhealthy.

In this mother’s tragic case, the medical profession’s rapid embrace of transgender identity actually cost a human life. This unborn baby had done nothing to deserve death, but because the baby’s mother identified as a man and because medical records listed her as male, her baby was not given the help this most vulnerable human needed to survive.

“It’s a very upsetting incident, it’s a tragic outcome,” Dr. Tamara Wexler, a hormone specialist at NYU Langone Medical Center, told the *Post*.

Yet she drew an absurd lesson from the tragedy. “Medical training should include exposure to transgender patients” so health workers

are better able to meet their needs. “A lot of doctors who are practicing don’t have that in their training.”

“There are implicit biases that need to be addressed,” Nic Rider, a transgender health specialist and psychologist at the University of Minnesota, told the *Post*. He insisted that training is not enough. People must be re-educated to stop thinking of human beings as male and female.

Health records may use male and female templates “for gender” but “it doesn’t mean that we just throw out critical thinking or think about how humans are diverse,” Rider argued.

Basic biology is accurate. Only women can get pregnant. Even though this mother identified herself as transgender, she should have been seen as a woman. Her false identity is not “diversity,” and in this case, it made it harder for doctors to save the life of her baby.

Accurate medical records cannot erase biological sex. Men and women have different health needs, and even when a transgender person takes hormones and surgery, his or her body is still impacted by his or her biological sex. In the case of a “transgender man” like this, doctors need to know that she is truly female — this can be a matter of life and death.

The tragedy in this case is not “those bigoted doctors and nurses” but the prevailing fiction that this woman is “really a man.” Had the medical records not listed her as male, her baby might be alive today.

Follow Tyler O’Neil, the author of this article, on Twitter at @Tyler2ONeil.

Huh? Biological Man Identifies as a Woman But Plays a Man as the First Transgender Lead in U.S. Opera

Tyler O'Neil is an author and conservative commentator. He has written for numerous publications, including The Christian Post, National Review, The Washington Free Beacon, The Daily Signal, AEI's Values & Capitalism, and the Colson Center's Breakpoint. He enjoys Indian food, board games, and talking ceaselessly about politics, religion, and culture. He has appeared on Fox News' "Tucker Carlson Tonight." He is the author of *Making Hate Pay: The Corruption of the Southern Poverty Law Center*. Follow him on Twitter at @Tyler2ONeil.

Read more by Tyler O'Neil

Tags: 2019 CHILDBIRTH HEALTH TRANSGENDER

Around the Web

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Doctor: if You Have Tinnitus (Ear Ringing) Do This
Healthy Lifestyle

Escondido Entre Os Pinheiros - Está Um Avião a Jato Boeing
VEJA O QUE ESTA DENTRO

Les Plongeurs Atteignent Le Fond Du Grand Trou Bleu
Regarde ce qu'ils ont trouvé!

TRENDING

The Morning Briefing: Score Another One for the Tinfoil Hat COVID 'Disinformation' Crowd

Washington State Dems Want 'Minority Report' Commission to Destroy Conservative Wrong-Think

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EDITOR'S CHOICE

LOL: White House Official Shares Tweet From 'Biden Showered With His Daughter'

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MONDAY AT 3PM EASTERN: 'Five O'Clock Somewhere' with Kruiser, VodkaPundit

UFAVORABLE_SB0460_Jessica_Helms.pdf
Uploaded by: Jessica Helms
Position: UNF

UFAVORABLE

SB0460 -
Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

Jessica Helms

Capitol Heights, MD

I am writing to ask an UNFAVORABLE report on SB0460. We have seen many cases where doctors not knowing the truth about a person's birth assigned sex have caused errors in treatment that have lead to injury or death.

A baby died when the mother's medical records designated her male since doctors looked for issues they would normal see on a male and not for things a woman would present with.

Many have missed out on cancer screenings and treatments when not disclosing their birth assigned gender because, again, doctors are going to look for things associated with the gender on record if having transitioned is not disclosed.

We do not need to make doctor's jobs harder as it will delay these people getting the treatments they need.

As a former teacher, I worry about the impulsivity of teens and how this lack of true health care knowledge may affect them. I have attached an article discussing teens who regret their transition and say doctors have failed them and I encourage you to read it.

Doctors as medical experts need honest information on scientific fact - XX or XY chromosomes at birth – more than they need to know how one identifies to ensure they can give the person proper treatment.

Please return an unfavorable report on SB0460.

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WEBMD HEALTH NEWS

Transgender Docs Warn About Gender-Affirmative Care for Youth

Written by Alicia Ault

Nov. 29, 2021 -- Leading experts on transgender medicine are accusing trans activists of muffling their concerns about the quality of evaluations of adolescents and young adults with gender dysphoria.

While clinicians who have raised the warning flags say the health of young people is their primary concern, activists worry that open questioning of the situation will fuel the anti-trans legislation sweeping across the nation, and further stigmatize trans youth.

Others agree that it is time to take a closer look at the widely backed "gender-affirmative care" model and the quality of care being delivered, but they believe it should be done in the halls of academia, not through the lay press or on social media.

The latest skirmish was set off by comments made by Marci Bowers, MD, president-elect of the World Professional Association for Transgender Health and Erica Anderson, PhD, president of the U.S. Professional Association for Transgender Health.

researcher Lisa Littman, MD, MPH, president of the Institute for Comprehensive Gender Dysphoria Research.

However, many researchers acknowledge the phenomenon that it describes: A huge increase in the Western world of teenagers and young adults suddenly expressing a transgender identity seemingly out of the blue, when previously there had been no indication that they were uncomfortable with their biological sex.

This phenomenon has also been called late- or adolescent-onset gender dysphoria. It is different from earlier descriptions of gender dysphoria, which was primarily observed in younger children.

'We're Going to Have More Young Adults Who Regret...This Process'

In their comments, Bowers and Anderson (both of whom are transgender themselves) criticize the quality of assessments and care for children and adolescents experiencing gender dysphoria.

Anderson, a clinical psychologist, said that "due to some of the -- I'll call it just 'sloppy' health care work -- that we're going to have more young adults who will regret having gone through this process."

In an interview with, Anderson says she stands by the comments. "I'm concerned that there are some...providers of mental health [care] and medical providers who are not observing (official) standards of care and who may be less fully qualified to deliver care."

One of the "sloppy" things she says she's witnessed is providers "believing that the gender-affirmative approach is simply taking what the children say and running with it."

The "gender affirmative" approach for children with gender dysphoria means different things at different ages. In the case of kids who have not yet entered puberty, this might include prescribing so-called "puberty blockers" to delay natural puberty — these are drugs that block the hormones that will start puberty, which are licensed for use in excessively early (precocious) puberty in children, as well as for prostate cancer in men.

They have not been licensed for use in children with gender dysphoria, so any such use is so-called 'off-label'. That is, the FDA has not approved these drugs for use in gender dysphoria.

Following puberty blockade, or in cases where adolescents have already undergone natural puberty, the next step is to begin "cross-sex" hormones. So, for a girl (female) who wants to transition to male, that would be lifelong testosterone, and for a male who wants to be female, it involves lifelong estrogen. Again, use of such hormones in transgender individuals is 'off-label' and is not approved by

the FDA.

Many of these individuals also decide to undergo surgery, although this usually happens when they are legally adults (at age 18 and older). In the case of females-transitioning-to-male, surgery involves a double mastectomy --often called "top surgery" by transgender people-- to remove the breasts and give the chest the appearance of a male. Boys wishing to transition to female may get breast implants, although in many cases, estrogen causes enough breast tissue to grow.

So-called "bottom surgery" is more complex. For males-transitioning-to-female, it involves removal of the testicles and turning the penis inside out, to form a "neo-vagina". And for female-to-male surgery, it may involve a hysterectomy, removal of the ovaries, and a complex and multistage procedure called a phalloplasty, which involves removal of a large amount of skin, usually from the arm, to create a fleshy protuberance that is shaped like a penis.

A proper evaluation for gender dysphoria requires a comprehensive analysis of every young person, their journey, and a medical and psychological profile, Anderson stresses.

"To simply act as if a child is a reliable reporter about this area but not nearly every other area is preposterous," she says.

Anderson says she's not criticizing all providers or all transgender care.

But she's concerned "that in the haste which some, in my opinion, have exercised to provide gender care to youth...some providers are either ignoring what they know about adolescents, or they're setting it aside for the time being in the service of expediting care that's gender-affirming."

"It disturbs me a great deal, which is why I'm speaking out, even though I've incurred the ire of some people who think that just by speaking out I am causing problems," says Anderson.

Bowers, a gynecologic surgeon, has felt similar pressure. She said in her comments, "There are definitely people who are trying to keep out anyone who doesn't absolutely buy the party line that everything should be affirming and that there's no room for dissent."

She also said she was "not a fan" of administering puberty blockers during the middle of puberty.

Puberty blockers prevent genital tissue growth, which can make gender-affirming 'bottom surgeries' more difficult, for example for male to female transitions, because if a boy takes puberty blockers, his penis doesn't grown to the size of an adult male, which makes it more difficult to form a 'neo-vagina' from it, Bowers says. This is what happened to Jazz Jennings, whose transition journey has been broadcast on television in the series, *I Am Jazz*.

Bowers is also worried that puberty blockers, combined with cross-sex hormones afterward, may impact children's "sexual health later and ability to find intimacy."

Bowers did not respond to requests for additional comment.

Discussions Should Be in Academia, Not on Social Media or in Lay Press

Some 8 days after the their comments were published, USPATH and WPATH issued a joint statement that it stood behind "the appropriate care of transgender and gender diverse youth, which includes the use of 'puberty blockers,'" and "the use of gender-affirming hormones such as estrogen or testosterone."

The two organizations also say they "oppose the use of the lay press, either impartial or of any political slant or viewpoint, as a forum for scientific debate of these issues, or the politicization of these issues in any way."

Jason Rafferty, MD, MPH, lead author of the American Academy of Pediatrics 2018 policy statement on caring for transgender and gender-diverse children and adolescents, said he agrees that discussions about the gender-affirmative care model should be held mainly among professionals.

He also acknowledged that "parents are coming to us with a lot of fear and trepidation about what's ahead."

Bowers' and Anderson's comments "played on some of those fears — that the future after gender-affirmative care is really scary," says Rafferty, a pediatrician and child psychiatrist at the gender and sexuality clinic at Hasbro Children's Hospital in Providence, RI.

Nevertheless, he says concerns voiced by Bowers and Anderson are "legitimate."

"The Brave Ones"

Anderson says that she and another psychologist, Laura Edwards-Leeper, PhD, are among the few willing to speak out.

"Others have dubbed Dr Edwards-Leeper and I the 'brave ones' because we're willing to talk about these issues," she says.

Anderson was, until October, a clinical psychologist at the Child and Adolescent Gender Clinic at the University of California at San Francisco. She says she resigned "to pursue other opportunities."

Edwards-Leeper is professor emeritus in the School of Graduate Psychology at Pacific University in Hillsboro, OR, and was on the American Psychological Association Task Force that developed practice guidelines for working with transgender individuals.

She is currently chair of the child and adolescent committee for WPATH.

Anderson and Edwards-Leeper have been criticized for speaking about their concerns, whether in a *60 Minutes* broadcast in May that focused on detransitioners (individuals who transition to the opposite sex but then change their minds and 'detransition'), or in other forums.

The two psychologists recently submitted an opinion-editorial to *The New York Times* but it was turned down by the newspaper.

Even that was fodder for critics. "Please don't talk to anti-trans journalists because you're mad the NYT rejected your op-ed," tweeted Jack Turban, MD, a few weeks after the original comments appeared.

Turban is a child psychiatry fellow at Stanford University School of Medicine who specializes in the mental health of transgender youth, and he also writes op-eds for *TheNew York Times*. He did not

appear to tweet directly at anyone, but his target seemed clear.

Is Gender-Affirmative Care Reversible?

Rafferty, from the American Academy of Pediatrics, believes that transitioning is not a "one-time decision," where "once they start, they're on this train that's left the station and they can't turn back, they can't change anything." He tells parents, "That's not the gender-affirmative care model."

The model says that with every visit the care is affirming, he says. "And if something doesn't feel affirming, to slow down, to explore it," Rafferty emphasizes.

Puberty blockers may be the right approach initially, but they can always be stopped if it's no longer the right tactic, he explains.

"At the end of the day, it's not about people being transgender, it's about people being really confident and comfortable in their body and their identity," he says.

The Endocrine Society, global community of thousands of clinicians from more than 100 countries says the American Medical Association, the APA, the Pediatric Endocrine Society, the European Society of Endocrinology, the European Society for Paediatric Endocrinology, and the AAP "are in alignment with us on the importance of gender-affirming care," which includes puberty blockers.

"Being forced to experience puberty consistent with the sex recorded at birth is extremely distressing for many transgender and gender-diverse individuals," the Endocrine Society says in a statement. That, in turn, can "result in higher psychological problem scores and can raise the person's risk of committing suicide or other acts of self-harm."

It is, however, widely accepted that most children who take puberty blockers will progress to medically transition with cross-sex hormones.

Therefore, far from being reversible, puberty blockers appear to be a "one-way path" to medical transition, say critics.

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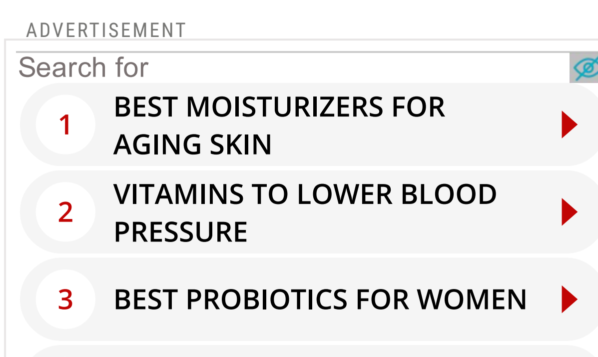

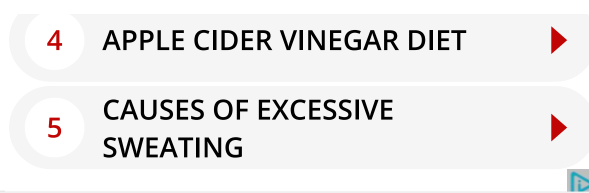

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WEBMD HEALTH NEWS

Doctors Have Failed Them, Say Those Who Regret Transitioning

Written by Alicia Ault

March 22, 2022 -- People who had transitioned to the opposite gender and later decided to reverse their transition shared about how they felt the medical establishment had failed them in a unique Zoom conference earlier this month.

The forum was convened by Genspect, a parent-based organization seeking to put the brakes on medical transitions for adolescents and children. The group has doubts about the gender-affirming care model supported by the World Professional Association for Transgender Health, the American Medical Association, the American Academy of Pediatrics, and other medical groups.

"Affirmative" medical care is defined as treatment with puberty blockers and cross-sex hormones for those with gender dysphoria to transition to the opposite sex, and is often followed by gender reassignment surgery.

However, there is growing concern among many doctors and other healthcare professionals as to

The purpose of the second annual Genspect meeting, held March 12 and dubbed #DetransitionAwarenessDay, was to shed light on the experiences of individuals who have detransitioned — those that identified as transgender and transitioned, but then decided to end their medical transition. People logged on from the United States, Canada, New Zealand, Australia, the United Kingdom, Germany, Spain, Chile, and Brazil, among other countries.

"This is a minority within a minority," said Genspect advisor Stella O'Malley, adding that the first meeting in 2021 was held because "too many people were dismissing the stories of the detransitioners." O'Malley is a psychotherapist, a clinical advisor to the Society for Evidence-Based Gender Medicine, and a founding member of the International Association of Therapists for Desisters and Detransitioners.

"It's become blindingly obvious over the last year that...'detrans' is a huge part of the trans phenomenon," said O'Malley, adding that detransitioners have been "undermined and dismissed."

Laura Edwards-Leeper, PhD (@DrLauraEL), a prominent gender therapist who has recently expressed concern regarding adequate gatekeeping when treating youth with gender dysphoria, agreed.

She tweeted: "You simply can't call yourself a legit gender provider if you don't believe that detransitioners exist. As part of the informed consent process for transitioning, it is unethical to not discuss this possibility with young people." Edwards-Leeper is professor emeritus in the School of Graduate Psychology at Pacific University in Hillsboro, Oregon.

Speakers in the forum largely offered experiences, not data. They pointed out that there has been little to no study of detransition, but all testified that it was less rare than it has been portrayed by the transgender community.

Struggles With Going Back

"There are so many reasons why people detransition," said Sinead Watson, 30, a Genspect advisor who transitioned from female to male, starting in 2015, and who decided to detransition in 2019.

Citing a study by Lisa Littman, MD, MPH, published last year, Watson said the most common reasons for detransitioning were realizing that gender dysphoria was due to other issues; internal homophobia; and the unbearable nature of transphobia.

Watson said the hardest part of detransitioning was admitting to herself that her transition had been a mistake. "It's embarrassing and you feel ashamed and guilty," she said, adding that it may mean losing

friends who now regard you as a "bigot, while you're also dealing with transition regret."

"It's a living hell, especially when none of your therapists or counselors will listen to you," she said. "Detransitioning isn't fun."

Carol (@sourpatches2077) said she knew for a year that her transition had been a mistake.

"The biggest part was I couldn't tell my family," said Carol, who identifies as a lesbian. "I put them through so much. It seems ridiculous to go, 'Oops, I made this huge [expletive] mistake," she said, describing the moment she did tell them as "devastating."

Grace (@hormonehangover) said she remembers finally hitting a moment of "undeniability" some years after transitioning. "I accept it, I've ruined my life, this is wrong," she remembers thinking. "It was devastating, but I couldn't deny it anymore."

Don't Trust Therapists

People experiencing feelings of unease "need a therapist who will listen to them," said Watson. When she first detransitioned, her therapists treated her badly, she said. "They just didn't want to speak about detransition," she noted, adding that "it was like a kick in the stomach."

Watson said she'd like to see more training about detransition, but also on "preventative techniques," adding that many people transition who should not. "I don't want more detransitioners — I want less," she said.

"In order for that to happen, we need to treat people with gender dysphoria properly," said Watson, saying that the affirmative model is "disgusting, and that's what needs to change."

"I would tell somebody to not go to a therapist," said Carol. Identifying as a butch lesbian, she said she felt like her therapists had pushed her into transitioning to male. "The number one thing not understood by the mental health professionals is that the vast majority of homosexuals were gender-nonconforming children," she said, adding that this is especially true of butch lesbians.

Therapists — and doctors — also need to acknowledge both the trauma of transition and detransition, she said.

Kaiser, where she had transitioned, offered her breast reconstruction. Carol said it felt demeaning. "Like you're Mr Potatohead: 'Here, we can just...put on some new parts and you're good to go,'" she said.

"Doctors are concretizing transient obsessions," said Helena Kerschner (@lacroicsz), quoting a chat room user.

Kerschner gave a presentation on "fandom": becoming obsessed with a movie, book, TV show,

musician, or celebrity, spending every waking hour chatting online or writing fan fiction, or attempting to interact with the celebrities online. It's a fantasy-dominated world and "the vast majority" of participants are teenage girls who are "identifying as trans," in part, because they are fed a community-reinforced message that it's better to be a boy, claimed Kerschner.

Therapists and physicians who help them transition "are harming them for life based on something they would have grown out of or overcome without the permanent damage," she added

Doctors "Gaslighting" People Into Belief That Transition Is Answer

A pervasive theme during the webinar was that many people are being misdiagnosed with gender dysphoria, which may not be resolved by medical transition.

Allie, a 22-year-old who stopped taking testosterone after one-and-a-half years, said she initially started the transition to male when she gave up trying to figure out why she could not identify with, or befriend, women, and after a childhood and adolescence spent mostly in the company of boys and being more interested in traditionally male activities.

She endured sexual abuse as a teenager and her parents divorced while she was in high school. Allie also had multiple suicide attempts and many incidents of self-harm, she said. When she decided to transition, at age 18, she went to a private clinic and received cross-sex hormones within a few months of her first and only 30-minute consultation. "There was no explorative therapy," she said, adding that she was never given a formal diagnosis of gender dysphoria.

For the first year, she said she was "over the freaking moon" because she felt like it was the answer. But things started to unravel while she attended university and she attempted suicide attempt at age 20. A social worker at the school identified her symptoms — which had been the same since childhood — as autism. She then decided to cease her transition.

Another detransitioner, Laura Becker, said it took 5 years after her transition to recognize that she had undiagnosed post-traumatic stress disorder (PTSD) from emotional and psychiatric abuse. Despite a history of substance abuse, self-harm, suicidal ideation, and other mental health issues, she was given testosterone and had a double-mastectomy at age 20. She became fixated on gay men, which devolved into a methamphetamine- and crack-fueled relationship with a man she met on the gay dating platform Grindr.

"No one around me knew any better or knew how to help, including the medical professionals who performed the mastectomy and who casually signed-off and administered my medical transition," she said.

Once she was aware of her PTSD she started to detransition, which itself was traumatic, said Laura.

Limpida, aged 24, said he felt pushed into transitioning after seeking help at a Planned Parenthood clinic. He identified as trans at age 15 and spent years attempting to be a woman socially, but every step made him feel more miserable, he said. When he went to the clinic at age 21 to get estrogen, he said he felt like the staff was dismissive of his mental health concerns — including that he was suicidal, had substance abuse, and was severely depressed. He was told he was the "perfect candidate" for transitioning.

A year later, he said he felt worse. The nurse suggested he seek out surgery. After Limpida researched what was involved, he decided to detransition. He has since received an autism diagnosis.

Robin, also aged 24, said the idea of surgery had helped push him into detransitioning, which began in 2020 after 4 years of estrogen. He said he had always been gender-nonconforming and knew he was gay at an early age. He believes that gender-nonconforming people are "gaslighted" into thinking that transitioning is the answer.

Lack of Evidence-Base, Informed Consent

Michelle Alleva, who stopped identifying as transgender in 2020 but had ceased testosterone 4 years earlier because of side effects, cited what she called a lack of evidence base for the effectiveness and safety of medical transitions.

"You need to have a really, really good evidence base in place if you're going straight to an invasive treatment that is going to cause permanent changes to your body," she said.

Access to medical transition used to involve more "gatekeeping," through mental health evaluations and other interventions, she said, but there has been a shift from treating what was considered a psychiatric issue to essentially affirming an identity.

"This shift was activist-driven, not evidence-based," she emphasized.

Most studies showing satisfaction with transition only involve a few years of follow-up, she said, adding that the longest follow-up study of transition, published in 2011, spanning 30 years, showed that the suicide rate 10-15 years post-surgery was 20 times higher than the general population.

Studies of regret were primarily conducted before the rapid increase in the number of trans-identifying individuals, she said, which makes it hard to draw conclusions about pediatric transition. Getting estimates on this population are difficult because so many who detransition do not tell their clinicians, and many studies have short follow-up times or a high loss to follow-up.

Alleva also took issue with the notion that physicians were offering true informed consent, noting that

it's not possible to know if someone is psychologically sound if they haven't had a thorough mental health evaluation, and that there are so many unknowns with medical transition, including that many of the therapies are not approved for the uses being employed.

With regret on the rise, "We need professionals that are prepared for detransitioners," said Alleva. "Some of us have lost trust in health care professionals as a result of our experience," she said.

"It's a huge feeling of institutional betrayal," said Grace.

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Bone Health: Puberty Blockers Not "Fully Reversible"

By / October 20, 2021

Written by Simon Tegg, who is part of Fully Informed, a group of people from across New Zealand concerned about the legality and long-term impacts of prescribing puberty blockers to children.

Please use hashtag #WorldOsteoporosisDay

October 20 is World Osteoporosis Day. Osteoporosis affects a huge number of us as we get older, contributing to bone fractures in 1 in 3 women and 1 in 5 men over 50. These fractures can be life threatening and cause ongoing disability.

The website includes a risk factor tool where you can enter your details and get a summarised assessment of your osteoporosis risk. Clicking through the tool, you will be asked if you've ever had "*Androgen deprivation therapy used to treat prostate cancer*." 'Androgen deprivation therapy' is of course GnRH agonists, the same class of drugs used to block puberty in gender-dysphoric adolescents. A question asking about puberty suppression is missing from the tool because it's targeted at older people, while the adolescents treated with GnRH agonists are still young and the treatment is relatively novel. This article outlines the existing research on puberty suppression and its impacts on bone health for these young people.

What is the state of the research?

The research on the bone health impacts of puberty suppression is quite limited. There are only seven studies that track bone health impacts, two published this year. None have controls. Nevertheless, we know more about the impacts of puberty blockers on bone health than on cognitive or emotional development, for example. Clinicians who suppress puberty in adolescents know that they're likely increasing the risk, and consent forms include warnings about unknown long-term impacts on bone health.

How does puberty suppression impact bone density?

Sex hormones are important to maintaining healthy bones. This is why postmenopausal women and men treated for prostate cancer have a greater risk

of osteoporosis after sex hormone production declines or is halted with treatment. For adolescents treated with GnRH agonists, the impacts are especially concerning. Puberty is when adolescents gain adult levels of bone density; without sex hormones, the research indicates that absolute bone density usually flatlines or declines while on treatment. Flatlining bone density in adolescence represents a failure to accumulate adult bone density, and a decline in bone density relative to peers. Declining absolute bone density during adolescence is even more serious.

Across the studies and all measures of bone density, treated adolescents lost around -0.8 of a standard deviation compared to peers, with a wide range of outcomes depending on the measured location (measured at the spine or hip, etc.). In adults, bone density more than -1 standard deviations below the mean and more than -2.5 standard deviations is considered to be *osteopenia*. Bone density below -2.5 (or the 0.6th percentile) standard deviations is considered *osteoporosis*. However, adolescent bone density is interpreted differently. Below -2 standard deviations is considered "low for age," and a diagnosis of paediatric osteoporosis also relies on fracture history.

Gender-dysphoric males in particular have lower than average bone density before starting GnRHa treatment. This is probably due to this group getting less exercise and sunshine than peers. A significant minority will be classified as 'low for age' after GnRH agonist treatment. Most studies have not tracked fractures, so we don't know if the treatment has induced paediatric osteoporosis.

Does bone density recover after the treatment is withdrawn?

Only four studies have examined the recovery of bone density after GnRH agonist treatment but only follow up with patients who received cross-sex hormones after GnRHa. No studies have looked at patients who discontinued GnRHa and did not receive cross-sex hormones.

In the three studies mentioned, females who went on to testosterone treatment recovered to the normal range if somewhat below baseline values for most measures of bone density.

For males, the picture is less clear. Some measures recovered, some showed no improvement, and a small number showed further declines.

Implications

For men treated with GnRH agonist for prostate cancer, "*the cessation of [treatment] does not guarantee the recovery of bone to the previous status*." Given the results above, it's reasonable to conclude that the same is true for adolescents as well, and that treated adolescents will be more likely to develop osteoporosis later in life. Describing GnRHa treatment for adolescents as "fully reversible" is misleading if not downright dishonest.

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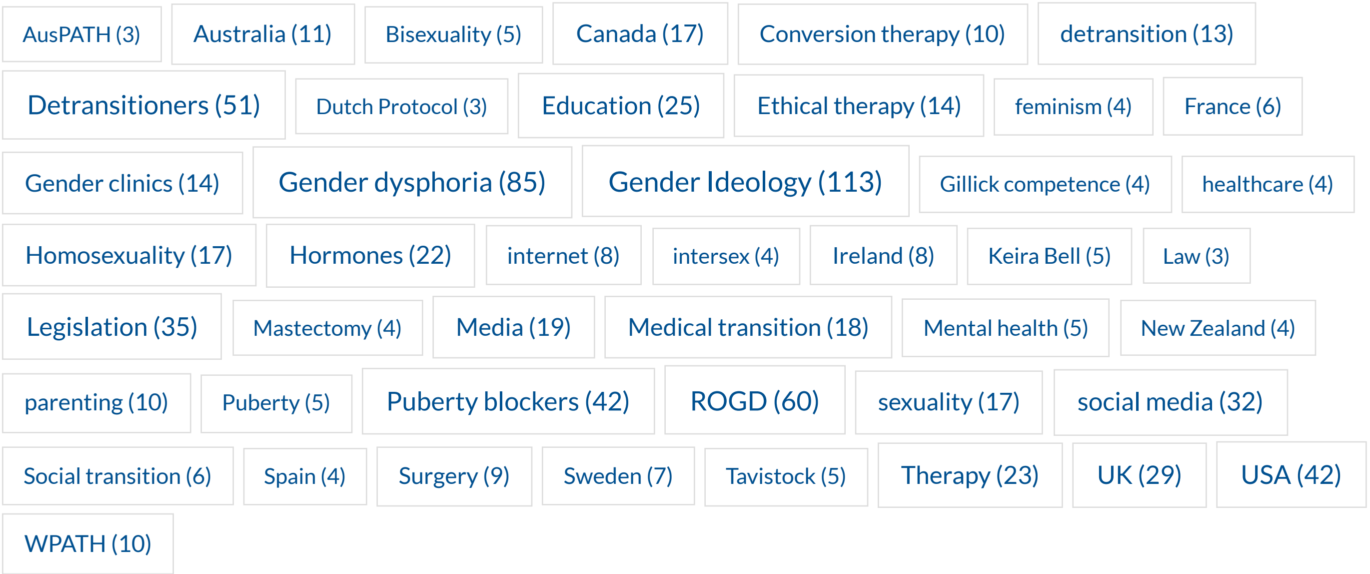

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Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands

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ABSTRACT

OBJECTIVE
To investigate the incidence and characteristics of breast cancer in transgender people in the Netherlands compared with the general Dutch population.

DESIGN
Retrospective, nationwide cohort study.

SETTING
Specialised tertiary gender clinic in Amsterdam, the Netherlands.

PARTICIPANTS
2260 adult trans women (male sex assigned at birth, female gender identity) and 1229 adult trans men (female sex assigned at birth, male gender identity) who received gender affirming hormone treatment.

MAIN OUTCOME MEASURES
Incidence and characteristics (eg, histology, hormone receptor status) of breast cancer in transgender people.

RESULTS
The total person time in this cohort was 33 991 years for trans women and 14 883 years for trans men. In the 2260 trans women in the cohort, 15 cases of invasive breast cancer were identified (median duration of hormone treatment 18 years, range 7-37 years). This was 46-fold higher than in cisgender men (standardised incidence ratio 46.7, 95% confidence interval 27.2 to 75.4) but lower than in cisgender women (0.3, 0.2 to 0.4). Most tumours were of ductal origin and oestrogen and progesterone receptor positive, and 8.3% were human epidermal growth factor 2 (HER2) positive. In 1229 trans men, four cases of invasive breast cancer were identified (median duration of hormone treatment 15 years, range 2-17 years). This was lower than expected compared with cisgender women (standardised incidence ratio 0.2, 95% confidence interval 0.1 to 0.5).

CONCLUSIONS
This study showed an increased risk of breast cancer in trans women compared with cisgender men and a lower risk in trans men compared with cisgender women. In trans women, the risk of breast cancer increased during a relatively short duration of hormone treatment and the characteristics of the breast cancer resembled a more female pattern. These results suggest that breast cancer screening guidelines for cisgender people are sufficient for transgender people using hormone treatment.

WHAT IS ALREADY KNOWN ON THIS TOPIC

Transgender people, defined as an incongruence between sex assigned at birth and experienced gender, can receive gender affirming hormone treatment (sex steroids) to induce desired physical changes

Whether (exogenous) sex steroids influence breast cancer risk and pathogenesis in transgender people is not fully understood

Currently, information about the risk of breast cancer in transgender people is limited

WHAT THIS STUDY ADDS

An increased risk of breast cancer was observed in trans women (male sex assigned at birth, female gender identity) compared with cisgender men and a lower risk in trans men (female sex assigned at birth, male gender identity) compared with cisgender women

A striking finding was that in trans women the risk of breast cancer increased in a relatively short time

The absolute risk of breast cancer in transgender people remains low, and therefore following breast cancer screening guidelines for cisgender people seems sufficient for transgender people using hormone treatment

Introduction

Breast cancer is the most common malignancy in females,[1] but it is rare in males. The lifetime risk in the general female population is 12% and in the general male population is 0.1%.[2] Several risk factors have been identified for breast cancer, including advancing age, genetics (eg, BReast CAncer 1/2 mutations (BRCA1/2)), family history, overweight or obesity, breast density, tobacco use, alcohol use, and null parity in females.[3 4] The molecular pathogenesis of breast cancer differs between sexes.[5] For instance, cancers positive for human epidermal growth factor receptor 2 (HER2) are rare in males (1.7%), whereas 6-12% of the breast cancers in females express HER2.[5-7]

Transgender people experience an incongruence between the sex assigned to them at birth and their experienced or expressed gender. In the Netherlands, an estimated one in 2800 birth assigned males and one in 5200 birth assigned females identify themselves as transgender.[8] However, a substantial increase in the number of referrals for psychological counselling, for endocrine or surgical treatment, or a combination of those has been seen over the past 10 years.[8] Transgender people can receive gender affirming hormones (sex steroids) to reduce psychological distress and to induce desired physical changes, such as for body hair and body composition.[9 10] In trans women (male sex assigned at birth, female gender identity), treatment usually consists of antiandrogens and oestrogens. In trans men (female sex assigned at birth, male gender identity), treatment usually consists of testosterone. Besides gender affirming hormone treatment, transgender people might also want surgical transition, which can consist of breast augmentation

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and orchiectomy or vaginoplasty in trans women and subcutaneous mastectomy and uterus extirpation or oophorectomy, or both, and phalloplasty in trans men. Subcutaneous mastectomy in trans men is often subtotal to obtain an aesthetic masculine thorax.

Whether (exogenous) sex steroids influence breast cancer risk and pathogenesis in transgender people is not fully understood. It is known that sex steroids induce changes in breast tissue.[2 11] During female puberty and in trans women receiving hormone treatment, mammary development includes duct and lobule formation and an increase in deposition of fat in the breasts.[2] Some structural changes occur in breast tissue under the influence of testosterone, such as an increase in fibrous tissue[2 11] and the up regulation of potential oncogenes.[12] Large prospective studies have shown that hormone replacement therapy increases the risk of breast cancer in cisgender postmenopausal women,[13-15] in particular in those using both oestrogens and progestogens, which could suggest an increased breast cancer risk in trans women receiving hormone treatment compared with cisgender men.

Currently, information about the risk of breast cancer in transgender people is limited. To date, 22 cases of breast cancer in trans women and 20 cases in trans men have been published.[16-19] However, reliable estimations of the risk in transgender people are lacking because of the heterogeneity in the population and study cohorts.[20]

To gain more insight into the risk of breast cancer in transgender people receiving hormone treatment and the influence of (exogenous) sex steroids on the development of breast cancer, we investigated the incidence and characteristics of breast cancer in a well documented cohort of transgender people receiving hormone treatment in the Netherlands, compared with the general Dutch population.

Methods

Study population

For this retrospective cohort study, we identified all transgender people who visited the gender clinic of the VU University Medical Centre Amsterdam between 1972 and January 2016 for either psychological, endocrine, or surgical treatment. More than 95% of transgender people in the Netherlands receive healthcare at our centre.[8] People were excluded from analyses if they never used hormone treatment or the start date was unknown, they were younger than 18 years at the time of the study, or they used alternating oestrogen and testosterone during the follow-up time because of regret about their transition. As data on breast cancer diagnosis were retrieved from the Nationwide Network and Registry of Histopathology and Cytopathology in the Netherlands (PALGA), which covers all pathology diagnoses since 1991,[21] we also excluded those whose last visit to our gender identity clinic was before 1991.

Most trans women were treated with a combination of antiandrogens and oestrogens. Antiandrogen treatment usually consisted of cyproterone acetate (a progestogenic antiandrogen, 10 to 100 mg daily) or spironolactone (100 to 200 mg daily), and treatment was often stopped after orchiectomy. Oestrogen was prescribed as ethinylestradiol (25 to 100 µg daily), conjugated oestrogens (0.625 to 1.25 mg daily), estradiol patches (50 to 150 µg/24 hours twice weekly), estradiol implants (20 mg every 3 to 6 months), estradiol injections (10 to 100 mg every 2 to 4 weeks), estradiol valerate (2 to 6 mg daily), or estradiol gel (0.75 to 3.0 mg daily). In recent years, mainly estradiol valerate, estradiol patches, or estradiol gel have been used. Trans men were treated with either testosterone gel (20 to 100 mg daily), intramuscular testosterone esters (150 to 250 mg every 2 to 3 weeks), or oral or intramuscular testosterone undecanoate (orally: 40 to 160 mg daily, intramuscularly: 1000 mg every 10 to 14 weeks). Trans men who experienced persistent menstrual blood loss during testosterone treatment were in some cases treated with additional progestogens such as lynestrenol (5 to 10 mg daily). People who started hormone treatment younger than 18 years often received only gonadotrophin releasing hormone agonists before the addition of oestrogen or testosterone treatment.

Data collection

After inclusion of eligible people, we collected data about age at start of hormone treatment, type of treatment, gender affirming surgery, and medical history. Subsequently, the data were linked to PALGA and Statistics Netherlands (CBS). We retrieved data on year of breast cancer diagnosis and breast cancer histology from PALGA. To adequately calculate the follow-up time, we retrieved data on mortality from Statistics Netherlands.

Statistical analysis

Data from trans women and trans men were analysed separately. Baseline data are presented as means with standard deviations for normally distributed data, and medians with interquartile ranges, ranges, or both for non-normally distributed data. For those people who had started hormone treatment before treatment at our clinic, we used the first known start date of the treatment to calculate the most accurate duration. To calculate standardised incidence ratios, we determined the number of observed breast cancer cases in this cohort. Person time was calculated as the number of years from the first known start date of hormone treatment to the first terminating event: breast cancer diagnosis, death, or end of study period (31 August 2017). The number of expected cases were calculated using age matched incidence rates for cisgender men and women from the Netherlands Comprehensive Cancer Organisation (IKNL).[22] We calculated the number of expected cases for the whole study population and for the age categories younger than 30 years, 30 to 50 years, and older than 50 years. Finally, standardised incidence ratios with 95% confidence intervals were calculated with a mid-P exact test. Mean oestradiol and testosterone concentrations for each participant

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were calculated by averaging the results from the measurements performed during hormone treatment.

Analyses were carried out using STATA statistical software, version 14.1 (Statacorp, College Station, TX) and OpenEpi version 3.01 (www.OpenEpi.com).

Patient and public involvement

Owing to the design of this study, there was no patient or public involvement. The results of this paper will be shared with the public through our institutions' website and during an open science evening at our centre, which is intended for transgender people, their friends and family, and other interested people.

Results

Of 6793 transgender people identified, 4432 were birth assigned males and 2361 were birth assigned females. After exclusions, 2260 trans women and 1229 trans men were included in this study (fig 1). The median age at start of hormone treatment in trans women was 31 years (interquartile range 23-41 years) and in trans men was 23 (interquartile range 19-31) years. The median person time in trans women was 13 (interquartile range 5-23, range 0-63) years and in trans men was 8 years (interquartile range 3-20, range 0-47) years. The total person time was 33 991 years and 14 883 years, respectively. Table 1 shows the baseline characteristics of the study cohort.

In 17 of the 2260 trans women, a total of 18 cases of breast cancer (15 invasive and three non-invasive) were diagnosed after a median 18 (interquartile range 12-27, range 7-37) years of hormone treatment. The median age at diagnosis was 50 (interquartile range 43-55) years. The breast cancers were mostly tumours of ductal origin (67%, n=10/15). The oestrogen receptor was positive in 83% (n=10/12) of the tumours, the progesterone receptor was positive in 67% (n=8/12), and HER2 was positive in 8% (n=1/12). In trans women with breast cancer the median oestradiol level was 236 pmol/L (range 20-492 pmol/L) and the median testosterone level was 1.3 nmol/L (range 0.8-1.3 nmol/L), both comparable with the median levels in the whole cohort of trans women (table 1). Table 2 shows the standardised incidence ratios. A higher overall risk of breast cancer was found (standardised incidence ratio 46.7, 95% confidence interval 27.2 to 75.4) compared with Dutch cisgender men. A lower overall risk of breast cancer was found compared with Dutch cisgender women (0.3, 0.2 to 0.4).

In four of 1229 trans men, four cases of invasive breast cancer were diagnosed at a median age of 47 (range 35-59) years and after a median 15 (range 2-17) years of hormone treatment, but no cases of non-invasive breast cancer. Three of the four cases of breast cancer were of ductal origin. Two cases were oestrogen and progesterone receptor positive, one was HER2 positive, and one was androgen receptor positive. Three of the four cases of breast cancer were diagnosed several years after subcutaneous mastectomy, the other at the time of mastectomy. The median oestradiol level in trans men with breast cancer was 116 pmol/L (range 60-191 pmol/L), comparable with the median level in the whole cohort of trans men. The mean testosterone level in trans men with breast cancer was lower than the median level in the whole cohort (13.2 nmol/L (range 12.8-16.0 nmol/L) *v* 23.3 (15.9-35.2) nmol/L, respectively). With an overall standardised incidence ratio of 0.2 (95% confidence interval 0.1 to 0.5) in trans men, the risk of breast cancer was lower compared with Dutch cisgender women. Compared with Dutch cisgender men, trans men had a higher overall risk of breast cancer (58.9, 18.7 to 142.2). Table 2 shows the standardised incidence ratios.

We were unable to perform analyses on different types of hormone treatment, because treatment was often changed over the follow-up period or there was too little variation in treatment regimen (this was particularly the case for antiandrogen treatment).

