

September 7, 2018

To: Director
Office of Regulation Policy and Management (OOREG)
Department of Veterans Affairs
810 Vermont Ave., NW, Room 1063B
Washington, DC 20420

From: Scott B. Wilkens
JENNER & BLOCK LLP
1099 New York Ave, NW, Suite 900
Washington, DC 20001

Andrew G. Sullivan
Eugene Lim
JENNER & BLOCK LLP
633 W 5th St., Suite 3600
Los Angeles, CA 90071

On behalf of the American Academy of Nursing, the American Medical Association, the American Medical Student Association, American Medical Women's Association, the American Nurses Association, the Association of LGBTQ Psychiatrists, the Association of Nurses in AIDS Care, GLMA: Health Professionals Advancing LGBT Equality, the HIV Medicine Association, the LGBT Caucus of Public Health Professionals of the American Public Health Association, the Lesbian, Bisexual, Gay and Transgender Physician Assistant Caucus of the American Academy of PAs, Inc., the National Association of Social Workers, and the World Professional Association for Transgender Health.

Re: Notice of Petition for Rulemaking and Request for Comments – Exclusion of Gender Alterations from the Medical Benefits Package

I. Introduction

The Department of Veterans Affairs (VA) seeks comments to assist in determining whether to amend its medical regulations by removing a provision that excludes gender-affirming surgery, also referred to as “gender alteration surgery” or “sex reassignment surgery” (SRS), from the VA’s medical benefits package. The undersigned medical and mental health

organizations submit the comments below in strong support of allowing veterans access to SRS, which for many patients is a clinically effective, medically necessary, and potentially life-saving treatment for gender dysphoria.

The VA's notice for comments references the Department of Defense's February 2018 Implementation Report (the "Implementation Report") which noted that uncertainty exists with respect to the effectiveness of SRS as a treatment for gender dysphoria. The undersigned medical and mental health organizations disagree that any uncertainty exists. These organizations have found, based on reasons set forth herein, that transition-related care is not only medically necessary, it is also effective in improving health outcomes for many individuals with gender dysphoria, especially patients for whom psychotherapy and hormone therapy are insufficient treatment for gender dysphoria.

The standards of care for gender dysphoria require individualized assessment and provision of medically necessary care to each patient. These standards are based on the fundamental principle that medical and mental health professionals must make a case-by-case assessment and treatment plan for each patient to identify the severity of, and to treat, each patient's condition or medical needs. If the VA continues to impose a blanket exclusion of medically necessary gender-affirming surgery from the VA's medical benefits package, the VA would deny patients with the most serious levels of gender dysphoria medically necessary care, placing them at substantially greater risk of serious physical and emotional trauma, including suicidal ideation, suicide attempts, and suicide.

In short, the internationally-recognized standards of care for gender dysphoria created by medical and mental health professional organizations across the globe compel the conclusion that providing care relating to gender transition, including gender-affirming surgery, is medically

necessary and clinically effective for a significant portion of the VA's patient population experiencing gender dysphoria. The VA's ban on SRS denies veterans access to potentially life-saving care and must be put to an end.

II. These Comments Represent the Interests of Leading Medical and Mental Health Professionals Dedicated to Providing the Proper Health Care and Treatment for All Individuals in Need.

The following well-recognized medical and mental health organizations offer these comments to explain that the exclusion of medically necessary transition-related surgeries from the VA's medical benefits package impinges upon medical and mental health professionals' ability to provide medically necessary care to each veteran patient with gender dysphoria. These organizations promulgate the leading standards of care in the field and are comprised of medical professionals charged with ensuring proper treatment for their patients.

The American Academy of Nursing ("AAN") serves the public and nursing profession by advancing health policy and practice through the generation, synthesis, and dissemination of nursing knowledge. The Academy's more than 2,500 members, known as fellows, are nursing's most accomplished leaders in education management, practice, and research. The Academy is committed to ensuring dignified and respectful health care for all persons, regardless of sexual orientation or gender identity. The Academy supports initiatives to address the health needs of transgender individuals and supports policy initiatives which support transgender individuals' unique health concerns and reduce the health care barriers that transgender individuals encounter.