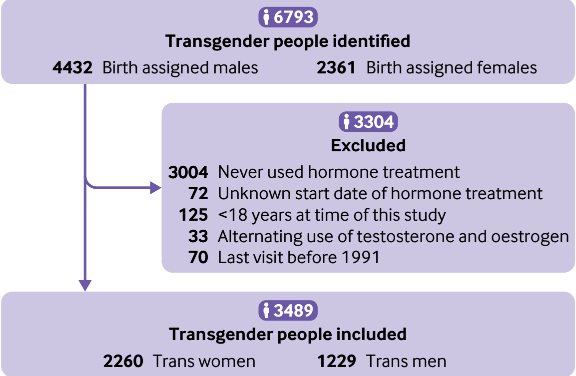

Fig 1 | Study flowchart

Discussion

This study found an increased risk of breast cancer in trans women in the Netherlands compared with Dutch cisgender men. In both trans women and trans men, the risk of breast cancer was lower than in Dutch cisgender women. This suggests that hormone treatment alters the risk of breast cancer in transgender people compared with initial risk based on their birth assigned sex. The median age at breast cancer diagnosis was 52 years in trans women and 46 years in trans men, both lower than the average age of 61 years in Dutch cisgender women. HER2 receptor status in trans women was higher than expected in male breast cancer.

Comparison with other studies

The overall incidence of breast cancer for trans women and trans men combined in the current study was 43.0 per 100 000 person years, which is higher than the numbers found in two previous studies (20.0 per 100 000 person years and 4.5 per 100 000 person years).[23 24] Both studies concluded that the risk of breast cancer in transgender people is comparable to the risk in cisgender men. The incidence in the first of the studies, however, was 31.4 per 100 000 person years in people who underwent hormone treatment, which

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Table 1 | Baseline characteristics of study cohort. Values are medians (interquartile ranges) unless stated otherwise

Characteristics	Overall (n=3489)	Trans women (n=2260)	Trans men (n=1229)
Age (years)	47 (31-57)	51 (38-60)	39 (26-51)
Age at start of hormone treatment (years)	28 (21-38)	31 (23-41)	23 (19-31)
% (No) white	96.5* (2509)	96.7† (1579)	96.3‡ (930)
% (No) ever smokers*	38.9 (1356)	39.1 (884)	38.4 (472)
BMI§	22.9 (20.5-26.2)	22.7 (20.4-25.6)	23.2 (20.7-27.3)
% (No) gonadectomy	-	68.9 (1556)	68.5 (842)
Oestradiol levels (pmol/L)	-	217¶ (129-335)	125** (78-176)
Testosterone levels (nmol/L)	-	1.3†† (0.8-1.3)	23.3‡‡ (15.9-35.2)
Person time (years)	12 (4-22)	13 (5-23)	8 (3-20)
Total person time (years)	48 874	33 991	14 883

Data available for *2599 people, †1633 people, ‡966 people, §2201 people, ¶1521 people, ††1334 people, **919 people, ‡‡924 people of cohort.

is in line with our results. In the other study, the breast cancer risk could have been underestimated because of technical limitations resulting in overestimation of the total follow-up time and not including people who underwent treatment for breast cancer in other hospitals. We addressed these limitations in our study. None of the reported cases in this study have been previously published.

In accordance with previous studies, we observed a younger age at time of breast cancer diagnosis in transgender people compared with cisgender women.[25] Moreover, the exposure to hormone treatment before breast cancer diagnosis was relatively short in trans women, at a median of 18 years, suggesting a rapid development of breast tumours in a subset of people. This observation could be explained by genetic susceptibility. Genetics data were available for one trans woman who is a carrier of a BRCA 1 germ line mutation. Another explanation might be the presence of undiagnosed hormone sensitive cancer before treatment, which could become apparent when stimulated by hormones. In trans women, most breast tumours were of the luminal type, suggesting that the tumours are driven in a cell autonomous fashion by the growth stimulatory actions of oestrogens as well as the progestogenic characteristics of the predominantly used antiandrogen cyproterone acetate. As androgens are known to inhibit the progression of luminal breast cancer, antiandrogenic treatment and orchiectomy might have contributed to tumour initiation in the affected people.[26]

Breast cancer screening advise

Current recommendations suggest that trans women and trans men who have not undergone mastectomy should be biennially screened with mammography from the age of 50 years and if they are using hormone treatment for more than five years.[27-29] After subcutaneous mastectomy, monitoring of trans men with mammography is not considered feasible owing to the minimal residual breast tissue, and therefore self examination is advised, although there is no evidence for effectiveness.[2 27 29] The absolute risk of breast cancer in transgender people is still low in this study, and, more importantly, is not increased compared with cisgender women. We believe therefore that awareness in both doctors and transgender people[30] is of more importance than the start of screening at a younger age or intensifying available screening, even though the median age at diagnosis in the current study was lower than in cisgender women. Besides, discontinuation of hormone treatment in older transgender people can be considered, which might from then decrease the risk of breast cancer.[31] Trans women and trans men who have

Table 2 | Standardised incidence ratios of 18 cases of breast cancer (15 invasive and three non-invasive) in 17 trans women and four cases of invasive breast cancer in four trans men

Variables	Observed cases	Expected cases	Standardised incidence ratio (95% CI)	Expected cases	Standardised incidence ratio (95% CI)
		Reference: incidence ratio in cisgender men		Reference: incidence ratio in cisgender women	
Trans women (n=2260)					
Invasive	15	0.32	46.7 (27.2 to 75.4)	59.95	0.3 (0.2 to 0.4)
Age (years):					
<30	0	0.00	-	0.14	-
30-50	9	0.01	659.4 (321.6 to 1210.0)	9.16	1.0 (0.5 to 1.8)
>50	6	0.31	19.5 (7.9 to 40.6)	50.65	0.1 (0.1 to 0.3)
Non-invasive	3	0.03	96.1 (24.5 to 261.6)	12.10	0.3 (0.1 to 0.7)
Age (years):					
<30	0	0.00	-	0.01	-
30-50	1	0.00	5288.0 (264.6 to 26 080.0)	1.25	0.8 (0.0 to 4.0)
>50	2	0.03	64.5 (10.8 to 213.0)	10.83	0.2 (0.0 to 0.6)
Trans men (n=1229)					
Invasive	4	0.07	58.9 (18.7 to 142.2)	18.54	0.2 (0.1 to 0.5)
Age (years):					
<30	0	0.00	-	0.14	-
30-50	2	0.01	282.3 (47.3 to 932.5)	4.78	0.4 (0.1 to 1.4)
>50	2	0.06	32.9 (5.5 to 108.8)	13.62	0.2 (0.0 to 0.5)
Non-invasive	0	0.01	-	3.55	-

not had a mastectomy are advised to undergo the same intensified breast surveillance as their close female relatives if the risk of breast cancer is increased because of a familial predisposition. It is important to remember that transgender people who changed their legal sex might not be automatically invited for population based screenings, including breast cancer screening.

Strengths and limitations of this study

This study provides novel insights into the risk of breast cancer in transgender people. The reported risk in the current study is higher than estimates from previous studies, possibly related to cohort size and data quality, including the use of a national pathology database. Furthermore, this study included people with a wide range of ages. This study does, however, have some limitations. Owing to the retrospective design of the study, information about hormone use, family history, genetic mutations, benign breast lesions and breast density, tobacco and alcohol use, and body mass index is missing or incomplete. Although these risk factors for breast cancer should not be underestimated, the most important difference between transgender people and cisgender men and women is the use of hormone treatment. It would be interesting to study these risk factors in more detail, to investigate whether certain factors determine the observed increased risk in trans women. The study participants with breast cancer did not necessarily undergo treatment in our centre, and thus detailed data about type and outcome of the treatment are lacking in most of the cases. Although this would be interesting to study in more detail, it was not the purpose of this study. It would be worthwhile for future studies to investigate whether treatment outcomes of breast cancer in trans women are comparable to those of cisgender women.

Conclusions

This large nationwide cohort study in the Netherlands showed an increased risk of breast cancer in trans women compared with cisgender men. The risk in trans women is still lower than in Dutch cisgender women and resembles a more female type of breast cancer and hormone receptor status. In trans men, a lower risk compared with Dutch cisgender women was observed. Based on this study, we conclude that the absolute overall risk of breast cancer in transgender people remains low and therefore it seems sufficient for transgender people using hormone treatment to follow screening guidelines as for cisgender people. As the risk of breast cancer in trans women increased during a relatively short duration of hormone treatment, it would be worthwhile for future studies to investigate in more detail the cause of breast cancer in transgender people receiving hormone treatment.

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Contributors: CdB, CW, NN, and MdH designed the study. CdB, CW, NN, KvE, EB, and MdH collected the data. CdB, CW, and NN analysed the data. CdB, CW, NN, KvE, MA, KD, EB, IK, and MdH interpreted the data. CdB drafted the manuscript. CdB, CW, NN, KvE, MA, KD, EB, IK, and MdH revised the manuscript and approved the final version. CdB and MdH are the guarantors. This manuscript is an honest, accurate, and transparent account of the study being reported and no important aspects of the study have been omitted. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted.

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Ethical approval: This study was reviewed by the ethical review board of the VU University Medical Centre Amsterdam. It was determined that the Medical Research Involving Human Subjects Act (WMO) does not apply to this study, and necessity for informed consent was waived. All data were processed anonymously.

Data sharing: Statistics Netherlands prohibit data sharing at an individual level to guarantee the anonymity of the people in its databases.

Transparency: The lead authors (CdB and MdH) affirm that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

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Letter to the Editor

Michael Biggs*

Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria

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Keywords: bone mineral density; gender dysphoria; GnRHa treatment; transgender.

To the Editors,

I write to respond to Joseph, Ting, and Butler's recent article, describing the effect of administering gonadotropin-releasing hormone analogue (GnRHa) to suppress puberty in adolescents diagnosed with gender dysphoria [1]. The mean of the patients' bone mineral density (BMD)—relative to the norm for their sex and age—declined significantly over 2 years. What really matters is the lower tail of the distribution, but this information was omitted by Joseph et al. This letter analyses individual data on 24 patients from Joseph et al.'s sample of 31 [2]. It finds that after 2 years of GnRHa, up to a third of patients had abnormally low bone density, in the lowest 2.3% of the distribution for their sex and age. A few patients recorded extremely low values, in the lowest 0.13% of the distribution. This finding undermines Joseph et al.'s conclusions.

The Dutch pioneers of this experimental treatment for gender dysphoria warned that patients could 'end with a decreased bone density, which is associated with a high risk of osteoporosis' [3]. The effects on bone density have been described by four Dutch studies [4–7], besides Joseph et al. BMD is measured by a dual energy X-ray absorptiometry (DXA) scan over the spine (lumbar) and the hip (femoral neck). The absolute value of BMD is standardized as a Z-score, expressing this individual's BMD relative to the population of the same sex and age. BMD can be adjusted for height to derive the volumetric bone mineral apparent density (BMAD), which is likewise standardized as a Z-score.

A Z-score below –2 is considered low; it indicates bone density in the lowest 2.3% of the population of the same sex and age [8]. Joseph et al. argue that 'this is not the sole definition of low bone mass in children, nor is this criterion a recognized predictor of later fracture risk'. But this threshold was prominent in the experiment which introduced puberty suppression for gender dysphoria to Britain. The original experimental protocol (co-authored by Butler) in 2010 excluded any child with a spine or hip BMD Z-score below –2. In 2012, however, this exclusion criterion was relaxed 'in exceptional circumstances'—if clinicians 'feel that on the balance of risks, pubertal suppression is an appropriate option despite risks of osteoporosis in later adult life' and patients 'understand the risks of GnRH analogue treatment for bone density (i.e., risks of later osteoporosis)' [9].

Information on the lower tail of the distribution of Z-scores—below –2—is omitted by Joseph et al. and by three out of four Dutch studies. Describing distributions by mean (and standard deviation) is not sufficient when clinical concern focuses on very low values. This will be illustrated for patients experiencing 2 years of puberty suppression. Joseph et al.'s sample after 24 months on GnRHa comprised 31 patients. Data on 24 of these patients —or at least patients from the same clinic at University College London Hospital—have recently been released, though sex is unavailable [2]. These patients were enrolled in the British experiment which recruited patients from 2011 to 2015. The Stata do file to replicate the analysis is posted at https://doi.org/10.7910/DVN/FSOMME.

Table 1 shows mean Z-scores for Joseph et al.'s three measures of BMD, at baseline and at 24 months (the hip measure is missing for three patients). The 2011–15 sample is naturally similar to Joseph et al.'s. The decline in the mean of all three scores is statistically significant in both samples ($p \leq 0.004$ in every paired t-test).

Using data from the 2011–15 sample, Figure 1 depicts the distributions of Z-scores at 24 months, along with the

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Table 1: Bone density in adolescents undergoing puberty suppression.

	Hip BMD		Spine BMD		Spine BMAD	
	Joseph et al.	2011–15	Joseph et al.	2011–15	Joseph et al.	2011–15
Mean Z-score at baseline	−0.58	−0.55	−0.44	−0.34	−0.09	−0.46
Mean Z-score at 24 months	−1.40	−1.45	−1.64	−1.46	−0.71	−1.28
Change in Z-score	−0.82	−0.90	−1.20	−1.12	−0.62	−0.81
p-value (two-tailed)	0.000	0.000	0.000	0.000	0.000	0.004
n	31	21	31	24	31	24

BMD, bone mineral density; BMAD, bone mineral apparent density.

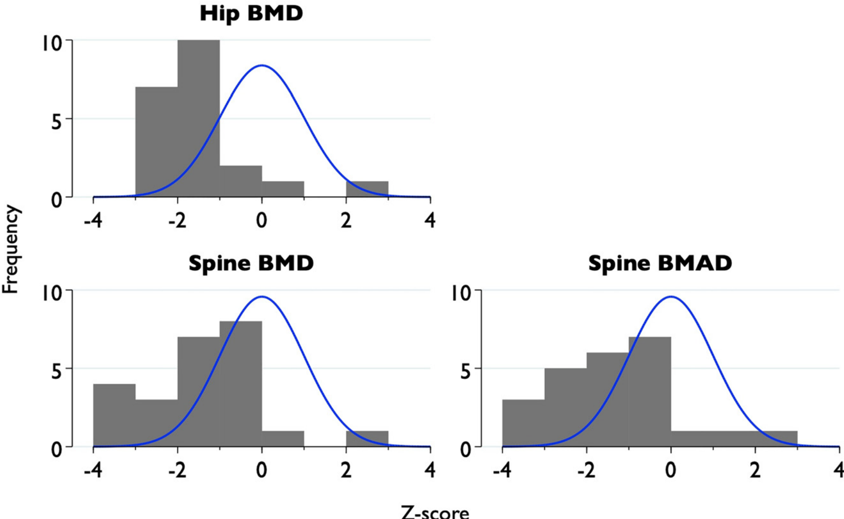

Figure 1: Bone density after 24 months of puberty suppression.

Normal distribution to compare with the population of the same sex and age. For hip BMD, a third of patients had a low Z-score, below −2. For spine BMD, more than a quarter of patients had low Z-scores. The lower tail extended far beyond. Indeed, four patients had Z-scores below −3, putting them in the bottom 0.13% of the population. Adjusting for height, by computing spine BMAD, does not shrink the lower tail.

Given that puberty suppression left up to a third of patients with abnormally low bone density, Joseph et al.'s recommendations are surprisingly complacent. One is to reduce DXA monitoring which 'can have significant financial implications for healthcare providers'. Another is to change the computation of Z-scores; 'reference ranges may need to be re-defined for this select patient cohort'. Rather than altering a measure that provides inconvenient findings, practitioners of puberty suppression must record fractures as adverse events. One British patient who started GnRHa at age 12 then experienced four broken bones by the age of 16 [10]. This history, if it were combined with BMD Z-scores below −2, would meet the diagnostic criteria for paediatric osteoporosis [11]. Whether this case is exceptional is unknown because clinicians have failed to collect relevant data.

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I Thought I Was Saving Trans Kids. Now I’m Blowing

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Jamie Reed at home in Missouri. (Theo R. Welling.)

I Thought I Was Saving Trans Kids. Now I'm Blowing the Whistle.

There are more than 100 pediatric gender clinics across the U.S. I worked at one. What's happening to children is morally and medically appalling.

By Jamie Reed
February 9, 2023

I am a 42-year-old St. Louis native, a queer woman, and politically to the left of Bernie Sanders. My worldview has deeply shaped my career. I have spent my professional life providing counseling to vulnerable populations: children in foster care, sexual minorities, the poor.

For almost four years, I worked at The Washington University School of Medicine Division of Infectious Diseases with teens and young adults who were HIV positive. Many of them were trans or otherwise gender nonconforming, and I could relate: Through childhood and adolescence, I did a lot of gender questioning myself. I'm now married to a transman, and together we are raising my two biological children from a previous marriage and three foster children we hope to adopt.

All that led me to a job in 2018 as a case manager at The Washington University Transgender Center at St. Louis Children's Hospital, which had been established a year earlier.

The center's working assumption was that the earlier you treat kids with gender dysphoria, the more anguish you can prevent later on. This premise was shared by the center's doctors and therapists. Given their expertise, I assumed that abundant evidence backed this consensus.

During the four years I worked at the clinic as a case manager—I was responsible for patient intake and oversight—around a thousand distressed young people came through our doors. The majority of them received hormone prescriptions that can have life-altering consequences—including sterility.

I left the clinic in November of last year because I could no longer participate in what was happening there. By the time I departed, I was certain that the way the American medical system is treating these patients

is the opposite of the promise we make to "do no harm." Instead, we are permanently harming the vulnerable patients in our care.

Today I am speaking out. I am doing so knowing how toxic the public conversation is around this highly contentious issue—and the ways that my testimony might be misused. I am doing so knowing that I am putting myself at serious personal and professional risk.

Almost everyone in my life advised me to keep my head down. But I cannot in good conscience do so. Because what is happening to scores of children is far more important than my comfort. And what is happening to them is morally and medically appalling.

Reed in her office. (Theo R. Welling).

The Floodgates Open

Soon after my arrival at the Transgender Center, I was struck by the lack of formal protocols for treatment. The center's physician co-directors were essentially the sole authority.

At first, the patient population was tipped toward what used to be the "traditional" instance of a child with gender dysphoria: a boy, often quite young, who wanted to present as—who wanted to be—a girl.

Until 2015 or so, a very small number of these boys comprised the population of pediatric gender dysphoria cases. Then, across the Western world, there began to be a dramatic increase in a new population: Teenage girls, many with no previous history of gender distress, suddenly declared they were transgender and demanded immediate treatment with testosterone.

I certainly saw this at the center. One of my jobs was to do intake for new patients and their families. When I started there were probably 10 such calls a month. When I left there were 50, and about 70 percent of the new patients were girls. Sometimes clusters of girls arrived from the same high school.

This concerned me, but didn't feel I was in the position to sound some kind of alarm back then. There was a team of about eight of us, and only one other person brought up the kinds of questions I had. Anyone who raised doubts ran the risk of being called a transphobe.

The girls who came to us had many comorbidities: depression, anxiety, ADHD, eating disorders, obesity. Many were diagnosed with autism, or had autism-like symptoms. A report last year on a British pediatric transgender center found that about one-third of the patients referred there were on the autism spectrum.

Frequently, our patients declared they had disorders that no one believed they had. We had patients who said they had Tourette syndrome (but they didn't); that they had tic disorders (but they didn't); that they had multiple personalities (but they didn't).

The doctors privately recognized these false self-diagnoses as a manifestation of social contagion. They even acknowledged that suicide

has an element of social contagion. But when I said the clusters of girls streaming into our service looked as if their gender issues might be a manifestation of social contagion, the doctors said gender identity reflected something innate.

To begin transitioning, the girls needed a letter of support from a therapist —usually one we recommended—who they had to see only once or twice for the green light. To make it more efficient for the therapists, we offered them a template for how to write a letter in support of transition. The next stop was a single visit to the endocrinologist for a testosterone prescription.

That's all it took.

When a female takes testosterone, the profound and permanent effects of the hormone can be seen in a matter of months. Voices drop, beards sprout, body fat is redistributed. Sexual interest explodes, aggression increases, and mood can be unpredictable. Our patients were told about some side effects, including sterility. But after working at the center, I came to believe that teenagers are simply not capable of fully grasping what it means to make the decision to become infertile while still a minor.

Side Effects

Many encounters with patients emphasized to me how little these young people understood the profound impacts changing gender would have on their bodies and minds. But the center downplayed the negative consequences, and emphasized the need for transition. As the center's website said, "Left untreated, gender dysphoria has any number of consequences, from self-harm to suicide. But when you take away the gender dysphoria by allowing a child to be who he or she is, we're noticing that goes away. The studies we have show these kids often wind up functioning psychosocially as well as or better than their peers."

There are no reliable studies showing this. Indeed, the experiences of many of the center's patients prove how false these assertions are.

Here's an example. On Friday, May 1, 2020, a colleague emailed me about a 15-year-old male patient: "Oh dear. I am concerned that [the patient] does not understand what Bicalutamide does." I responded: "I don't think that we start anything honestly right now."

From: [redacted]>
Sent: Friday, May 1, 2020 11:58 AM
To: Reed, Jamie [redacted]
Subject: Re: Letter

Oh dear. I am concerned that [redacted] does not understand what Bicalutamide does.
It's not
just a blocker, it will cause breast development.... the family seemed certain that
was their first
choice of therapy to start with. The statement made in the letter that: "At times it
seems scary,
so she wants to move slowly, but eventually sees herself as being on estrogen," is
concerning....
and the wrote name at the end....

What do we do now?

From: Reed, Jamie
Sent: Friday, May 1, 2020 12:12 PM
To: [redacted]
Subject: RE: Letter

I don't think that we start anything honestly right now.
I think that this is a letter saying wait more time and yes I think that [redacted] does
not understand what
Bicalutamide does.

Bicalutamide is a medication used to treat metastatic prostate cancer, and one of its side effects is that it feminizes the bodies of men who take it, including the appearance of breasts. The center prescribed this cancer drug as a puberty blocker and feminizing agent for boys. As with most cancer drugs, bicalutamide has a long list of side effects, and this patient experienced one of them: liver toxicity. He was sent to another unit of the hospital for evaluation and immediately taken off the drug. Afterward, his mother sent an electronic message to the Transgender Center saying that we were lucky her family was not the type to sue.

How little patients understood what they were getting into was illustrated by a call we received at the center in 2020 from a 17-year-old biological female patient who was on testosterone. She said she was bleeding from the vagina. In less than an hour she had soaked through an extra heavy pad, her jeans, and a towel she had wrapped around her waist. The nurse at the center told her to go to the emergency room right away.

We found out later this girl had had intercourse, and because testosterone thins the vaginal tissues, her vaginal canal had ripped open. She had to be sedated and given surgery to repair the damage. She wasn't the only vaginal laceration case we heard about.

Other girls were disturbed by the effects of testosterone on their clitoris, which enlarges and grows into what looks like a microphallus, or a tiny penis. I counseled one patient whose enlarged clitoris now extended below her vulva, and it chafed and rubbed painfully in her jeans. I advised her to get the kind of compression undergarments worn by biological men who dress to pass as female. At the end of the call I thought to myself, "Wow, we hurt this kid."

There are rare conditions in which babies are born with atypical genitalia —cases that call for sophisticated care and compassion. But clinics like the one where I worked are *creating* a whole cohort of kids with atypical genitals—and most of these teens haven't even had sex yet. They had no idea who they were going to be as adults. Yet all it took for them to permanently transform themselves was one or two short conversations with a therapist.

Being put on powerful doses of testosterone or estrogen—enough to try to trick your body into mimicking the opposite sex—-affects the rest of the body. I doubt that any parent who's ever consented to give their kid testosterone (a lifelong treatment) knows that they're also possibly signing their kid up for blood pressure medication, cholesterol medication, and perhaps sleep apnea and diabetes.

But sometimes the parents' understanding of what they had agreed to do to their children came forcefully:

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On Thu, Jun 9, 2022 at 11:20 AM [redacted]> wrote:
Hello,

Please be advised that I'm revoking my consent for this course of medical treatment.
Grades
have dropped, there's been an in-patient behavioral health visit and now he's on 5
different
medications. Lexipro, Trazadone, Buspar, etc.

[redacted] is a shell of his former self riddled with anxiety. Who knows if it's because
the hormone
blockers or the other medications. I revoke my consent. I want the hormone blocker
removed.
Thank you.
```

Neglected and Mentally Ill Patients

Besides teenage girls, another new group was referred to us: young people from the inpatient psychiatric unit, or the emergency department, of St. Louis Children's Hospital. The mental health of these kids was deeply concerning—there were diagnoses like schizophrenia, PTSD, bipolar disorder, and more. Often they were already on a fistful of pharmaceuticals.

This was tragic, but unsurprising given the profound trauma some had been through. Yet no matter how much suffering or pain a child had endured, or how little treatment and love they had received, our doctors viewed gender transition—even with all the expense and hardship it entailed—as the solution.

Some weeks it felt as though almost our entire caseload was nothing but disturbed young people.

For example, one teenager came to us in the summer of 2022 when he was 17 years old and living in a lockdown facility because he had been sexually abusing dogs. He'd had an awful childhood: His mother was a drug addict,

his father was imprisoned, and he grew up in foster care. Whatever treatment he may have been getting, it wasn't working.

During our intake I learned from another caseworker that when he got out, he planned to reoffend because he believed the dogs had willingly submitted.

Somewhere along the way, he expressed a desire to become female, so he ended up being seen at our center. From there, he went to a psychologist at the hospital who was known to approve virtually everyone seeking transition. Then our doctor recommended feminizing hormones. At the time, I wondered if this was being done as a form of chemical castration.

That same thought came up again with another case. This one was in spring of 2022 and concerned a young man who had intense obsessive-compulsive disorder that manifested as a desire to cut off his penis after he masturbated. This patient expressed no gender dysphoria, but he got hormones, too. I asked the doctor what protocol he was following, but I never got a straight answer.

In Loco Parentis

Another disturbing aspect of the center was its lack of regard for the rights of parents—and the extent to which doctors saw themselves as more informed decision-makers over the fate of these children.

In Missouri, only one parent's consent is required for treatment of their child. But when there was a dispute between the parents, it seemed the center always took the side of the affirming parent.

My concerns about this approach to dissenting parents grew in 2019 when one of our doctors actually testified in a custody hearing against a father who opposed a mother's wish to start their *11-year-old daughter* on puberty blockers.

I had done the original intake call, and I found the mother quite disturbing. She and the father were getting divorced, and the mother described the daughter as "kind of a tomboy." So now the mother was convinced her child was trans. But when I asked if her daughter had adopted a boy's name, if she was distressed about her body, if she was saying she felt like a boy, the mother said no. I explained the girl just didn't meet the criteria for an evaluation.

Then a month later, the mother called back and said her daughter now used a boy's name, was in distress over her body, and wanted to transition. This time the mom and daughter were given an appointment. Our providers decided the girl was trans and prescribed a puberty blocker to prevent her normal development.

The father adamantly disagreed, said this was all coming from the mother, and a custody battle ensued. After the hearing where our doctor testified in favor of transition, the judge sided with the mother.

```
From:   Reed, Jamie
Sent:   Wednesday, June 23, 2021 10:55 AM
To:     ████████████████████████████████████████
Subject:        RE: Request Guidance

Thanks, I was not having any issue with interpreting or understanding the elements
that she commented
on below. I was looking at the bigger question about how consent is now being
determined.

My concerns are that the Judge is essentially removing the element of parental
consent and placing it in
our hands.

The Judge could have awarded the medical decision making to the Dad or awarded the
legal custody to
the Dad.
Instead the Judge put in the center's hands the decision making for medical
transition. And this is a
patient who is not yet 16.

-Jamie
```

'I Want My Breasts Back'

Because I was the main intake person, I had the broadest perspective on our existing and prospective patients. In 2019, a new group of people

appeared on my radar: desisters and detransitioners. Desisters choose not to go through with a transition. Detransitioners are transgender people who decide to return to their birth gender.

The one colleague with whom I was able to share my concerns agreed with me that we should be tracking desistance and detransition. We thought the doctors would want to collect and understand this data in order to figure out what they had missed.

We were wrong. One doctor wondered aloud why he would spend time on someone who was no longer his patient.

But we created a document anyway and called it the Red Flag list. It was an Excel spreadsheet that tracked the kind of patients that kept my colleague and me up at night.

One of the saddest cases of detransition I witnessed was a teenage girl, who, like so many of our patients, came from an unstable family, was in an uncertain living situation, and had a history of drug use. The overwhelming majority of our patients are white, but this girl was black. She was put on hormones at the center when she was around 16. When she was 18, she went in for a double mastectomy, what's known as "top surgery."

Three months later she called the surgeon's office to say she was going back to her birth name and that her pronouns were "she" and "her." Heartbreakingly, she told the nurse, "I want my breasts back." The surgeon's office contacted our office because they didn't know what to say to this girl.

My colleague and I said that we would reach out. It took a while to track her down, and when we did we made sure that she was in decent mental health, that she was not actively suicidal, that she was not using substances. The last I heard, she was pregnant. Of course, she'll never be able to breastfeed her child.

'Get On Board, Or Get Out'

My concerns about what was going on at the center started to overtake my life. By spring 2020, I felt a medical and moral obligation to do something. So I spoke up in the office, and sent plenty of emails.

Here's just one example: On January 6, 2022, I received an email from a staff therapist asking me for help with a case of a 16-year-old transgender male living in another state. "Parents are open to having patient see a therapist but are not supportive of gender and patient does not want parents to be aware of gender identity. I am having a challenging time finding a gender affirming therapist."

I replied:

"I do not ethically agree with linking a minor patient to a therapist who would be gender affirming with gender as a focus of their work without that being discussed with the parents and the parent agreeing to that kind of care."

From: Reed, Jamie
Sent: Thursday, January 6, 2022 12:52 PM
To: [redacted]
Subject: RE: therapy resource
Attachments: [redacted] Mental Health Providers Updated Version 11_2021.docx

This might be best discussed on a call, but I do not ethically agree with linking a minor patient to a therapist who would be gender affirming with gender as a focus of their work without that being discussed with the parent and the parent agreeing to that kind of care.

Within the center we do not link minor patients to gender affirming care without the consent of at least one parent or legal guardian.

With that said we have a list of therapist for [redacted] attached.

Sincerely,

In all my years at the Washington University School of Medicine, I had received solidly positive performance reviews. But in 2021, that changed. I got a below-average mark for my "Judgment" and "Working Relationships/Cooperative Spirit." Although I was described as "responsible, conscientious, hard-working and productive" the evaluation also noted: "At times Jamie responds poorly to direction from management with defensiveness and hostility."

Things came to a head at a half-day retreat in summer of 2022. In front of the team, the doctors said that my colleague and I had to stop questioning the "medicine and the science" as well as their authority. Then an administrator told us we had to "Get on board, or get out." It became clear that the purpose of the retreat was to deliver these messages to us.

The Washington University system provides a generous college tuition payment program for long-standing employees. I live by my paycheck and have no money to put aside for five college tuitions for my kids. I had to keep my job. I also feel a lot of loyalty to Washington University.

But I decided then and there that I had to get out of the Transgender Center, and to do so, I had to keep my head down and improve my next performance review.

I managed to get a decent evaluation, and I landed a job conducting research in another part of The Washington University School of Medicine. I gave my notice and left the Transgender Center in November of 2022.

(Theo R. Welling)

What I Want to See Happen

For a couple of weeks, I tried to put everything behind me and settled into my new job as a clinical research coordinator, managing studies regarding children undergoing bone marrow transplants.

Then I came across comments from Dr. Rachel Levine, a transgender woman who is a high official at the federal Department of Health and Human Services. The article read: "Levine, the U.S. assistant secretary for health, said that clinics are proceeding carefully and that no American children are receiving drugs or hormones for gender dysphoria who shouldn't."

I felt stunned and sickened. It wasn't true. And I know that from deep first-hand experience.

So I started writing down everything I could about my experience at the Transgender Center. Two weeks ago, I brought my concerns and documents to the attention of Missouri's attorney general. He is a

Republican. I am a progressive. But the safety of children should not be a matter for our culture wars.

Click here to read Jamie Reed's letter to the Missouri AG.

Given the secrecy and lack of rigorous standards that characterize youth gender transition across the country, I believe that to ensure the safety of American children, we need a moratorium on the hormonal and surgical treatment of young people with gender dysphoria.

In the past 15 years, according to Reuters, the U.S. has gone from having no pediatric gender clinics to more than 100. A thorough analysis should be undertaken to find out what has been done to their patients and why—and what the long-term consequences are.

There is a clear path for us to follow. Just last year England announced that it would close the Tavistock's youth gender clinic, then the NHS's only such clinic in the country, after an investigation revealed shoddy practices and poor patient treatment. Sweden and Finland, too, have investigated pediatric transition and greatly curbed the practice, finding there is insufficient evidence of help, and danger of great harm.

Some critics describe the kind of treatment offered at places like the Transgender Center where I worked as a kind of national experiment. But that's wrong.

Experiments are supposed to be carefully designed. Hypotheses are supposed to be tested ethically. The doctors I worked alongside at the Transgender Center said frequently about the treatment of our patients: "We are building the plane while we are flying it." No one should be a passenger on that kind of aircraft.

Tonight at 6:00 p.m. PST we are hosting a conversation with Jamie Reed. To join us (event details will be sent later today) become a subscriber now:

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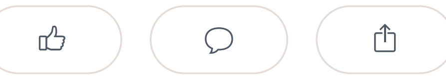
Sunday, February 26, 2023



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Long-Term Folow Up of Transsexual Persons Undergoi

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Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden

Cecilia Dhejne[1], Paul Lichtenstein[2], Marcus Boman[2], Anna L. V. Johansson[2], Niklas Långström[2,3], Mikael Landén[1,2,4]*

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Abstract

Context: The treatment for transsexualism is sex reassignment, including hormonal treatment and surgery aimed at making the person's body as congruent with the opposite sex as possible. There is a dearth of long term, follow-up studies after sex reassignment.

Objective: To estimate mortality, morbidity, and criminal rate after surgical sex reassignment of transsexual persons.

Design: A population-based matched cohort study.

Setting: Sweden, 1973-2003.

Participants: All 324 sex-reassigned persons (191 male-to-females, 133 female-to-males) in Sweden, 1973–2003. Random population controls (10:1) were matched by birth year and birth sex or reassigned (final) sex, respectively.

Main Outcome Measures: Hazard ratios (HR) with 95% confidence intervals (CI) for mortality and psychiatric morbidity were obtained with Cox regression models, which were adjusted for immigrant status and psychiatric morbidity prior to sex reassignment (adjusted HR [aHR]).

Results: The overall mortality for sex-reassigned persons was higher during follow-up (aHR 2.8; 95% CI 1.8–4.3) than for controls of the same birth sex, particularly death from suicide (aHR 19.1; 95% CI 5.8–62.9). Sex-reassigned persons also had an increased risk for suicide attempts (aHR 4.9; 95% CI 2.9–8.5) and psychiatric inpatient care (aHR 2.8; 95% CI 2.0–3.9). Comparisons with controls matched on reassigned sex yielded similar results. Female-to-males, but not male-to-females, had a higher risk for criminal convictions than their respective birth sex controls.

Conclusions: Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population. Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group.

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Introduction

Transsexualism (ICD-10),[1] or gender identity disorder (DSM-IV),[2] is a condition in which a person's gender identity - the sense of being a man or a woman - contradicts his or her bodily sex characteristics. The individual experiences gender dysphoria and desires to live and be accepted as a member of the opposite sex.

The treatment for transsexualism includes removal of body hair, vocal training, and cross-sex hormonal treatment aimed at making the person's body as congruent with the opposite sex as possible to alleviate the gender dysphoria. Sex reassignment also involves the surgical removal of body parts to make external sexual characteristics resemble those of the opposite sex, so called sex reassignment/confirmation surgery (SRS). This is a unique

intervention not only in psychiatry but in all of medicine. The present form of sex reassignment has been practised for more than half a century and is the internationally recognized treatment to ease gender dysphoria in transsexual persons.[3,4]

Despite the long history of this treatment, however, outcome data regarding mortality and psychiatric morbidity are scant. With respect to suicide and deaths from other causes after sex reassignment, an early Swedish study followed 24 transsexual persons for an average of six years and reported one suicide.[5] A subsequent Swedish study recorded three suicides after sex reassignment surgery of 175 patients.[6] A recent Swedish follow-up study reported no suicides in 60 transsexual patients, but one death due to complications after the sex reassignment surgery.[7] A Danish study reported death by suicide in 3 out of 29 operated male-to-female transsexual persons followed for an average of six years.[8] By contrast, a Belgian study of 107 transsexual persons followed for 4–6 years found no suicides or deaths from other causes.[9] A large Dutch single-centre study (N = 1,109), focusing on adverse events following hormonal treatment, compared the outcome after cross-sex hormone treatment with national Dutch standardized mortality and morbidity rates and found no increased mortality, with the exception of death from suicide and AIDS in male-to-females 25–39 years of age.[10] The same research group concluded in a recent report that treatment with cross-sex hormones seems acceptably safe, but with the reservation that solid clinical data are missing.[11] A limitation with respect to the Dutch cohort is that the proportion of patients treated with cross-sex hormones who also had surgical sex-reassignment is not accounted for.[10]

Data is inconsistent with respect to psychiatric morbidity post sex reassignment. Although many studies have reported psychiatric and psychological improvement after hormonal and/or surgical treatment,[7,12,13,14,15,16] other have reported on regrets,[17] psychiatric morbidity, and suicide attempts after SRS.[9,18] A recent systematic review and meta-analysis concluded that approximately 80% reported subjective improvement in terms of gender dysphoria, quality of life, and psychological symptoms, but also that there are studies reporting high psychiatric morbidity and suicide rates after sex reassignment.[19] The authors concluded though that the evidence base for sex reassignment "is of very low quality due to the serious methodological limitations of included studies."

The methodological shortcomings have many reasons. First, the nature of sex reassignment precludes double blind randomized controlled studies of the result. Second, transsexualism is rare [20] and many follow-ups are hampered by small numbers of subjects.[5,8,21,22,23,24,25,26,27,28] Third, many sex reassigned persons decline to participate in follow-up studies, or relocate after surgery, resulting in high drop-out rates and consequent selection bias.[6,9,12,21,24,28,29,30] Forth, several follow-up studies are hampered by limited follow-up periods.[7,9,21,22,26,30] Taken together, these limitations preclude solid and generalisable conclusions. A long-term population-based controlled study is one way to address these methodological shortcomings.

Here, we assessed mortality, psychiatric morbidity, and psychosocial integration expressed in criminal behaviour after sex reassignment in transsexual persons, in a total population cohort study with long-term follow-up information obtained from Swedish registers. The cohort was compared with randomly selected population controls matched for age and gender. We adjusted for premorbid differences regarding psychiatric morbidity and immigrant status. This study design sheds new light on transsexual persons' health after sex reassignment. It does not, however, address whether sex reassignment is an effective treatment or not.

Methods

National registers

The study population was identified by the linkage of several Swedish national registers, which contained a total of 13.8 million unique individuals. The Hospital Discharge Register (HDR, held by the National Board of Health and Welfare) contains discharge diagnoses, up to seven contributory diagnoses, external causes of morbidity or mortality, surgical procedure codes, and discharge date. Discharge diagnoses are coded according to the 8th (1969-1986), 9th (1987–1996), and 10th editions (1997-) of the International Classification of Diseases (ICD). The register covers virtually all psychiatric inpatient episodes in Sweden since 1973. Discharges that occurred up to 31 December 2003 were included. Surgical procedure codes could not be used for this study due to the lack of a specific code for sex reassignment surgery. The Total Population Register (TPR, held by Statistics Sweden) is comprised of data about the entire Swedish population. Through linkage with the Total Population Register it was possible to identify birth date and birth gender for all study subjects. The register is updated every year and gender information was available up to 2004/2005. The Medical Birth Register (MBR) was established in 1973 and contains birth data, including gender of the child at birth. National censuses based on mandatory self-report questionnaires completed by all adult citizens in 1960, 1970, 1980, and 1990 provided information on individuals, households, and dwellings, including gender, living area, and highest educational level. Complete migration data, including country of birth for immigrants for 1969–2003, were obtained from the TPR. In addition to educational information from the censuses, we also obtained highest educational level data for 1990 and 2000 from the Register of Education. The Cause of Death Register (CDR, Statistics Sweden) records all deaths in Sweden since 1952 and provided information on date of death and causes of death. Death events occurring up to 31 December 2003 are included in the study. The Crime Register (held by the National Council of Crime Prevention) provided information regarding crime type and date on all criminal convictions in Sweden during the period 1973–2004. Attempted and aggravated forms of all offences were also included. All crimes in Sweden are registered regardless of insanity at the time of perpetration; for example, for individuals who suffered from psychosis at the time of the offence. Moreover, conviction data include individuals who received custodial or non-custodial sentences and cases where the prosecutor decided to caution or fine without court proceedings. Finally, Sweden does not differ considerably from other members of the European Union regarding rates of violent crime and their resolution.[31]

Study population, identification of sex-reassigned persons (exposure assessment)

The study was designed as a population-based matched cohort study. We used the individual national registration number, assigned to all Swedish residents, including immigrants on arrival, as the primary key through all linkages. The registration number consists of 10 digits; the first six provide information of the birth date, whereas the ninth digit indicates the gender. In Sweden, a person presenting with gender dysphoria is referred to one of six specialised gender teams that evaluate and treat patients principally according to international consensus guidelines: Standards of Care.[3] With a medical certificate, the person applies to the National Board of Health and Welfare to receive permission for sex reassignment surgery and a change of legal sex status. A new national registration number signifying the new gender is assigned after sex reassignment surgery. The National

Board of Health and Welfare maintains a link between old and new national registration numbers, making it possible to follow individuals undergoing sex reassignment across registers and over time. Hence, sex reassignment surgery in Sweden requires (i) a transsexualism diagnosis and (ii) permission from the National Board of Health and Welfare.

A person was defined as exposed to sex reassignment surgery if two criteria were met: (i) at least one inpatient diagnosis of gender identity disorder diagnosis without concomitant psychiatric diagnoses in the Hospital Discharge Register, and (ii) at least one discrepancy between gender variables in the Medical Birth Register (from 1973 and onwards) or the National Censuses from 1960, 1970, 1980, or 1990 and the latest gender designation in the Total Population Register. The first criterion was employed to capture the hospitalization for sex reassignment surgery that serves to secure the diagnosis and provide a time point for sex reassignment surgery; the plastic surgeons namely record the reason for sex reassignment surgery, i.e., transsexualism, but not any co-occurring psychiatric morbidity. The second criterion was used to ensure that the person went through all steps in sex-reassignment and also changed sex legally.

The date of sex reassignment (start of follow-up) was defined as the first occurrence of a gender identity disorder diagnosis, without any other concomitant psychiatric disorder, in the Hospital Discharge Register after the patient changed sex status (any discordance in sex designation across the Censuses, Medical Birth, and Total Population registers). If this information was missing, we used instead the closest date in the Hospital Discharge Register on which the patient was diagnosed with gender identity disorder without concomitant psychiatric disorder prior to change in sex status. The reason for prioritizing the use of a gender identity disorder diagnosis *after* changed sex status over *before* was to avoid overestimating person-years at risk of sex-reassigned person.

Using these criteria, a total of 804 patients with gender identity disorder were identified, whereof 324 displayed a shift in the gender variable during the period 1973–2003. The 480 persons that did not shift gender variable comprise persons who either did not apply, or were not approved, for sex reassignment surgery. Moreover, the ICD 9 code 302 is a non specific code for sexual disorders. Hence, this group might also comprise persons that were hospitalized for sexual disorders other than transsexualism. Therefore, they were omitted from further analyses. Of the remaining 324 persons, 288 were identified with the gender identity diagnosis *after* and 36 *before* change of sex status. Out of the 288 persons identified *after* changed sex status, 185 could also be identified *before* change in sex status. The median time lag between the hospitalization *before* and *after* sex change for these 185 persons was 0.96 years (mean 2.2 years, SD 3.3).

Gender identity disorder was coded according to ICD-8: 302.3 (transsexualism) and 302.9 (sexual deviation NOS); ICD-9: 302 (overall code for sexual deviations and disorders, more specific codes were not available in ICD-9); and ICD-10: F64.0 (transsexualism), F64.1 (dual-role transvestism), F64.8 (other gender identity disorder), and F64.9 (gender identity disorder NOS). Other psychiatric disorders were coded as ICD-8: 290-301 and 303-315; ICD-9: 290-301 and 303-319; and ICD-10: F00-F63 as well as F65-F99.

Identification of population-based controls (unexposed group)

For each exposed person (N = 324), we randomly selected 10 unexposed controls. A person was defined as unexposed if there were no discrepancies in sex designation across the Censuses, Medical Birth, and Total Population registers *and* no gender identity disorder diagnosis according to the Hospital Discharge Register. Control persons were matched by sex and birth year and had to be alive and residing in Sweden at the estimated sex reassignment date of the case person. To study possible gender-specific effects on outcomes of interest, we used two different control groups: one with the same sex as the case individual at birth (birth sex matching) and the other with the sex that the case individual had been reassigned to (final sex matching).

Outcome measures

We studied mortality, psychiatric morbidity, accidents, and crime following sex reassignment. More specifically, we investigated: (1) all-cause mortality, (2) death by definite/uncertain suicide, (3) death by cardiovascular disease, and (4) death by tumour. Morbidity included (5) any psychiatric disorder (gender identity disorders excluded), (6) alcohol/drug misuse and dependence, (7) definite/uncertain suicide attempt, and (8) accidents. Finally, we addressed court convictions for (9) any criminal offence and (10) any violent offence. Each individual could contribute with several outcomes, but only one event per outcome. Causes of death (Cause of Death Registry from 1952 and onwards) were defined according to ICD as suicide (ICD-8 and ICD-9 codes E950-E959 and E980-E989, ICD-10 codes X60-X84 and Y10-Y34); cardiovascular disease (ICD-8 codes 390-458, ICD-9 codes 390-459, ICD-10 codes I00-I99); neoplasms (ICD-8 and ICD-9 codes 140-239, ICD-10 codes C00-D48), any psychiatric disorder (gender identity disorders excluded); (ICD-8 codes 290-301 and 303-315, ICD-9 codes 290-301 and 303-319, ICD-10 codes F00-F63 and F65-F99); alcohol/drug abuse and dependence (ICD-8 codes 303-304, ICD-9 codes 303-305 (tobacco use disorder excluded), ICD-10 codes F10-F16 and F18-F19 (x5 excluded); and accidents (ICD-8 and ICD-9 codes E800-E929, ICD-10 codes V01-X59).

Any criminal conviction during follow-up was counted; specifically, violent crime was defined as homicide and attempted homicide, aggravated assault and assault, robbery, threatening behaviour, harassment, arson, or any sexual offense.[32]

Covariates

Severe psychiatric morbidity was defined as inpatient care according to ICD-8 codes 291, 295-301, 303-304, and 307; ICD-9 codes 291-292, 295-298, 300-301, 303-305 (tobacco use disorder excluded), 307.1, 307.5, 308-309, and 311; ICD-10 codes F10-F16, F18-F25, F28-F45, F48, F50, and F60-F62. Immigrant status, defined as individuals born abroad, was obtained from the Total Population Register. All outcome/covariate variables were dichotomized (i.e., affected or unaffected) and without missing values.

Statistical analyses

Each individual contributed person-time from study entry (for exposed: date of sex reassignment; for unexposed: date of sex reassignment of matched case) until date of outcome event, death, emigration, or end of study period (31 December 2003), whichever came first. The association between exposure (sex reassignment) and outcome (mortality, morbidity, crime) was measured by hazard ratios (HR) with 95% CIs, taking follow-up time into account. HRs were estimated from Cox proportional hazard regression models, stratified on matched sets (1:10) to account for the matching by sex, age, and calendar time (birth year). We present crude HRs (though adjusted for sex and age through matching) and confounder-adjusted HRs [aHRs] for all outcomes. The two potential confounders, immigrant status (yes/no) and history of severe psychiatric morbidity (yes/no) prior to sex

reassignment, were chosen based on previous research[18,33] and different prevalence across cases and controls (Table 1).

Gender-separated analyses were performed and a Kaplan-Meier survival plot graphically illustrates the survival of the sex reassigned cohort and matched controls (all-cause mortality) over time. The significance level was set at 0.05 (all tests were two-sided). All outcome/covariate variables were without missing values, since they are generated from register data, which are either present (affected) or missing (unaffected). The data were analysed using SAS version 9.1 (SAS Institute Inc., Cary, NC, USA).

Ethics

The data linking of national registers required for this study was approved by the IRB at Karolinska Institutet, Stockholm. All data were analyzed anonymously; therefore, informed consent for each individual was neither necessary nor possible.

Results

We identified 324 transsexual persons (exposed cohort) who underwent sex reassignment surgery and were assigned a new legal sex between 1973 and 2003. These constituted the sex-reassigned (exposed) group. Fifty-nine percent (N = 191) of sex-reassigned persons were male-to-females and 41% (N = 133) female-to-males, yielding a sex ratio of 1.4:1 (Table 1).

The average follow-up time for all-cause mortality was 11.4 (median 9.1) years. The average follow-up time for the risk of being hospitalized for any psychiatric disorder was 10.4 (median 8.1).

Characteristics prior to sex reassignment

Table 1 displays demographic characteristics of sex-reassigned and control persons prior to study entry (sex reassignment). There were no substantial differences between female-to-males and male-to-females regarding measured baseline characteristics. Immigrant status was twice as common among transsexual individuals compared to controls, living in an urban area somewhat more common, and higher education about equally prevalent. Transsexual individuals had been hospitalized for psychiatric morbidity other than gender identity disorder prior to sex reassignment about four times more often than controls. To adjust for these baseline discrepancies, hazard ratios adjusted for immigrant status and psychiatric morbidity prior to baseline are presented for all outcomes [aHRs].

Mortality

Table 2 describes the risks for selected outcomes during follow-up among sex-reassigned persons, compared to same-age controls of the same birth sex. Sex-reassigned transsexual persons of both genders had approximately a three times higher risk of all-cause mortality than controls, also after adjustment for covariates. Table 2

Table 1. Baseline characteristics among sex-reassigned subjects in Sweden (N = 324) and population controls matched for birth year and sex.

Characteristic at baseline	Sex-reassigned subjects (N = 324)	Birth-sex matched controls (N = 3,240)	Final-sex matched controls (N = 3,240)
Gender			
Female at birth, male after sex change	133 (41%)	1,330 (41%)	1,330 (41%)
Male at birth, female after sex change	191 (59%)	1,910 (59%)	1,910 (59%)
Average age at study entry [years] (SD, min-max)			
Female at birth, male after sex change	33.3 (8.7, 20–62)	33.3 (8.7, 20–62)	33.3 (8.7, 20–62)
Male at birth, female after sex change	36.3 (10.1, 21–69)	36.3 (10.1, 21–69)	36.3 (10.1, 21–69)
Both genders	35.1 (9.7, 20–69)	35.1 (9.7, 20–69)	35.1 (9.7, 20–69)
Immigrant status			
Female at birth, male after sex change	28 (21%)	118 (9%)	100 (8%)
Male at birth, female after sex change	42 (22%)	176 (9%)	164 (9%)
Both genders	70 (22%)	294 (9%)	264 (8%)
Less than 10 years of schooling prior to entry vs. 10 years or more			
Females at birth, males after sex change	49 (44%); 62 (56%)	414 (37%); 714 (63%)	407 (36%); 713 (64%)
Males at birth, females after sex change	61 (41%); 89 (59%)	665 (40%); 1,011 (60%)	595 (35%); 1,091 (65%)
All individuals with data	110 (42%); 151 (58%)	1,079 (38%); 1,725 (62%)	1,002 (36%); 1,804 (64%)
Psychiatric morbidity* prior to study entry			
Female at birth, male after sex change	22 (17%)	47 (4%)	42 (3%)
Male at birth, female after sex change	36 (19%)	76 (4%)	72 (4%)
Both genders	58 (18%)	123 (4%)	114 (4%)
Rural [vs. urban] living area prior to entry			
Female at birth, male after sex change	13 (10%)	180 (14%)	195 (15%)
Male at birth, female after sex change	20 (10%)	319 (17%)	272 (14%)
Both genders	33 (10%)	499 (15%)	467 (14%)

Note:
*Hospitalizations for gender identity disorder were not included.
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Table 2. Risk of various outcomes among sex-reassigned subjects in Sweden (N = 324) compared to population controls matched for birth year and birth sex.

	Number of events cases/ controls 1973–2003	Outcome incidence rate per 1000 person-years 1973–2003 (95% CI)		Crude hazard ratio (95% CI) 1973–2003	Adjusted* hazard ratio (95% CI) 1973–2003	Adjusted* hazard ratio (95% CI) 1973–1988	Adjusted* hazard ratio (95% CI) 1989–2003
		Cases	Controls				
Any death	27/99	7.3 (5.0–10.6)	2.5 (2.0–3.0)	2.9 (1.9–4.5)	2.8 (1.8–4.3)	3.1 (1.9–5.0)	1.9 (0.7–5.0)
Death by suicide	10/5	2.7 (1.5–5.0)	0.1 (0.1–0.3)	19.1 (6.5–55.9)	19.1 (5.8–62.9)	N/A	N/A
Death by cardiovascular disease	9/42	2.4 (1.3–4.7)	1.1 (0.8–1.4)	2.6 (1.2–5.4)	2.5 (1.2–5.3)	N/A	N/A
Death by neoplasm	8/38	2.2 (1.1–4.3)	1.0 (0.7–1.3)	2.1 (1.0–4.6)	2.1 (1.0–4.6)	N/A	N/A
Any psychiatric hospitalisation‡	64/173	19.0 (14.8–24.2)	4.2 (3.6–4.9)	4.2 (3.1–5.6)	2.8 (2.0–3.9)	3.0 (1.9–4.6)	2.5 (1.4–4.2)
Substance misuse	22/78	5.9 (3.9–8.9)	1.8 (1.5–2.3)	3.0 (1.9–4.9)	1.7 (1.0–3.1)	N/A	N/A
Suicide attempt	29/44	7.9 (5.5–11.4)	1.0 (0.8–1.4)	7.6 (4.7–12.4)	4.9 (2.9–8.5)	7.9 (4.1–15.3)	2.0 (0.7–5.3)
Any accident	32/233	9.0 (6.3–12.7)	5.7 (5.0–6.5)	1.6 (1.1–2.3)	1.4 (1.0–2.1)	1.6 (1.0–2.5)	1.1 (0.5–2.2)
Any crime	60/350	18.5 (14.3–23.8)	9.0 (8.1–10.0)	1.9 (1.4–2.5)	1.3 (1.0–1.8)	1.6 (1.1–2.4)	0.9 (0.6–1.5)
Violent crime	14/61	3.6 (2.1–6.1)	1.4 (1.1–1.8)	2.7 (1.5–4.9)	1.5 (0.8–3.0)	N/A	N/A

Notes:
*Adjusted for psychiatric morbidity prior to baseline and immigrant status.
‡Hospitalisations for gender identity disorder were excluded.
N/A Not applicable due to sparse data.
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separately lists the outcomes depending on when sex reassignment was performed: during the period 1973-1988 or 1989–2003. Even though the overall mortality was increased across both time periods, it did not reach statistical significance for the period 1989–2003. The Kaplan-Meier curve (Figure 1) suggests that survival of transsexual persons started to diverge from that of matched controls after about 10 years of follow-up. The cause-specific mortality from suicide was much higher in sex-reassigned persons, compared to matched controls. Mortality due to cardiovascular disease was moderately increased among the sex-reassigned, whereas the numerically increased risk for malignancies was borderline statistically significant. The malignancies were lung cancer (N = 3), tongue cancer (N = 1), pharyngeal cancer (N = 1), pancreas cancer (N = 1), liver cancer (N = 1), and unknown origin (N = 1).

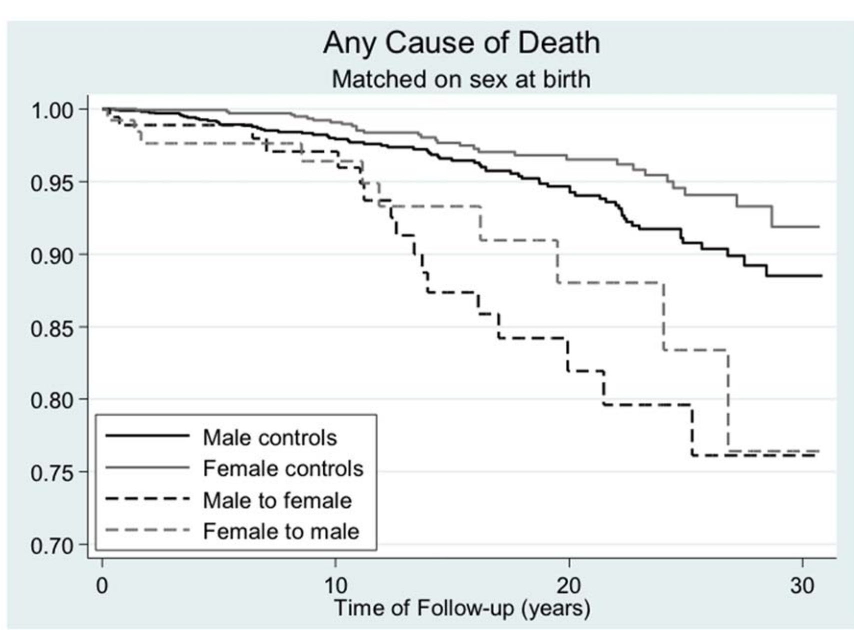

Figure 1. Death from any cause as a function of time after sex reassignment among 324 transsexual persons in Sweden (male-to-female: N = 191, female-to-male: N = 133), and population controls matched on birth year.
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Psychiatric morbidity, substance misuse, and accidents

Sex-reassigned persons had a higher risk of inpatient care for a psychiatric disorder other than gender identity disorder than controls matched on birth year and birth sex (Table 2). This held after adjustment for prior psychiatric morbidity, and was true regardless of whether sex reassignment occurred before or after 1989. In line with the increased mortality from suicide, sex-reassigned individuals were also at a higher risk for suicide attempts, though this was not statistically significant for the time period 1989–2003. The risks of being hospitalised for substance misuse or accidents were not significantly increased after adjusting for covariates (Table 2).

Crime rate

Transsexual individuals were at increased risk of being convicted for any crime or violent crime after sex reassignment (Table 2); this was, however, only significant in the group who underwent sex reassignment before 1989.

Gender differences

Comparisons of female-to-males and male-to-females, although hampered by low statistical power and associated wide confidence intervals, suggested mostly similar risks for adverse outcomes (Tables S1 and S2). However, violence against self (suicidal behaviour) and others ([violent] crime) constituted important exceptions. First, male-to-females had significantly increased risks for suicide attempts compared to both female (aHR 9.3; 95% CI 4.4–19.9) and male (aHR 10.4; 95% CI 4.9–22.1) controls. By contrast, female-to-males had significantly increased risk of suicide attempts only compared to male controls (aHR 6.8; 95% CI 2.1–21.6) but not compared to female controls (aHR 1.9; 95% CI 0.7–4.8). This suggests that male-to-females are at higher risk for suicide attempts after sex reassignment, whereas female-to-males maintain a female pattern of suicide attempts after sex reassignment (Tables S1 and S2).

Second, regarding any crime, male-to-females had a significantly increased risk for crime compared to female controls (aHR 6.6; 95% CI 4.1–10.8) but not compared to males (aHR 0.8; 95% CI 0.5–1.2). This indicates that they retained a male pattern regarding criminality. The same was true regarding violent crime. By contrast, female-to-males had higher crime rates than female controls (aHR 4.1; 95% CI 2.5–6.9) but did not differ from male controls. This indicates a shift to a male pattern regarding criminality and that sex reassignment is coupled to increased crime rate in female-to-males. The same was true regarding violent crime.

Discussion

Principal findings and comparison with previous research

We report on the first nationwide population-based, long-term follow-up of sex-reassigned transsexual persons. We compared our cohort with randomly selected population controls matched for age and gender. The most striking result was the high mortality rate in both male-to-females and female-to males, compared to the general population. This contrasts with previous reports (with one exception[8]) that did not find an increased mortality rate after sex reassignment, or only noted an increased risk in certain subgroups.[7,9,10,11] Previous clinical studies might have been biased since people who regard their sex reassignment as a failure are more likely to be lost to follow-up. Likewise, it is cumbersome to track deceased persons in clinical follow-up studies. Hence, population-based register studies like the present are needed to improve representativity.[19,34]

The poorer outcome in the present study might also be explained by longer follow-up period (median >10 years) compared to previous studies. In support of this notion, the survival curve (Figure 1) suggests increased mortality from ten years after sex reassignment and onwards. In accordance, the overall mortality rate was only significantly increased for the group operated before 1989. However, the latter might also be explained by improved health care for transsexual persons during 1990s, along with altered societal attitudes towards persons with different gender expressions.[35]

Mortality due to cardiovascular disease was significantly increased among sex reassigned individuals, albeit these results should be interpreted with caution due to the low number of events. This contrasts, however, a Dutch follow-up study that reported no increased risk for cardiovascular events.[10,11] A recent meta-analysis concluded, however, that data on cardiovascular outcome after cross-sex steroid use are sparse, inconclusive, and of very low quality.[34]

With respect to neoplasms, prolonged hormonal treatment might increase the risk for malignancies,[36] but no previous study has tested this possibility. Our data suggested that the cause-specific risk of death from neoplasms was increased about twice (borderline statistical significance). These malignancies (see Results), however, are unlikely to be related to cross-hormonal treatment.

There might be other explanations to increased cardiovascular death and malignancies. Smoking was in one study reported in almost 50% by the male-to females and almost 20% by female-to-males.[9] It is also possible that transsexual persons avoid the health care system due to a presumed risk of being discriminated.

Mortality from suicide was strikingly high among sex-reassigned persons, also after adjustment for prior psychiatric morbidity. In line with this, sex-reassigned persons were at increased risk for suicide attempts. Previous reports [6,8,10,11] suggest that transsexualism is a strong risk factor for suicide, also after sex reassignment, and our long-term findings support the need for continued psychiatric follow-up for persons at risk to prevent this.

Inpatient care for psychiatric disorders was significantly more common among sex-reassigned persons than among matched controls, both before and after sex reassignment. It is generally accepted that transsexuals have more psychiatric ill-health than the general population prior to the sex reassignment.[18,21,22,33] It should therefore come as no surprise that studies have found high rates of depression,[9] and low quality of life[16,25] also after sex reassignment. Notably, however, in this study the increased risk for psychiatric hospitalisation persisted even after adjusting for psychiatric hospitalisation prior to sex reassignment. This suggests that even though sex reassignment alleviates gender dysphoria, there is a need to identify and treat co-occurring psychiatric morbidity in transsexual persons not only before but also after sex reassignment.

Criminal activity, particularly violent crime, is much more common among men than women in the general population. A previous study of all applications for sex reassignment in Sweden up to 1992 found that 9.7% of male-to-female and 6.1% of female-to-male applicants had been prosecuted for a crime.[33] Crime after sex reassignment, however, has not previously been studied. In this study, male-to-female individuals had a higher risk for criminal convictions compared to female controls but not compared to male controls. This suggests that the sex reassignment procedure neither increased nor decreased the risk for criminal offending in male-to-females. By contrast, female-to-males were at a higher risk for criminal convictions compared to female controls and did not differ from male controls, which suggests increased crime proneness in female-to-males after sex reassignment.

Strengths and limitations of the study

Strengths of this study include nationwide representativity over more than 30 years, extensive follow-up time, and minimal loss to follow-up. Many previous studies suffer from low outcome ascertainment,[6,9,21,29] whereas this study has captured almost the entire population of sex-reassigned transsexual individuals in Sweden from 1973–2003. Moreover, previous outcome studies have mixed pre-operative and post-operative transsexual persons,[22,37] while we included only post-operative transsexual persons that also legally changed sex. Finally, whereas previous studies either lack a control group or use standardised mortality rates or standardised incidence rates as comparisons,[9,10,11] we selected random population controls matched by birth year, and either birth or final sex.

Given the nature of sex reassignment, a double blind randomized controlled study of the result after sex reassignment is not feasible. We therefore have to rely on other study designs. For the purpose of evaluating whether sex reassignment is an effective treatment for gender dysphoria, it is reasonable to compare reported gender dysphoria pre and post treatment. Such studies have been conducted either prospectively[7,12] or retrospectively,[5,6,9,22,25,26,29,38] and suggest that sex reassignment of transsexual persons improves quality of life and gender dysphoria. The limitation is of course that the treatment has not been assigned randomly and has not been carried out blindly.

For the purpose of evaluating the safety of sex reassignment in terms of morbidity and mortality, however, it is reasonable to compare sex reassigned persons with matched population controls. The caveat with this design is that transsexual persons before sex reassignment might differ from healthy controls (although this bias can be statistically corrected for by adjusting for baseline differences). It is therefore important to note that the current study is only informative with respect to transsexuals persons health after sex reassignment; no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism. In other words, the results should not be interpreted such as sex reassignment *per se* increases morbidity and mortality. Things might have been even worse without sex reassignment. As an analogy, similar studies have found increased somatic morbidity, suicide rate, and overall mortality for patients treated for bipolar disorder and schizophrenia.[39,40] This is important information, but it does not follow that mood stabilizing treatment or antipsychotic treatment is the culprit.

Other facets to consider are first that this study reflects the outcome of psychiatric and somatic treatment for transsexualism provided in Sweden during the 1970s and 1980s. Since then, treatment has evolved with improved sex reassignment surgery, refined hormonal treatment,[11,41] and more attention to psychosocial care that might have improved the outcome. Second, transsexualism is a rare condition and Sweden is a small country (9.2 million inhabitants in 2008). Hence, despite being based on a comparatively large national cohort and long-term follow-up, the statistical power was limited. Third, regarding psychiatric morbidity after sex reassignment, we assessed inpatient psychiatric care. Since most psychiatric care is provided in outpatient settings (for which no reliable data were available), underestimation of the *absolute* prevalences was inevitable. However, there is no reason to believe that this would change the *relative risks* for psychiatric morbidity unless sex-reassigned transsexual individuals were more likely than matched controls to be admitted to hospital for any given psychiatric condition.

Finally, to estimate start of follow-up, we prioritized using the date of a gender identity disorder diagnosis *after* changed sex status over *before* changed sex status, in order to avoid overestimating person-years at risk after sex-reassignment. This means that adverse outcomes might have been underestimated. However, given that the median time lag between the hospitalization before and after change of sex status was less than a year (see Methods), this maneuver is unlikely to have influenced the results significantly. Moreover, all deaths will be recorded regardless of this exercise and mortality hence correctly estimated.

Conclusion

This study found substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitalisations in sex-reassigned transsexual individuals compared to a healthy control population. This highlights that post surgical transsexuals are a risk group that need long-term psychiatric and somatic follow-up. Even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons. Improved care for the transsexual group after the sex reassignment should therefore be considered.

Supporting Information

Table S1 Risk of various outcomes in sex-reassigned persons in Sweden compared to population controls matched for birth year and *birth sex*.
(DOCX)

Table S2 Risk of various outcomes in sex-reassigned persons in Sweden compared to controls matched for birth year and *final sex*.
(DOCX)

Author Contributions

Conceived and designed the experiments: CD PL AJ NL ML. Performed the experiments: MB AJ. Analyzed the data: CD PL MB AJ NL ML. Contributed reagents/materials/analysis tools: PL NL AJ. Wrote the paper: CD PL MB AJ NL ML.

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Parent reports of adolescents and young adults per

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Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria

Lisa Littman

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Correction

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Abstract

Purpose

In on-line forums, parents have reported that their children seemed to experience a sudden or rapid onset of gender dysphoria, appearing for the first time during puberty or even after its completion. Parents describe that the onset of gender dysphoria seemed to occur in the context of belonging to a peer group where one, multiple, or even all of the friends have become gender dysphoric and transgender-identified during the same timeframe. Parents also report that their children exhibited an increase in social media/internet use prior to disclosure of a transgender identity. Recently, clinicians have reported that post-puberty presentations of gender dysphoria in natal females that appear to be rapid in onset is a phenomenon that they are seeing more and more in their clinic. Academics have raised questions about the role of social media in the development of gender dysphoria. The purpose of this study was to collect data about parents' observations, experiences, and perspectives about their adolescent and young adult (AYA) children showing signs of an apparent sudden or rapid onset of gender dysphoria that began during or after puberty, and develop hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among this demographic group.

Methods

For this descriptive, exploratory study, recruitment information with a link to a 90-question survey, consisting of multiple-choice, Likert-type and open-ended questions was placed on three websites where parents had reported sudden or rapid onsets of gender dysphoria occurring in their teen or young adult children. The study's eligibility criteria included parental response that their child had a sudden or rapid onset of gender dysphoria and parental indication that their child's gender dysphoria began during or after puberty. To maximize the chances of finding cases meeting eligibility criteria, the three websites (4thwavenow, transgender trend, and youthtranscriticalprofessionals) were selected for targeted recruitment. Website moderators and potential participants were encouraged to share the recruitment information and link to the survey with any individuals or communities that they thought might include eligible participants to expand the reach of the project through snowball sampling techniques. Data were collected anonymously via SurveyMonkey. Quantitative findings are presented as frequencies, percentages, ranges, means and/or medians. Open-ended responses from two questions were targeted for qualitative analysis of themes.

Results

There were 256 parent-completed surveys that met study criteria. The AYA children described were predominantly natal female (82.8%) with a mean age of 16.4 years at the time of survey completion and a mean age of 15.2 when they announced a transgender-identification. Per parent report, 41% of the AYAs had expressed a non-heterosexual sexual orientation before identifying as transgender. Many (62.5%) of the AYAs had reportedly been diagnosed with at least one mental health disorder or neurodevelopmental disability prior to the onset of their gender dysphoria (range of the number of pre-existing diagnoses 0–7). In 36.8% of the friendship groups described, parent participants indicated that the majority of the members became transgender-identified. Parents reported subjective declines in their AYAs' mental health (47.2%) and in parent-child relationships (57.3%) since the AYA "came out" and that AYAs expressed a range of behaviors that included: expressing distrust of non-transgender people (22.7%); stopping spending time with non-transgender friends (25.0%); trying to isolate themselves from their families (49.4%), and only trusting information about gender dysphoria from transgender sources (46.6%). Most (86.7%) of the parents reported that, along with the sudden or rapid onset of gender dysphoria, their child either had an increase in their social media/internet use, belonged to a friend group in which one or multiple friends became transgender-identified during a similar timeframe, or both

Conclusion

This descriptive, exploratory study of parent reports provides valuable detailed information that allows for the generation of hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among AYAs. Emerging hypotheses include the possibility of a potential new subcategory of gender dysphoria (referred to as rapid-onset gender dysphoria) that has not yet been clinically validated and the possibility of social influences and maladaptive coping mechanisms. Parent-child conflict may also explain some of the findings. More research that includes data collection from AYAs, parents, clinicians and third party informants is needed to further explore the roles of social influence, maladaptive coping mechanisms, parental approaches, and family dynamics in the development and duration of gender dysphoria in adolescents and young adults.

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Data Availability: The data cannot be made available due to ethical and regulatory restrictions. The study participants did not provide consent to have their responses shared publicly, shared in public databases, or shared with outside researchers. The Program for the Protection of Human Subjects (PPHS) at the Icahn School of Medicine at Mount Sinai is not permitting the sharing of data beyond what is reported in the paper owing to the sensitive nature of the collected information, the context of the study topic, its release's possible impact on the participants' reputation and standing in the community, and the risk of participant recognition through linkage of details. As participants' identifiers were not collected it is not possible to contact participants and ask for their consent to disclose at this time. For any questions about restriction on data sharing, please contact PPHS at the Icahn School of Medicine at Mount Sinai (IRB@mssm.edu).

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Competing interests: Lisa Littman, MD, MPH, provides public health consulting on topics unrelated to this research. She is a member of several professional organizations including the American College of Preventive Medicine (ACPM), the American Public Health Association (APHA), the Society for Adolescent Health and Medicine (SAHM), the Society of Family Planning (SFP), the International Academy of Sex Research (IASR), and the World Professional Association for Transgender Health (WPATH).

Introduction