The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. The AMA supports the equal rights, privileges and freedom of all individuals and opposes discrimination based on sex, sexual

orientation, gender identity, race, religion, disability, ethnic origin, national origin or age. Sexual orientation and gender identity are integral aspects of the AMA communities and AMA policies on LGBTQ issues that work to inform individuals about LGBTQ discrimination and abuse.

The American Medical Student Association (“AMSA”) is the oldest and largest independent association of physicians-in-training in the United States. Founded in 1950, AMSA is a student-governed, non-profit organization committed to representing the concerns of physicians-in-training. As the first mainstream national medical organization to adopt a policy supporting healthcare as a basic right for all Americans, for more than sixty years AMSA has represented the voice of physicians-in-training in their efforts to best serve the public. AMSA has a long-standing history advocating for equitable rights of the LGBT community and supports educating the medical community at large on issues that pertain to persons identifying in the LGBT community with the intention to increase provider competency and reduce the double stigma that these individuals face. AMSA opposes treatment policies that discriminate against patients based on their sexual orientation and gender identity, or that inhibit their access to quality care. AMSA believes healthcare for transgender people should be comprehensive; this comprehensive care should include, but not be limited to, psychiatric counseling for all stages of transitioning, endocrinological (hormone) treatment, surgical treatment, and routine care directed toward treating patients based on their entire anatomy and well-being.

The American Medical Women's Association (“AMWA”) is an organization which functions at the local, national, and international level to advance women in medicine and improve women's health. AMWA achieves this by providing and developing leadership, advocacy, education, expertise, mentoring, and strategic alliances. AMWA seeks to foster an inclusive environment for physicians, residents, and students who are lesbian, gay, bisexual

and/or transgender by providing educational and mentorship opportunities and supporting organizations that work toward equal rights for LGBTQ individuals and families in the broader community.

The American Nurses Association (“ANA”) represents the interests of the Nation’s four million registered nurses. With members in every State, ANA is comprised of state nurses associations and individual nurses. ANA is an advocate for social justice with particular attention to preserving the human rights of vulnerable groups, such as the poor, homeless, elderly, mentally ill, prisoners, refugees, women, children, and socially stigmatized groups.

The Association of LGBTQ Psychiatrists (“AGLP”) is a community of psychiatrists that educates and advocates on Lesbian Gay Bisexual and Transgender mental health issues. The AGLP firmly believes that gender identity is part of the natural spectrum of human experience and expression. The Transgender and Gender Non-Conforming (TGNC) Community has been marginalized and continues to fight for basic civil rights. The AGLP stands by all efforts to protect the legal rights of LGBTQ individuals, specifically our most vulnerable trans and gender non-conforming youth.

The Association of Nurses in AIDS Care (“ANAC”) is the leading nursing organization responding to HIV/AIDS. ANAC comprises a dedicated group of nurses, healthcare professionals and others from around the world who are committed to HIV/AIDS nursing. These affiliate members include social workers, pharmacists, physician assistants, lawyers and doctors. Since its founding in 1987, ANAC has been meeting the needs of nurses in HIV/AIDS care, research, prevention and policy. ANAC aims to promote the health and welfare of people affected by HIV/AIDS in numerous ways, including by advocating for effective public policies and quality care for people living with HIV.

GLMA: Health Professionals Advancing LGBT Equality (“GLMA”) is the largest and oldest association of LGBT healthcare professionals. GLMA’s mission is to ensure equality in healthcare for LGBT individuals and healthcare professionals, using the medical and health expertise of GLMA members in public policy and advocacy, professional education, patient education and referrals, and the promotion of research. GLMA (formerly known as the Gay & Lesbian Medical Association) was founded in 1981 in part as a response to the call to advocate for policy and services to address the growing health crisis that would become the HIV/AIDS epidemic. Since then, GLMA’s mission has broadened to address the full range of health issues affecting LGBT people and GLMA has become a leader in public policy advocacy related to LGBT health. To advance its mission, GLMA provides cultural competency courses for medical providers, including in transgender health.