In recent years, a number of parents have begun reporting in online discussion groups such as 4thwavenow in the US (https://4thwavenow.com) and Transgender Trend in the UK (https://www.transgendertrend.com) that their adolescent and young adult (AYA) children, who have had no histories of childhood gender identity issues, experienced a perceived sudden or rapid onset of gender dysphoria. Parents have described clusters of gender dysphoria in pre-existing friend groups with multiple or even all members of a friend group becoming gender dysphoric and transgender-identified in a pattern that seems statistically unlikely based on previous research [1–8]. Parents describe a process of immersion in social media, such as "binge-watching" YouTube transition videos and excessive use of Tumblr, immediately preceding their child becoming gender dysphoric [1–2, 9]. These types of presentations have not been described in the research literature for gender dysphoria [1–10] and raise the question of whether social influences may be contributing to or even driving these occurrences of gender dysphoria in some populations of adolescents and young adults. (Note: The terminology of "natal sex", including the terms "natal female" and "natal male", will be used throughout this article. Natal sex refers to an individual's sex as it was observed and documented at the time of birth. Some researchers also use the terminology "assigned at birth".)

Background

Gender dysphoria in adolescents

Gender dysphoria (GD) is defined as an individual's persistent discomfort with their biological sex or assigned gender [11]. Two types of gender dysphoria studied include early-onset gender dysphoria, where the symptoms of gender dysphoria begin in early childhood, and late-onset gender dysphoria, where the symptoms begin after puberty [11]. Late-onset gender dysphoria that occurs during adolescence is now called adolescent-onset gender dysphoria. The majority of adolescents who present for care for gender dysphoria are individuals who experienced early-onset gender dysphoria that persisted or worsened with puberty although an atypical presentation has been described where adolescents who did not experience childhood symptoms present with new symptoms in adolescence [7, 12]. Adolescent-onset of gender dysphoria has only recently been reported in the literature for natal females [5,10, 13–14]. In fact, prior to 2012, there were little to no research studies about adolescent females with gender dysphoria first beginning in adolescence [10]. Thus, far more is known about adolescents with early-onset gender dysphoria than adolescents with adolescent-onset gender dysphoria [6, 15]. Although not all research studies on gender dysphoric adolescents exclude those with adolescent-onset gender dysphoria [10], it is important to note that most of the studies on adolescents, particularly those about gender dysphoria persistence and desistance rates and outcomes for the use of puberty suppression, cross-sex hormones, and surgery only included subjects whose gender dysphoria began in childhood and subjects with adolescent-onset gender dysphoria would not have met inclusion criteria for these studies [16–24]. Therefore, most of the research on adolescents with gender dysphoria to date is not generalizable to adolescents experiencing adolescent-onset gender dysphoria [16–24] and the outcomes for individuals with adolescent-onset gender dysphoria, including persistence and desistence rates and outcomes for treatments, are currently unknown.

As recently as 2012, there were only two clinics (one in Canada and one in the Netherlands) that had gathered enough data to provide empirical information about the main issues for gender dysphoric adolescents [25]. Both institutions concluded that the management of adolescent-onset gender dysphoria is more complicated than the management of early-onset gender dysphoria and that individuals with adolescent-onset are more likely to have significant psychopathology [25]. The presentation of gender dysphoria can occur in the context of severe psychiatric disorders, developmental difficulties, or as part of large-scale identity issues and, for these patients, medical transition might not be advisable [13]. The APA Task Force on the Treatment of Gender Identity Disorder notes that adolescents with gender dysphoria "should be screened carefully to detect the emergence of the desire

for sex reassignment in the context of trauma as well as for any disorder (such as schizophrenia, mania, psychotic depression) that may produce gender confusion. When present, such psychopathology must be addressed and taken into account prior to assisting the adolescent's decision as to whether or not to pursue sex reassignment or actually assisting the adolescent with the gender transition." [25].

Demographic and clinical changes for gender dysphoria

Although, by 2013, there was research documenting that a significant number of natal males experienced gender dysphoria that began during or after puberty, there was little information about this type of presentation for natal females [5]. Starting in the mid-2000s there has been a substantial change in demographics of patients presenting for care with most notably an increase in adolescent females and an inversion of the sex ratio from one favoring natal males to one favoring natal females [26–28]. And now, some clinicians have noted that they are seeing increasingly in their clinic, the phenomenon of natal females expressing a post-puberty rapid onset of gender dysphoria [14]. Some researchers have suggested that increased visibility of transgender people in the media, availability of information online, with a partial reduction of stigma may explain some of the increases in numbers of patients seeking care [27], but these factors would not explain the reversal of the sex ratio, disproportionate increase in adolescent natal females, and the new phenomenon of natal females experiencing gender dysphoria that begins during or after puberty. If there were cultural changes that made it more acceptable for natal females to seek transition [27], that would not explain why the reversal of the sex ratio reported for adolescents has not been reported for older adult populations [26]. There are many unanswered questions about potential causes for the recent demographic and clinical changes for gender dysphoric individuals.

Social and peer influences

Parental reports (on social media) of friend clusters exhibiting signs of gender dysphoria [1–4] and increased exposure to social media/internet preceding a child's announcement of a transgender identity [1–2, 9] raise the possibility of social and peer influences. In developmental psychology research, impacts of peers and other social influences on an individual's development are sometimes described using the terms peer contagion and social contagion, respectively. The use of "contagion" in this context is distinct from the term's use in the study of infectious disease, and furthermore its use as an established academic concept throughout this article is not meant in any way to characterize the developmental process, outcome, or behavior as a disease or disease-like state, or to convey any value judgement. Social contagion [29] is the spread of affect or behaviors through a population. Peer contagion, in particular, is the process where an individual and peer mutually influence each other in a way that promotes emotions and behaviors that can potentially have negative effects on their development [30]. Peer contagion has been associated with depressive symptoms, disordered eating, aggression, bullying, and drug use [30–31]. Internalizing symptoms such as depression can be spread via the mechanisms of co-rumination, which entails the repetitive discussion of problems, excessive reassurance seeking (ERS), and negative feedback [30, 32–34]. Deviancy training, which was first described for rule breaking, delinquency, and aggression, is the process whereby attitudes and behaviors associated with problem behaviors are promoted with positive reinforcement by peers [35, 36].

Peer contagion has been shown to be a factor in several aspects of eating disorders. There are examples in the eating disorder and anorexia nervosa literature of how both internalizing symptoms and behaviors have been shared and spread via peer influences [37–41] which may have relevance to considerations of a rapid onset of gender dysphoria occurring in AYAs. Friendship cliques can set the norms for preoccupation with one's body, one's body image, and techniques for weight loss, and can predict an individual's body image concerns and eating behaviors [37–39]. Peer influence is intensified in inpatient and outpatient treatment settings for patients with anorexia and counter-therapeutic subcultures that actively promote the beliefs and behaviors of anorexia nervosa have been observed [39–41]. In these settings, there is a group dynamic where the "best" anorexics (those who are thinnest, most resistant to gaining weight, and who have experienced the most medical complications from their disease) are admired, validated, and seen as authentic while the patients who want to recover from anorexia and cooperate with medical treatment are maligned, ridiculed, and marginalized [39–41]. Additionally, behaviors associated with deceiving parents and doctors about eating and weight loss, referred to as the "anorexic tricks," are shared by patients in a manner akin to deviancy training [39–41]. Online environments provide ample opportunity for excessive reassurance seeking, co-rumination, positive and negative feedback, and deviancy training from peers who subscribe to unhealthy, self-harming behaviors. The pro-eating disorder sites provide motivation for extreme weight loss (sometimes calling the motivational content "thinspiration")[42–44]. Such sites promote validation of eating disorder as an identity, and offer "tips and tricks" for weight loss and for deceiving parents and doctors so that individuals may continue their weight-loss activities [42–44]. If similar mechanisms are at work in the context of gender dysphoria, this greatly complicates the evaluation and treatment of impacted AYAs.

In the past decade, there has been an increase in visibility, social media, and user-generated online content about transgender issues and transition [45], which may act as a double-edged sword. On the one hand, an increase in visibility has given a voice to individuals who would have been under-diagnosed and undertreated in the past [45]. On the other hand, it is plausible that online content may encourage vulnerable individuals to believe that nonspecific symptoms and vague feelings should be interpreted as gender dysphoria stemming from a transgender condition. Recently, leading international academic and clinical commentators have raised the question about the role of social media and online content in the development of gender dysphoria [46]. Concern has been raised that adolescents may come to believe that transition is the only solution to their individual situations, that exposure to internet content that is uncritically positive about transition may intensify these beliefs, and that those teens may pressure doctors for immediate medical treatment [25]. There are many examples on popular sites such as Reddit (www.reddit.com with subreddit ask/r/transgender) and Tumblr (www.tumblr.com) where online advice promotes the idea that nonspecific symptoms should be considered to be gender dysphoria, conveys an urgency to transition, and instructs individuals how to deceive parents, doctors, and therapists to obtain hormones quickly [47]. Fig 1 includes examples of online advice from Reddit and Tumblr.

Instructions on lying	• "TL;DR find out what they want to hear if they're gonna give you T and then tell them just that. It's about getting treatment, not about being true to those around you. It's not their business and a lot of time doctors will screw stuff up for you."[a] • "…Get a story ready in your head, and as suggested keep the lie to a minimum. And only for stuff that can't be verified. Like how you were feeling, but was too afraid to tell anyone including your family."[b] • "I'd also look up the DSM for the diagnostic criteria for transgender and make sure your story fits it, assuming your psych follows it."[c]
Urgency to transition	• "…If you don't do it when you are young. You'll be miserable and unhappy with your body for the rest of your life."[d]
Vague and nonspecific symptoms called signs of GD	• "Signs of indirect gender dysphoria: 1. Continual difficulty with simply getting through the day. 2. A sense of misalignment, disconnect, or estrangement from your own emotions. 3. A feeling of just going through the motions in everyday life, as if you're always reading from a script. 4. A seeming pointlessness to your life, and no sense of any real meaning or ultimate purpose. 5. Knowing you're somehow different from everyone else, and wishing you could be normal like them…"[e]
	a. https://www.reddit.com/r/asktransgender/comments/[illegible]/having_a_psych_eval_soon/#bottom-comments b. https://www.reddit.com/r/asktransgender/comments/[illegible]/is_it_best_to_be_completely_honest_or_lie_a/ c. https://www.reddit.com/r/asktransgender/comments/[illegible]/what_things_should_i_never_tell_my_psychologist/ d. https://www.reddit.com/r/asktransgender/comments/[illegible]/at_the_final_stage_of_questioning_need_some/#bottom-comments e. https://transgendersurvivalguide.tumblr.com/post/[illegible]/that-was-dysphoria-8-signs-and-symptoms-of

Fig 1. Example quotes of online advice from Reddit and Tumblr.
https://doi.org/10.1371/journal.pone.0202330.g001

Purpose

Rapid presentations of adolescent-onset gender dysphoria occurring in clusters of pre-existing friend groups are not consistent with current knowledge about gender dysphoria and have not been described in the scientific literature to date [1–8]. The purpose of this descriptive, exploratory research is to (1) collect data about parents' observations, experiences, and perspectives about their AYA children showing signs of a rapid onset of gender dysphoria that began during or after puberty, and (2) develop hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among this demographic group.

Materials and methods

The Icahn School of Medicine at Mount Sinai, Program for the Protection of Human Subjects provided approval of research for this project (HS#: 16–00744).

Participants

During the recruitment period, 256 parents completed online surveys that met the study criteria. The sample of parents included more women (91.7%) than men (8.3%) and participants were predominantly between the ages of 45 and 60 (66.1%) (Table 1). Most respondents were White (91.4%), non-Hispanic (99.2%), and lived in the United States (71.7%). Most respondents had a Bachelor's degree (37.8%) or graduate degree (33.1%). The adolescents and young adults (AYAs) described by their parents were predominantly female sex at birth (82.8%) with an average current age of 16.4 years (range, 11–27 years). See Table 2.

Characteristics of Parent-respondents		n	%
Sex		254	
	Female	233	91.7
	Male	21	8.3
Age (y)		254	
	18–29	3	1.2
	30–44	74	29.1
	45–60	168	66.1
	>60	9	3.5
Race/Ethnicity*		255	
	White	233	91.4
	Other**	22	8.6
Country of Residence		254	
	US	182	71.7
	UK	39	15.4
	Canada	17	6.7
	Other	16	6.3
Education		254	
	Bachelor's degree	96	37.8
	Graduate degree	84	33.1
	Some college or Associates degree	63	24.8
	HS grad or GED	10	3.9
	<High School	1	0.4
Parent attitude on allowing gay and lesbian couples to marry legally		256	
	Favor	220	85.9
	Oppose	19	7.4
	Don't know	17	6.6
Parent belief that transgender people deserve the same rights and protections as others		255	
	Yes	225	88.2
	No	8	3.1
	Don't know	20	7.8
	Other	2	0.8

* may select more than one answer.
** declining order includes: Other, Multiracial, Asian, Hispanic.

https://doi.org/10.1371/journal.pone.0202330.t001

Table 1. Demographic and other baseline characteristics of parent respondents.
https://doi.org/10.1371/journal.pone.0202330.t001

Characteristics of AYAs		n	[illegible]
AYA sex at birth (natal sex)		256	
	Female	212	82.8
	Male	44	17.2
AYA average current age (range of ages)	16.4 (11–27)	256	
Academic diagnoses		253	
	Gifted	120	47.4
	Learning Disability	11	4.3
	Both	27	10.7
	Neither	95	37.5
Natal female expressed sexual orientation before announcement*		212	
	Asexual	18	8.5
	Bisexual or Pansexual	78	36.8
	Gay or Lesbian	58	27.4
	Straight (Heterosexual)	75	35.4
	Did not express	57	26.9
Natal male expressed sexual orientation before announcement*		44	
	Asexual	4	9.1
	Bisexual or Pansexual	5	11.4
	Gay	5	11.4
	Straight (Heterosexual)	25	56.8
	Did not express	11	25.0
Gender dysphoria began		256	
	During puberty	125	48.8
	After puberty	131	51.2
Along with a rapid onset of GD, the AYA also:		256	
	Belonged to a friend group where one or multiple friends became transgender-identified during a similar timeframe	55	21.5
	Had an increase in social media/internet use	51	19.9
	Both of the above	116	45.3
	Neither	13	5.1
	Don't know	21	8.2

* may select more than one answer.

https://doi.org/10.1371/journal.pone.0202330.t002

Table 2. Demographic and other baseline characteristics of AYAs.
https://doi.org/10.1371/journal.pone.0202330.t002

Procedure

A 90-question survey instrument with multiple choice, Likert-type, and open-ended questions was created by the researcher. The survey was designed for parents (respondents) to complete about their adolescent and young adult children. The survey was uploaded onto Survey Monkey (SurveyMonkey, Palo Alto, CA, USA) via an account that was HIPPA-enabled. IRB approval for the study from the Icahn School of Medicine at Mount Sinai in New York, NY was received. Recruitment information with a link to the survey was placed on three websites where parents and professionals had been observed to describe what seemed to be a sudden or rapid onset of gender dysphoria (4thwavenow, transgender trend, and youthtranscriticalprofessionals), although the specific terminology "rapid onset gender dysphoria" did not appear on these websites until the recruitment information using that term was first posted on the sites. Website moderators and potential participants were encouraged to share the recruitment information and link to the survey with any individuals or communities that they thought might include eligible participants to expand the reach of the project through snowball sampling techniques. The survey was active from June 29, 2016 to October 12, 2016 (3.5 months) and took 30–60 minutes to complete. Participants completed the survey at a time and place of their own choosing. Data were collected anonymously and stored securely with Survey Monkey.

Participation in this study was voluntary and its purpose was clearly described in the recruitment information. Electronic consent was obtained. Participants had the option to withdraw consent at any time prior to submitting responses. Inclusion criteria were (1) completion of a survey with parental response that the child had a sudden or rapid onset of gender dysphoria; and (2) parental indication that the child's gender dysphoria began during or after puberty. There was logic embedded in the survey that disqualified surveys that answered "no" (or skipped the question) about whether the child had a sudden or rapid onset of gender dysphoria and 23 surveys were disqualified prior to completion (20 "no" answers and 3 skipped answers). After cleaning the data for the 274 completed surveys, 8 surveys were excluded for not having a sudden or rapid onset of gender dysphoria and 10 surveys were excluded for not having gender dysphoria that began during or after puberty, which left 256 completed surveys for inclusion. As the survey was voluntary there was no refusal or dropout rate.

Recruitment sites

There were four sites known to post recruitment information about the research study. The first three were posted due to direct communication with the moderators of the sites. The fourth site posted recruitment information secondary to the snowball sampling technique. The following descriptions provide details about these sites.

4thwavenow

4thwavenow was created in 2015. The site, as seen in digitally archived screenshots from 2015 and 2016, stated that it is a "safe place for gender-skeptical parents and their allies", offered support for parents, and expressed concern about the rush to diagnose young people as transgender and the rush to proceed to medical treatment for them [2, 48]. By June 2016, the site had expanded to include the writing of several parents, "formerly trans-identified people, and people with professional expertise and experience with young people questioning their gender identity" [9]. The perspective of this site might be described as cautious about medical and surgical transition overall—specifically with a cautious or negative view of medical and surgical interventions for children, adolescents, and young adults and an accepting view that mature adults can make their own decisions about transition [2, 9].

Transgendertrend

Transgendertrend was founded in November 2015. The digitally archived screenshots from November 2015 and July 2016 "Who Are We?" section include the following description, "We are an international group of parents based mainly in the UK, US and Canada, who are concerned about the current trend to diagnose 'gender non-conforming' children as transgender. We reject

current conservative, reactionary, religious-fundamentalist views about sexuality. We come from diverse backgrounds, some with expertise in child development and psychology, some who were themselves extreme gender non-conforming children and adolescents, some whose own children have self-diagnosed as 'trans' and some who know supportive trans adults who are also questioning recent theories of 'transgenderism'" [49]. In July of 2016, there was additional text added, expressing concern about legislation regarding public bathrooms and changing rooms [50].

Youth trans critical professionals

Youth Trans Critical Professionals was created in March 2016. The digitally archived screenshot from the April 2016 "About" section stated the following: "This website is a community of professionals "thinking critically about the youth transgender movement. We are psychologists, social workers, doctors, medical ethicists, and academics. We tend to be left-leaning, open-minded, and pro-gay rights. However, we are concerned about the current trend to quickly diagnose and affirm young people as transgender, often setting them down a path toward medical transition. Our concern is with medical transition for children and youth. We feel that unnecessary surgeries and/or hormonal treatments which have not been proven safe in the long-term represent significant risks for young people" [51].

Parents of transgender children

Parents of Transgender Children is a private Facebook group with more than 8,000 members [52]. The current "About" section states that requests to join the group "will be denied if you are not the parent (or immediate caregiver or family member) of a transgender, gender-fluid, gender-questioning, agender, or other gender-nonconforming child (of any age); or if you are uncooperative during screening" and that the "group is comprised of parents and parenting figures, as well as a select group of advocates INVITED by the admin[istrative] staff to assist & help us with understanding legal and other concerns" [52]. Although the parent discussions and comments are not viewable to non-members [52], this group is perceived to be pro -gender-affirming. The Parents of Transgender Children Facebook group is considered to be a site to find parents who are supportive of their child's gender identity [53], and it is listed as a resource in a gender affirming parenting guide [54] and by gender affirming organizations [55–56].

Measures

Basic demographic and baseline characteristics

Basic demographic and baseline characteristic questions, including parental attitudes about LGBT rights, were included. Parents were asked about their children's mental health disorders and neurodevelopmental disabilities that were diagnosed before their child's onset of gender dysphoria as well as during and after. The question, "Has your child been formally identified as academically gifted, learning disabled, both, neither?" was used as a proxy to estimate rates of academic giftedness and learning disabilities. Questions about trauma and non-suicidal self-injury were also included as were questions about social difficulties described in a previous research study about gender dysphoric adolescents [13].

DSM-5 diagnostic criteria for gender dysphoria in children

The DSM 5 criteria for gender dysphoria in children consist of eight indicators of gender dysphoria [57]. To meet criteria for diagnosis, a child must manifest at least six out of eight indicators including the one designated A1, "A strong desire to be the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)." Three of the indicators (A1, A7, and A8) refer to desires or dislikes of the child. Five of the indicators (A2-A6) are readily observable behaviors and preferences such as a strong preference or strong resistance to wearing certain kinds of clothing; a strong preference or strong rejection of specific toys, games and activities; and a strong preference for playmates of the other gender [57]. The eight indicators were simplified for language and parents were asked to note which, if any, their child had exhibited prior to puberty. The requirement of six-month duration of symptoms was not included.

DSM-5 diagnostic criteria for gender dysphoria in adolescents and adults

The DSM-5 criteria for gender dysphoria in adolescents and adults consist of six indicators of gender dysphoria [57]. To meet criteria for diagnosis, an adolescent or adult must manifest at least two of the six indicators. The six indicators were simplified for language, the first indicator was adjusted for a parent to answer about their child, and parents were asked to note which, if any, their child was expressing currently. The requirement of six-month duration of symptoms was not included.

Exposure to friend groups and social media/internet content

Survey questions were developed to describe AYA friend groups, including number of friends that became transgender-identified in a similar time period as the AYA, peer group dynamics and behaviors, and exposure to specific types of social media/internet content and messages that have been observed on sites popular with teens, such as Reddit and Tumblr.

Behaviors, outcomes, clinical interactions

Survey questions were developed to specifically quantify adolescent behaviors that had been described by parents in online discussions and observed elsewhere. Participants were asked to describe outcomes such as their child's mental well-being and parent-child relationship since becoming transgender-identified. Parents were also asked about experiences with clinicians and their children's disposition regarding steps taken for transition and duration of transgender-identification both for children who were still transgender-identified and for children who were no longer transgender-identified.

Coping with strong or negative emotions

Two questions about the AYAs' ability to cope with negative and strong emotions were included. One question was "How does your child handle strong emotions? (please select the best answer)." Offered answers were "My child is overwhelmed by strong emotions and goes to great lengths to avoid feeling them," "My child is overwhelmed by strong emotions and tries to avoid feeling them," "My child neither avoids not seeks out strong emotions," "My child tries to seek out situations in order to feel strong emotions," "My child goes to great lengths to seek out situations in order to feel strong emotions," "None of the above," "I don't know." The other question was "How would you rate your child's ability to deal with their negative emotions and channel them into something productive?" An example was given regarding dealing with a low test grade by studying harder for the next test (excellent) or by ignoring it, throwing a tantrum, blaming the teacher or distracting themselves with computer games, alcohol, drugs, etc. (extremely poor). Offered answers were: excellent, good, fair, poor, extremely poor, and I don't know.

Data analysis

Statistical analyses of quantitative data were performed using Excel and custom shell scripts (Unix). Quantitative findings are presented as frequencies, percentages, ranges, means and/or medians. ANOVAs, chi-squared, and t-tests comparisons were used where appropriate using publicly available calculators and $p<0.05$ was considered significant. Qualitative data were obtained from open text answers to questions that allowed participants to provide additional information or comments. The types of comments and descriptions were categorized, tallied, and reported numerically. A grounded theory approach was selected as the analytic strategy of choice for handling the qualitative responses because it allowed the researcher to assemble the data in accordance with the salient points the respondents were making without forcing the data into a preconceived theoretical framework of the researcher's own choosing [58]. Illustrative respondent quotes and summaries from the qualitative data are used to illustrate the quantitative results and to provide relevant examples. Two questions were targeted for full qualitative analysis of themes (one question on friend group behaviors and one on clinician interactions). For these questions, a second reviewer with expertise in qualitative methods was engaged (MM). Both the author (LL) and reviewer (MM) independently analyzed the content of the open text answers and identified major themes. Discrepancies were resolved with collaborative discussion and themes were explored and refined until agreement was reached for the final lists of themes. Representative quotes for each theme were selected by LL, reviewed by MM, and agreement was reached.

Results

Baseline characteristics

Baseline characteristics (Table 1) included that the vast majority of parents favored gay and lesbian couples' right to legally marry (85.9%) and believed that transgender individuals deserve the same rights and protections as other individuals in their country (88.2%). Along with the sudden or rapid onset of gender dysphoria, the AYAs belonged to a friend group where one or multiple friends became gender dysphoric and came out as transgender during a similar time as they did (21.5%), exhibited an increase in their social media/internet use (19.9%), both (45.3%), neither (5.1%), and don't know (8.2%) (Table 2). For comparisons, the first three categories will be combined and called "social influence" (86.7%) and the last two combined as "no social influence" (13.3%). Nearly half (47.4%) of the AYAs had been formally diagnosed as academically gifted, 4.3% had a learning disability, 10.7% were both gifted and learning disabled, and 37.5% were neither. Sexual orientation as expressed by the AYA prior to transgender-identification is listed separately for natal females and for natal males (Table 2). Overall, 41% of the AYAs expressed a non-heterosexual sexual orientation prior to disclosing a transgender-identification.

It is important to note that none of the AYAs described in this study would have met diagnostic criteria for gender dysphoria in childhood (Table 3). In fact, the vast majority (80.4%) had zero indicators from the DSM-5 diagnostic criteria for childhood gender dysphoria with 12.2% possessing one indicator, 3.5% with two indicators, and 2.4% with three indicators. Breaking down these results, for readily observable indicators (A2-6), 83.5% of AYAs had zero indicators, 10.2% had one indicator, 3.9% had two indicators, and 1.2% had three indicators. For the desire/dislike indicators (A1, A7, A8), which a parent would have knowledge of if the child expressed them verbally, but might be unaware if a child did not, 95.7% had zero indicators and 3.5% had one indicator. Parents responded to the question about which, if any, of the indicators of the DSM criteria for adolescent and adult gender dysphoria their child was experiencing currently. The average number of positive current indicators was 3.5 (range 0–6) and 83.2% of the AYA sample was currently experiencing two or more indicators. Thus, while the focal AYAs did not experience childhood gender dysphoria, the majority of those who were the focus of this study were indeed gender dysphoric at the time of the survey completion.

Characteristics		n	%
AYAs who would have met diagnostic criteria for gender dysphoria in childhood		0	0
Number of DSM 5 indicators for gender dysphoria in children exhibited prior to puberty		255	
	Zero indicators	205	80.4
	One indicator	31	12.2
	Two indicators	9	3.5
	Three indicators	6	2.4
	Four indicators	3	1.2
Desire/Dislike Indicators (A1, A7, or A8)		255	
	Zero indicators	244	95.7
	One indicators	9	3.5
	Two indicators	0	0
	Three indicators	1	0.4
Readily observable indicators (A2-A6)		254	
	Zero indicators	212	83.5
	One indicator	26	10.2
	Two indicators	10	3.9
	Three indicators	3	1.2
	Four indicators	3	1.2
Average number of DSM 5 indicators for adolescent and adult gender dysphoria that the AYA is experiencing currently (range)			
	3.5 (range 0–6)	247	
AYAs currently experiencing two or more indicators of gender dysphoria for adolescents and adults		250	
	Yes	208	83.2
	No	40	16.0
	Don't know	2	0.8

https://doi.org/10.1371/journal.pone.0202330.t003

Table 3. DSM 5 Indicators for gender dysphoria.

https://doi.org/10.1371/journal.pone.0202330.t003

The AYAs who were the focus of this study had many comorbidities and vulnerabilities predating the onset of their gender dysphoria, including psychiatric disorders, neurodevelopmental disabilities, trauma, non-suicidal self-injury (NSSI), and difficulties coping with strong or negative emotions (Table 4). The majority (62.5%) of AYAs had one or more diagnoses of a psychiatric disorder or neurodevelopmental disability preceding the onset of gender dysphoria (range of the number of pre-existing diagnoses 0–7). Many (48.4%) had experienced a traumatic or stressful event prior to the onset of their gender dysphoria. Open text descriptions of trauma were categorized as "family" (including parental divorce, death of a parent, mental disorder in a sibling or parent), "sex or gender related" (such as rape, attempted rape, sexual harassment, abusive dating relationship, break-up), "social" (such as bullying, social isolation), "moving" (family relocation or change of schools); "psychiatric" (such as psychiatric hospitalization), and medical (such as serious illness or medical hospitalization). Almost half (45.0%) of AYAs were engaging in non-suicidal self-injury (NSSI) behavior before the onset of gender dysphoria. Coping styles for these AYAs included having a poor or extremely poor ability to handle negative emotions productively (58.0%) and being overwhelmed by strong emotions and trying to avoid (or go to great lengths to avoid) experiencing them (61.4%) (Table 4). The majority of respondents (69.4%) answered that their child had social anxiety during adolescence; 44.3% that their child had difficulty interacting with their peers, and 43.1% that their child had a history of being isolated (not associating with their peers outside of school activities).

Characteristics		n	
Mental disorder or neurodevelopmental disability diagnosed prior to the onset of gender dysphoria*		251	
	Anxiety	117	46.6
	Depression	99	39.4
	Attention Deficit Hyperactivity Disorder (ADHD)	29	11.6
	Obsessive Compulsive Disorder (OCD)	21	8.4
	Autism Spectrum Disorder (ASD)	20	8.0
	Eating Disorder	12	4.8
	Bipolar Disorder	8	3.2
	Psychosis	6	2.4
	None of above	94	37.5
	(Other) Borderline	3	1.2
	(Other) Oppositional Defiant Disorder	2	0.8
Traumatic or stressful experience prior to the onset of gender dysphoria		252	
	Yes	122	48.4
	No	91	36.1
	Don't know	38	15.1
	Other	1	0.4
Types of trauma*		113	
	Family	50	44.2
	Sex/Gender related	34	30.1
	Social	23	20.4
	Moving	20	17.7
	Psychiatric	9	8.0
	Medical	7	6.2
Non-suicidal self-injury (NSSI) before the onset of gender dysphoria		180	
		81	45.0
Ability to handle negative emotions productively		255	
	Excellent/Good	34	13.3
	Fair	70	27.5
	Poor/Extremely Poor	148	58.0
	Don't know	3	1.2
Coping style for dealing with strong emotions		254	
	Overwhelmed by strong emotions and tries to /goes to great lengths to avoid feeling them	156	61.4
	Neither avoids nor seeks out strong emotions	29	11.4
	Tries to/goes to great lengths to seeks out strong emotions	33	13.0
	Don't know	25	9.8
	None of the above	11	4.3
Social vulnerabilities		255	
	During adolescence child had social anxiety	177	69.4
	Child had difficulty interacting with their peers	113	44.3
	History of being isolated (not interacting with peers outside of school activities)	110	43.1
	Child felt excluded by peers throughout most of grade school	93	36.5
	Child had persistent experiences of being bullied before the onset of gender dysphoria	74	29.0

*may select more than one answer.

https://doi.org/10.1371/journal.pone.0202330.t004

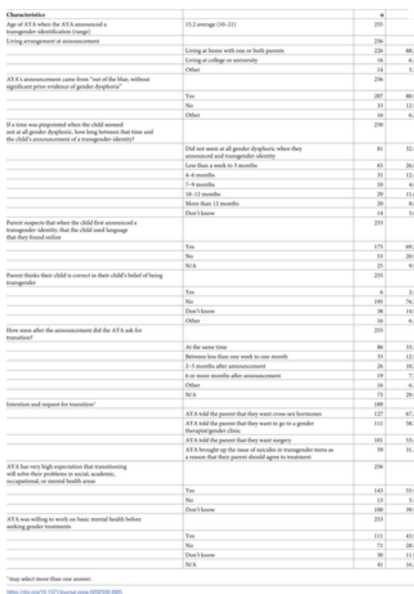
Table 4. AYA baseline comorbidities and vulnerabilities predating the onset of gender dysphoria.

https://doi.org/10.1371/journal.pone.0202330.t004

Announcing a transgender-identification

At the time the AYA announced they were transgender-identified ("came out"), most were living at home with one or both parents (88.3%) and a small number were living at college (6.2%). The average age of announcement of a transgender-identification was 15.2 years of age (range 10–21) (Table 5). Most of the parents (80.9%) answered affirmatively that their child's announcement of being transgender came "out of the blue without significant prior evidence of gender dysphoria." Respondents were asked to pinpoint a time when their child seemed not at all gender dysphoric and to estimate the length of time between that point and their child's announcement of a transgender-identity. Almost a third of respondents (32.4%) noted that their child did not seem gender dysphoric when they made their announcement and 26.0% said the length of time from not seeming gender dysphoric to announcing a transgender identity was between less than a week to three months. The most striking examples of "not seeming at all gender dysphoric" prior to making the announcement included a daughter who loved summers and seemed to love how she looked in a bikini, another daughter who happily wore bikinis and makeup, and another daughter who previously said, "I love my body!"

The majority of respondents (69.2%) believed that their child was using language that they found online when they "came out." A total of 130 participants provided optional open text responses to this question, and responses fell into the following categories: why they thought the child was using language they found online (51); description of what the child said but didn't provide a reason that they suspected the child was using language they found online (61); something else about the conversation (8) or the child (7) and don't know (3). Of the 51 responses describing reasons why respondents thought their child was reproducing language they found online, the top two reasons were that it didn't sound like their child's voice (19 respondents) and that the parent later looked online and recognized the same words and phrases that their child used when they announced a transgender identity (14 respondents). The observation that it didn't sound like their child's voice was also expressed as "sounding scripted," like their child was "reading from a script," "wooden," "like a form letter," and that it didn't sound like their child's words. Parents described finding the words their child said to them "verbatim," "word for word," "practically copy and paste," and "identical" in online and other sources. The following quotes capture these top two observations. One parent said, "It seemed different from the way she usually talked—I remember thinking it was like hearing someone who had memorized a lot of definitions for a vocabulary test." Another respondent said, "The email [my child sent to me] read like all of the narratives posted online almost word for word."



Characteristics		n	
Age of AYA when the AYA announced a transgender identification (range)	15.2 average (10–21)	255	
Living arrangement at announcement		256	
	Living at home with one or both parents	226	88.3
	Living at college or university	16	6.2
	Other	14	5.5
AYA's announcement came from "out of the blue, without significant prior evidence of gender dysphoria"		256	
	Yes	207	80.9
	No	33	12.9
	Other	16	6.2
If a time was pinpointed when the child seemed not at all gender dysphoric, how long between that time and the child's announcement of a transgender identity?		250	
	Did not seem at all gender dysphoric when they announced and transgender identity	81	32.4
	Less than a week to 3 months	65	26.0
	4–6 months	31	12.4
	7–9 months	10	4.0
	10–12 months	29	11.6
	More than 12 months	20	8.0
	Don't know	14	5.6
Parent suspects that when the child first announced a transgender identity, that the child used language that they found online		253	
	Yes	175	69.2
	No	53	20.9
	N/A	25	9.9
Parent thinks their child is correct in their child's belief of being transgender		255	
	Yes	6	2.4
	No	195	76.5
	Don't know	38	14.9
	Other	16	6.3
How soon after the announcement did the AYA ask for transition?		255	
	At the same time	86	33.7
	Between less than one week to one month	33	12.9
	2–5 months after announcement	26	10.2
	6 or more months after announcement	19	7.5
	Other	16	6.3
	N/A	75	29.4
Intention and request for transition*		189	
	AYA told the parent that they want cross-sex hormones	127	67.2
	AYA told the parent that they want to go to a gender therapist/gender clinic	111	58.7
	AYA told the parent that they want surgery	101	53.4
	AYA brought up the issue of suicides in transgender teens as a reason that their parent should agree to treatment	59	31.2
AYA has very high expectation that transitioning will solve their problems in social, academic, occupational, or mental health areas		256	
	Yes	143	55.9
	No	13	5.1
	Don't know	100	39.1
AYA was willing to work on basic mental health before seeking gender treatments		253	
	Yes	111	43.9
	No	71	28.1
	Don't know	30	11.9
	N/A	41	16.2

*may select more than one answer.

https://doi.org/10.1371/journal.pone.0202330.t005

Table 5. Announcing a transgender-identification.

https://doi.org/10.1371/journal.pone.0202330.t005

The following case summaries were selected to illustrate peer, trauma, and psychiatric contexts that might indicate more complicated clinical pictures.

- A 12-year-old natal female was bullied specifically for going through early puberty and the responding parent wrote "as a result she said she felt fat and hated her breasts." She learned online that hating your breasts is a sign of being transgender. She edited her diary (by crossing out existing text and writing in new text) to make it appear that she has always felt that she is transgender.
- A 14-year-old natal female and three of her natal female friends were taking group lessons together with a very popular coach. The coach came out as transgender, and, within one year, all four students announced they were also transgender.
- A natal female was traumatized by a rape when she was 16 years of age. Before the rape, she was described as a happy girl; after the rape, she became withdrawn and fearful. Several months after the rape, she announced that she was transgender and told her parents that she needed to transition.
- A 21-year-old natal male who had been academically successful at a prestigious university seemed depressed for about six months. Since concluding that he was transgender, he went on to have a marked decline in his social functioning and has become increasingly angry and hostile to his family. He refuses to move out or look for a job. His entire family, including several members who are very supportive of the transgender community, believe that he is "suffering from a mental disorder which has nothing to do with gender."
- A 14-year-old natal female and three of her natal female friends are part of a larger friend group that spends much of their time talking about gender and sexuality. The three natal female friends all announced they were trans boys and chose similar masculine names. After spending time with these three friends, the 14-year-old natal female announced that she was also a trans boy.

The majority (76.5%) of the surveyed parents felt that their child was incorrect in their belief of being transgender (Table 5). More than a third (33.7%) of the AYAs asked for medical and/or surgical transition at the same time that they announced they were transgender-identified. Two thirds (67.2%) of the AYAs told their parent that they wanted to take cross-sex hormones; 58.7% that they wanted to see a gender therapist/gender clinic; and 53.4% that they wanted surgery for transition. Almost a third (31.2%) of AYAs brought up the issue of suicides in transgender teens as a reason that their parent should agree to treatment. More than half of the AYAs (55.9%) had very high expectations that transitioning would solve their problems in social, academic, occupational or mental health areas. While 43.9% of AYAs were willing to work on basic mental health before seeking gender treatments, a sizable minority (28.1%) were not willing to work on their basic mental health before seeking gender treatment. At least two parents relayed that their child discontinued psychiatric care and medications for pre-existing mental health conditions once they identified as transgender. One parent, in response to the question about if their child had very high expectations that transitioning would solve their problems elaborated, "Very much so. [She] discontinued anti-depressant quickly, stopped seeing psychiatrist, began seeing gender therapist, stopped healthy eating. [She] stated 'none of it' (minding what she ate and taking her Rx) 'mattered anymore.' This was her cure, in her opinion."

Friend-group exposure

The adolescent and young adult children were, on average, 14.4 years old when their first friend became transgender-identified (Table 6). Within friendship groups, the average number of individuals who became transgender-identified was 3.5 per group. In 36.8% of the friend groups described, the majority of individuals in the group became transgender-identified. The order that the focal AYA "came out" compared to the rest of their friendship group was calculated from the 119 participants who provided the number of friends coming out both before and after their child and 74.8% of the AYAs were first, second or third of their group. Parents described intense group dynamics where friend groups praised and supported people who were transgender-identified and

ridiculed and maligned non-transgender people. Where popularity status and activities were known, 60.7% of the AYAs experienced an increased popularity within their friend group when they announced a transgender-identification and 60.0% of the friend groups were known to mock people who were not transgender or LGBTIA (lesbian, gay, bisexual, transgender, intersex, or asexual).

Characteristics		n	%
The AYA has been part of a friend group where one or more friends has come out as transgender around a similar timeframe as they did		254	
	Yes	176	69.3
	No	47	18.5
	Don't know	31	12.2
Age of AYA when their first friend became transgender-identified (range)	14.4 average (11–21)	174	
Number of friends from the friendship group who became gender dysphoric average (range)	3.5 average (2–10)	138	
Where numbers known, friend groups where the MAJORITY of the friends in the friendship group became transgender-identified		125	
	Yes	46	36.8
	No	79	63.2
Order of the AYAs "coming out" compared to the others in the friendship group		119	
	First in the friendship group	4	3.4
	Second in the friendship group	52	43.7
	Third in the friendship group	33	27.7
	Fourth in the friendship group	18	15.1
	Fifth in the friendship group	5	4.2
	Sixth or Seventh in the friendship group	6	5.0
Where popularity status known, change in popularity within friend group when AYA announced their transgender-identification		178	
	Increased popularity	108	60.7
	Decreased popularity	11	6.2
	Unchanged popularity	59	33.1
Where friend group activities known, friend group known to mock people who are not transgender/LGBT		145	
	Yes	87	60.0
	No	58	40.0

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Table 6. Friend group exposure.

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For the question about popularity changes when the child came out as having a transgender-identification, 79 participants provided optional open text responses which were categorized as: descriptions of the responses the child received (39); descriptions of the friends (14); description that the child did not "come out" to friends (8); not sure (9); speculation on how the child felt from the response (4), other (5). Of the 39 descriptions of responses, 19 of these responses referred to positive benefits the child received after coming out including positive attention, compliments, increased status, increased popularity, increased numbers of online followers, and improved protection from ongoing bullying. The following are quotes from parents about the perceived benefits of transgender-identification afforded to their child. One respondent said, "Great increase in popularity among the student body at large. Being trans is a gold star in the eyes of other teens." Another respondent explained, "not so much 'popularity' increasing as 'status'…also she became untouchable in terms of bullying in school as teachers who ignored homophobic bullying …are now all at pains to be hot on the heels of any trans bullying." Seven respondents described a mixed response where the child's popularity increased with some friends and decreased with others. Seven respondents described a neutral response such as "All of the friends seemed extremely accepting." Two described a temporary increase in their child's popularity: "There was an immediate rush of support when he came out. Those same friends have dwindled to nothing as he rarely speaks to any of them now." Another described the loss of friends. And two parents described that "coming out" prevented the loss of friends explained by one respondent as "to not be trans one would not have been included in his group."

Several AYAs expressed significant concern about the potential repercussions from their friend group when they concluded that they were not transgender after all. There were two unrelated cases with similar trajectories where the AYAs spent some significant time in a different setting, away from their usual friend group, without access to the internet. Parents described that these AYAs made new friendships, became romantically involved with another person, and during their time away concluded that they were not transgender. In both cases, the adolescents, rather than face their school friends, asked to move and transfer to different high schools. One parent said that their child, "…couldn't face the stigma of going back to school and being branded as a fake or phony. … Or worse, a traitor or some kind of betrayer…[and] asked us if we could move." In the other case, the parent relayed that their child thought none of the original friends would understand and expressed a strong desire to "…get out of the culture that 'if you are cis, then you are bad or oppressive or clueless.'" Both families were able to relocate and both respondents reported that their teens have thrived in their new environments and new schools. One respondent described that their child expressed relief that medical transition was never started and felt there would have been pressure to move forward had the family not moved away from the peer group.

Qualitative analysis

The open-ended responses from the question about whether the AYAs and friends mocked, teased, or made fun of individuals who weren't transgender or LGBTIA was selected for additional qualitative analysis. Seven major themes were identified from the comments provided by participants and are described, with representative supporting quotes.

Theme: Groups targeted.