The HIV Medicine Association (“HIVMA”) represents more than 5,000 HIV medical professionals who practice HIV medicine across the U.S. and in countries around the world. The Association was created by the Infectious Diseases Society of America in 2002 to represent the interests of HIV healthcare providers and researchers and their patients by promoting quality in HIV care and advocating for policies that ensure a comprehensive and humane response to the AIDS pandemic informed by science and social justice.

Since it was established in 1975, the Lesbian, Gay, Bisexual, and Transgender Caucus of Public Health Professionals (the “LGBT Caucus”) has been an active group of interdisciplinary public health professionals committed to furthering LGBT issues within the American Public Health Association, and the field of public health at large. The LGBT Caucus is especially aligned with ensuring the health and well-being of transgender veterans, which is why it adamantly supports the Veterans Administration offering full coverage for all necessary

surgeries in addition to other transition related care. The LGBT Caucus includes public health professionals from many diverse disciplines, including researchers, clinicians, community health workers, public health students, and a diverse group of other public health professionals. The LGBT Caucus supports access and coverage of transition surgery for America's veterans. The VA has previously been at the forefront of ensuring that America's veterans receive the best world class healthcare for the entire range of their health needs, and the LGBT Caucus strongly urges the VA to not stop short of ensuring full coverage for surgery.

The Lesbian, Bisexual, Gay and Transgender ("LGBT") Physician Assistant ("PA") Caucus of the American Academy of PAs, Inc. is the national professional society for PAs and PA students who share a common interest in the art of LGBT health. It is an officially recognized constituent organization of the American Academy of PAs. Since 1979, the LGBT PA Caucus has been serving the PA profession on all aspects of sexual and gender minority diversity and inclusion in the PA workforce, PA education, and the health of the public. The LGBT PA Caucus endeavors toward a future where health outcomes will be independent of social determinants including age; sex; kinship networks; racial, ethnic, gender or sexual orientation identity groups; religious affiliations; social classes; geographic regions; occupation; (dis)ability; and HIV or marital status. The LGBT PA Caucus joins these comments for reasons expressed in PA professional practice policies regarding non-discrimination in healthcare delivery on the basis of sex, gender identity, and gender expression, and the elimination of arbitrary condition-based exclusions that inhibit access to medically-necessary health care.

The National Association of Social Workers ("NASW") is the largest membership organization of professional social workers in the world, with more than 120,000 members. NASW works to enhance the professional growth and development of its members, to create and

maintain professional standards, and to advance sound social policies. The social workers that comprise NASW are key allies in the necessary efforts to ensure wellness, safety, and equity for all LGBT persons. They have a shared commitment to promoting laws, policies and programming that affirm, support, and value LGBT individuals, families, and communities.

The World Professional Association for Transgender Health (“WPATH”) is an interdisciplinary professional association committed to developing the best practices and supportive policies to promote health, research, education, respect, dignity, and equality for transgender people in all settings. WPATH was founded in 1979 and based on the principles of Dr. Harry Benjamin, one of the first physicians to work with transgender individuals. It is the only medical association devoted solely to the study and treatment of gender dysphoria, and maintains a leading role in setting medically-accepted standards for treatment. WPATH publishes *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* that articulate a professional consensus about the medical, psychiatric, psychological, and surgical management of gender dysphoria. The *Standards of Care* recognize the role of surgery to change sex characteristics in treating gender dysphoria. WPATH also offers training for healthcare providers in the management of transgender health.