The groups targeted for mocking by the friend groups are often heterosexual (straight) people and non-transgender people (called "cis" or "cisgender"). Sometimes animosity was also directed towards males, white people, gay and lesbian (non-transgender) people, aromantic and asexual people, and "terfs". One participant explained, "They are constantly putting down straight, white people for being privileged, dumb and boring." Another participant elaborated, "In general, cis-gendered people are considered evil and unsupportive, regardless of their actual views on the topic. To be heterosexual, comfortable with the gender you were assigned at birth, and non-minority places you in the 'most evil' of categories with this group of friends. Statement of opinions by the evil cis-gendered population are consider phobic and discriminatory and are generally discounted as unenlightened."

Theme: Individuals targeted.

In addition to targeting specific groups of people for mocking, the AYAs and their friend groups also directed mocking towards individuals in the AYAs' lives such as parents, grandparents, siblings, peers, allies, and teachers. The following quotes describe individuals targeted. One participant said, "They call kids who are not LGBT dumb and cis. And the mocking has been aimed at my transgender-identified child's [sibling]." Another parent said, "They definitely made fun of parents and teachers who did not agree with them." And a third participant said, "…they were asked to leave [a school-based LGBT club] because they were not queer enough [as straight and bisexual allies]. [One of them] was [then] bullied, harassed and denounced online."

Theme: Behaviors occurred both in person and in online settings.

Parents observed the behaviors both in-person and in online settings, and specifically mentioned seeing posts and conversations on Tumblr, Twitter, Facebook, and Instagram. On participant said, "They speak with derision about how cis-gendered people do not understand them and are so close-minded." Another participant said, "I hear them disparaging heterosexuality, marriage and nuclear families." Another participant said, "On my daughter's Tumblr blog, she has liked or favorited or re-posted disparaging comments about those who aren't transgender or seem to misunderstand the transgender identity." And another parent reported, "Her real life friends don't [mock non-LGBT people] but online they are always swapping jokes and comments about cisgender and about transphobia."

Theme: Examples of behaviors.

Participants gave many examples of the observed behaviors that were mocking towards non-transgender people and non-LGB people. One participant said, "My daughter called me a 'breeder' and says things in a mocking 'straight person voice'. Her friends egg her on when she does this." Another parent offered, "If they aren't mocking 'cis' people, they are playing pronoun police and mocking people who can't get the pronouns correct." Another participant said, "New vocabulary includes 'cis-stupid' and 'cis-stupidity.'" And a fourth participant described, "They assume anyone that is critical about being transgender (even just asking questions) is either ignorant or filled with hate."

Theme: Emphasizing victimhood.

Participants described that their children and friend group seemed to focus on feeling as though they were victims. One participant described, "They seem to wear any problems they may have, real or perceived like badges of honor…I feel like they want to believe they are oppressed & have really 'been through life', when they have little life experience." Another participant said, "…there is a lot of feeling like a victim [and being] part of a victimized club." Another parent said "But all talk is very 'victim' centered". And finally, another said, "They passionately decry 'Straight Privilege' and 'White Male Privilege'—while emphasizing their own 'Victimhood.'"

Theme: Consequences of behaviors.

A few participants describe that because of their child's behavior, there were consequences, including making it difficult for one child to return to her school and the following description from another parent, "Most relatives have blocked her on [social media] over constant jokes regarding cis and straight people."

Theme: Fueling the behaviors.

In some cases, parents describe a synergistic effect of kids encouraging other kids to persist in the behavior as was described in a previous quote, "Her friends egg her on when she does this" as well as the following, "Lots of discussion revolving around how their teachers 'discriminate' or are 'mean' to them based on their declared LGBTIA identity, and they get each other riled up convincing each other of their persecution by these perceived wrongs … privately they mock our intolerance, and in person act upon these false beliefs by treating us as people out to get them…"

Internet/social media exposure

In the time period just before announcing that they were transgender, 63.5% of AYAs exhibited an increase in their internet/social media (Table 7). To assess AYA exposure to existing online content, parents were asked what kind of advice their child received from someone/people online. AYAs had received online advice including how to tell if they were transgender (54.2%); the reasons that they should transition right away (34.7%); that if their parents did not agree for them to take hormones that the parents were "abusive" and "transphobic" (34.3%); that if they waited to transition they would regret it (29.1%); what to say and what not to say to a doctor or therapist in order to convince them to provide hormones (22.3%); that if their parents were reluctant to take them for hormones that they should use the "suicide narrative" (telling the parents that there is a high rate of suicide in transgender teens) to convince them (20.7%); and that it is acceptable to lie or withhold information about one's medical or psychological history from a doctor or therapist in order to get hormones/get hormones faster (17.5%). Two respondents, in answers to other questions, described that their children later told them what they learned from online discussion lists and sites. One parent reported, "He has told us recently that he was on a bunch of discussion lists and learned tips there. Places where teens and other trans people swap info. Like to use [certain, specific] words [with] the therapist when describing your GD, because [they are] code for potentially suicidal and will get you a diagnosis and Rx for hormones." Another parent disclosed, "The threat of suicide was huge leverage. What do you say to that? It's hard to have a steady hand and say no to medical transition when the other option is dead kid. She learned things to say that would push our buttons and get what she wanted and she has told us now that she learned that from trans discussion sites."

		n	
AYAs internet/social media use just prior to announcement		255	
	Increased social media/internet use	162	63.5
	Decreased social media/internet use	3	1.2
	Unchanged social media/internet use	49	19.2
	Don't know	41	16.1
AYA exposure to internet content/advice*		251	
	How to tell if they are transgender	136	54.2
	The reasons that they should transition right away	87	34.7
	That if their parents did not agree to take them for hormones, that the parents are "abusive" and "transphobic"	86	34.3
	That if they waited to transition they would regret it	73	29.1
	That if they didn't transition immediately they would never be happy	72	28.7
	How to order physical items (binders, packers, etc) without parents finding out	67	26.7
	What to say and what NOT to say to a doctor or therapist in order to convince them to provide hormones	56	22.3
	That if their parents are reluctant to take them for hormones, that they should use the "suicide narrative" to convince them (telling the parents that there is a high rate of suicide in transgender teens.)	52	20.7
	Medical advice about the risks and benefits of hormones	55	21.9
	Medical advice about the risks and benefits of surgery	47	18.7
	That it is acceptable to lie to or withhold information about one's medical or psychological history from a doctor or therapist in order to get hormones/ get hormones faster	44	17.5
	How to hide physical items from parents	40	15.9
	How to hide or make excuses for physical changes	26	10.4
	How to get money from others online in order to pay for medications, etc	25	10.0
	How to get hormones from online sources	24	9.6
	How to hide hormones from parents	21	8.4
	I don't know if my child received online advice about these topics	127	50.6

*may select more than one answer.

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Table 7. Internet/Social media exposures.
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Parents identified the sources they thought were most influential for their child becoming gender dysphoric. The most frequently answered influences were: YouTube transition videos (63.6%); Tumblr (61.7%); a group of friends they know in person (44.5%); a community/group of people that they met online (42.9%); a person they know in-person (not online) 41.7%. In contrast to the majority of responses, two participants commented that they didn't think the sources influenced their child to become gender dysphoric, rather they gave their child a name for their feelings or gave the child confidence to come out. The following quotes illustrate the dominant quantitative findings. One parent wrote, "We believe the biggest influence was the online pro-transition blogs and youtube videos. We feel she was highly influenced by the 'if you are even questioning your gender-you are probably transgender' philosophy…In the 'real world' her friends, other trans peers, and newfound popularity were additional areas of reinforcement." Another respondent described the online influence as part of a different question, "I believe my child experienced what many kids experience on the cusp of puberty—uncomfortableness!—but there was an online world at the ready to tell her that those very normal feelings meant she's in the wrong body."

Mental well-being, mental health, and behaviors

The trajectories of the AYAs were not consistent with the narrative of discovering one's authentic self and then thriving. Specifically, parents reported that, after "coming out," their children exhibited a worsening of their mental well-being. Additionally, parents noted worsening of the parent-child relationship and observed that their children had narrowed their interests (Table 8). Although small numbers of AYAs had improvement in mental well-being (12.6%), parent-child relationship (7.4%), grades/academic performance (6.4%), and had broadened their interests and hobbies (5.1%); the most common outcomes were worsened mental well-being (47.2%); worsened parent child relationship (57.3%); unchanged or mixed grades/academic performance (59.1%); and a narrowed range of interests and hobbies (58.1%). One parent describing her child's trajectory offered, "After announcing she was transgender, my daughter's depression increased significantly. She became more withdrawn. She stopped participating in activities which she previously enjoyed, stopped participating in family activities, and significantly decreased her interaction with friends. Her symptoms became so severe that she was placed on medication by her physician." Table 9 describes cumulative rates of mental illness and neurodevelopmental disability at the time of survey.

Characteristics		n	
AYA mental well-being since announcement		254	
	Worse	120	47.2
	Better	32	12.6
	Unchanged or mixed	101	39.8
	Don't know	1	0.4
Parent-child relationship since announcement		253	
	Worse	145	57.3
	Better	18	7.4
	Unchanged or mixed	89	35.2
	Don't know	1	0.4
Grades/academic performance		220	
	Worse	76	34.5
	Better	14	6.4
	Unchanged/mixed	130	59.1
Range of interests and hobbies		255	
	Much broader	2	0.8
	Somewhat broader	11	4.3
	Unchanged	93	36.5
	Somewhat narrower	64	25.1
	Much narrower	56	22.0
	There are very few topics outside of transgender issues that my child is interested in	28	11.0
	Don't know	1	0.4

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Table 8. Outcomes and behaviors.
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Characteristics		n	
Mental disorder or neurodevelopmental disability		243	
	Anxiety	154	63.4
	Depression	143	58.8
	Attention Deficit Hyperactivity Disorder (ADHD)	36	14.8
	Obsessive Compulsive Disorder (OCD)	30	12.3
	Autism Spectrum Disorder (ASD)	30	12.3
	Eating Disorder	17	7.0
	Bipolar Disorder	17	7.0
	Psychosis	8	3.3
	None of above	52	21.4
	(Other) Borderline	7	2.9
	(Other) Oppositional Defiant Disorder	2	0.8

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Table 9. AYA Cumulative mental disorder and neurodevelopmental disability diagnoses.
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A total of 63.8% of the parents have been called “transphobic” or “bigoted” by their children for one or more reasons, the most common being for: disagreeing with the child about the child’s self-assessment of being transgender (51.2%); recommending that the child take more time to figure out if their feelings of gender dysphoria persist or go away (44.6%); expressing concerns for the child’s future if they take hormones and/or have surgery (40.4%); calling their child by the pronouns they used to use (37.9%); telling the child they thought that hormones or surgery would not help them (37.5%); recommending that their child work on other mental health issues first to determine if they are the cause of the dysphoria (33.3%); calling the child by their birth name (33.3%); or recommending a comprehensive mental health evaluation before starting hormones and/or surgery (20.8%) (Table 10). There were eight cases of estrangement. Estrangement was child-initiated in six cases where the child ran away, moved out, or otherwise refused contact with parent. There were two cases where the estrangement was initiated by the parent because the AYA’s outbursts were affecting younger siblings or there was a threat of violence made by the AYA to the parent.

		n	
Parents have been called "transphobic" or "bigoted" by their child for the following reasons*		240	
	Disagreeing with their child about the child's assessment of being transgender	123	51.2
	Recommending that their child take more time to figure out if their feelings of gender dysphoria persist or go away	107	44.6
	Expressing concerns for their child's future if the child were to take hormones and/or have surgery	97	40.4
	Referring to their child by the pronouns that they used to use before announcement	91	37.9
	Telling their child that they thought hormones/surgery would not help them	90	37.5
	Calling their child by the child's birth name	80	33.3
	Recommending that their child work on other mental health issues first to determine if they are the cause of their dysphoria	80	33.3
	Recommending therapy for basic mental health issues (not related to gender)	74	30.8
	Recommending a comprehensive evaluation before starting hormones and/or surgery	50	20.8
	None of the above	87	36.2
Distrust and isolating behaviors exhibited by AYAs*		251	
	Expressed distrust of information about gender dysphoria and transgenderism coming from mainstream doctors and psychologists	130	51.8
	Tried to isolate themselves from their family	124	49.4
	Expressed that they ONLY trust information about gender dysphoria and transgenderism that comes from transgender websites and/or transgender people and sources	117	46.6
	Lost interest in activities where participants aren't predominantly transgender or LGBTIA	81	32.3
	Lost interest in activities that were not related to transgender or LGBTIA issues	65	25.9
	Stopped spending time with friends who are not transgender	63	25.1
	Expressed distrust of people who are not transgender	57	22.7
	Expressed hostility towards people who are not transgender	46	18.3
	None of the above	44	17.5
Other behavior and outcomes for AYAs*		249	
	Withdrawn from family	112	45.0
	Told other people or posted on social media that their parent is "transphobic", "abusive", or "toxic" because the parent does not agree with the child's assessment of being transgender	107	43.0
	Refused to speak to parent	71	28.5
	Defended the practice of lying to or withholding information from therapists or doctors in order to obtain hormones for transition more quickly	41	16.5
	Tried to run away	17	6.8
	Been unable to obtain a job	25	10.0
	Been unable to hold a job	18	7.2
	Dropped out of college	12	4.8
	Dropped out of high school	12	4.8
	Needed to take a leave of absence from college	12	4.8
	Been fired from a job	9	3.6
	Needed a leave of absence from high school	1	0.4
	None of the above	86	34.5
For any of the above, is this a significant change from the child's baseline behavior?		161	
	Yes	115	71.4
	No	46	28.6

*may select more than one answer.

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Table 10. Additional behaviors.
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AYAs are reported to have exhibited one or more of the following behaviors: expressed distrust of information about gender dysphoria and transgenderism coming from mainstream doctors and psychologists (51.8%); tried to isolate themselves from their family (49.4%); expressed that they only trust information about gender dysphoria and transgenderism that comes from transgender websites and/or transgender people and sources (46.6%); lost interest in activities where participants aren’t predominantly transgender or LGBTIA (32.3%); stopped spending time with friends who were not transgender (25.1%); expressed distrust of people who were not transgender (22.7%) (Table 10). Many AYAs have also: withdrawn from their family (45.0%); told other people or posted on social media that their parent is “transphobic,” “abusive,” or “toxic” because the parent does not agree with child’s self-assessment of being transgender (43.0%); refused to speak to their parent (28.5%), defended the practice of lying to or withholding information from therapists or doctors in order to obtain hormones for transition more quickly (16.5%); tried to run away (6.8%). The behaviors and outcomes listed above were considered significant changes from the child’s baseline behaviors for 71.4% of respondents checking any of the items.

There was a subset of eight cases where parents described watching their child have declining mental well-being as they became gender dysphoric and transgender-identified and then had improving mental well-being as they dropped or backed away from a transgender-identification. One parent described a marked change in her daughter when she was out of school temporarily. “[Her] routine was disrupted. She spent all day on the internet, and lost her many school friends—her only friends were on-line and members of the trans community. In three months, my daughter announced she is trans, gender dysphoric, wants binders and top surgery, testosterone shots…she started self-harming. Now back at school…she tweeted that she’s so young, isn’t sure if she is trans, no longer wants to be referred to by the male name she had chosen…Since she has started back at school and is being exposed to a wide variety of people she is WAY happier.” Another parent described, “My daughter’s insight has improved considerably over the last few years, and she has also outgrown the belief that she is transgender. My daughter actually seemed to be looking for a reason for her depression which is now being successfully treated…My daughter is MUCH happier now that she is being treated for her genuine issues. Coming out as trans made her much worse for a while.”

There was a subset of 30 cases where the AYAs' transgender-identification occurred in the context of a decline in their ability to function (such as dropping out of high school or college, needing a leave of absence from high school or college, and/or being unable to obtain or hold a job), which parents reported as a significant change from their child's baseline behavior. The declines were substantial as 43.3% of these AYAs had been identified as academically gifted students (some described as top of their class in high school, earning outstanding grades at prestigious universities) before they began to fail their classes, drop out of high school or college, and became unable to hold a job. In most of these cases (76.7%), there was one or more psychiatric diagnosis made at the same time or within the year (60.0%) or within two years (16.7%) of the AYA's new transgender-identification. Of the 23 individuals who had a psychiatric diagnosis made within two years of assuming a transgender-identification, 91.3% (21/23) were diagnosed with depression; 73.9% (17/23) with anxiety; 26.0% (6/23) with bipolar disorder; 17.4% (4/23) with borderline personality disorder; 8.7% (2/23) with psychosis/psychotic episode: and 8.7% (2/23) with an eating disorder.

Clinical encounters

Parents were asked if their child had seen a gender therapist, gone to a gender clinic, or seen a physician for the purpose of beginning transition and 92 respondents (36.2%) answered in the affirmative (Table 11). Many of the respondents clarified that their child had seen a clinician regarding their gender dysphoria for evaluation only. Although participants were not asked directly what kind of provider their child saw, specialties that were mentioned in answers included: general psychologists, pediatricians, family doctors, social workers, gender therapists, and endocrinologists. For parents who knew the content of their child's evaluation, 71.6% reported that the clinician did not explore issues of mental health, previous trauma, or any alternative causes of gender dysphoria before proceeding and 70.0% report that the clinician did not request any medical records before proceeding. Despite all of the AYAs in this study sample having an atypical presentation of gender dysphoria (no gender dysphoria prior to puberty), 23.8% of the parents who knew the content of their child's visit reported that the child was offered prescriptions for puberty blockers and/or cross-sex hormones at the first visit.

		n	
Did the AYA see a gender therapist, go to a gender clinic or see a physician for the purpose of transition?		254	
	No	151	59.4
	Yes	92	36.2
	Don't know	11	4.3
Did the therapist/physician/clinic staff explore issues of mental health, previous trauma, or any alternative causes of gender dysphoria before proceeding?		100	
	Yes	21	21.0
	No	53	53.0
	Don't know	26	26.0
Did the therapist/physician/clinic staff request any medical records before proceeding?		99	
	Yes	21	21.2
	No	49	49.5
	Don't know	29	29.3
Of parents who knew the content of the visit, did the AYA receive an Rx for puberty blockers and/or cross-sex hormones at their first visit?		80	
	AYA received an Rx for puberty blockers and/or cross-sex hormones at their first visit	17	21.2
	AYA was offered a Rx for puberty blockers and/or cross-sex hormones at their first visit, but AYA or parent declined	2	2.5
	Total number of AYAs who received or were offered an Rx at first visit	19	23.8
	AYAs who did not receive/were not offered an Rx at their first visit	61	76.2
Did AYA misrepresent their history to the doctor or relay their history accurately?		96	
	Parent is reasonably sure or positive that their child misrepresented or omitted parts of their history	64	66.7
	Parent is reasonable sure or positive that their child relayed their history completely and accurately	12	12.5
	Don't know	20	20.8

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Table 11. Interactions with clinicians.
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One participant described, "For the most part, I was extremely frustrated with providers NOT acknowledging the mental disorder, anxiety, depression, etc before recommending hormone replacement therapy." And two participants described how the clinician treating their child's gender dysphoria refused to speak with the patients' primary care physicians. One participant said, "When we phoned the clinic, the doctor was hostile to us, told us to mind our own business. Our family doctor tried to reach our son's new doctor, but the trans doctor refused to speak with her." Another respondent shared "The pediatrician/'gender specialist' did not return calls or emails from the primary care physician who requested to talk with her about my son's medical history before she saw and treated him…she disregarded all historical information provided by the family and primary care physician…did not verify any information provided by my…son at his first visit even after being provided with multiple other historical sources which differed significantly from his story."

When asked about whether their child relayed their history completely and accurately to clinicians or whether they misrepresented or omitted parts of their history, of those who knew the content of their child's visit, 84.2% of the parent respondents were reasonably sure or positive that their child had misrepresented or omitted parts of their history. Twenty-eight participants provided optional open text responses to this question and the responses were categorized into: describing how the parent knew that the child misrepresented their history (5); the content of what the child misrepresented (6 misrepresenting in general, 4 misrepresenting to the clinician for a total of 10 examples); don't know/not sure (4); expressing certainty (1); and not relevant (8). For the five participants describing how they knew, the reasons included: being present when it happened, reading the report from the gender specialist, being told by their child that the child had misrepresented the truth, and being informed by the child's psychiatrist. One respondent shared, "I have read the report from the gender specialist and it omits all the relevant context painting an almost unrecognizable picture of my son." A second parent simply responded, "I was present." Another respondent relayed about their (natal male) child, "My daughter told me and her mother that the first therapist she saw asked her stereotypical questions…She was afraid that if she didn't describe herself as a 'typical girl' she would not be believed." And finally, one respondent wrote, "He has said now that he did [misrepresent his history] and used key words he was advised to say." Ten participants provided 13 examples of the content of misrepresentations and of these, 6 examples could have been easily verified to be false (claiming to be under the care of a psychiatrist, claiming to be on medication to treat a psychiatric condition, how one was doing academically, and claiming a childhood history of having playmates of one sex when the opposite was observed, and claiming strong childhood preferences for specific toys and clothing that is the opposite of what multiple individuals observed). Three of the content examples would have been challenging to verify as false including: how one was feeling as a child, how one was feeling when a picture was taken, and

whether one was from an abusive home. And four of the content examples did not provide enough information to determine if they would be easy or challenging to verify as false, such as “My child distorts her history and our family life on a regular basis,” and “He has created an entire narrative that just isn’t true.”

In addition to the previously mentioned case where the child literally rewrote her history by editing her diary, there were seven respondents who conveyed a process where their child was constantly rewriting their personal history to make it consistent with the idea that they always were transgender and/or had created a childhood history that was not what others had observed. It is unclear whether this process was deliberate or if the individuals were unaware of their actions. The following are quotes describing this phenomenon. One parent said, “…she is actively rewriting her personal history to support the idea that she was always trans.” Another respondent added,”…my daughter denies events I recollect from her childhood and puberty that contradicts her narrative of ‘always knowing she was a boy.’” Another respondent offered, “He is rewriting his personal history to suit his new narrative.” And a fourth respondent described, “[Our] son has completely made up his childhood to include only girl friends and dressing up in girls clothes and playing with dolls, etc. This is not the same childhood we have seen as parents.”

Qualitative analysis

The open-ended comments from the question about whether the clinician explored mental health, trauma or alternative causes of gender dysphoria before proceeding were selected for qualitative analysis. Nine major themes emerged from the data. Each theme is described in the following paragraphs with supporting quotes from participants.

Theme: Failure to explore mental health, trauma or alternative causes of GD.

Parents described that clinicians failed to explore their child’s mental health, trauma, or any alternative causes for the child’s gender dysphoria. This failure to explore mental health and trauma occurred even when patients had a history of mental health disorder or trauma, were currently being treated for a mental health disorder, or were currently experiencing symptoms. One participant said, “Nothing other than gender dysphoria was considered to explain my daughter's desire to transition.” Another participant said, “My daughter saw a child therapist and the therapist was preparing to support transgendering and did not explore the depression and anxiety or previous trauma.”

Theme: Insufficient evaluation.

Another theme was insufficient evaluation where parents described evaluations that were too limited or too superficial to explore mental health, trauma or alternative causes of gender dysphoria. The following are three quotes by three different parents describing insufficient evaluations. One parent said, “The exploration was egregiously insufficient, very shallow, no effort to ask questions, engage in critical thinking about coexisting anxiety, or put on the brakes or even slow down.” Another participant stated, “When we tried to give our son’s trans doctor a medical history of our son, she refused to accept it. She said the half hour diagnosis in her office with him was sufficient, as she considers herself an expert in the field.” And a third parent wrote, “We were STUNNED by the lack of information, medical history sought by therapist and radical treatment suggestion. [One]visit. The idea is, ‘if they say they were born in the wrong body, they are. To question this will only hurt her and prolong her suffering.’ [Our] daughter has had trauma in [the] past. [She] never was asked about it. [The] therapist did not ask parents a single question about our daughter.”

Theme: Unwillingness or disinterest in exploring mental health, trauma or alternative causes of GD.

Parents described that clinicians did not seem interested or willing to explore alternative causes. One parent described. “Her current therapist seems to accept her self diagnosis of gender dysphoria and follows what she says without seeming too much interested in exploring the sexual trauma in her past.” Another parent wrote, “The Asperger psychiatrist did not seem to care whether our daughter's gender dysphoria stemmed from Asperger's. If our daughter wanted to be male, then that was enough.” And a third parent said. “The therapist did ask about those issues but seemed to want to accept the idea wholeheartedly that my daughter was transgender first and foremost, all other factors aside.”

Theme: Mental health was explored.

A few parents had the experience where the clinician either made an appropriate referral for further evaluation or the issues had been addressed previously. One parent said, “[The] previous mental health issues [were] already explored by other therapists ([my] child was in therapy and medicated before coming out as transgender).”

Theme: Failure to communicate with patients’ medical providers.

Several participants described clinicians who were unwilling to communicate with primary care physicians and mental health professionals even those professionals who were currently treating the patient. One participant relayed, “She did not review the extensive psychiatric records that were available in a shared EMR [electronic medical record] and she did not consult with his outpatient psychiatrist prior to or after starting cross-sex hormonal therapy.” Another parent said, “My child had been seen for mental health issues for several years before presenting this new identity, but the endocrinologist did not consult the mental health professionals for their opinions before offering hormones.”

Theme: Misrepresentation of information by the patient.

Several participants described how their child misrepresented their history to the clinician, thus, limiting the clinician’s ability to adequately explore mental health, trauma and alternative causes. One participant wrote, “At [the] first visit, [my] daughter's dialogue was well-rehearsed, fabricated stories about her life told to get [the] outcome she desired. She parroted people from the internet.” Another parent reported, “My son concealed the trauma and mental health issues that he and the family had experienced.” And a third parent said, “I overheard my son boasting on the phone to his older brother that ‘the doc swallowed everything I said hook, line and sinker. Easiest thing I ever did.’”

Theme: Transition steps were pushed by the clinician.

Some parents described clinicians who seemed to push the process of transition before the patient asked for it. One parent described that the doctor gave her daughter a prescription that she didn't ask for, "The family doctor who gave her the Androgel Rx [prescription] did NOT ask her many questions (she was surprised by this), nor did he await her assessment by a licensed psychiatrist before giving her this Rx. Nor did she ask him for this Rx." Another parent reported that she and her child were at the endocrinologist's office only to ask questions, and described, "…[he] didn't listen to a word we were saying. He was too eager to get us set up with a 'gender therapist' to get the legal form he needed to start hormones, all while making sure we set up our next appointment within 6 months to start the hormones…"

Theme: Parent views were discounted or ignored.

Parents describe that the clinicians did not take their concerns seriously. One parent described, "I have to say I don't know, but it is hard to believe that they adequately examined the history of bullying and being ostracized for being different, and the autistic traits that would lend a person like my son to risk everything for identifying with a group. I know that in the few contacts I had with the providers, my concerns were discounted." And another said, "All of our emails went unanswered and were ignored. We are left out of everything because of our constant questioning of this being right for our daughter [because of her] trauma and current depression, anxiety and self-esteem problems."

Theme: Parent had concerns about the clinicians' competence, professionalism or experience.

Parents expressed doubts about the clinicians regarding their experience, competence or professionalism. One parent said, "The clinic told me they explored these issues. I asked the risk manager at [redacted] if they'd considered a personality disorder. 'Oh, no,' she laughed. 'That's only with the older patients, not the teenagers.' I'm deeply suspicious of their competence." Another parent described, "What does concern me is that the people she talked to seemed to have no sense of professional duties, but only a mission to promote a specific social ideology."

Steps towards transition and current identification status

This section reports on the duration of AYA transgender-identification (time from the AYA's announcement of a transgender identity until the time the parent completed the survey) that covers, on average, 15.0 months (range 0.1–120 months) with a median of 11 months (Table 12). The steps taken towards transition during this timeframe are listed in Table 12. At the end of the timeframe, 83.2% of the AYAs were still transgender-identified, 5.5% were not still transgender-identified (desisted), 2.7% seemed to be backing away from transgender-identification, and 8.6% of the parents did not know if their child was still identifying as transgender. Descriptions of backing away or moving from transgender-identified to not transgender-identified include the following. One parent observed, "She identified as trans for six months … Now back at school, she is thinking maybe she's not trans." Another parent offered, "My daughter [identified] as trans from ages 13–16. She gradually desisted as she developed more insight into who she is." One parent described that after one year of identifying as transgender, "basically, she changed her mind once she stopped spending time with that particular group of friends." The duration of transgender-identification of the AYAs who were still transgender-identified at the time of survey was compared to the duration of those who were no longer transgender-identified and those who seemed to be backing away from a transgender-identification (combined) by t-test. The difference between these groups was statistically significant ($p = .025$), with a t-value of -2.25 showing that those who were no longer transgender-identified and backing away had a longer duration of identification (mean = 24.1 months) and those who were still transgender-identified had a shorter mean duration (mean = 14.4 months).

		n	
Transition Steps*		256	
	Changed hairstyle	216	84.4
	Changed style of clothing	210	82.0
	Asks to be called a new name	188	73.4
	Asks for different pronouns	175	68.4
	Taken cross-sex hormones	29	11.3
	Legally changed name on government documents	19	7.4
	Taken anti-androgens	11	4.3
	Taken puberty blockers	7	2.7
	Had surgery	5	2.0
	None of the above	14	5.5
Disposition		256	
	Still transgender-identified	213	83.2
	Not transgender-identified any more (desisted)	14	5.5
	Seems to be backing away from transgender-identification	7	2.7
	Parent doesn't know if the child is still transgender-identified	22	8.6
	De-transitioned (also counted in desisted category)	3	1.2
Duration of transgender-identification overall	Median duration 11 months, Mean duration 15.0 months (range 0.1 months-120 months), median 11 months	225	
Duration of transgender-identification if still transgender-identified	Median duration 11 months, mean duration 14.4 months, ange (0.1 months-72 months)	204	
Duration of transgender-identification if no longer transgender-identified	Median duration 12 months, mean duration 24.2 months, range (.75 months to 120 months)	13	
Duration of transgender-identification if backing away	Median duration 12 months, mean duration 15 months, range (3 months-36 months)	8	

*may select more than one answer.

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Table 12. Transition steps and disposition.
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To explore the differences between the AYAs who had exposure to social influence (friend group, internet/social media, or both) and AYAs who did not have a clear exposure to social influence (neither and don't know), a series of chi-squared calculations were performed for selected variables. (See Table 13.) Statistically significant differences were revealed for AYAs with exposure to social influences having worse outcomes for mental well-being and parent-child relationships, and greater numbers exhibiting distrust, isolating and anti-social behaviors including: narrowed range of interests and hobbies, expressing that they only trusted information from transgender sources, trying to isolate themselves from their family, losing interest in activities that weren't predominantly with transgender or LGBTIA participants, and telling people or posting on social media that their parent is "transphobic," "abusive," or "toxic" because the parent doesn't agree with the child's assessment of being transgender. Although the differences in additional isolating and anti-social behaviors did not reach statistical significance, these behaviors trended towards higher rates in the AYAs who were exposed to social influence and may have not reached significant levels due to small numbers. No significant difference for age of AYA (at announcement or at time of survey completion) was detected between groups by a one-way ANOVA.

		SI n (%)	NSI n (%)	
Sex		222	34	.123
	Female	187 (84.2)	25 (73.5)	
	Male	35 (15.8)	9 (26.5)	
Indicators of childhood GD		221	33	**.004**
	0–2 indicators	**216 (97.7)**	**29 (87.9)**	
	3–4 indicators	**5 (2.3)**	**4 (12.1)**	
Currently have two or more GD indicators		214	34	.808
	Yes	179(83.6)	29 (85.3)	
	No	35(16.4)	5(14.7)	
No mental health or NDD diagnoses before onset of GD		222	34	**.056**
	Answered "None of the above"	**87(39.9)**	**7 (20.6)**	
Mental well-being since announcement		220	33	**.001**
	Worse	**114 (51.8)**	**6 (18.2)**	
	Better	**24 (10.9)**	**8 (24.2)**	
	Unchanged/Mixed	**82 (37.3)**	**19 (57.6)**	
Parent-child relationship since announcement		219	33	**.006**
	Worse	**134 (61.2)**	**11 (33.3)**	
	Better	**13 (5.9)**	**5 (15.2)**	
	Unchanged/Mixed	**72 (32.9)**	**17 (51.5)**	
Range of interests and hobbies		**220**	**34**	**<0.001**
	Broader range of interests and hobbies	**10 (4.5)**	**3 (8.8)**	
	Narrowed range of interest and hobbies	**139 (63.2)**	**9 (26.5)**	
	Unchanged range	**71 (32.3)**	**22 (64.7)**	
Distrust and Isolating Behaviors		222	34	
	Tried to isolate themselves from family	**114(51.4)**	**10 (29.4)**	**.017**
	Expressed that they ONLY trust information about GD and transgenderism that comes from transgender sources	**107 (48.2)**	**10 (29.4)**	**.043**
	Lost interest in activities where participants aren't predominantly transgender or LGBTIA	**76 (34.2)**	**5 (14.7)**	**.023**
	Stopped spending time with non-transgender friends	59 (26.6)	4 (11.8)	.062
	Expressed distrust of people who are not transgender	52 (23.4)	5 (14.7)	.255
	Told people or posted on social media that their parent is "transphobic," "abusive," or "toxic" because the parent doesn't agree with the child's assessment of being transgender	**102 (45.9)**	**5 (14.7)**	**<0.001**
	Defended the practice of lying to or withholding information from doctors/therapists to get hormones for transition more quickly	38 (17.1)	3 (8.8)	.219
	Brought up the issue of suicide in transgender teens as a reason parents should agree to treatment	55 (24.8)	4 (11.8)	.093
Did the AYA misrepresent their history to the doctor or relay it accurately?		68	8	.075
	Parent is reasonable sure or positive that their child misrepresented or omitted parts of their history	59 (86.8)	5 (62.5)	
	Parent is reasonable sure or positive that child relayed their history completely and accurately	9 (13.2)	3 (37.5)	

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Table 13. chi-squared comparisons for exposure to social influence (SI) vs not exposure to social influence (NSI).
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Discussion

This research describes parental reports about a sample of AYAs who would not have met diagnostic criteria for gender dysphoria during their childhood but developed signs of gender dysphoria during adolescence or young adulthood. The strongest support for considering that the gender dysphoria was new in adolescence or young adulthood is the parental answers for DSM 5 criteria for childhood gender dysphoria. Not only would none of the sample have met threshold criteria, the vast majority had zero indicators. Although one might argue that three of the indicators could plausibly be missed by a parent (A1, A7, and A8 if the child had not expressed these verbally), five of the indicators (A2-6) are readily observable behaviors and preferences that would be difficult for a parent to miss. Six indicators (including A1) are required for a threshold diagnosis. The nonexistent and low numbers of readily observable indicators reported in the majority of this sample does not support a scenario in which gender dysphoria was always present but was only recently disclosed to the parents.

Parents reported that before the onset of their gender dysphoria, many of the AYAs had been diagnosed with at least one mental health disorder or neurodevelopmental disability and many had experienced a traumatic or stressful event. Experiencing a sex or gender related trauma was not uncommon, nor was experiencing a family stressor (such as parental divorce, death of a parent, or a mental health disorder in a sibling or parent). Additionally, nearly half were described as having engaged in self-harm prior to the onset of their gender dysphoria. In other words, many of the AYAs and their families had been navigating multiple challenges and stressors before gender dysphoria and transgender-identification became part of their lives. This context could possibly contribute to friction between parent and child and these complex, overlapping difficulties as well as experiences of same-sex attraction may also be influential in the development of a transgender identification for some of these AYAs. Care should be taken not to overstate or understate the context of pre-existing diagnoses or trauma in this population as they were absent in approximately one third and present in approximately two thirds of the sample.

This research sample of AYAs also differs from the general population in that it is predominantly natal female, white, and has an over-representation of individuals who are academically gifted, non-heterosexual, and are offspring of parents with high educational attainment [59–61]. The sex ratio favoring natal females is consistent with recent changes in the population of individuals seeking care for gender dysphoria. Gender clinics have reported substantial increases in referrals for adolescents with a change in the sex ratio of patients moving from predominantly natal males seeking care for gender dysphoria to predominantly natal females [26–28, 62]. Although increased visibility of transgender individuals in the media and availability of information online, with a partial reduction of stigma might explain some of the rise in the numbers of adolescents presenting for care [27], it would not directly explain why the inversion of the sex ratio has occurred for adolescents but not adults or why there is a new phenomenon of natal females experiencing late-onset and adolescent-onset gender dysphoria. The unexpectedly high rate of academically gifted AYAs may be related to the high educational attainment of the parents and may be a reflection of parents who are online, able to complete online surveys and are able to question and challenge current narratives about gender dysphoria and transition. There may be other unknown variables that render academically gifted AYAs susceptible to adolescent-onset and late-onset gender dysphoria. The higher than expected rate of non-heterosexual orientations of the AYAs (prior to announcement of a transgender-identity) may suggest that the desire to be the opposite sex could stem from experiencing homophobia as a recent study showed that being the recipient of homophobic name calling from one's peers was associated with a change in gender identity for adolescents [63]. The potential relationship of experienced homophobia and the development of a rapid onset of gender dysphoria during adolescence or young adulthood as perceived by parents deserves further study.

This sample is distinctively different than what is described in previous research about gender dysphoria because of the distribution of cases occurring in friendship groups with multiple individuals identifying as transgender, the preponderance of adolescent (natal) females, the absence of childhood gender dysphoria, and the perceived suddenness of onset. In this study, parental reports of transgender identification duration in AYAs suggest that in some cases (~8% in this study) gender dysphoria and transgender-identification may be temporary, and that longer observation periods may be needed to assess such changes. Further research is needed to verify these results. There have been anecdotal reports of adolescents who desisted approximately 9–36 months after showing signs of a rapid onset of gender dysphoria, but longitudinal research following AYAs with gender dysphoria would be necessary to study desistance trends. Although it is still unknown whether transition in gender dysphoric individuals decreases, increases, or fails to change the rates of attempted or completed suicides [64], this study documents AYAs using a suicide narrative

as part of their arguments to parents and doctors towards receiving support and transition services. Despite the possibility that the AYAs are using a suicide narrative to manipulate others, it is critical that any suicide threat, ideation or concern is taken seriously and the individual should be evaluated immediately by a mental health professional.

The majority of parents were reasonably sure or certain that their child misrepresented or omitted key parts of their history to their therapists and physicians. In some cases, the misrepresentation of one's history may simply be a deliberate act by a person who is convinced that transition is the only way that they will feel better and who may have been coached that lying is the only way to get what they think they need. For others, the misrepresentation may not be a conscious act. The creation of an alternate version of one's childhood that conforms to a story of always knowing one was transgender and that is in sharp contrast to the childhood that was observed by third parties raises the question of whether there has been the creation of false childhood memories as part of, or outside of, the therapy process. Respondent accounts of clinicians who ignored or disregarded information (such as mental health symptoms and diagnoses, medical and trauma histories) that did not support the conclusion that the patient was transgender, suggests the possibility of motivated reasoning and confirmatory biases on the part of clinicians. In the 1990s, the beliefs and practices of many mental health professionals may have contributed to their patients' creation of false childhood memories consistent with a child sexual abuse narrative and research since then has shown that false childhood memories of mundane events can be implanted in laboratory settings [65–67]. It may be worthwhile to explore if, in today's culture, there might be beliefs and practices of some mental health professionals that are contributing to their patients' creation of false childhood memories consistent with an "always knew/always were transgender" narrative.

Emerging hypotheses

Hypothesis 1: Social influences can contribute to the development of gender dysphoria

It is unlikely that friends and the internet can make people transgender. However, it is plausible that the following can be initiated, magnified, spread, and maintained via the mechanisms of social and peer contagion: (1) the *belief* that non-specific symptoms (including the symptoms associated with trauma, symptoms of psychiatric problems, and symptoms that are part of normal puberty) should be perceived as gender dysphoria and their presence as proof of being transgender; 2) the *belief* that the only path to happiness is transition; and 3) the *belief* that anyone who disagrees with the self-assessment of being transgender or the plan for transition is transphobic, abusive, and should be cut out of one's life. The spread of these beliefs could allow vulnerable AYAs to misinterpret their emotions, incorrectly believe themselves to be transgender and in need of transition, and then inappropriately reject all information that is contrary to these beliefs. In other words, "gender dysphoria" may be used as a catch-all explanation for any kind of distress, psychological pain, and discomfort that an AYA is feeling while transition is being promoted as a cure-all solution.

One of the most compelling findings supporting a potential role of social and peer contagion in the development or expression of a rapid onset of gender dysphoria is the clusters of transgender-identification occurring within friendship groups. The expected prevalence of transgender young adult individuals is 0.7% [8]. Yet, according to the parental reports, more than a third of the friendship groups described in this study had 50% or more of the AYAs in the group becoming transgender-identified in a similar time frame. This suggests a localized increase to more than 70 times the expected prevalence rate. This is an observation that demands urgent further investigation. One might argue that high rates of transgender-identified individuals within friend groups may be secondary to the process of friend selection: choosing transgender-identified friends deliberately rather than the result of group dynamics and observed coping styles contributing to multiple individuals, in a similar timeframe, starting to interpret their feelings as consistent with being transgender. More research will be needed to finely delineate the timing of friend group formation and the timing and pattern of each new declaration of transgender-identification. Although friend selection may play a role in these high percentages of transgender-identifying members in friend groups, the described pattern of multiple friends (and often the majority of the friends in the friend group) *becoming* transgender-identified in a similar timeframe suggests that there may be more than just friend selection behind these elevated percentages.

There are many insights from our understanding of peer contagion in eating disorders and anorexia that may apply to the potential role(s) of peer contagion in the development of gender dysphoria. Just as friendship cliques can set the level of preoccupation with one's body, body image, weight, and techniques for weight loss [37–39], so too may friendship cliques set a level of preoccupation with one's body, body image, gender, and the techniques to transition. The descriptions of pro-anorexia subculture group dynamics where the thinnest anorexics are admired while the anorexics who try to recover from anorexia are ridiculed and maligned as outsiders [39–41] resemble the group dynamics in friend groups that validate those who identify as transgender and mock those who do not. And the pro-eating-disorder websites and online communities providing inspiration for weight loss and sharing tricks to help individuals deceive parents and doctors [42–44] may be analogous to the inspirational YouTube transition videos and the shared online advice about manipulating parents and doctors to obtain hormones.

Hypothesis 2: Parental conflict might provide alternative explanations for selected findings

Parents reported subjective declines in their AYAs' mental health and in parent-child relationships after the children disclosed a transgender identification. Additionally, per parent report, almost half of the AYAs withdrew from family, 28.5% refused to speak to a parent, and 6.8% tried to run away. It is possible that some of these findings might be secondary to parent-child conflict. Parent-child conflict could arise from disagreement over the child's self-assessment of being transgender. It is also possible that some parents might have had difficulty coping or could have been coping poorly or maladaptively with their child's disclosure. Other potential explanations for the above findings include worsening of AYAs' pre-existing (or onset of new) psychiatric conditions or the use of maladaptive coping mechanisms. To further evaluate these possibilities, future studies should incorporate information about family dynamics, parent-child interactions, parent coping, child coping, and psychiatric trajectories. This study did not collect data about the parents' baseline coping styles, how they were coping with their child's disclosure, and whether their coping seemed to be maladaptive or adaptive. Nor did it explore parents' mental well-being. Future studies should explore these issues as well.

Although most parents reported an absence of childhood indicators for gender dysphoria, it is possible that these indicators might have existed for some of the AYAs and that some parents either failed to notice or ignored these indicators when they occurred. Because the readily observable indicators could also have been observed by other people in the child's life, future studies should

include input from parents, AYAs and from third party informants such as teachers, pediatricians, mental health professionals, babysitters, and other family members to verify the presence or absence of readily observable behaviors and preferences during childhood. Parental approaches to their child's gender dysphoria might contribute to specific outcomes. This study did not specifically explore parental approaches to gender dysphoria or parental views on medical or surgical interventions. Additional studies that explore whether parents support or don't support: gender exploration; gender nonconformity; non-heterosexual sexual identities; mental health evaluation and treatment; and exploration of potential underlying causes for dysphoria would be extremely valuable. It would also be worthwhile to explore whether parents favor affirming the child as a person or affirming the child's gender identity and whether parents hold liberal, cautious, or negative views about the use of medical and surgical interventions for gender dysphoria in AYAs.

Hypothesis 3: Maladaptive coping mechanisms may underlie the development of gender dysphoria for some AYAs

For some individuals, the drive to transition may represent an ego-syntonic but maladaptive coping mechanism to avoid feeling strong or negative emotions similar to how the drive to extreme weight loss can serve as an ego-syntonic but maladaptive coping mechanism in anorexia nervosa [68–69]. A maladaptive coping mechanism is a response to a stressor that might relieve the symptoms temporarily but does not address the cause of the problem and may cause additional negative outcomes. Examples of maladaptive coping mechanisms include the use of alcohol, drugs, or self-harm to distract oneself from experiencing painful emotions. One reason that the treatment of anorexia nervosa is so challenging is that the drive for extreme weight loss and weight loss activities can become a maladaptive coping mechanism that allows the patient to avoid feeling and dealing with strong emotions [69–70]. In this context, dieting is not felt as distressing to the patient, because it is considered by the patient to be the solution to her problems, and not part of the problems. In other words, the dieting and weight loss activities are ego-syntonic to the patient. However, distress is felt by the patient when external actors (doctors, parents, hospital staff) try to interfere with her weight loss activities thus curtailing her maladaptive coping mechanism.

Findings that may support a maladaptive coping mechanism hypothesis include that the most likely description of AYA ability to use negative emotions productively was poor/extremely poor and the majority of AYAs were described as "overwhelmed by strong emotions and tries to/goes to great lengths to avoid experiencing them." Although these are not validated questions, the findings suggest, at least, that there is a history of difficulty dealing with emotions. The high frequency of parents reporting AYA expectations that transition would solve their problems coupled with the sizable minority who reported AYA unwillingness to work on basic mental health issues before seeking treatment support the concept that the drive to transition might be used to avoid dealing with mental health issues and aversive emotions. Additional support for this hypothesis is that the sample of AYAs described in this study are predominantly female, were described by parents as beginning to express symptoms during adolescence and contained an overrepresentation of academically gifted students which bears a strong resemblance to populations of individuals diagnosed with anorexia nervosa [71–75]. The risk factors, mechanisms and meanings of anorexia nervosa [69–70, 76] may ultimately prove to be a valuable template to understand the risk factors, mechanisms, and meanings for some cases of gender dysphoria.

Transition as a drive to escape one's gender/sex, emotions, or difficult realities might also be considered when the drive to transition arises after a sex or gender-related trauma or within the context of significant psychiatric symptoms and decline in ability to function. Although trauma and psychiatric disorders are not specific for the development of gender dysphoria, these experiences may leave a person in psychological pain and in search of a coping mechanism. The first coping mechanism that a vulnerable person adopts may be the result of their environment and which narratives for pain and coping are most prevalent in that environment—in some settings a gender dysphoria/drive to transition may be the dominant paradigm, in some settings a body dysphoria/drive for extreme weight loss is dominant, and in another the use of alcohol and drugs to cope with pain may be dominant. Because maladaptive coping mechanisms do not address the root cause of distress and may cause their own negative consequences, an outcome commonly reported for this sample, AYAs experiencing a decline in their mental well-being after transgender-identification, is consistent with this hypothesis. There was a subset of AYAs for whom parents reported improvement in their mental well-being as they desisted from their transgender-identification which would not be inconsistent with moving from a maladaptive coping mechanism to an adaptive coping mechanism.

If the above hypotheses are correct, rapid onset of gender dysphoria that is socially mediated and/or used as a maladaptive coping mechanism may be harmful to AYAs in the following ways: (1) non-treatment or delayed treatment for trauma and mental health problems that might be the root of (or at least an inherent part of) the AYAs' issues; (2) alienation of the AYAs from their parents and other crucial social support systems; (3) isolation from mainstream, non-transgender society, which may curtail educational and vocational potential; and (4) the assumption of the medical and surgical risks of transition without benefit. In addition to these indirect harms, there is also the possibility that this type of gender dysphoria, with the subsequent drive to transition, may represent a form of intentional self-harm. Promoting the affirmation of a declared gender and recommending transition (social, medical, surgical) without evaluation may add to the harm for these individuals as it can reinforce the maladaptive coping mechanism, prolong the length of time before the AYA accepts treatment for trauma or mental health issues, and interfere with the development of healthy, adaptive coping mechanisms. It is especially critical to differentiate individuals who would benefit from transition from those who would be harmed by transition before proceeding with treatment.

Reflections

Clinicians need to be aware of the myriad of barriers that may stand in the way of making accurate diagnoses when an AYA presents with a desire to transition including: the developmental stage of adolescence; the presence of subcultures coaching AYAs to mislead their doctors; and the exclusion of parents from the evaluation. In this study, 22.3% of AYAs were reported as having been exposed to online advice about what to say to doctors to get hormones, and 17.5% to the advice that it is acceptable to lie to physicians; and the vast majority of parents were reasonably sure or positive that their child misrepresented their history to their doctor or therapist. Furthermore, although parents may be knowledgeable informants on matters of their own child's developmental, medical, social, behavioral, and mental health history- and quite possibly *because* they are knowledgeable- they are often excluded from the clinical discussion by the AYAs, themselves. An AYA telling their clinician that their parents are transphobic and abusive may indeed mean that the parents are transphobic and abusive. However, the findings of this research indicate that it is also

possible that the AYA calls the parent transphobic and abusive because the parent disagrees with the child's self-diagnosis, has expressed concern for the child's future, or has requested that the child be evaluated for mental health issues before proceeding with treatment.

The findings of this study suggest that clinicians need to be cautious before relying solely on self-report when AYAs seek social, medical or surgical transition. Adolescents and young adults are not trained medical professionals. When AYAs diagnose their own symptoms based on what they read on the internet and hear from their friends, it is quite possible for them to reach incorrect conclusions. It is the duty of the clinician, when seeing a new AYA patient seeking transition, to perform their own evaluation and differential diagnosis to determine if the patient is correct or incorrect in their self-assessment of their symptoms and their conviction that they would benefit from transition. This is not to say that the convictions of the patient should be dismissed or ignored, some may ultimately benefit from transition. However, careful clinical exploration should not be neglected, either. The patient's history being significantly different than their parents' account of the child's history should serve as a red flag that a more thorough evaluation is needed and that as much as possible about the patient's history should be verified by other sources. The findings that the majority of clinicians described in this study did not explore trauma or mental health disorders as possible causes of gender dysphoria or request medical records in patients with atypical presentations of gender dysphoria is alarming. The reported behavior of clinicians refusing to communicate with their patients' parents, primary care physicians, and psychiatrists betrays a resistance to triangulation of evidence which puts AYAs at considerable risk.

It is possible that some teens and young adults may have requested that their discussions with the clinicians addressing gender issues be kept confidential from their parents, as is their right (except for information that would put themselves or others at harm). However, maintaining confidentiality of the patient does not prevent the clinician from listening to the medical and social history of the patient provided by the parent. Nor does it prevent a clinician from accepting information provided by the patient's primary care physicians and psychiatrists. Because adolescents may not be reliable historians and may have limited awareness and insight about their own emotions and behaviors, the inclusion of information from multiple informants is often recommended when working with or evaluating minors. One would expect that if a patient refuses the inclusion of information from parents and physicians (prior and current), that the clinician would explore this with the patient and encourage them to reconsider. At the very least, if a patient asks that all information from parents and medical sources be disregarded, it should raise the suspicion that what the patient is presenting may be less than forthcoming and the clinician should proceed with caution.

The argument to surface from this study is not that the insider perspectives of AYAs presenting with signs of a rapid onset of gender dysphoria should be set aside by clinicians, but that the insights of parents are a pre-requisite for robust triangulation of evidence and fully informed diagnosis. All parents know their growing children are not always right, particularly in the almost universally tumultuous period of adolescence. Most parents have the awareness and humility to know that even as adults they are not always right themselves. When an AYA presents with signs of a rapid onset of gender dysphoria it is incumbent upon all professionals to fully respect the young person's insider perspective but also, in the interests of safe diagnosis and avoidance of clinical harm, to have the awareness and humility themselves to engage with parental perspectives and triangulate evidence in the interest of validity and reliability.

The strengths of this study include that it is the first empirical description of a specific phenomenon that has been observed by parents and clinicians [14] and that it explores parent observations of the psychosocial context of youth who have recently identified as transgender with a focus on vulnerabilities, co-morbidities, peer group interactions, and social media use. Additionally, the qualitative analysis of responses about peer group dynamics provides a rich illustration of AYA intra-group and inter-group behaviors as observed and reported by parents. This research also provides a glimpse into parent perceptions of clinician interactions in the evaluation and treatment of AYAs with an adolescent-onset (or young adult-onset) of gender dysphoria symptoms.

The limitations of this study include that it is a descriptive study and thus has the known limitations inherent in all descriptive studies. This is not a prevalence study and does not attempt to evaluate the prevalence of gender dysphoria in adolescents and young adults who had not exhibited childhood symptoms. Likewise, this study's findings did not demonstrate the degree to which the onset of gender dysphoria symptoms may be socially mediated or associated with a maladaptive coping mechanism, although these hypotheses were discussed here. Gathering more data on the topics introduced is a key recommendation for further study. It is not uncommon for first, descriptive studies, especially when studying a population or phenomenon where the prevalence is unknown, to use targeted recruiting. To maximize the possibility of finding cases meeting eligibility criteria, recruitment is directed towards communities that are likely to have eligible participants. For example, in the first descriptive study about children who had been socially transitioned, the authors recruited potential subjects from gender expansive camps and gender conferences where parents who supported social transition for young children might be present and the authors did not seek out communities where parents might be less inclined to find social transition for young children appropriate [77]. In the same way, for the current study, recruitment was targeted primarily to sites where parents had described the phenomenon of a rapid onset of gender dysphoria because those might be communities where such cases could be found. The generalizability of the study must be carefully delineated based on the recruitment methods, and, like all first descriptive studies, additional studies will be needed to replicate the findings.

Three of the sites that posted recruitment information expressed cautious or negative views about medical and surgical interventions for gender dysphoric adolescents and young adults and cautious or negative views about categorizing gender dysphoric youth as transgender. One of the sites that posted recruitment information is perceived to be pro-gender-affirming. Hence, the populations viewing these websites might hold different views or beliefs from each other. And both populations may differ from a broader general population in their attitudes about transgender-identified individuals. This study did not explore specific participant views about medical and surgical interventions for gender dysphoric youth or whether participants support or don't support: exploration of gender identity, exploration of potential underlying causes for gender dysphoria, affirmation of children as valued individuals or affirmation of children's gender identity. Future studies should explore all these issues. This study cannot speak to those details about the participants.

Respondents were asked, “Do you believe that transgender people deserve the same rights and protections as others in your country?” which is a question that was adapted from a question used for a US national poll [78]. Although this question cannot elicit specific details about a persons’ beliefs about medical interventions, beliefs about transgender identification, or their beliefs about their own child, it can be used to assess if the participants in this study are similar in their basic beliefs about the rights of transgender people to the participants in the US national poll. The majority (88.2%) of the study participants gave affirmative answers to the question which is consistent with the 89% affirmative response reported in a US national poll [78]. All self-reported results have the potential limitation of social desirability bias. However, comparing this self-report sample to the national self-report sample [78], the results show similar rates of support. Therefore, there is no evidence that the study sample is appreciably different in their support of the rights of transgender people than the general American population. It is also important to note that recruitment was not limited to the websites where the information about the study was first posted. Snowball sampling was also used so that any person viewing the recruitment information was encouraged to share the information with any person or community where they thought there could be potentially eligible participants, thus substantially widening the reach of potential respondents. In follow up studies on this topic, an even wider variety of recruitment sources should be attempted.

Another limitation of this study is that it included only parental perspective. Ideally, data would be obtained from both the parent and the child and the absence of either perspective paints an incomplete account of events. Input from the youth would have yielded additional information. Further research that includes data collection from both parent and child is required to fully understand this condition. However, because this research has been produced in a climate where the input from parents is often neglected in the evaluation and treatment of gender dysphoric AYAs, this research supplies a valuable, previously missing piece to the jigsaw puzzle. If Hypothesis 3 is correct that for some AYAs gender dysphoria represents an ego-syntonic maladaptive coping mechanism, data from parents are especially important because affected AYAs may be so committed to the maladaptive coping mechanism that their ability to assess their own situation may be impaired. Furthermore, parents uniquely can provide details of their child’s early development and the presence or absence of readily observable childhood indicators of gender dysphoria are especially relevant to the diagnosis. There are, however, obvious limitations to relying solely on parent report. It is possible that some of the participating parents may not have noticed symptoms of gender dysphoria before their AYA’s disclosure of a transgender identity; could have been experiencing shock, grief, or difficulty coping from the disclosure; or even could have chosen to deny or obscure knowledge of long term gender dysphoria. Readers should hold this possibility in mind. Overall, the 200 plus responses appear to have been prepared carefully and were rich in detail, suggesting they were written in good faith and that parents were attentive observers of their children's lives. Although this research adds the necessary component of parent observation to our understanding of gender dysphoric adolescents and young adults, future study in this area should include both parent and child input.

This research does not imply that no AYAs who become transgender-identified during their adolescent or young adult years had earlier symptoms nor does it imply that no AYAs would ultimately benefit from transition. Rather, the findings suggest that *not all* AYAs presenting at these vulnerable ages are correct in their self-assessment of the cause of their symptoms and *some* AYAs may be employing a drive to transition as a maladaptive coping mechanism. It may be difficult to distinguish if an AYA’s declining mental health is occurring due to the use of a maladaptive coping mechanism, due to the worsening of a pre-existing (or onset of a new) psychiatric condition, or due to conflict with parents. Clinicians should carefully explore these options and try to clarify areas of disagreement with confirmation from outside sources such as medical records, psychiatrists, psychologists, primary care physicians, and other third party informants where possible. Further study of maladaptive coping mechanisms, psychiatric conditions and family dynamics in the context of gender dysphoria and mental health would be an especially valuable contribution to better understand how to treat youth with gender dysphoria.

More research is needed to determine the incidence, prevalence, persistence and desistence rates, and the duration of gender dysphoria for adolescent-onset gender dysphoria and to examine whether rapid-onset gender dysphoria is a distinct and/or clinically valid subcategory of gender dysphoria. Adolescent-onset gender dysphoria is sufficiently different from early-onset of gender dysphoria that persists or worsens at puberty and therefore, the research results from early-onset gender dysphoria should not be considered generalizable to adolescent-onset gender dysphoria. It is currently unknown whether the gender dysphorias of adolescent-onset gender dysphoria and of late-onset gender dysphoria occurring in young adults are transient, temporary or likely to be long-term. Without the knowledge of whether the gender dysphoria is likely to be temporary, extreme caution should be applied before considering the use of treatments that have permanent effects such as cross-sex hormones and surgery. Research needs to be done to determine if affirming a newly declared gender identity, social transition, puberty suppression and cross-sex hormones can cause an iatrogenic persistence of gender dysphoria in individuals who would have had their gender dysphoria resolve on its own and whether these interventions prolong the duration of time that an individual feels gender dysphoric before desisting. There is also a need to discover how to diagnose these conditions, how to treat the AYAs affected, and how best to support AYAs and their families. Additionally, analyses of online content for pro-transition sites and social media should be conducted in the same way that content analysis has been performed for pro-eating disorder websites and social media content [44]. Finally, further exploration is needed for potential contributors to recent demographic changes including the substantial increase in the number of adolescent natal females with gender dysphoria and the new phenomenon of natal females experiencing late-onset or adolescent-onset gender dysphoria.

Conclusion

Collecting data from parents in this descriptive exploratory study has provided valuable, detailed information that allows for the generation of hypotheses about potential factors contributing to the onset and expression of gender dysphoria among AYAs. Emerging hypotheses include the possibility of a potential new subcategory of gender dysphoria (referred to as rapid-onset gender dysphoria) that has not yet been clinically validated and the possibility of social influences and maladaptive coping mechanisms contributing to the development of gender dysphoria. Parent-child conflict may also contribute to the course of the dysphoria. More research that includes data collection from AYAs, parents, clinicians and third party informants is needed to further explore the roles of social influence, maladaptive coping mechanisms, parental approaches, and family dynamics in the development and duration of gender dysphoria in adolescents and young adults.

Supporting information

S1 Appendix. Survey instrument.
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(PDF)

S2 Appendix. COREQ checklist.
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Puberty suppression in adolescents with gender ide
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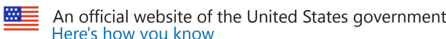
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Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study

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Abstract

Introduction: Puberty suppression by means of gonadotropin-releasing hormone analogues (GnRHa) is used for young transsexuals between 12 and 16 years of age. The purpose of this intervention is to relieve the suffering caused by the development of secondary sex characteristics and to provide time to make a balanced decision regarding actual gender reassignment.

Aim: To compare psychological functioning and gender dysphoria before and after puberty suppression in gender dysphoric adolescents.

Methods: Of the first 70 eligible candidates who received puberty suppression between 2000 and 2008, psychological functioning and gender dysphoria were assessed twice: at T0, when attending the gender identity clinic, before the start of GnRHa; and at T1, shortly before the start of cross-sex hormone treatment.

Main outcome measures: Behavioral and emotional problems (Child Behavior Checklist and the Youth-Self Report), depressive symptoms (Beck Depression Inventory), anxiety and anger (the Spielberger Trait Anxiety and Anger Scales), general functioning (the clinician's rated Children's Global Assessment Scale), gender dysphoria (the Utrecht Gender Dysphoria Scale), and body satisfaction (the Body Image Scale) were assessed.

Results: Behavioral and emotional problems and depressive symptoms decreased, while general functioning improved significantly during puberty suppression. Feelings of anxiety and anger did not change between T0 and T1. While changes over time were equal for both sexes, compared with natal males, natal females were older when they started puberty suppression and showed more problem behavior at both T0 and T1. Gender dysphoria and body satisfaction did not change between T0 and T1. No adolescent withdrew from puberty suppression, and all started cross-sex hormone treatment, the first step of actual gender reassignment.

Conclusion: Puberty suppression may be considered a valuable contribution in the clinical management of gender dysphoria in adolescents.

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SB 460 Written Testimony.pdf
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Dear Finance Committee Members,

I am writing to urge you to give an unfavorable report on SB 460 to protect the health and well-being of Maryland's youth from forces that would seek to prey upon their vulnerability and susceptibility to influence.

After watching the committee hearing for HB 283 in the House of Delegates, I expect that this bill will receive a favorable report. If you do give a favorable report, I urge you to explicitly restrict all medical "gender affirming treatments" to persons at least 18 years of age. Minors cannot consent to the short and long-term consequences of these treatments.

I am going to provide several reasons for my exhortation, but I would first urge you to read the article titled "I Thought I Was Saving Trans Kids. Now I'm Blowing the Whistle" written by Jamie Reed, a self-described "queer woman" who is "politically to the left of Bernie Sanders" and is "married to a transman." I have attached this article with my written testimony. Having worked for several years as a case manager at The Washington University Transgender Center at St. Louis Children's Hospital, Jamie Reed has an insider's perspective on the harm that the "gender affirming model" is doing to children. Please commit to reading this whistleblower's testimony. It is disturbing and heartbreaking. Jamie Reed is taking a great personal and professional risk because "the safety of our children should not be a matter of our culture wars" and because "what is happening to [children] is medically and morally appalling."

I will now explain why I believe that at a minimum you should amend SB 460 to restrict gender affirming treatments to legal adults.

Gender dysphoria is a very rare phenomenon that is recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and affects approximately 0.002% - 0.003% of biological girls and 0.005% - 0.014% of biological boys. Child onset gender dysphoria has been shown in numerous studies to have a high rate of resolution, with 61 - 98% of children desisting by puberty if they are not socially transitioned or put on a path of medical intervention. I have included those citations with working links below.

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Wallien, M. S. C, & Cohen-Kettenis, P.T. (2008). Pyschosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry, 47,* 1412-1423.

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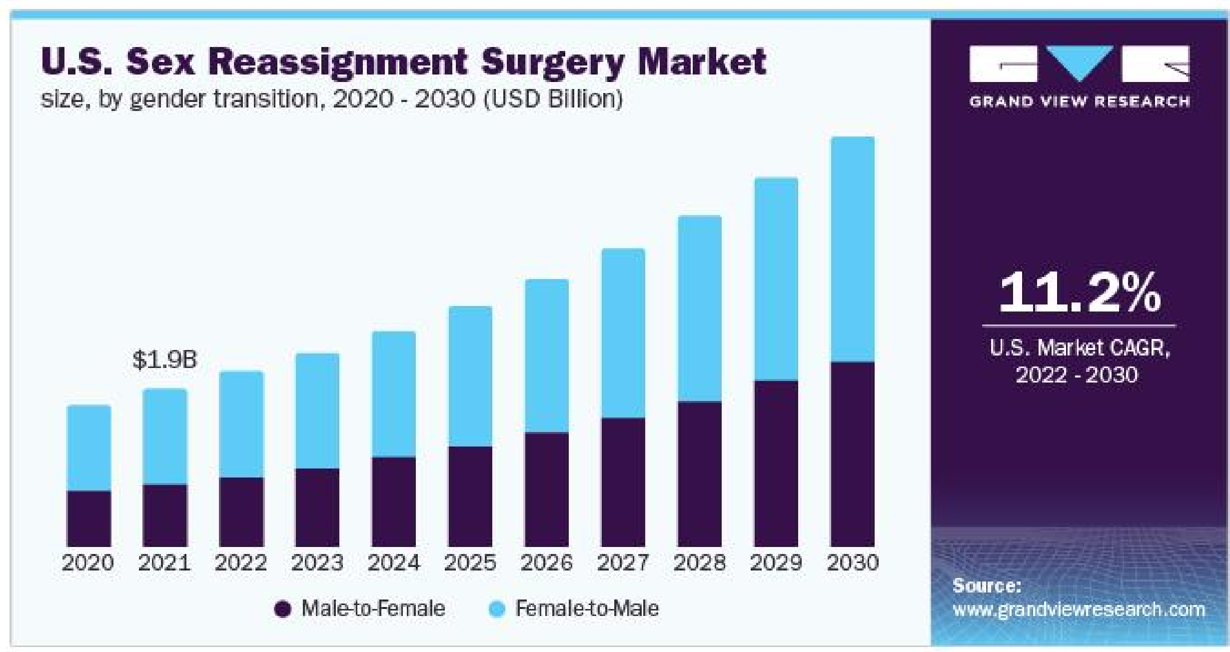
Historically, the rare cases of gender dysphoria in children were allowed to resolve naturally when children reached puberty. However, the situation has changed dramatically in a couple of ways in recent years. First, the number of children experiencing gender dysphoria or identifying as transgender or non-binary has risen in recent years. Furthermore, while gender dysphoria historically was mostly experienced by boys starting at an early age, there has been an explosion in many western nations of adolescent girls suddenly identifying as transgender or non-binary. The phenomenon has been termed Rapid Onset Gender Dysphoria and is causing turmoil in many families across the county. Please take time to read their stories at https://www.parentsofrogdkids.com/. I have attached a few of their stories at the end of this written testimony. Dr. Lisa Littman documented the phenomenon and identified it as a social contagion in a 2018 study titled "Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria" that caused significant controversy and resulted in professional consequences for Dr. Littman. Her findings provide an explanation for the trend and suggest that the influence of culture, entertainment, social media, and peer influence are causing the shift rather than immutable biological characteristics. I have attached a copy of this study with my written testimony.

Second, there has been a move away from treating gender dysphoria through either therapy or a "wait and see" approach to an aggressive medical approach. Students who express any confusion or discomfort with their gender are quickly put on a medicalized path that includes puberty blockers, cross-sex hormones, and eventually surgical modifications of the body. There are powerful financial motives that are behind this shift. Puberty blockers cost between $1,200 - $18,000 per month depending on the type of pharmaceutical used. The sex-reassignment industry is currently valued at $1.9 billion and is expected to grow by 11% annually through 2030, as documented below. In 2017, Johns Hopkins Hospital resumed sex-reassignment surgeries after a 38-year lapse. To explain the reversal, one only needs to follow the money. To no one's surprise, Johns Hopkins is in favor of this bill. How can you trust testimony from the very people who stand to profit from a growing medical industry? That is a clear conflict of interest.



Source: https://www.grandviewresearch.com/industry-analysis/us-sex-reassignment-surgery-market#:~:text=The%20U.S.%20sex%20reassignment%20surgery,11.23%25%20from%202022%20to%202030.

I am calling on you to either give an unfavorable report to SB 460 or amend it so that it will protect minors from puberty blockers, cross-sex hormones and sex-reassignment surgeries for minors.

Proponents of puberty blockers claim that they are completely reversible and just putting a "pause" on puberty. After watching the committee hearing for HB 283, I can assure you that the proponents of this bill will make that claim but they will not support their claim with data and studies. They claim that puberty can be resumed at any time should a child desist from their gender dysphoria. There are many problems with this claim. First, while most children would naturally desist from gender dysphoria, the use of puberty blockers leads to persistence and drastically increases the likelihood that children will progress to cross-sex hormones and sex-reassignment surgery. A study conducted in Amsterdam from 2000 -2007 showed that all 70 children that were placed on puberty blockers progressed to cross-sex hormones. This study titled “Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study” is included with my written testimony.

Furthermore, the long-term side effects of puberty blockers have not been properly studied. The FDA has only approved the use of puberty blockers to treat precocious puberty. It has not been approved for use on gender dysphoric youth. Studies have shown that puberty blockers stunt bone development (see “Effect of puberty blockers on bone density” in attachments) and that patients often continue to lag behind their peers in bone density even if puberty blockers are stopped (see “Bone Health: Puberty Blockers Not Fully Reversible” in attachments). Scientists do not know the long-term side effects of suppressing sex-hormones during a crucial period of brain development. Dr. Sheri Berenbaum, head of a gender research lab at Penn State expressed her concerns: "If the brain is expecting to receive those hormones at a certain time and doesn’t, what happens? We don’t know.” Finally, while proponents of puberty blockers claim that they improve mental health outcomes, a study from England shows that children taking puberty blockers experienced an increase in suicide ideation one year after starting

puberty blockers (see “Transgender treatment: Puberty blockers study under investigation” in attachments).

Proponents of puberty blockers claim that they will not cause infertility if a child chooses to stop treatment. This claim is not substantiated by long-term studies and the people testifying in favor of this bill will not provide long-term studies to support their claims that puberty blockers are fully reversible. However, it is almost certain that an adolescent's fertility will be permanently disrupted if they progress to cross-sex hormones. Since studies show that the use of puberty blockers leads to the persistence of gender dysphoria, it can be safely assumed that most children who start to take puberty blockers will lose their fertility.

Cross-sex hormones have also been shown to increase cancer risks. One study showed that biological males who take estrogen experience a 46-fold increase in their risk of breast cancer (see “Breast cancer risk in transgender people receiving hormone treatment” in attachments). Biological females who take testosterone experience increased risks of myocarditis, stroke, and blood clots (see “The effects of gender-affirming hormone therapy on cardiovascular and skeletal health: A literature review” in attachments).

The long-term effects of sex-reassignment surgery should be obvious. Such drastic measures are often promoted as the only way to prevent gender dysphoric youth from committing suicide. You will certainly hear that claim from the many people who will likely testify in favor of this bill. However, the data does not support this conclusion. Studies show that adults who medically transition to the opposite sex continue to have significantly higher rates of suicide even in very inclusive and affirming countries. In a long-term study in Sweden, individuals who had undergone sex-reassignment surgery had a suicide rate that was 20 times higher than comparable peers, even 10 to 15 years after the procedure (see “Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery” in attachments). There have been no long-term studies conducted to analyze the long-term outcomes for minors who have undergone sex-reassignment surgery.

For all the reasons shared above, I implore you to either oppose or amend SB 460 so that the Maryland Medical Assistance Program does not fund puberty blockers, cross-sex hormones or sex-reassignment surgeries for minors. Minors cannot consent to the known and unknown long-term side-effects that I have shared above. There are many things that we legally prohibit minors from participating in because they cannot understand the long-term consequences and side-effects. In my opinion, it should be obvious that the use of puberty blockers, cross-sex hormones and sex-reassignment surgery as medical interventions falls into that category.

As a legislator you are called to serve and protect the youth who do not have a voice in this process, even those who believe they want access to these treatments. There are powerful forces at work that want to see the "transing" of our youth for either ideological or financial reasons. There are both political power and financial riches to be gained through gender ideology and "gender affirming" medical interventions. You are called to stand with those without power and those without a voice, not with the powerful elites who stand to benefit from the confusion and medicalization of our youth. You must stand and speak for our children who cannot do it for themselves and cannot consent to the ideological and medical threat that confronts them. If you choose not to act, I believe there will come a day in which you will realize that it was a failure of courage and discernment.

Thank you for your consideration. I close by returning to a quote from Jamie Reed's article: "The safety of our children should not be a matter of our culture wars." Please protect our children.

Sincerely,

Justin Kuk
Baltimore City

Stories of Parents of Children Experiencing Rapid Onset Gender Dysphoria

March 9, 2020
Female to Male, Teenagers
Editor's Note: *The following parent's story originally appeared in a post entitled, "*In Their Own Words: Parents of Kids who Think They are Trans Speak Out*". It is posted here with the permission of the mother who wrote it. This mother is a single mother and her daughter is her only child.*

My daughter, at age fourteen, spontaneously decided that she is actually a male. After suffering multiple traumatic events in her life and spending a large amount of time on the internet, she announced that she was "trans." Her personality changed almost overnight, and she went from being a sweet, loving girl to a foul-mouthed, hateful "pansexual male." At first, I thought she was just going through a phase. But the more I tried to reason with her, the more she dug her heels in. Around this time, she was diagnosed with ADHD, depression, and anxiety. But mental health professionals seemed mainly interested in helping her process her new identity as a male and convincing me to accept the notion that my daughter is actually my son.

At age sixteen, my daughter ran away and reported to the Department of Child Services that she felt unsafe living with me because I refused to refer to her using male pronouns or her chosen male name. Although the Department investigated and found she was well cared for, they forced me to meet with a trans-identified person to "educate" me on these issues. Soon after, without my knowledge, a pediatric endocrinologist taught my daughter—a minor—to inject herself with testosterone. My daughter then ran away to Oregon where state law allowed her—at the age of seventeen, without my knowledge or consent—to change her name and legal gender in court, and to undergo a double mastectomy and a radical hysterectomy.

My once beautiful daughter is now nineteen years old, homeless, bearded, in extreme poverty, sterilized, not receiving mental health services, extremely mentally ill, and planning a radial forearm phalloplasty (a surgical procedure that removes part of her arm to construct a fake penis).

The level of heartbreak and rage I am experiencing, as a mother, is indescribable. Why does Oregon law allow children to make life-altering medical decisions? As a society, we are rightly outraged about "female circumcision." Why are doctors, who took an oath to first do no harm, allowed to sterilize and surgically mutilate mentally ill, delusional children?

Since the time of this writing, the daughter has undergone a radial forearm phalloplasty. The the daughter would allow her mother to be present only on condition that she apologize to the surgeon for begging him not to do it.

September 8, 2019

Female to Male, Teenagers

Our daughter has struggled with anxiety and feeling that she is "ugly" since elementary school. She is, of course, not ugly, but she does not fit the current socially preferred appearance for young girls (thin, long legs, straight blonde hair, etc.). Once she reached middle school, these feelings intensified, and she started to associate with a group of other kids (mostly girls) who also do not fit the mold of who she calls the "popular girls." Her new peer group was very into being "broken" even though they were mostly a bunch of fairly privileged, middle-class, suburban kids. They constantly tried to one-up each other with diagnoses of depression, eating disorders, suicidal ideation, etc. Our daughter would make up stories and symptoms to try to fit in with this group and even began self-harming (another huge obsession for the group). We found a therapist for her, but while the self-harm eventually stopped, the other behaviors persisted.

Her new peer group was very into being "broken" even though they were mostly a bunch of fairly privileged, middle-class, suburban kids. They constantly tried to one-up each other with diagnoses of depression, eating disorders, suicidal ideation, etc.

At the end of 6th grade, she "came out" to us as lesbian. While we were, and still are, somewhat skeptical of this as she was only 12 with no real sexual experience, we told her that we completely respected her feelings and that we love and support her no matter what her sexual preference is. Her godparents (our neighbors and best friends) are a lesbian couple with twin girls the same age as our daughter. We even jokingly commented that her being lesbian would be a relief for us since we would not have to worry about teen pregnancy or boys trying to coerce her into things she did not want to do.

She seemed to actually be a little disappointed by our reaction. She seemed to want resistance from us so that she could tell her friends about how awful her parents are. Her interactions and communications with the girls she was dating, as the kids called it, mainly consisted of female teen drama. "I love you so much!" "No, I love you more!" and so on. It is our opinion that many of the girls involved (and perhaps our daughter) found lesbian relationships as a way to engage in the romantic drama that teen girls typically love. The boys their age did not want or know how to engage in this, so relationships with other girls was perfect.

At the end of 6th grade, she "came out" to us as lesbian. We told her that we completely respected her feelings and that we love and support her no matter what her sexual preference is. She seemed to be a little disappointed by our reaction.

Still, it truly did not matter to us whether our daughter was lesbian or not. She would find out for herself on her own and no permanent harm is done either way.

However, just before the start of 8th grade, she informed us that she is transgender and wanted to be called by a different name with male pronouns. Up until this point, she had always acted and behaved as female. She was proud to be a girl and had signs and posters with sayings like "Girl Power" and "Girls Rule, Boys Drool." Her friends were almost exclusively female, and still are, as were her interests (romance, horses, art, etc.). I know that I am being stereotypical here as there are many boys who like the same things. I am only making the point that there were no prior indications of any discomfort with

her gender.

Our reaction was one of love and support, but not affirmation. We told her that we cannot control what she does with her friends, and we would not force her to dress in any particular way. However, at home we would still call her by her given name and refer to her with female pronouns, and there would be no medical interventions or use of things like binders. Our main comment was that she should slow down. Being a teen, especially a female one, is incredibly stressful and confusing. So much is going to change for her over the next few years. There is no need to make permanent decisions until she has had a chance to fully explore who she is.

Just before the start of 8th grade, she informed us that she is transgender. Our reaction was one of love and support, but not affirmation. Our main comment was that she should slow down. There is no need to make permanent decisions until she has had a chance to fully explore who she is.

This response was met with grudging resignation by our daughter. However, among her peers and even among some school staff members, she received lavish praise for being so "brave." Her teachers immediately validated her, and the school allowed her to use the nurse's office to change for PE or use the restroom. She has received almost exclusively positive reinforcement for "coming out." Even the few negative responses from other kids have only served to make her more of a "hero" to her friends. She and her friends use all of the current terminology about gender and about transgender transition in particular ("starting on T," "top surgery," "bottom surgery," etc.) that is clearly straight from online sources, even though we restrict her internet use.

However, among her peers and even among some school staff members, she received lavish praise for being so "brave." Her teachers immediately validated her, and the school allowed her to use the nurse's office to change for PE or use the restroom. She has received almost exclusively positive reinforcement for "coming out."

We recently moved and she has started school at a small, private, non-religious institution. We did this mainly because of academic concerns with the public schools here, but we did hope that a smaller environment and a "fresh start" might allow her to back off from her extreme stance. Unfortunately, that has not happened. She has already informed all of her teachers that she is transgender and asked them to call her a different name with male pronouns. They have all said that they will do so. My wife and I met with the teachers before the school year started to discuss the issue. We really like the teachers, and we know their intentions are good. But they have not known our daughter for her whole life. They, like everyone else, feel like they have to "respect" our daughter's identification.

My wife and I are liberal people. We are not homophobic or transphobic. If all that being transgender led to was being called a different name and pronouns then we would have no problem allowing our child to explore her identity. However, in the current climate, our daughter and her friends understand transgender as an innate condition that a person is born with and that can only be treated with hormone therapy and radical surgeries which have irreversible consequences. There is no discussion of a teen possibly misunderstanding their feelings (like every teen in the history of teenagers has done) and no discussion of the long-term effects.

My wife and I are liberal people. We are not homophobic or transphobic, but as concerned parents, we feel like reeds in a river fighting to hold our ground against a torrent of influences pushing our daughter down a path that she cannot possibly fully understand.

As concerned parents, we feel like reeds in a river fighting to hold our ground against a torrent of influences pushing our daughter down a path that she cannot possibly fully understand. While she cannot do anything medically while she is a minor, we are terrified that once she is 18 she will continue down this path simply because she has so fully committed to it.

We completely accept that we may be wrong. It may be that our child is one of the very small percentage of people for whom radical interventions are necessary in order to live a happy and fulfilled life (which is all we want for her). However, we also feel strongly that no 12, 13, or 14-year-old child is capable of making such a decision. She has also adamantly insisted that she wanted to be a horse trainer, veterinarian, and pediatric surgeon only to change her mind later. We resent the way the media and society at large are presenting to children that being transgender is standard human behavior and that affirmation and medical intervention is the only option.

Teens desperately want to feel special and accepted. Being transgender offers a way out of that pressure that cannot be challenged since the only criteria is a personal declaration.

Teens desperately want to feel special and accepted. We all have been through it. For girls, there is tremendous pressure to be "pretty" and liked by boys. Being transgender offers a way out of that pressure that cannot be challenged since the only criteria is a personal declaration. We feel powerless against this. All we can do is be here for her and try to maintain a safe space where she can come back to if her feelings change. Otherwise, we just have to sit by and watch helplessly.