III. Sex Reassignment Surgery Is A Clinically Effective, Medically Necessary Treatment For Certain Patients For Whom Psychotherapy And Hormone Therapy Are Not Sufficient To Treat Gender Dysphoria

a. Many Individuals With Gender Dysphoria Require Medical Treatment

Gender dysphoria is the medical term for the distress indicated by a strong, persistent cross-gender identification in which individuals “are cruelly imprisoned in a body incompatible with their subjective gender identity.” *Merck Manual of Diagnosis and Therapy* 1568 (Robert S. Porter et al. eds., 19th ed. 2011) (hereinafter *Merck Manual*). Most individuals’ gender identities

are congruent with their bodies. Individuals with gender dysphoria, in contrast, experience a degree of incongruence that is often severe, distressing, and long-standing. *Id.* When not properly treated, gender dysphoria can result in clinically significant psychological distress, dysfunction, debilitating depression, and, for some people, self-mutilation, thoughts of and attempts at suicide, and death. *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 454-55 (5th ed. 2013) (hereinafter DSM-5); George R. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder*, 12 Int'l J. Transgenderism 31, 31-39 (2010).

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders recognizes the following diagnostic criteria for gender dysphoria in adolescents and adults:

- A) A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
- (1) A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.
 - (2) A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.
 - (3) A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - (4) A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 - (5) A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 - (6) A strong conviction that one has the typical feelings and reactions of the other gender.... and
- B) The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM-5 at 452-53.

Similarly, the World Health Organization's International Classification of Diseases recognizes that gender dysphoria is "characterized by a persistent and intense distress about

assigned sex, together with a desire to be (or insistence that one is) of the other sex.” World Health Organization (“WHO”), *International Classification of Diseases-10* F64.2 (2015 ed.), <http://apps.who.int/classifications/icd10/browse/2015/en#/F64.2>. One court recently held that gender dysphoria is a disability within the meaning of the Americans with Disabilities Act. *Blatt v. Cabela’s Retail, Inc.*, No. 5:14-cv-04822, 2017 WL 2178123, at *4 (E.D. Pa. May 18, 2017).

At the core of the assessment of gender dysphoria are the persistent cross-gender identification and discomfort and distress that result from gender incongruence. The World Health Organization has recognized that gender dysphoria involves a “profound disturbance” with an individual’s gender identity and “a persistent preoccupation with the dress and/or activities of the opposite sex and/or repudiation of the patient’s own sex.” WHO, *supra* p. 10, F64.2. Before treatment begins, individuals with gender dysphoria “live in a dissociated state of mind and body.” David Seil, *The Diagnosis and Treatment of Transgendered Patients*, 8 J. Gay & Lesbian Psychotherapy 99, 115 (2004) (describing the diagnosis and treatment of 271 transgender patients between 1979 and 2001). In these individuals, “[t]he mind is of one gender, and the body is of the other.” *Id.*

As a result of the gender dysphoria, some male-to-female individuals resort to self-treatment with hormones or, in some cases, attempt their own castration or penectomy. DSM-5 at 454; Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment*, at 33. In these cases, individuals with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicide. *Id.* The literature in the field is replete with accounts of individuals who have taken their own lives or attempted to do so because their gender dysphoria was not properly assessed and treated, with some studies finding as many as one in four male-to-female individuals and one in five female-to-male individuals attempted

suicide before treatment. *See, e.g.,* Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment*, at 31-39; Bram Kuiper & Peggy Cohen-Kettenis, *Sex Reassignment Surgery: A Study of 141 Dutch Transsexuals*, 17 *Archives Sexual Behav.* 439, 451 (1988).

b. Sex Reassignment Surgery Is A Widely-Accepted Treatment For Many Individuals With Gender Dysphoria

The medical and mental health communities have well-established protocols for assessing and treating gender dysphoria, which specifically recognize the medical necessity and therapeutic importance of sex reassignment surgery, or SRS. First published in 1979 by the World Professional Association for Transgender Health (WPATH), the WPATH *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* are the internationally-recognized professional standards of care regarding the treatment of individuals with gender dysphoria. *See* WPATH, *Standards of Care*, at 8-9 (7th ed. 2011), <https://www.wpath.org/publications/soc>; *see also* *Merck Manual*, at 1570 (recognizing that WPATH’s Standards of Care are “the internationally accepted standards of care for the treatment of gender identity disorders”). Informed by current consensus in medical research and clinical practice, the WPATH Standards of Care emphasize that treatment must consider each patient’s unique anatomic, social, and psychological situation. WPATH, *Standards of Care*, at 2. “Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person.” *Id.* at 5. “While many transsexual, transgender, and gender-nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria.” *Id.* at 54. Studies have shown that SRS is a safe and effective treatment for gender dysphoria. *See id.* at 55 (“Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes.”).