July 17, 2019

Female to Male, Teenagers, BPD

My wife was diagnosed with breast cancer when our daughter was 9-years-old. Although breast cancer was foremost in our minds after the diagnosis, it was only one of many medical conditions that my wife suffered over the last years of her life. My wife died when my daughter was 12-years-old. A good death, if there is such a thing, would have been bad enough. My wife did not have a good death. There were many unnecessary layers of trauma inflicted on my daughter surrounding my wife's illness and death.

Even before my wife's illness, I had been my daughter's primary caregiver for most of her life. Shortly after our daughter's birth, my wife returned to work, and I began my career as a free-lancer. I was able to make my own hours, and most of those hours were spent at home with my infant daughter. Once my wife died, I was, of course, my daughter's only caregiver.

A good death, if there is such a thing, would have been bad enough. My wife did not have a good death.

My daughter did spend a lot of time on the internet in the months after her mother's death. I was aware of it, but felt that if we continued our candid relationship that it was better that she experience social media while I could still help her work through the pitfalls. Due to her mother's illness, she had been

given a cell phone while still in grade school. This isn't something that I would have allowed normally, but we were not in what I considered to be a normal situation.

My daughter started counseling about two years before my wife died. She was ten-and-a-half, and the counselling was aimed at helping her deal with her mother's illness. She continued seeing a counselor through my wife's death, and then stopped shortly thereafter. At age 14, she decided she needed more counseling. At the intake meeting, she was asked what her sexual orientation was. She stated that it was heterosexual. This was at a time when everyone understood that to mean that she was a girl who was attracted to boys. This was not a surprise. There was never any indication that she was anything else.

At 14 ½ my daughter began cutting herself to relieve stress. Later, we talked about her first instance of cutting herself, and she told me that she did it while thinking about her mother's death.

A couple of months after beginning to cut herself, my daughter made a new female friend that was transgender and had changed her name. Like my daughter, this girl had no masculine behaviors or characteristics.

A couple of months after beginning to cut herself, my daughter made a new female friend that was transgender and had changed her name. Like my daughter, this girl had no masculine behaviors or characteristics. Within a month, my daughter asked me to call her by a different name. I said that I would consider it. She said that she was going to change her name at school, and was in the process of telling her teachers. A few days later, I told her I've decided to continue calling her by her given name and I explained why. For their part, the school changed her name and gender on her official records without even notifying me.

At age 15 my daughter's mental health issues boiled over. We spent some time in the psychiatric ward of a hospital. My approach to dealing with her delusions and hallucinations has been to acknowledge that they exist, but to deny that they contain any internal truth: "Yes, you are having an hallucination, but the thing that you are hallucinating is not really happening." This approach has since been validated by the psychiatrists at the hospital. I was given techniques to help "ground" my daughter in reality. This involves bringing her back from a psychotic episode to the world of reality based on the things around her which her senses tell her are real. She has been taking anti-psychotics since her trip to the hospital. She has been provisionally diagnosed as having Borderline Personality Disorder. The diagnosis is provisional because, technically, minors cannot be diagnosed with mental disorders.

My approach to dealing with her delusions and hallucinations has been to acknowledge that they exist, but to deny that they contain any internal truth: "Yes, you are having an hallucination, but the thing that you are hallucinating is not really happening."

At age 16 my daughter told me that she was transgender. She wanted to have hormone treatment and top surgery. She told me that she was worried that having told me this, that I would not support her. I told her that I will always support her, but that doesn't mean that she will necessarily like what my support looks like. We don't always like what is good for us.

Her family doctor gave her a referral to the gender clinic at a local hospital based on nothing more than a conversation that the two of them had. I was not consulted. The hospital called me, ready to have me sign papers so she could be given hormones. The person on the other end of the phone sounded chipper

and upbeat. When they asked me to make an appointment, I asked what the appointment was for. Was it for treatment (hormones)? Or was it for counseling? I was told that it was for treatment, and not for counseling. I declined the opportunity to make an appointment. The voice on the other end was no longer chipper, and it seemed clear to me that I had just become the bad guy.

At age 16 ½ my daughter made an announcement to the whole family via text message that she was a transgender male who was using male pronouns. She didn't send the text to me: just to the rest of the family. As far as I know, they are all going along with this. Only one person even bothered to tell me that they would now be using that name and those pronouns. No one even felt it necessary to call and ask what I thought would be best. It isn't for nothing that I'm calling her by her given name and matching pronouns. I don't consider this delusion to be different from her other delusions. I'm using the same techniques to ground her regarding this delusion as with the others. And I'm trying to prevent my child from having unnecessary surgery and dangerous hormone treatment.

It isn't for nothing that I'm calling her by her given name and matching pronouns. I don't consider this delusion to be different from her other delusions. I'm using the same techniques to ground her regarding this delusion as with the others.

I met with my daughter's counseling team to enlist their help in slowing down her rush to permanent, dangerous, irreversible "treatment". They told me that they can do nothing other than affirm her. In a previous meeting, one of my daughter's counselors did make a point of communicating to me that if I did not accept my daughter's transgender status that I was risking her attempting suicide. They claim that they are not supporting transition; they are only providing resources. I tell them that if I walked in and claimed to be a giraffe, they would direct me to a giraffe support group: that is support.

Their position was that my daughter is capable of making this decision, and that all they could offer me was assistance in accepting that fact. I told them that I have found myself alone in doing what is right for my daughter before, and I'll do this on my own too. Prior to this time, I was considered (I'm not making this up, and I'm really quoting them) the "model parent".

Their position was that my daughter is capable of making this decision, and that all they could offer me was assistance in accepting that fact.

I allow my daughter to dress and behave as she likes. I don't put restrictions on her "gender-expression". At this point almost everybody else does refer to her with a different name and mismatched pronouns. My approach to dealing with her transgenderism is consistent with my approach to her other delusions and hallucinations. I acknowledge its existence without acting as if it contains any internal truth. There is no one else in her life that does this. I am her only remaining parent, so I should be leading this effort and shouldering the majority of the responsibility. However, it never occurred to me that I would be alone in this effort: the only one on this side of sanity.

After a particularly adamant episode of my daughter screaming that she wanted to cut off her breasts, I thought that I would have to find some way to help her work through her desire for medical intervention before she turns 18 and the decision is no longer in my hands. We sat down and discussed things that we might do prior to using hormones or surgery. I wanted to show her that we could work up to things gradually. I suggested that there were some behaviors and activities that she could try that were more masculine. She angrily insisted that there were no typically masculine behaviors, and that

she should not be asked to “over compensate” simply because she had never behaved in a way that I considered masculine. I took a step back and asked her, “OK, since I don’t know what a boy is, what do you consider to be a boy?” She said, “Someone who wants people to refer to them using masculine pronouns.” That was it. That is the only thing that divides male from female: a desire to be referred to using masculine pronouns.

I am her only remaining parent, so I should be leading this effort and shouldering the majority of the responsibility. However, it never occurred to me that I would be alone in this effort: the only one on this side of sanity.

My daughter’s background now makes her a poster-child for ROGD: the condition appeared suddenly; she has no masculine qualities or behaviors; she has suffered a significant amount of childhood trauma; she spent too much time on the internet and with social media; she engages in cutting; she has depression; she has anxiety; she has BPD; and, prior to discovering her transgender state, she had friends with the same condition.

On 4thWavenow’s website there is an article regarding transgenderism. At the bottom of the article is a picture of a woman with a sign. It says, “I love my transgender child”. I thought, *I love my transgender child too: too much to abuse her by affirming her delusions*.

The effects of gender-affirming hormone therapy on

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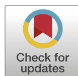

The effects of gender-affirming hormone therapy on cardiovascular and skeletal health: A literature review

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ABSTRACT

Approximately 1.5 million people in the United States currently identify as transgender. The use of gender affirming hormone therapy is integral to routine clinical care of transgender individuals, yet our understanding of the effects of this therapy is limited. There are reasons to believe that gender affirming hormone therapy may have important effects on cardiovascular risk and bone health in transgender individuals. The purpose of this review article is to summarize the evidence for the cardiovascular effects (including coronary artery disease, hypertension and stroke) as well as the effects on bone metabolism associated with gender affirming hormone therapy in both transgender men and transgender women.

1. Introduction

Approximately 1.5 million adults in the United States (0.6% of the population in 2016) identify as transgender, with 99.5% of these individuals younger than 65 years [1]. Transgender persons are a diverse group whose gender identity differs from the sex assigned at birth [2]. Some transgender persons undergo medical treatment which includes gender-affirming hormone therapy (GAHT) and/or surgery to align their physical characteristics with their gender identity and to alleviate gender dysphoria. GAHT is provided in order to induce feminizing or masculinizing changes [2].

The prevalence of transgender population in the United States has been increasing. This is likely due to the fact that transgender individuals are now more likely to identify as such in demographics surveys [3]. Understanding the terminology used to describe transgender individuals (Table 1) and the commonly used hormone therapies (Table 2) is essential to improve care for this population. Awareness of the potential side effects of GAHT is needed to make informed decisions and to individualize GAHT. This article reviews the available evidence regarding the effects of GAHT on the cardiovascular and skeletal health in the transgender population.

1.1. Research methodology

We searched online electronic databases (Embase, Medline Cochrane Library, Google Scholar and Pubmed) to identify all relevant studies from 1990 until 2022. We used keywords such as "transgender", "gender", "gender dysphoria", "cisgender", "sex assigned at birth", "natal sex", "gender affirming therapy", "gender affirming surgery", "cardiovascular", "cardiovascular disease", "myocardial infarction", "stroke", "cerebrovascular disease", "cardiometabolic", "diabetes", "lipid", "cholesterol", "dyslipidemia", "body fat", "visceral fat",

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Table 1
Definitions of terms [2,53].

Terms	Definition
Sex	Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia
Gender identity	A person's intrinsic sense of being male, female or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer)
Gender dysphoria	Distress that is caused by a discrepancy between a person's gender identity and sex assigned at birth
Transgender man	Individual assigned female at birth who identifies as male
Transgender woman	Individual assigned male at birth who identifies as female
Gender-affirming hormone therapy (GAHT)	Hormonal therapy aiming to align the physical characteristics of an individual with their gender identity
Gender-affirming surgery	Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity

Table 2
Gender-affirming hormone therapy (GAHT) used in transgender persons [32,42].

Transgender Women		Dose
Estrogen	Micronized estradiol, oral	2–4 mg/day
	Estradiol valerate, oral	2–4 mg/day
	17 β-Estradiol transdermal patch, TD	100–200 μg/day
	Estradiol valerate, IM	5–20 mg/2 weeks
	Estradiol cypionate, IM	3 mg/month
Anti-androgens	Spironolactone, oral	100–400 mg/day
	Flutamide, oral	250–500 mg/day
	Bicalutamide, oral	25–50 mg/day
	Enzalutamide, oral	160 mg/day
5α-reductase inhibitor	Finasteride, oral	5 mg/day
	Dutasteride, oral	0.5 mg/day
Progesterone	Cyproterone acetate, oral*	25–100 mg/day
	Medroxyprogesterone, oral	10 mg/day
GnRH agonist	Leuprolide, IM	3.75 mg/4 weeks
	Triptorelin, IM or SC	3.75 mg/4 weeks
	Goserelin, SC	3.8 mg/4 weeks
	Buserelin, SC or intranasal	200–1200 μg/day
	Histrelin, SC	50 μg/day
Transgender Men		**Dose**
Androgen	Testosterone enanthate, IM or SC	250 mg/4 weeks
	Testosterone cypionate, IM or SC	200 mg/4 weeks
	Testosterone undecanoate, IM	1000 mg/12 weeks
	Testosterone gel, TD	5 g/day
	Testosterone transdermal patch, TD	5 mg/day
	Crystalline Testosterone (testosterone pellets; SC depot)	600 mg/4–6 months
	Testosterone undecanoate, oral	80–160 mg/day

Abbreviations: GnRH, Gonadotropin releasing hormone, IM, intramuscularly; SC, subcutaneously; TD, transdermal.
*Not available in the US, Cyproterone acetate is also an anti-androgen.
In transgender women, estrogen is often used together with either anti-androgen or GnRH analog.

"pulmonary embolism", "venous thromboembolism", "bone mineral density", "bone health" in order to screen studies that included gender affirming therapy effects on our desired outcome.

Retrospective studies, prospective studies, observational studies, systematic reviews, meta-analyses and randomized trials were all included when applicable.

A total of 150 articles were screened. 53 articles were retained based on the outcomes related to our review.

2. Cardiovascular health

2.1. Transgender women

2.1.1. Ischemic heart disease

Two early observational studies reported that the crude incidence of myocardial infarction and mortality related to myocardial infarction in transgender women receiving GAHT were not different from sex assigned at birth men [4,5]. Nokoff et al. analyzed the data from a 2015 behavioral risk factor surveillance survey (BRFSS) and found that transgender women on GAHT had a higher risk of myocardial infarction than sex assigned at birth women (OR 2.9; 95% CI 1.6–5.3) but this risk was not higher than in sex assigned at birth men (OR 1.09; 95% CI 0.59–2.03) [6]. Similar results were found by Getahun et al. in a retrospective cohort study of 2842 transgender women (mean study duration: 4 years): transgender women receiving GAHT had higher risk of ischemic heart disease than sex assigned at birth women (HR 1.9; 95% CI 1.3–2.6) but the risk was not different from that of sex assigned at birth men [7].

A case control study showed a higher prevalence of myocardial infarction in transgender women who had received GAHT for an average of 7.7 years compared with sex assigned at birth women (18.7/1000 cases vs. 0; P = 0.001), with the prevalence of myocardial infarction similar to sex assigned at birth men [8]. The incidence of myocardial infarction in transgender women on GAHT was similarly higher than in sex assigned at birth women (SIR 2.64 [95% CI 1.81–3.72]) and similar to sex assigned at birth men in a retrospective cohort [9].

Transgender women were found to have higher mortality rate due to ischemic heart disease than adjusted expected mortality of the general population (SMR 1.64; 95% CI: 1.43–1.87) in a retrospective cohort study. Transgender women treated with ethinyl estradiol had a particularly high event rate with a 3-fold increased risk of cardiovascular mortality compared with former users or never-users (HR 3.12; 95% CI 1.28–7.63) [10].

Overall, the available data indicate that transgender women on GAHT are at a higher risk of ischemic heart disease (including myocardial infarction) compared with sex assigned at birth women, however transgender women appear to have similar cardiovascular risk when compared to sex assigned at birth men.

2.1.2. Cerebrovascular disease

The incidence of cerebrovascular disease in transgender women receiving GAHT was found to be similar to sex assigned at birth men [4] and to the general population [5] in two early retrospective observational studies. In a retrospective cohort study of 966 transgender women receiving GAHT, the mortality related to cerebrovascular disease in transgender women was not statistically different from the general population [10].

In a case-control study of 214 transgender women on GAHT, the prevalence of ischemic stroke in transgender women was however higher than that in sex assigned at birth men (23.4/1000 cases vs. 9.4/1000 cases; P = 0.03), but similar to sex assigned at birth women [8].

In contrast, a subsequent retrospective cohort study (n = 2842) found that the risk of ischemic stroke in transgender women receiving GAHT was higher than that in sex assigned at birth women (HR 1.9; 95% CI 1.4–2.7) but similar to that of sex assigned at birth men (median follow up: 4 years) [7]. In the subgroup analysis, transgender women who had received GAHT for longer than 6 years (n = 853) had higher risk of ischemic stroke than both sex assigned at birth men (HR 9.9; 95% CI 3.0–33.1) and sex assigned at birth women (HR 4.1; 95% CI 1.5–11.4) indicating increased risk of stroke with prolonged exposure to hormone therapy [7]. A similar higher risk of ischemic stroke in transgender women on GAHT compared with both sex assigned at birth men (SIR 1.80 [95% CI 1.23–2.56]) and sex assigned at birth women (SIR 2.42 [95% 1.65–3.42]) was shown in another retrospective cohort of 2517 patients [9].

Overall, the available data for cerebrovascular disease are equivocal. However there seems to be an increased long-term risk of ischemic stroke in transgender women on GAHT compared to both sex assigned at birth men and women.

2.1.3. Cardiometabolic risk factors

A meta-analysis of 29 studies, which included 3231 transgender women, showed no significant differences in total cholesterol (TC), LDL-C, HDL-C or triglyceride levels (TG) in transgender women receiving GAHT at 3–6 months, 12 months or ≥ 24 months compared to baseline [11]. Serum TG level was higher than baseline after 24 months of GAHT [11]. A prospective cohort study of 30 transgender women found no significant changes in lipid profiles after 6 months of estrogen therapy compared with baseline [12].

In contrast, a prospective observational study showed that GAHT in transgender women was associated with deleterious alteration in lipid prolife: TC, TG, LDL-C increased and HDL-C decreased after 1 year and 2 years of GAHT compared with baseline [13]. The study also demonstrated alteration in glyco-insulinemic profile in transgender women with homeostatic model assessment-insulin resistance index (HOMA-IR index) of 6.57 (SD 2.69) after 2 years of GAHT compared with baseline HOMA-IR index of 3.63 (SD 0.77) [13]. A higher prevalence of diabetes was observed in transgender women receiving estrogen compared with both sex assigned at birth men and sex assigned at birth women in a case-control study [8]. While data regarding insulin resistance in transgender patients are limited, a recent systematic review of 26 studies showed that in transgender women feminizing hormone therapy (estradiol, with or without anti-androgen agents) decreases lean mass, increases fat mass, and may worsen insulin resistance. However, the data on insulin resistance are not as consistent due to paucity of randomized prospective research, small cohorts and short follow up periods. More data are needed for better and more consistent results [14]. In a recent prospective study, the cardiometabolic profile of 179 transgender women on GAHT was evaluated at 1 year. The authors found that total body fat had increased without a change in visceral fat. These changes were not associated with a change in the lipid profile or HOMA-IR index [15].

Conflicting effects of GAHT on the lipid profile of transgender women were observed in some studies. LDL-C decreased (−12%), HDL-C increased (+24%) while TG increased (+86%) and TC remained unchanged after one year of GAHT compared with baseline in an observational study of 20 transgender women (mean age 26 ± 6)[16]. Reductions in TC, LDL-C, TG, HDL-C were observed after one year of GAHT compared with baseline in a prospective cohort study of 53 transgender women [17]. A similar pattern compared to baseline was seen in another cohort study of 242 transgender women after one year of GAHT [18].

In summary, the existing literature related to dyslipidemia and cardiometabolic profiles in transgender women is mixed and it is difficult to draw conclusions about any consistent effects of estrogen therapy on lipid profile in transgender women. While data on total cholesterol, LDL-C and insulin resistance are equivocal, there seems to be consistent evidence for the increase in TG levels and total body fat.

2.1.4. Blood pressure

The incidence of hypertension (defined then as BP > 160/90 mmHg) in transgender women receiving GAHT was shown to be similar to sex assigned at birth men (crude incidence 14 [95% CI 7.8–23.1] vs. 18.708) in a study reported in 1989 [4]. A small prospective observational study in 1993 found significantly decreased level of endothelin in transgender women after 4 months of GAHT [19]. The effect of lower endothelin level on blood pressure, however, remains unclear. Modest reduction of blood pressure was seen in transgender women receiving GAHT in multiple observational studies lasting 6 months to one year [17,18,20]. The subjects in these studies were taking various formulations of GAHT including oral estradiol valerate and transdermal estradiol.

In contrast, an observational study of 79 transgender women showed an increase in blood pressure (both systolic and diastolic) after 1 year and 2 years of GAHT compared with baseline [13]. A similar increase in blood pressure was seen in another prospective observational study of 20 transgender women [16].

In summary, evidence for the effects of GAHT on BP in transgender women remains scarce and equivocal making it difficult to draw definite conclusions.

2.1.5. Venous thromboembolism

Two early observational studies showed increased risk of VTE and pulmonary embolism in transgender women: one study showed a 45-fold increase in risk compared to sex assigned at birth men (crude incidence 19 [95% CI 11.7–29.4] vs. 0.42) [4] while another showed a 20-fold increase in risk compared to general population (SIR 19.56 [95% CI 12.27–26.18])[5]; all cases of VTE occurred in patients using oral ethinyl estradiol except for one patient using transdermal 17 β-estradiol in the latter study.

Similarly, a retrospective cohort study of 2842 transgender women found higher risk of VTE in transgender women receiving GAHT compared to sex assigned at birth men (HR 1.9 [95% CI 1.4–2.7]) and sex assigned at birth women (HR 2.0; 95% CI 1.4–2.8) with the highest risk seen with longer exposure to hormone therapy [7]. In a recently published retrospective observational study of 6793 transgender persons, higher incidence of VTE was seen in transgender women receiving GAHT compared with both sex assigned at birth men (SIR 4.55 [95% CI 3.59–5.69]) and sex assigned at birth women (SIR 5.52 [95% CI 4.36–6.90]) [9].

In contrast to the studies described above, no cases of VTE were detected in a retrospective cohort study of 162 transgender women who received GAHT for a mean duration of 4.4 years. Of note, all the subjects in this study received transdermal 17β-estradiol along with cyproterone acetate and finasteride rather than oral estrogen, suggesting that the increased risk of VTE with estrogen therapy applies to oral formulations [21].

In regards to progesterone in transfeminine care, it is not currently recommended by clinical guidelines for routine GAHT. This is mostly due to lack of efficacy and safety data. However, there are increasing data in favor of the use of progesterone and its derivatives in transgender women for feminization, bone health and mood disorders. Data regarding cardiovascular safety remain scarce [22,23].

In summary, the data for VTE in transgender women are consistent and show an increased risk of VTE and pulmonary embolism in transgender women compared to both sex assigned at birth men and women.

2.2. Transgender men

2.2.1. Ischemic heart disease and cerebrovascular disease

A retrospective observational study of 293 transgender men taking GAHT in the Netherlands found a similar incidence of myocardial infarction between transgender men and the general Dutch population over 2418 patient-years (SIR 0.34 [0.01–1.92]) [5]. Multiple observational studies have not found an increased risk of myocardial infarction or increased mortality related to myocardial infarction in transgender men receiving GAHT compared with sex assigned at birth men or sex assigned at birth women [6–8,10]. Similarly, a cohort study that followed 50 transgender men receiving testosterone (mean age 37 ± 8.2 years) for an average of 10 years (range 2–35 years) did not report any cases of myocardial infarction [24].

One cross-sectional study using population-based data (BRFSS data from 2014 to 2017) found that transgender men had a >4-fold and 2-fold increased risk of myocardial infarction compared with sex assigned at birth women (OR 4.90 [95% CI 2.21–10.90], P < 0.01) and sex assigned at birth men (OR 2.53 [95% CI 1.14–5.63], P 0.02) [25]. Information regarding specific hormone therapy was not provided in this study making it difficult to assess the factors related to this increased

risk [25]. The risk and prevalence of ischemic stroke in transgender men on GAHT were also shown to be similar to those of sex assigned at birth men and sex assigned at birth women [7,8,10].

In summary, while data are scarce and not consistent, there seems to be no increased risk of cardiovascular disease, myocardial infarction or stroke in transgender men on hormone therapy.

2.2.2. *Cardiometabolic risk factors*

Deleterious changes in lipid profile were observed in two prospective cohorts: TC, LDL-C and TG increased and HDL-C decreased in transgender men after one year of GAHT compared with baseline values [17, 18]. A similar pattern of changes in lipid profile was seen in transgender men in another prospective cohort study after two years of GAHT compared with baseline [13].

This unfavorable trend in lipid profile in transgender men was supported by a meta-analysis of 29 studies, which included 1500 transgender men. The authors concluded that LDL-C and TG increased and HDL-C decreased significantly while TC remained unchanged after 2 years of GAHT compared with baseline, with mixed results seen before 2 years of GAHT, indicating that longer duration of GAHT is associated with undesirable effects on lipid profile [11].

Unfavorable changes in lipid profile in transgender men receiving GAHT were fairly consistent in multiple studies despite some mixed results: a cross-sectional study of 111 transgender men showed that transgender men treated with testosterone had higher TC, TG and lower HDL-C compared with transgender men not treated with testosterone [26]; two additional prospective observational studies showed that TG increased and HDL-C decreased in transgender men after one year [16] and two years [27] of GAHT compared to baseline while TC and LDL-C remained unchanged. Another prospective study reported decreased HDL-C in transgender men after one year of GAHT with other lipid parameters unchanged [28].

The data on the risk for diabetes mellitus in transgender men are mixed. A case-control study showed increased prevalence of diabetes in transgender men receiving GAHT compared with sex assigned at birth women but it was not different from sex assigned at birth men [8]. Conversely, HOMA-IR in transgender men was not different from baseline after one year and two years of GAHT in a prospective observational study [13]. HbA1c was similar in transgender men treated with GAHT and those not treated with GAHT in a cross-sectional study [26]. In a recent prospective study, the cardiometabolic factors of 162 transgender men was evaluated before and after 1 year of GAHT. The authors found that total body fat decreased without changes in visceral fat. Those changes were not related to changes in blood lipids or HOMA-IR index [15]. The investigators concluded that cardiometabolic effects of GAHT are not related to changes in visceral fat and total body fat.

In summary, GAHT seems to increase LDL-C, TGL and decease HDL-C in transgender men. Some studies indicate that these changes are more pronounced after 2 years of therapy.

2.2.3. *Blood pressure*

Two observational studies published in 1989 and 1997 did not find an increased incidence of hypertension (defined then as blood pressure >160/95 mmHg and >160/90 mmHg) respectively in transgender men receiving GAHT compared with the general population [4,5]. Chandra et al. also found no changes in mean arterial blood pressure in a prospective cohort study of 12 transgender men after one year of GAHT [28]. Giltay et al. demonstrated a slightly decreased blood pressure in transgender men after 3–4 months of GAHT in an observational study [29].

In contrast, a cross-sectional study of 111 transgender men (48 on IM testosterone esters and 63 not on any hormone therapy) showed that transgender men treated with androgens had significantly higher blood pressure (systolic, diastolic, and mean arterial pressure) than those who were not treated over mean study duration of 45 ± 38.1 months [26]. A variable increase in systolic blood pressure (+4.1–13.4 mmHg) was seen in transgender men after receiving GAHT for 1–2 years compared with baseline across observational studies ranging in sample size from 43 to 50 individuals [13,17,27].

In summary, data on blood pressure in changes in transgender men on GAHT remain controversial and it is thus difficult to draw definite conclusions without better data. Table 3 summarizes the effect of GAHT on the cardiovascular risk and different cardiometabolic parameters in transgender men and women.

3. Skeletal health

Bone strength, which determines fracture risk, reflects the integration of bone density and bone quality. Dual energy X-ray absorptiometry (DXA), a noninvasive measurement of bone density, is the current standard of care to diagnose osteoporosis and to assess fracture risk [30]. Bone quality assessment involves macro- and microarchitectural characteristics of bone tissue and can be conducted invasively (using a bone biopsy), or noninvasively (using a program to measure the trabecular bone score, a marker of variation obtained from the lumbar spine bone density image).

Sex steroids are major determinants of bone homeostasis. Estrogen plays a significant role in bone remodeling [31]. A deficiency in estrogen is associated with increased bone resorption, increased bone loss, and increased fracture risk in the general population. Testosterone plays an important role in bone gain and maintenance in sex assigned at birth men, and testosterone deficiency is associated with increased bone resorption, bone loss, and fracture risk.

There are currently no estimates on the prevalence of osteoporosis or low bone mass in transgender persons. Screening for osteoporosis in transgender individuals should be performed with DXA similar to the general population according to the Endocrine Society Clinical Practice Guidelines [32]. Risk factors to be assessed to determine the need for DXA screening include age, medical conditions and or medications that increase the risk of osteoporosis [33]. The T-score represents the number of standard deviations above or below the average bone density of a young healthy Caucasian sex assigned at birth woman. The T-score establishes fracture risk and the need for further treatment and lifestyle modifications.

A recent study evaluating BMD in pre-pubertal transgender youth showed decreased BMD in the transgender group compared to their sex assigned at birth counterparts, suggesting the need for BMD surveillance at an even earlier stage [34].

There are limited data on the long-term risks of GAHT on skeletal health. Most of the studies in transgender individuals have been cross-sectional or retrospective, with very few prospective or longitudinal

Table 3
The effect of GAHT on the cardiovascular health in transgender women and men.

Conditions	Effects of GAHT	
	Transgender Women	Transgender Men
Ischemic heart disease	↑↔	↔
Cerebrovascular disease	↑	↔
Blood pressure	∴	↑↔
Venous thromboembolism	↑	↔
Total cholesterol	↓↔	↑↔
HDL-C	↓↔	↓
LDL-C	↓↔	↑↔
Triglycerides	∴	↑↔
Diabetes	↔	↔

Abbreviation: LDL-C, low density lipoprotein cholesterol; HDL-C, high density lipoprotein cholesterol.
↑ denotes a significant increase.
↓ denotes a significant decrease.
↔ denotes no significant change.
∴denotes inconclusive results.
Table format adapted from Connelly PJ et al. Hypertension.2019 [53].

studies and data prior to 2019 were summarized in 2 large meta-analyses. Below we provide a review of those two meta-analyses.

A systematic review and meta-analysis [35,36] of the effects of gender affirming hormone therapy on bone mass in transgender individuals were performed in 2017 [35] and later updated in 2019 [36]. A single study has been performed using trabecular bone score in transgender individuals [37]. The 2017 systematic review and meta-analysis examined 13 studies published from 1980 to 2015. [35] The outcomes of interest were bone mineral density and the incidence of fractures. 392 transgender women and 247 transgender men were identified. The updated 2019 systematic review and meta-analysis selected 19 studies published before August 2018. The quality of the studies was assessed by the National Institutes of Health scale to be fair and/or good. 812 transgender women and 487 transgender men were identified. A list of individual studies is shown in Table 4.

The study on trabecular bone score reviewed patient data from the American University Medical Center in the Netherlands from 1972 to 2016. DXA scan results along with additional clinical data corresponding to bone health were retrieved. The trabecular bone score was calculated based on lumbar spine DXA imaging. 535 transgender women and 473 transgender men were included.

3.1. Transgender women

In both meta-analyses, transgender women showed an increase in bone mineral density in the lumbar region at 12 and 24 months. Fracture rates were only evaluated in a single cohort study with no reported events in either gender. The trabecular bone scores (TBS) in transgender women regardless of age, were found to be higher compared to baseline (+0.04, 95%CI + 0.00; +0.08). TBS, calculated from the lumbar region of the DXA scan, in both meta-analyses had an associated increase in bone mineral density.

3.2. Transgender men

In both meta-analyses transgender men showed no statistically significant changes in bone mineral density in the lumbar spine, femoral neck, or total hip at 12 or 24 months. Most transgender men received IM preparations of testosterone, and some received transdermal or oral androgens. All patients had a baseline DXA scan prior to initiation of GAHT. Among the transgender men less than 40 years of age, TBS tended to be lower in those who used GAHT compared to the baseline groups. For transgender men greater than 40 years of age, TBS was lower in those using 5 years GAHT versus baseline (−0.05, 95%CI −0.08; −0.01) [37]. Although there was evidence of a decrease, the score remained above 1.3, which is in normal architectural range. There was no obvious increase in fracture risk.

In summary, the available data show that in transgender women, GAHT increases bone mineral density and TBS. In transgender men, there was a decrease in TBS which nevertheless remained above 1.3, still in normal architectural range. There was no increase in fracture risk in both populations. Those results are also summarized in Table 5.

4. Discussion

GAHT is a collective term that encompasses androgen and estrogen therapy in different formulations and routes of administration along with other endocrine therapies. The inconsistent and conflicting results found in the current literature can be explained by the highly heterogenous GAHT used in different studies as well as lack of information on lifestyle and psychosocial aspects of the included transgender individuals.

Transgender women appear to have higher risk of myocardial

Table 5
The effects of GAHT on Skeletal health in transgender women and men.

Parameters		Effects of GAHT	
		Transgender Women	Transgender Men
BMD	**Lumbar spine**	↑	↔
	Femoral neck	↔	↔
TBS		↑	↓ˆ

Abbreviation: GAHT, gender affirming hormone therapy; BMD, bone mineral density; TBS, trabecular bone score.
↑ denotes a significant increase.
↓ denotes a significant decrease.
↔ denotes no significant change.
ˆ TBS decreases but is still within normal range.

Table 4
Studies included in the 2017 and 2019 Meta-analyses of Studies Examining Skeletal Health in Transgender Individuals.

Study	Country	Design	Patients	N	Mean Age (years)	Duration
Studies included in 2017 Systematic Review [35]						
Dittrich 2005	Germany	Cohort	Transgender women	60	38.37	24 mos
Klink 2015	Netherlands	Cohort	Transgender women/Transgender men	15/19	14.9/15	7.1/6.9 yrs
Mueller 2011	Germany	Cohort	Transgender women	84	36.3	24 mos
Mueller 2010	Germany	Cohort	Transgender men	45	30.4	12 and 24 mos
Pelusi 2014	Italy	Cohort	Transgender men	45	29.4	12 mos
Reutraku1998	Thailand	Cohort	Transgender women	11	21.2	<24 mos
Sosa 2003	Spain	Cohort	Transgender women	17/27	24.1/43	>24 mos
Turner2004	USA	Cohort	Transgender men	8	33.1	24 mos
VanCaenegem 2015	Belgium	Cohort	Transgender men/Transgender women	23/49	27/33	12 and 24 mos
VanCaenegem 1996	Belgium	Cohort	Transgender women/Transgender men	56/35	33/25	12 mos
VanCaenegem 1998	Netherlands	Cohort	Transgender women/Transgender men	20/19	25.4/25	45.5/38.2 mos
Wierckx 2014	Belgium	Cohort	Transgender women	47/6	31.7/19.3	12 mos
Wierckx 2014	Belgium	Cohort	Transgender men	27/26	27.3/21.7	12 mos
Additional Studies included in 2019 Systematic Review [36]						
Study	**Country**	**Design**	**Patients**	**N**	**Mean Age** (years)	**Duration**
Haraldsen 2007	Norway	Cohort	Transgender men/Transgender women	21/12	25.1/29.3	12 mos
Wiepjes 2017	Belgium	Cohort	Transgender men/Transgender women	199/231	23.9/22.5	12 mos
Gava 2016	Italy	Cohort	Transgender women	40	32.9	12 mos
Fighera 2018	Brazil	Cohort	Transgender women	46	33.7	31 mos
Van Kesteren 1996	Netherlands	Cohort	Transgender men/Transgender women	35/56	25/33	12 mos
Van Kesteren 1998	Netherlands	Cohort	Transgender men/Transgender women	19/20	25/25.4	38.2 mos

Abbreviations: mos, months; yrs, years.
Adapted and expanded from Singh-Ospina N et al. J Clin Endocrinol Metab. 2017 [35].

infarction than sex assigned at birth women but not sex assigned at birth men and higher risk of ischemic stroke than both sex assigned at birth men and sex assigned at birth women. It is unclear if the increase in cardiovascular morbidity and mortality in transgender women is due to alterations in cardiovascular risk factors or a direct effect of GAHT. The current literature, however, has not shown a consistent undesirable alteration in conventional cardiovascular risk factors (i.e., hypertension, hyperlipidemia, and diabetes) in transgender women receiving GAHT.

Administration of GAHT to transgender women suppresses the natal androgens resulting in reduced testosterone levels in transgender women compared with sex assigned at birth men. Sex assigned at birth men with low testosterone levels have a high prevalence of cardiovascular disease [38,39] and low baseline testosterone levels are inversely related to cardiovascular mortality in sex assigned at birth men [40]. Suppressed testosterone levels in transgender women along with the greater plaque burden of the natal gender [41] might be one of the mechanisms responsible for the increased cardiovascular morbidity and mortality in this population.

GAHT is associated with increased risk of VTE in transgender women. Oral ethinyl estradiol is now less commonly prescribed due to this recognized higher risk, with micronized estradiol and estradiol valerate now the preferred forms of oral estrogen [42]. To the best of our knowledge, no study had demonstrated increased risk of VTE in transgender men receiving GAHT.

Alteration in the lipid profile, particularly an increase in TG and a decrease in HDL-C, was found to be fairly consistent in transgender men receiving GAHT along with mixed results for TC and LDL-C. Blood pressure was also found to be elevated in some studies although there are conflicting results. The evidence of elevated cardiovascular risk in transgender men is limited. .

It is important to note that transgender men initiate GAHT at ages younger than transgender women. The individuals in the current studies are relatively young and reported study durations are too short to detect cardiovascular events in the primary prevention setting. A prospective study of longer duration or a registry that collects data on lifestyle and psychosocial history would be ideal to assess the cardiovascular effects of GAHT in transgender individuals. Addition of “gender identity” variable to the national health registry may also help assess long-term cardiovascular and metabolic risk in this population [43].

Transgender individuals experience stress due to minority identity, self-stigma, and discrimination [44] and may be more likely to smoke tobacco, drink alcohol and be less physically active compared with cisgender population [43]. A study has also shown that transgender patients are more likely to suffer from drug use disorder, with the highest risk seen with amphetamine (aOR 2.22, 95% CI 1.82–2.70), but also cocaine (aOR 1.59, 95% CI 1.29–1.95), and cannabis (aOR 1.82, 95% CI 1.62–2.05) [45]. Transgender individuals are also more likely to have poor mental health [46]. There is evidence that mental health improves in both transgender men and transgender women after gender affirming therapy, including surgery although not necessarily with GAHT [47].

Additional evidence documents a link between discrimination and cardiovascular health indexes (e.g., tobacco use, hypertension, and obesity) in this stigmatized population [48,49].

Fracture risk in transgender individuals remains uncertain. Estrogen therapy has a positive correlation with TBS and bone mineral density in the lumbar region of transgender women but not elsewhere. Testosterone therapy produces no significant changes in bone mineral density in transgender men. The decrease in the trabecular bone score in transgender men had no significant association with fracture risk since TBS remained in the normal range. The studies conducted so far have been mainly retrospective and of short duration. The average age of the patients was young (20–30 years), and they were followed for about 12–24 months (Table 4). The analysis of additional factors that affect bone health such as smoking, physical activity and vitamin D status was limited. There are limited fracture data.

Further prospective and longitudinal studies are necessary to obtain useful data to assess risk of osteoporosis in the transgender population. Additional factors that can affect bone mineral density need to be assessed. Bone mineral density as considered in the studies and practice is compared to natal reference ranges. With further research, guidelines with reference values for bone mineral density should be established for transgender individuals.

5. Conclusion

Current limited evidence from non-randomized studies suggests that transgender women taking GAHT have increased risks of myocardial infarction, ischemic stroke and VTE. The current evidence does not indicate increased cardiovascular risk in transgender men receiving GAHT. Estrogen therapy has a positive correlation with trabecular bone score and bone mineral density in the lumbar region of transgender women but not elsewhere. The literature should be interpreted with caution due to the risk of bias in these studies.

The evidence shows that GAHT decreases or resolves gender dysphoria in transgender individuals and improves their quality of life [50,51]. Awareness of the potential risk of GAHT by clinicians can help transgender individuals make better informed decisions and can guide clinicians towards early intervention to prevent adverse cardiovascular outcomes. Transgender individuals receiving GAHT should be monitored for conventional cardiovascular risk factors and managed according to current guidelines with lifestyle programs and optimal preventive medical therapy [52]. The psychological well-being of transgender individuals should also be addressed with referral to mental health professionals as needed. Prospective randomized controlled studies are needed to elucidate the mechanisms and effects on GAHT on cardiovascular and skeletal health.

Declaration of competing interest

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Transgender treatment_ Puberty blockers study unde

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Transgender treatment: Puberty blockers study under investigation

22 July 2019

By Deborah Cohen and Hannah Barnes
BBC Newsnight

England's only NHS youth gender clinic lowered the age at which it offers children puberty blockers, partly based on a study now being investigated.

The study's full findings have not been published - but early data showed some taking the drugs reported an increase in thoughts of suicide and self-harm.

The clinic said data was from a "small sample" and so no "meaningful conclusion" could be drawn from it.

Children as young as 11 are now being offered these hormone-blocking drugs.

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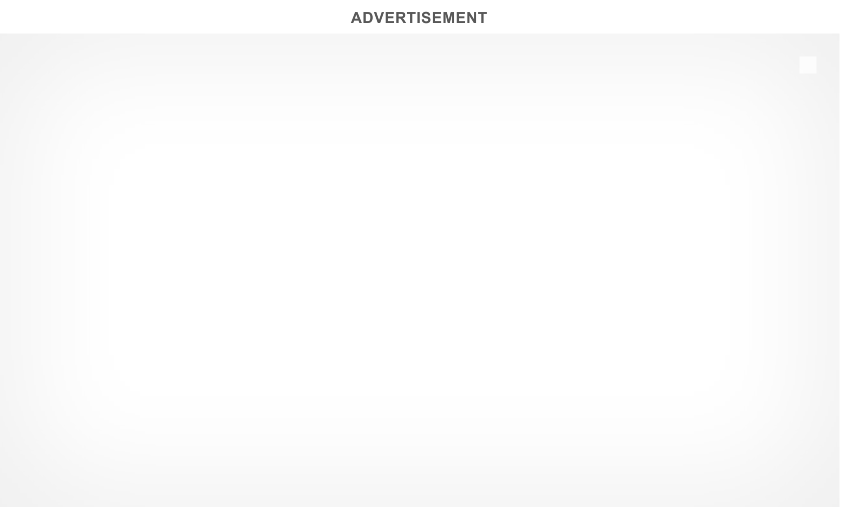

Experts on clinical trials have criticised the design of the study, which they say makes it hard to tell if the reported effects were due to the puberty blockers or something else. But experts said they warranted further investigation.

The Health Research Authority - which ensures medical studies are ethical and transparent - is now investigating claims brought to them by the BBC's Newsnight programme about the early findings from the study - and the information that is understood to have been shared with patients and parents about the possible effects of puberty blocking drugs.

- **Transgender kids 'need help from all sides'**
- **Transgender teen care 'needs regulation'**
- **NHS child gender reassignment 'too quick'**

When a child in the UK is questioning their gender, they can be referred to the Gender Identity Development Service (Gids) at the Tavistock and Portman NHS Foundation Trust in London and Leeds.

One treatment on offer is puberty blockers. They work on the brain to stop the eventual release of oestrogen or testosterone - the sex hormones that increase during puberty. This prevents the development of sex characteristics such as periods, breasts or voice-breaking.

Before 2011, Gids would give puberty blockers to children only once they had turned 16.

But as gender clinics around the world began providing blockers to those who had just begun puberty, reports grew of UK children going overseas to buy the drugs.

And in 2011, a medical study was approved through which younger children could access these drugs.

'A life-changing step'

Acknowledging the weak evidence for the drugs, the research team, made up of Gids and University College Hospitals staff, set out to "evaluate the psychological, social and physical effects" of the blockers on a carefully selected group of young people.

Details about risks - such as potential adverse effects on bone strength, the development of sexual organs, body shape or final adult height - were provided in a patient information sheet. But Newsnight found certain information had not been included.

Previous research had suggested all young people who took the blockers went on to take cross-sex hormones - the next stage towards fully transitioning to the opposite gender. But patients and parents were not told this in the information sheet.

"I don't see that the parents and their children could really have given informed consent given the lack of information that was provided," said Michael Biggs, associate professor of sociology at Oxford University.

Prof Biggs, who has attracted criticism from some in the transgender community for his views, added: "They were not given the information they needed in order to take this momentous life-changing step."

He gave Newsnight a series of documents relating to the research study he had obtained via freedom of information requests, which were independently looked at.

Gids, together with lead investigator Prof Russell Viner, said: "We are confident that informed consent was obtained."

He said the "possibility that blocking puberty may crystallise gender identity" had been raised with the patients and parents.

Preliminary data for 30 of the 44 young people on the study was made available to the Tavistock's board in 2015. **It showed** that after a year on

puberty blockers, there was a significant increase found in those answering the statement "I deliberately try to hurt or kill myself".

Prof Susan Bewley, who chairs Healthwatch, a charity for science and integrity in healthcare, is one of a number of doctors raising concerns about the lack of evidence in this area of medicine.

She said seeing any change around suicidal thoughts "is very worrying".

"Good medical practice would normally be very reflective about an increase in harms," she added.

Because of flaws in how the study was set up, it is not possible to infer cause and effect or even to say whether rates of suicidal thoughts are higher or lower in this group than in children with gender dysphoria who don't take puberty blockers.

The study had no control group, of children not taking the drugs, to compare results with. In addition, the outcomes it was measuring were unclear.

Nevertheless, experts say these observations should have given Gids pause for thought.

Gids told Newsnight: "All patients were seen regularly by mental health professionals. They concluded that there was no evidence of harms that could be directly attributed to the treatment and that continuation of the study was appropriate."

This early data was not shared with the Health Research Authority, despite its demands for updates on the study over a period of three years.

In response to Newsnight sharing this preliminary data and other concerns about the study, Teresa Allen, chief executive of the HRA, said: "The information that Newsnight has brought to our attention has not been raised with us before.

"We will therefore investigate further, which may include a review of the original ethics opinion."

The HRA told Newsnight they do not currently have all the information they need. They have reviewed minutes from the ethics committee that approved the study and these have not raised a specific concern.

'Nothing could have stopped me'

Hannah Phillips, 19, started taking puberty blockers when she was 16. She said the doctors had been clear about how little was known about the treatment and explained that it was "in testing".

"I don't think there could have been anything that the doctors could have said to stop me from wanting to go on to hormone blockers," the Youtuber told Newsnight.

While acknowledging the need for more research, Ms Phillips said there shouldn't be a halt to the current rules that allowed young people access to puberty blockers.

Receiving treatment "feels as if someone's just finally listening to you", she said.

Newsnight's investigation comes amid growing concern over the way Gids is operating.

In **an open letter** last week, former Gids clinician Dr Kirsty Entwistle raised concerns over the way puberty blockers were being presented to children as "fully reversible", when their long-term impact was unknown.

She also said staff were unable to raise concerns without risking being branded transphobic.

Tavistock and Portman Trust chief executive Paul Jenkins told BBC Radio 4's Today programme: "Puberty blockers are reversible."

He said Gids was looking at processes to make it easier for clinicians to focus on their work, "rather than being swayed or influenced by the very heated debate", but concerns over staff being falsely accused of transphobia had not been raised in the organisation.

However, a former Gids member of staff told Newsnight: "Myself and countless colleagues raised concerns in all the forums available to us."

And in **a statement last year**, the trust said concerns that staff were facing allegations of transphobia revealed "a negative attitude to... gender identity".

Policy change

In 2014, despite the patchwork of information about the study - which was still running - a change in Gids' policy was approved by NHS England: children with gender dysphoria, who were just beginning puberty, could now be eligible for blockers.

Gids' data suggests that between 2012 and 2018, 267 people under the age of 15 started using the blockers.

The service told Newsnight the use of hormone blockers at this earlier age "remains only available to a carefully selected group".

NHS England says the policy change followed an evaluation of the study. Newsnight has asked for a copy of this evaluation - but none was provided.

An NHS England official said its "2016 service specification for gender identity services was based on international evidence and developed with clinical experts and publicly consulted on".

"The specification will be reviewed," they added, which would include "a review of the most up-to-date research... and advice from clinical and academic experts".

If you are affected by any of the issues raised in this article, you can find support and advice via BBC Action Line.

You can watch Newsnight on BBC Two weekdays at 22:30 or on iPlayer, subscribe to the programme on YouTube and follow it on Twitter.

More on this story

NHS child gender reassignment 'too quick'

25 February 2019

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HB0460 - Google Docs.pdf

Uploaded by: Kit Hart

Position: UNF

Dear Senator Washington and respected members of the Finance Committee,

I am writing to request that you submit an unfavorable report on SB0460. Requiring medical assistance to cover the procedures outlined in the bill is unethical and discriminatory. Should medical assistance also cover Botox for people who are uncomfortable with the process of aging, or liposuction for those who find themselves despondent over the fact that they have gained weight?

This is nothing to say about the permanent and irreversible damage that these procedures will cause. **Not one person who has undergone a vaginoplasty or phalloplasty has ever achieved orgasm.** The scars created by a mastectomy never disappear and the chest of someone who has had this procedure does not resemble a man's. To insinuate that puberty can be put on pause is to liken a child to a robot that does what its master instructs. In reality, the damage done to a child who halts a natural process is debilitating.

We are seeing more and more courageous men, women and children who are desisting from these ruinous procedures; there is a Reddit group of over 48,000 "detransitioners" all of whom regret the abuse which was done to their body in the name of "care." To really care for a person is to assess his or her mental state and get to the root of the issue.

Please consider what most Marylanders know to be common sense. Taxpayers should not be required to fund procedures and drugs which are contrary to their morals and values,

Thank you,

Kit Hart

Oppose SB460.pdf
Uploaded by: Mark Meyerovich
Position: UNF

Oppose SB 460

- Irreversible procedures, such as “gender-affirming treatment” are suitable only for adults and only after substantial mental health or psychological evaluation. However, the bill does not specify any age limit. Since the bill requires the Medical Assistance Program to cover all costs, schools and doctors may influence and coerce children to undergo such procedures. Even providers who have financial interest in such procedures may be able to recommend them to vulnerable children.

- The bill talks about medical necessity but does not describe whether the program covers the cost of evaluating the medical necessity.

- Some school systems allow recommending such treatments to children and concealing the fact from parents. Having expenses covered by a state program completely excludes parents from the evaluation and decision making process.

- The bill allows for abuse of taxpayer funds, since reporting requirements do not include review of the amount spent on such procedures, independent review of the necessity of procedures, or any evaluation of patient benefit versus risks.

Sincerely,
Mark Meyerovich
Gaithersburg, MD

SB 460_mgoldstein_unfav 2023.pdf

Uploaded by: Mathew Goldstein

Position: UNF

Secular Maryland secularmaryland@tutanota.com

February 28, 2023

SB 460 - OPPOSE

Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

Dear Chair Griffith, Vice-Chair Klausmeier, and Members of the Finance Committee,

A recent study https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full followed 139 boys with a mean age of 7.49 and a standard deviation of 2.66 who were diagnosed as experiencing gender dysphoria (GD). 88 (63.3%) boys met complete DSM criteria for GD in childhood, 51 (36.7%) boys were subthreshold for a DSM diagnosis. The follow-up assessment mean age was 20.58 with standard deviation of 5.22 (six patients declined the follow-up which yielded a participation rate of 95.9%.). Of the 88 participants who met the full diagnostic criteria for GD in childhood, 12 (13.6%) were classified as persisters and the remaining 76 (86.4%) were not. Of the 51 participants who were subthreshold for the GD diagnosis in childhood, 5 (9.8%) were classified as persisters and the remaining 46 (90.2%) were not.

Among the components of “gender affirmation” the American Academy of Pediatrics (AAP) names social transition, puberty blockers, sex hormones, and surgeries. The low rate of persistence of GD into adulthood implies that sex focused hormones and surgery on young people will result in a high rate of subsequent regret. Yet the World Professional Association of Transgender Health (WPATH) recently dropped their age restrictions on such surgery. Members on the WPATH committee who worked on the current Standard of Care (SOC) Report document have significant conflict of interests (COIs). They receive income based on recommendations in the guidelines, work at clinics or universities who receive funds from advocacy groups, foundations, or pharmaceutical companies who heavily favour a certain treatment paradigm, or have received grants and published papers or research in transgender care. Some of them have affiliations with the same university–the University of Minnesota Program in Sexuality, which is primarily funded by a transgender advocacy organization, the Tawani Foundation.

According to the British Medical Journal article “Gender dysphoria in young people is

rising—and so is professional disagreement" [BMJ 2023; 380 doi: https://doi.org/10.1136/bmj.p382 (Published 23 February 2023)] Sweden's National Board of Health and Welfare, which sets guidelines for care, determined last year that the risks of puberty blockers and treatment with hormones "currently outweigh the possible benefits" for minors. Finland's Council for Choices in Health Care, a monitoring agency for the country's public health services, issued similar guidelines, calling for psychosocial support as the first line treatment. (Both countries restrict surgery to adults.) Medical societies in France, Australia, and New Zealand have also leant away from early medicalisation. And NHS England, which is in the midst of an independent review of gender identity services, recently said that there was "scarce and inconclusive evidence to support clinical decision making" for minors with gender dysphoria and that for most who present before puberty it will be a "transient phase," requiring clinicians to focus on psychological support and to be "mindful" even of the risks of social transition.

Sweden conducted systematic reviews in 2015 and 2022 and found the evidence on hormonal treatment in adolescents "insufficient and inconclusive." The UK's National Institute for Health and Care Excellence, which looked at puberty blockers and hormones for adolescents in 2021. "That review found the evidence to be inconclusive, and there have been no significant primary studies published since." As the number of young people receiving medical transition treatments rises, so have the voices of those who call themselves "detransitioners" or "retransitioners," some of whom claim that early treatment caused preventable harm. Large scale, long term research is lacking and researchers disagree about how to measure the phenomenon, but two recent studies suggest that as many as 20-30% of patients may discontinue hormone treatment within a few years. Yet the World Professional Association for Transgender Health (WPATH) asserts that detransition is "rare."

At the 2017 USPATH/WPATH conference, activists protested, and were allowed to shut down, a session with Dr. Kenneth Zucker, who endorsed a cautious approach to treating children with gender dysphoria. Rather than engaging with different viewpoints, WPATH agreed to cancel Dr. Zucker (who was on the WPATH SOC committee) and apologize on their website for inviting him. WPATH thus limited discussion and engaging with presenters to appease activists. That approach is the antithesis to a professional organization, or evidence-based inquiry. The overall message in the WPATH guidelines is to urge physicians to follow the patient's wishes only, putting aside scientific evidence and ethical delivery of care. We should instead be conducting more quality clinical research and setting guidelines that we can be confident will do more good than harm.

This proposed legislation is at best premature and should be rejected.

Mathew Goldstein
3838 Early Glow Ln
Bowie, MD 20716

OPPOSE SB460.pdf
Uploaded by: Ronit Zelivinski
Position: UNF

Dear Senator Washington,

I strongly OPPOSE SB460.

I am a Certified Nurse Midwife practicing in MD, DC, and VA. I am an expert in reproductive health, particularly for females. I am gravely concerned about this legislature that purports that it is remotely safe to alter one's entire body and hormonal make-up without any mandatory mental health counseling.

Transitioning genders is **ABSOLUTELY** not a decision that should be made without intensive collaborative care from physicians and clinicians addressing the individual's overall health and wellbeing.

I am even more concerned that the bill mentions no age limit for accessing care. Minors should not be independently allowed to make decisions under the influence of doctors when it is well established that the frontal cortex of the brain, responsible for decision making and future-driven logic, is not fully developed until twenty-five years of age.

There is a way to offer support to people who want to transition genders, but it is absolutely not appropriate without consideration of the person's maturity, mental health status and physical wellbeing in collaboration with multiple providers. There must be basic, preventative requirements met before accessing life-altering and potentially debilitating as well as irreversible changes to one's hormonal make-up, body, and existence.

Please **withdraw** SB460.

Thank you,

Ronit Zelivinski

SB0460-ACRWC-OPPOSE.pdf

Uploaded by: Sarah Reichert-Price

Position: UNF

Senator Melony Griffith, Chair,
and Members of The Finance Committee
Maryland Senate
Annapolis, MD

RE: SB0460 – Trans Health Equity Act-OPPOSE

Inasmuch as I support equal treatment in all aspects of life for all individuals, I must urge your opposition to SB0460 for several reasons.

- Maryland Medical Assistance, being funded by Marylanders' tax dollars, should not be required to pay for **elective** gender-affirming treatment. Consistent with the fact that I am not a physician, I fail to comprehend any situation that gender-affirming treatment would be medically necessary.
- Payment for all other elective surgical procedures is denied by any and all medical insurance entities; gender affirming treatment is no different.
- HB0283 does not exclude children or teens under 21 years from puberty blockers, cross-sex hormones, and/or surgery to remove breasts or reproductive organs.

I urge you to consider these arguments against SB0460 and present an UNFAVORABLE report against SB0460.

Thank you for your time and attention to this matter.

Sarah Price
Westernport, MD

SB460.pdf
Uploaded by: Theresa Myers
Position: UNF

February 27, 2023

Maryland Senate
Finance Committee

Ref: SB460- Maryland Medical Assistance Program- Gender- Affirming Treatment (Trans Health Equity Act)

Dear Finance Committee,

I am asking you to vote UNFAVORABLE for SB460.

Here are just some RED Flags I have with this bill:

-In 2022, ONLY 98 individuals received gender-affirming treatment through Medicaid
-Proposing $7.6 million increase for every 125 individuals
-Offering Reversal Treatment
-Cover fertility preservation services
-On going continuous hormone therapy
-Laboratory testing to monitor continuous hormone therapy

I do not want my tax dollars to pay for a Life Long change. Please vote UNFAVORABLE for this bill.

Sincerely,

Theresa Myers

SB0460_Tom and Tina Wilson_Unfavorable.pdf
Uploaded by: Thomas Wilson
Position: UNF

Written Testimony of Thomas P. and Tina M. Wilson

RE: In Opposition to Senate Bill SB0460 - Maryland Medical Assistance Program – Gender–Affirming Treatment (Trans Health Equity Act)

February 27, 2023

As citizens of the state of Maryland, we oppose Maryland **Senate Bill SB0460** as currently drafted**.** This testimony seeks to express our concerns around **SB0460.**

In a statement released earlier this month, the Association of American Physicians and Surgeons (AAPS) warned against sex-change treatments' long-term, irreparable harm: "*Conflicting motivations have led to a growing industry dedicated to providing "gender-affirming" procedures that are generally irreversible and have a high probability of causing sterilization. These include puberty "blockers," sex hormones, and surgery, such as castration, penectomy, and mastectomy. They commit a patient to a lifelong need for medical, surgical, and psychological care.*" Representing 5,000 medical professionals across the United States, the AAPS, through its announcement, also called out the lack of authentic care for young patients when doctors tinker with their physical appearance. The statement further explained "'[g]ender-affirming care' in minors is medically and ethically contraindicated because of a lack of informed consent. There are inherently unknown and unknowable long-term risks, and the consequences of removing normal, healthy organs are irreversible."

While other medical organizations may take a different posture, the fact that such "polar opposites" exist in the medical community suggests that there is not uniformity of opinion on the safety and efficacy of these "affirming" procedures.

Like the members of AAPS, we believe it's dangerous to assume that minors have all the mental capacity to fully understand the long-term implications of these procedures to achieve "informed consent". The bill, as currently drafted, does not exclude children or teens under 21 years of age from puberty blockers, cross sex hormones or surgery to remove breasts or reproductive organs for Sexual Dysphoria or Sexual Identity. At a minimum, an amendment in required to restrict such surgery to adults. Young people under 21 do not have the maturity to make an irreversible decision on removing their reproductive related body parts.

Without the suggested changes, we oppose SB0460 and ask the committee to oppose it as well. Thank you for your consideration.

Trans Health Equity Act .pdf
Uploaded by: Victoria Harvey
Position: UNF

I oppose this legislation. Dr. Kaltiala, a psychiatrist who has presided over youth gender transition treatments for more than a decade says "four out of five" gender-questioning children eventually accept their bodies if no medical interventions are carried out. Dr. Kaltiala — described as "Finland's leading expert on pediatric gender medicine and chief psychiatrist at its largest gender clinic". The doctor said data from 12 separate studies supported her claim.

There is little oversight to these life-changing procedures that have the potential to destroy the lives of many children. I vehemently oppose this legislation.

2022 Annual Report - Maryland Commission on LGBTQ

Uploaded by: Jeremy Browning

Position: INFO

Maryland Commission on LGBTQ Affairs

2022 Annual Report

Maryland Commission on LGBTQ Affairs
Governor's Office of Community Initiatives
100 Community Place
Crownsville, MD 21032

LARRY HOGAN
GOVERNOR

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

Maryland State House
100 State Circle
Annapolis, MD 21401

Dear Marylanders,

I am pleased to share with you the 2022 Maryland Commission on LGBTQ Affairs Annual Report.

Created by the Maryland General Assembly in 2021 and now part of the Governor's Office of Community Initiatives, the Maryland Commission on LGBTQ Affairs has been hard at work over the past year selecting leadership and establishing bylaws and subcommittees. These critical first steps will help enable the commission's core work in assessing the challenges that Maryland's LGBTQ+ communities face and delivering the voices of LGBTQ Marylanders to leadership in state government.

I would like to recognize the leadership of Chair Joe Toolan, Vice Chair Joseph M. Clapsaddle, and Administrative Director Jeremy Browning who, supported by their fellow commissioners, led the commission during a productive first year.

On behalf of the State of Maryland, I want to sincerely thank the Maryland Commission on LGBTQ Affairs for their diligent work to improve the quality of life among our nearly half million LGBTQ+ Maryland residents, and I look forward to seeing the commission's continued progress in the years to come.

Sincerely,

Larry Hogan
Governor

Message from the Executive Director of the Governor’s Office of Community Initiatives

Dear Friends:

It is with pleasure that I present the first annual report for the Maryland Commission on LGBTQ Affairs.

The Maryland Commission on LGBTQ Affairs is the newest commission under the Governor’s Office of Community Initiatives, which connects Marylanders to economic, volunteer, and human service opportunities through government, business, and nonprofit partners. Through more than 700 community-based engagements every year, we connect citizens across the state to the executive branch of Maryland’s government, raising their voices and expanding opportunities to help more directly address their needs.

Created by the 2021 Maryland General Assembly, the commission has hit the ground running, beginning the critical work of advocating for solutions to help address challenges facing Maryland’s LGBTQIA+ community. Commissioners are to be commended for their hard work and sense of service—their dedication brought the commission to fruition this year and will undoubtedly propel its work going forward.

I would also like to offer my sincere thanks and congratulations to chair Joe Toolan, vice chair Joseph M. Clapsaddle, and administrative director Jeremy Browning for a productive and successful first year. With continued perseverance and excellence in leadership, I look forward to seeing the commission continue to meet its goals and directives in service of making a better state for all Marylanders.

Sincerely,

Steven J. McAdams
Executive Director
Governor’s Office of Community Initiatives

Message from the Chair of the Maryland Commission on LGBTQ Affairs

Dear Community Members and Friends,

I am pleased to present the inaugural Maryland Commission on LGBTQ Affairs Annual Report. Over the past year, our commission has made important and historic strides to assess and address the challenges facing Maryland's LGBTQIA+ communities. We know this year has brought challenges for many members of our community, but we are optimistic about the road ahead and we are grateful for the many partnerships that we continue to forge in support of our work across the entire state.

I first want to thank the Governor Hogan administration, and Executive Director of the Governor's Office of Community Initiatives Steven J. McAdams for all their support as we built the commission from the ground up in our first year.

I would also like to thank commission vice chair Joseph Clapsaddle and our administrative director, Jeremy Browning, for their leadership and contribution to our growth.

Finally, I would like to recognize Delegate Lili Qi, whose work helped establish this commission and who endeavors daily to raise the voices of LGBTQIA+ Marylanders.

Our commission brings together members from across the state who have many different identities and backgrounds, representing our vibrant and diverse community. We are thankful for their passionate perspective, insight, and contribution to our work. As we continue to grow, learn, and educate one another, we remain steadfast in our commitment to raising the voices of LGBTQIA+ Marylanders as we work to build a stronger, safer, more inclusive state for all.

It is an honor and privilege to serve as chair of the Maryland Commission on LGBTQ Affairs. On behalf of the commission, we look forward to continuing to serve Maryland's LGBTQIA+ community for many years to come.

Sincerely,

Joseph Toolan (he/him)
Chair
Maryland Commission on LGBTQ Affairs

Message from the Administrative Director of the Maryland Commission on LGBTQ Affairs

Dear Fellow Marylanders:

It is my great honor and privilege to serve as the Administrative Director of the Maryland Commission on LGBTQ Affairs and I am pleased to present this first annual report.

The Maryland Commission on LGBTQ Affairs was created by the 2021 Maryland General Assembly to provide a coordinated approach for addressing the distinct needs of our lesbian, gay, bisexual, transgender, queer, questioning, intersex, agender, aromantic, asexual (LGBTQIA+) community members throughout Maryland.

We are working towards our goal of supporting a more inclusive and equitable state by raising awareness about LGBTQIA+ issues, developing policy recommendations and offering technical assistance to Maryland agencies as they become increasingly aware of policies impacting our community.

The Maryland Commission on LGBTQ Affairs is the only state agency dedicated solely to building awareness and advocating for our LGBTQIA+ community. During my first year guiding the commission, I have sought to create a strong foundation by building relationships with state agencies, nonprofits, policy makers, community partners and leaders to ensure that the commission can be impactful and effective.

I would like to thank Governor Hogan and Steve McAdams, executive director of the Governor's Office of Community Initiatives, for setting up and supporting the commission. I would also like to offer special thanks to chair Joe Toolan and vice chair Joseph M. Clapsaddle for their dedication and service in this first year. As a result of their efforts and the hard work of our commissioners, we have been able to make progress towards creating a more inclusive and equitable state.

Sincerely,

Jeremy Browning

Jeremy Browning (he/him)
Administrative Director
Maryland Commission on LGBTQ Affairs

Section 1

About the Maryland Commission on LGBTQ Affairs

About the Maryland Commission on LGBTQ Affairs

The Maryland Commission on LGBTQ Affairs is within the Governor's Office of Community Initiatives and was created during the 2021 Maryland General Assembly to:

- ➢ Assess challenges facing our LGBTQ community
- ➢ Collect data across state agencies on:
  - ○ Implementation of LGBTQ-inclusive policies
  - ○ Complaints alleging discrimination based on sexual orientation or gender identity
- ➢ Study and establish best practices for inclusion of LGBTQ individuals and communities
- ➢ Offer testimony on issues concerning LGBTQ persons before legislative and administrative bodies
- ➢ Act as a clearinghouse for activities to avoid duplication of efforts
- ➢ Create surveys and appoint advisory committees

More information about the commission may be found at https://goci.maryland.gov/lgbtq/.

Please note, the commission has recommended updates to the legislation to change the name to the Maryland Commission on LGBTQIA+ Affairs.

Commission Meetings

The Maryland Commission on LGBTQ Affairs is required to meet at least four times a year and is subject to the Maryland Open Meetings Act. View upcoming meetings and previously recorded meetings by visiting: https://goci.maryland.gov/lgbtq/meetings/

2022 Meetings

- January 3, 2022
- February 8, 2022
- March 14, 2022
- May 2, 2022
- July 11, 2022
- September 19, 2022
- November 7, 2022

The Maryland Commission on LGBTQ Affairs strives to make our meetings as accessible as possible. The commission now provides ASL interpreters and CART live captioning at our meetings. If you need accommodations or assistance, please contact the administrative director at jeremy.browning@maryland.gov.

Timeline: Maryland Commission on LGBTQ Affairs

- **April 12, 2021 -** The 2021 Maryland General Assembly passed House Bill 130 sponsored by Delegate Lily Qi that created the Maryland Commission on LGBTQ Affairs in the Governor's Office of Community Initiatives (GOCI).
- **Summer/Fall 2021** - Following the passage of Bill HB 130 the Hogan administration sought to appoint the 15 members of the commission through the advice and consent of the senate.
- **January 3, 2022** - The commission held its first public meeting with 11/15 commissioners seated and present.
- **February 8, 2022** - The commission held a special meeting to elect officers for the calendar year 2022. Joe Toolan was elected as chair and Joseph M. Clapsaddle was elected as vice chair.
- **March 2022** - The remaining four commission seats were filled.
- **June 4, 2022** - The commission participated in the Annapolis Pride Parade and attended Baltimore Trans Pride hosted by Baltimore Safe Haven.
- **July 27, 2022** - Candidates were recommended by the commission and Jeremy Browning was appointed to serve as administrative director of the commission by Governor Hogan.
- **October 2022** - Commissioners and the administrative director attended several events around the state to celebrate LGBTQIA+ History Month.
- **November 7, 2022** - The commission approved by-laws and established policy priorities for the 2023 legislative session.

2022 Maryland Commission on LGBTQ Affairs Commissioners

The 15-member Maryland Commission on LGBTQ Affairs reflects the gender, racial, ethnic and geographic diversity of Maryland. Members are required to know the issues facing the LGBTQ community and advocate for solutions to problems facing the community.

*2022 Commissioners:

- Joseph L. Toolan, chair (he/him)
- Joseph M. Clapsaddle, vice chair (he/him)
- Sarcia Adkins (she/her)
- Nicholas Augustine (he/him)
- Lee Blinder (they/them)
- Joan B. Bryan (she/her)
- Amit Dhir, NP-C, MBA (he/him)
- Kurt B. Doan, Ed.D (he/him)
- Deborah Dunn, PAC, MBA (she/her)
- Anthony E. Fox (he/him)
- Jabari Lyles (he/they)
- Stephen J. Martin (he/him)
- Margo Quinlan (she/they)
- Mark Ridderhoff, LCSW-C (he/him)
- Rowan Willis-Powell (she/they)

**Commissioners and Officers as of 12/31/2022*

Section 2

Legislative Mandates and Progress

Legislative Mandates and Progress

➢ Assessing Challenges and Facing Our LGBTQIA+ Community in Maryland

While progress has been made towards achieving equality and equity across Maryland and the United States, significant work remains. Our LGBTQIA+ community still faces challenges in almost every aspect of daily life from housing, employment, healthcare, and education, while living with increased risks of discrimination, harassment, and violence.

Below are key findings from some of the largest studies that assess challenges faced by our LGBTQIA+ community across the U.S. and within the State of Maryland. The highlighted findings below are merely a snapshot and readers are encouraged to read the full reports referenced to fully understand the challenges facing our LGBTQIA+ community members. Please note, there are many other studies not included in this report that reflect similar challenges facing our LGBTQIA+ communities.

The Report of the 2015 U.S. Transgender Survey (James et al., 2016, 4-7)

The National Center for Transgender Equality (NCTE) is the nation's leading source of social justice policy advocacy organization devoted to ending discrimination and violence against transgender people. NCTE conducted the 2015 U.S. Transgender Survey (USTS) with 27,715 respondents from across the country. Please note, NCTE repeated the USTS again in fall of 2022 and results will be published in 2023.

"The findings reveal disturbing patterns of mistreatment and discrimination and startling disparities between transgender people in the survey and the U.S. population when it comes to the most basic elements of life, such as finding a job, having a place to live, accessing medical care, and enjoying the support of family and community. Survey respondents also experienced harassment and violence at alarmingly high rates."

Key Findings:

- **Pervasive mistreatment, harassment, and violence in every aspect of life:** In the year prior to completing the survey, 46% of respondents were verbally harassed and 9% were physically attacked because of being transgender.
- **Severe economic hardship and instability:** There were large disparities between transgender people in the survey and the U.S. population. Nearly one-third (29%) of respondents were living in poverty, compared to 12% in the U.S. population.
- **Harmful effects on physical and mental health:** 39% of respondents experienced serious psychological distress in the month prior to completing the survey, compared with only 5% of the U.S. population.

- **The compounding impact of other forms of discrimination:** Transgender people of color experience deeper and broader patterns of discrimination than white respondents and the U.S. population.
- **Increased visibility and growing acceptance:** Despite the undeniable hardships faced by transgender people, respondents' experiences also show some of the positive impacts of growing visibility and acceptance of transgender people in the United States.

The 2021 National School Climate Survey: The Experiences of LGBTQ+ Youth in Our Nation's Schools (Clark et al., 2022, xvi-xviii)

Since 1990, GLSEN has worked to ensure that LGBTQ+ students are able to learn and grow in a school environment free from bullying and harassment. Every two years GLSEN conducts the National School Climate Survey to understand the experiences of LGBTQ+ students.

"Schools nationwide are hostile environments for a distressing number of LGBTQ+ students, the overwhelming majority of whom routinely hear anti-LGBTQ+ language and experience victimization and discrimination at school. As a result, many LGBTQ+ students avoid school activities or miss school entirely."

Key Findings:

- **School Safety:** 81.8% of LGBTQ+ students in our survey reported feeling unsafe in school because of at least one of their actual or perceived personal characteristics.
- **Anti-LGBTQ+ Remarks at School:** Nearly all LGBTQ+ students (97.0%) heard "gay" used in a negative way (e.g., "that's so gay") at school; 68.0% heard these remarks frequently or often, and 93.7% reported that they felt distressed because of this language.
- **Harassment and Assault at School:** 76.1% experienced in-person verbal harassment (e.g., called names or threatened) specifically based on sexual orientation, gender expression, and gender at some point in the past year—60.7% of LGBTQ+ students were verbally harassed based on their sexual orientation, 57.4% based on gender expression, and 51.3% based on gender.
- **Student Reporting of Harassment and Assault Incidents:** 61.5% of LGBTQ+ students who were harassed or assaulted in school did not report the incident to school staff, most commonly (69.6% of students experiencing harassment or assault) because they did not think school staff would do anything about the harassment even if they did report it.
- **Discriminatory School Policies and Practices:** Most LGBTQ+ students (58.9%) had experienced LGBTQ+-related discriminatory policies or practices at school. Some of the most common discriminatory policies and practices experienced by LGBTQ+ students were those that targeted students' gender, potentially limiting their ability to make gender-affirming choices and negatively impacting their school experience.

2022 National Survey on LGBTQ Youth Mental Health Maryland (The Trevor Project, 2022, 1-7)

The Trevor Project has a mission to end suicide among LGBTQ young people and conducts annual surveys that provide critical insights into suicide risk faced by LGBTQ young people. The 2022 National Survey on LGBTQ Youth Mental Health is the first to be segmented by all 50 states.

Key Findings:

- **Suicide Risk:** 43% of LGBTQ youth in Maryland seriously considered suicide in the past year, including 49% of transgender and nonbinary youth. 14% of LGBTQ youth in Maryland attempted Suicide in the past year, including 17% of transgender and nonbinary youth.
- **Anxiety & Depression:** 68% of LGBTQ youth in Maryland reported experiencing symptoms of anxiety, including 73% of transgender and nonbinary youth. 53% of LGBTQ Youth in Maryland reported experiencing symptoms of depression, including 60% of transgender and nonbinary youth.
- **Access to care:** 52% of LGBTQ youth in Maryland who wanted mental health care in the past year were not able to get it.

Department of Homeland Security added the LGBTQI+ community to groups under threat of potential attacks

On November 30, 2022 the Department of Homeland Security added the LGBTQI+ community to their list of groups that could be targets of potential violence.

"The United States remains in a heightened threat environment. Lone offenders and small groups motivated by a range of ideological beliefs and/or personal grievances continue to pose a persistent and lethal threat to the Homeland. Domestic actors and foreign terrorist organizations continue to maintain a visible presence online in attempts to motivate supporters to conduct attacks in the Homeland. Threat actors have recently mobilized to violence, citing factors such as reactions to current events and adherence to violent extremist ideologies. In the coming months, threat actors could exploit several upcoming events to justify or commit acts of violence, including certifications related to the midterm elections, the holiday season and associated large gatherings, the marking of two years since the breach of the U.S. Capitol on January 6, 2021, and potential sociopolitical developments connected to ideological beliefs or personal hostility. Targets of potential violence include public gatherings, faith-based institutions, the LGBTQI+ community, schools, racial and religious minorities, government facilities and personnel, U.S. critical infrastructure, the media, and perceived ideological opponents."
(Department of Homeland Security, 2022)

➢ Collecting Data Across State Agencies

The Maryland Commission on LGBTQ Affairs is mandated to collect data across state agencies on the implementation of LGBTQ-inclusive policies and complaints alleging discrimination based on sexual orientation or gender identity. Initial findings show that many state agencies do not currently collect this type of data and if they do it is not readily available to the commission or the public.

It is important to note that the commission is still in the process of establishing connections with our state agencies and more time is needed to fully understand the data that is collected and available. In this report, the commission will publish the data that has been collected and we encourage all state agencies to connect with the Maryland Commission on LGBTQ Affairs to discuss available data and data collection. Contact administrative director Jeremy Browning at jeremy.browning@maryland.gov.

State Equal Employment Opportunity Complaints

The Maryland Department of Budget and Management Annual Statewide Equal Employment Opportunity Report - Fiscal Year 2021 includes State Equal Employment Opportunity Complaints by agency, basis, issue, and disposition. Basis categories include gender identity, and sexual orientation.
(Maryland Department of Budget and Finance, EEO Office, 2022, 1-97)

The report shows that a total of four (4) complaints were received on the basis of gender identity:

- Three (3) to the Department of Public Safety & Correctional Services
- One (1) to the Maryland Department of Health

The report shows that a total of eight (8) complaints were received on the basis of sexual orientation:

- One (1) to Department of Human Services
- One (1) to Department of Juvenile Services
- Three (3) to the Department of Public Safety & Correctional Services
- Three (3) to the Maryland Department of Health

See full table on next page.
(Maryland Department of Budget and Finance, EEO Office, 2022, 60)

STATEWIDE DISCRIMINATION COMPLAINTS BY AGENCY, BASIS, ISSUE AND DISPOSITION — FISCAL YEAR 2021

Agency	Agency Employees	External	Internal		Basis*													Issue*				Disposition*					
				Other	ADA	Age	Ancestry	Color	Creed	Disability	Marital Status	National Origin	Race	Religious Affiliation	Sex/Gender	Gender Identity	Sexual Orientation	Harassment	Sexual Harassment	Retaliation	Other	Probable Cause	No Cause	Administrative Closure	Mediation/ Settled/Resolved	Open/Pending	Withdrawn
Baltimore City Sheriff's Department	109	1	0																								
Dept of Budget & Management	262	0	3										3							2	1		3				
Dept of Commerce	163	0	1										1					1					1				
Dept of General Services	590	2	2							1					1			1	1				2				
Dept of Human Services	5,413	16	13	4		1		2		4			3	1	6		1	7	2	4			8	5			
Dept of Information Technology	163	1	0																		1						
Dept of Juvenile Services	1,899	6	24	15		1		1		6	1	2	4	2	7		1	9	4	1	22	2	20	1			1
Dept of Natural Resources	1224	1	0																								
Dept of Public Safety & Correctional Services	8156	25	59	25		8		6		4	4	4	11	1	15	3	3	35	9	17	54	2		54		3	
MD Dept of Health	8,495	35	23	10		4		3		3		1	11	1	8	1	3	2		9	42		20	2		1	
MD Dept of Labor	1,399	2	1							1								1					1				
MD Dept of the Environment	764	3	1												1						1		1				
MD Dept of Transportation	9,679	28	45	17		10		3				2	10		14			11	8	1	37	7	22	11		5	
MD Dept of Veterans Affairs	109	1	0																								
MD Environmental Services	856	1	1										1					1				1					
MD Lottery Gaming & Control Agency	295	2	1	1																	1		1				
MD State Dept of Education	1,217	4	8	2				4		3		4	6		1						9	1	6	1			
MD State Police	2,230	6	11	6		3		2		1			5		2						24		2	3		6	
Military Department	213	1	11	8									3		3			2			14	4	2		2	1	2
Morgan State University	1,574	7	17			3				1		3	4	1	9			8	4	6	8	1	3	9		4	1
Office of the Attorney General	662	1	4							1			2		1			3	1					4			
Office of the Public Defender	824	3	2	2														1			1	1		1			
St. Mary's College	330	1	0																								
State Board of Elections	220	0	1					1													1		1				
State Dept of Assessment and Taxation	506	3	2	2																2			2				
Uninsured Employer's Fund	7	1	1	1														1					1				
TOTAL	**47,359**	**151**	**231**	**93**	**0**	**30**	**0**	**22**	**0**	**25**	**5**	**16**	**64**	**6**	**68**	**4**	**8**	**83**	**29**	**42**	**216**	**19**	**96**	**91**	**2**	**20**	**4**

**In order to avoid duplication, Basis, Issues, and Dispositions are only counted on Internal complaints. Please note: Some complaints have multiple basis. An employee may file a complaint alleging that more than one protected class has been violated; therefore, the total number of internal complaints may differ from the total number for basis and dispositions.*

(1) "Internal" complaints are those filed at the agency level, with a State agency's Fair Practices Officer or Equal Employment Opportunity Officer.

(2) "External" complaints are those filed with the Maryland Commission on Civil Rights, Department of Justice, Courts, and/or Equal Employment Opportunity Commission.

(3) "Other" Complaints include employment related complaints, not discriminatory in basis.

State of Maryland 2021 Hate Bias Report

The Maryland Department of State Police publishes the Hate Bias Report annually each fall for the previous calendar year. The 2021 Hate Bias Report includes all reported and verified incidents which includes reports of bias motivations based on sexual orientation and gender identity.

Below are some findings and figures from the report that include bias motivations based on sexual orientation and gender identity. Readers are encouraged to read the full report referenced.
(Maryland Department of State Police, 2022, 1-63)

Bias Motivation

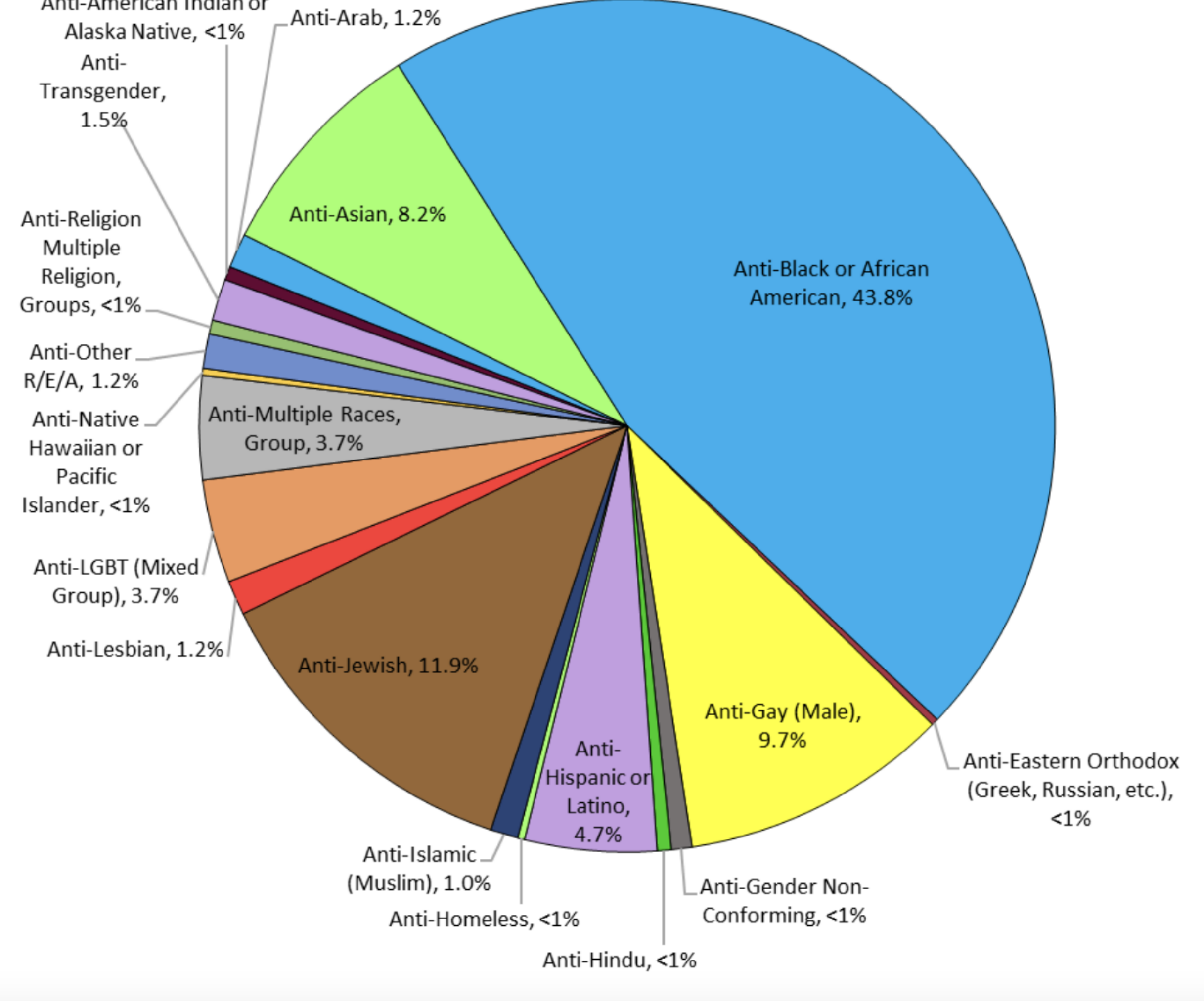
In 2021, R/E/A made up 68.7% of all bias motivations for reported incidents. Between 2019 - 2021, R/E/A comprised the majority of all hate bias motivations followed by Religion and Sexual Orientation.

Category	Verified			All Reports		
	2019	2020	2021	2019	2020	2021
R/E/A	58	85	75	262	293	276
Religion	19	12	9	84	63	57
Sexual Orientation	10	15	15	50	36	59
Disability	0	0	0	1	0	0
Gender	0	0	0	2	2	0
Gender Identity	3	2	3	9	5	9
Homelessness	0	1	1	0	1	1
Total	**90**	**115**	**103**	**408**	**400**	**402**

Figure 6: Three-year comparison of verified incidents by bias motivation compared to all incidents by bias motivation is shown here. Incidents can have more than one bias motivation. This accounts for differences between bias motivation numbers and the total number of incidents reported.

(Maryland Department of State Police, 2022, 7)

Figure 7: Total hate bias motivations for all reports as a percentage in 2021 is shown here.



(Maryland Department of State Police, 2022, 7)

➢ Study and establish best practices for inclusion of LGBTQIA+ individuals and communities

The commission has formed committees to review and make recommendations on best practices for state agencies. The commission looks forward to supporting state agencies and providing recommendations and technical assistance on policies concerning LGBTQIA+ persons.

➢ Offer testimony on issues concerning LGBTQIA+ persons before legislative and administrative bodies

The commission voted unanimously at their November 7, 2022 meeting to establish the following policy priorities during the 2023 legislative session:

- Trans Health Equity Act
- Transgender Respect, Agency, and Dignity Act
- The Birth Certificate Modernization Act

The commission looks forward to offering testimony on these and other important issues during the 2023 legislative session.

➢ Act as a clearinghouse for activities to avoid duplication of efforts

In 2022 the commission began building the foundation to act as a clearing house for LGBTQIA+ efforts in the state by connecting with state agencies, nonprofit organizations, community groups and leaders. Future plans include a community calendar and resource directory to be housed on the commission webpage: https://goci.maryland.gov/lgbtq/

➢ Create surveys and appoint advisory committees

The commission established two advisory committees, Youth & Education Committee and a Health Committee. The advisory committees will begin gathering data and information to better understand the needs of our LGBTQIA+ communities around the state.

The commission also created a Strategic Planning Committee to lead an intentional strategic planning process to engage all levels of our LGBTQIA+ community to inform and guide the commission's work and priorities over the next 3-5 years. The commission looks forward to hosting community listening sessions, town hall meetings, focus groups, and conducting surveys to reach as many stakeholders as possible.

Section 3

Events & Outreach

Events & Outreach

Commissioners and staff had the opportunity to participate and attend several events throughout the calendar year 2022.

June 4, 2022 - Baltimore Trans Pride, Baltimore, MD

Members of the Commission attended Baltimore Trans Pride, hosted by Baltimore Safe Haven, a trans-led drop-in wellness center that provides transitional housing and resources for LGBTQIA+ community members. Learn more at baltimoresafehaven.org.

Baltimore Safe Haven founder and executive director, Iya Dammons. Photo credit: EK Outlaw Black Lens Photos and Media Copyright © 2022 All Rights Reserved.

June 4, 2022 - Annapolis Pride Parade, Annapolis, MD

The Commission participated in the Annapolis Pride Parade to honor Delegate Lily Qi, the sponsor of the bill that created the Maryland Commission on LGBTQ Affairs and celebrate Pride Month. The event was hosted by Annapolis Pride, learn more at annapolispride.org.

Delegate Lily Qi in the Annapolis Pride Parade, accompanied by vice chair Joseph Clapsaddle (passenger) and commissioner Mark Ridderhoff (driver). Photo credit: Chair Joe Toolan.

June 26, 2022 - Pride in the Plaza, Silver Spring, MD

Montgomery County hosted their second annual Pride in the Plaza Festival at Veterans Plaza in Downtown Silver Spring with exhibitors and entertainment. The event was organized with Councilmember Evan Glass, Montgomery County's first openly LGBTQIA+ councilmember.

Commissioner Lee Blinder exhibiting with Trans Maryland at Pride in the Plaza. Photo credit: Trans Maryland.

August 20, 2022 - Maryland Commission on Civil Rights Dinner, Hanover, MD

The awards dinner was held at Maryland Live and attended by chair Joe Toolan, vice chair Joseph Clapsaddle, and administrative director Jeremy Browning. The dinner was hosted by the Maryland Commission on Civil Rights, which ensures opportunity for all through the enforcement of Maryland's laws against discrimination in employment, housing, public accommodations, and state contracts. Learn more at mccr.maryland.gov.

October 8, 2022 - Laurel Pride, Laurel, MD

The inaugural Laurel Pride celebration was held at Granville Gude Park and organized by the City of Laurel, Laurel Pride Day Committee. Learn more at the cityoflaurel.org.

Performer Shawnna Alexander introduces Craig A. Moe, Mayor of the City of Laurel, to make welcoming remarks.

October 8, 2022 - Upper Chesapeake Bay Pride Festival, Havre De Grace, MD

The Upper Chesapeake Bay Pride celebration was held at Concord Point Lighthouse Keeper's House and hosted by Upper Chesapeake Bay Pride and featured local vendors, performances, and speakers. Learn more at ucbpride.com.

From left to right: Vice chair Joseph Clapsaddle, chair Joe Toolan, UCB Pride board member Sue Knause, administrative director presenting governor's citation, and UCB Pride board member and commissioner Kurt Doan. Photo credit: UCB Pride.

Commissioner Lee Blinder exhibiting with [Trans Maryland](). Photo credit: Trans Maryland.

October 9, 2022 - Southern Maryland Pride in Lexington, MD

Southern Maryland Pride was held at Lexington Manor Passive Park and hosted by Pride SoMD (Southern Maryland). The event featured live performances, speakers, and local vendors. Learn more at pridesomd.com.

Chair Joe Toolan gives the keynote address.

October 9, 2022 - Howard County Pride, Columbia, MD

The second Howard County Pride Festival was hosted by HoCo Pride and held at Merriweather Post Pavilion featuring vendors, speakers, and performances from local artists. Learn more at howardcountypride.org

Attendees enjoy a performance at Merriweather Post Pavilion.

October 15 - FreeState Justice Jazz Brunch, Baltimore, MD

A fundraiser for FreeState Justice held at Guilford Hall Brewery in Baltimore, MD. Learn more at freestate-justice.org.

Freestate Justice staff from left to right: Em Espey, Shayne Miller-Westfield, Tina Jones, Philip Westry, Luaren Pruitt, Mackenzie Dadswell, Jamie Grace Alexander. Photo credit: FreeState Justice.

December 6, 2022 - Maryland Correctional Institution Facility Tours of MCI-W and MCI-J, Jessup, MD

Hosted by the Maryland Department of Public Safety and Correctional Services (DPSCS) and attended by GOCI staff and several Commissioners.

December 9, 2022 - Maryland LGBT+ Champions Awards Dinner, Linthicum Heights, MD

The event honored a number of Champions including commissioner Jabari Lyles as Emerging Leader of the Year.

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Thank you for reading our 2022 Annual Report

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Maryland Commission on LGBTQ Affairs

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Informational Only Testimony SB0460 - Trans Health

Uploaded by: Jeremy Browning
Position: INFO

Maryland Commission on LGBTQ Affairs

TESTIMONY OF JEREMY BROWNING
ADMINISTRATIVE DIRECTOR, MARYLAND COMMISSION ON LGBTQ AFFAIRS
INFORMATION STATEMENT ON SB0460
Maryland Medical Assistance Program - Gender - Affirming Treatment
(Trans Health Equity Act)

FEBRUARY 28, 2023

SENATE - Finance Committee

The Hon. Melony Griffith, Chair
The Hon. Katherine Klausmeier, Vice Chair

Good afternoon, Madame Chair and members of the committee. Thank you for the opportunity to provide informational testimony on SB0460 on behalf of the Maryland Commission on LGBTQ Affairs. My name is Jeremy Browning (he/him), I am the Administrative Director of the Maryland Commission on LGBTQ Affairs.

I would like to commend the members of the General Assembly for their work on behalf of our LGBTQIA+ communities and their families. The efforts to create a Commission and Office to address the needs and issues of the communities are laudable.

The Maryland Commission on LGBTQ Affairs was created by the 2021 Maryland General Assembly to assess challenges facing our LGBTQ community, collect data across state agencies, study and establish best practices for LGBTQ inclusion, and offer testimony on issues concerning LGBTQ persons before legislative and administrative bodies.

Senate bill 460 is a vital step in ensuring that transgender individuals in Maryland have access to the medical care they need. Gender-affirming treatment has a profound impact on the physical and mental well-being of transgender individuals and it is essential that these treatments are provided in a non-discriminatory manner.

The bill prohibits adverse benefit determinations unless a health care provider with experience providing gender-affirming treatment has reviewed and confirmed the

appropriateness of the determination. Additionally it ensures that the highest quality of care is available and prescribed in accordance with current clinical standards of care for transgender individuals.

With this information, Madame Chair and members of the committee, I conclude my testimony. I am optimistic that the Commission will continue to work hard and have tremendous success in improving the lives of our LGBTQIA+ communities and their families. I look forward to furthering those activities and I would be happy to answer any questions.