The decision to undergo SRS “is not taken lightly.” Hilary Daniel & Renee Butkus, *Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper From the American College of Physicians*, 163 *Annals of Internal Med.* 135 (2015), <http://annals.org/aim/article/2292051/lesbian-gay-bisexual-transgender-health-disparities-executive-summary-policy-position>. “Transgender patients and their health care team, which may include primary care physicians, endocrinologists, mental health professionals, and others, are in the best position to determine the most appropriate care plan unique to the patient’s needs.” *Id.* In other words, “[g]enital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures.” See WPATH, *Standards of Care*, at 55. They are medically necessary treatments for gender dysphoria to be undertaken only after “assessment of the patient by qualified mental health professionals” to determine that the patient has “met the criteria for a specific surgical treatment.” *Id.*

c. Some Individuals With Severe Gender Dysphoria Cannot Manage Their Gender Dysphoria With Psychotherapy And Hormone Therapy

Medical and mental health professionals widely recognize that for some individuals, especially those with severe gender dysphoria, it is impossible to manage their distress with psychotherapy and/or hormone therapy alone. Seil, *The Diagnosis and Treatment of Transgendered Patients* at 114-16; Yolanda L.S. Smith, *et al.*, *Adolescents With Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-up Study*, 40 *J. Am. Academy Child Adolescent Psychiatry* 472, 473 (2001); Walter O. Bockting & Eli Coleman, *A Comprehensive Approach to the Treatment of Gender Dysphoria*, 5 *J. Psychol. & Human Sexuality*, vol. 4 1993, at 131, 150. For these patients, “relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.” WPATH, *Standards of Care*, at 54-55.

As medical and mental health professionals have recognized, gender identity cannot be changed through psychotherapy, “[h]owever, the body can be changed, and when a proper transition to the other gender has been completed, the dissociation” of gender dysphoria may be lessened. Seil, *The Diagnosis and Treatment of Transgendered Patients*, at 115. Research has shown that many of those seeking treatment for gender dysphoria regard their genitals and sexual features with repugnance. *Merck Manual*, at 1570. As a result, some individuals with gender dysphoria prioritize “obtain[ing] hormones and genital surgery that will make their physical appearance approximate their felt gender identity.” *Id.* It is the combination of psychotherapy, hormone therapy, and SRS that “is often curative when the disorder is appropriately diagnosed and clinicians follow the internationally accepted standards of care.” *Id.* Empirical studies reflect the importance of the interplay among treatments, finding hormone therapy in conjunction with psychotherapy and, for some, SRS, to be necessary elements of treating severe levels of gender dysphoria. *See* Gianna E. Israel & Donald E. Tarver II, *Transgender Care: Recommended Guidelines, Practical Information & Personal Accounts* 56-73 (1997).

Treatment utilizing SRS for individuals with severe gender dysphoria may be vital to a patient’s health. *See* Smith, 40 *J. Am. Academy Child & Adolescent Psychiatry*, at 473. In a study of outcomes of sex reassignment surgery, including SRS in adolescents, sex reassignment surgery significantly improved anxiety, depression, and hostility. *Id.* at 475-77.

Many transgender veterans “have experienced and continue to experience extreme and sometimes life-threatening hardships because they cannot obtain coverage” for medically-necessary healthcare services to complete their transition. *See* Attachment 1 (Affidavit of Evan Young, May 5, 2016, filed in *Fulcher v. Secretary of Veterans Affairs*, Federal Circuit, No. 17-1460, Dkt. 126 at 114). For example, in June 2015 a transgender veteran, a retired Sergeant,

took her own life, referencing in her suicide note her inability to have “medical procedures covered as a reason for her desperation and hopelessness.” *See id.* Thus, “[i]f the VA were to amend its regulations to include coverage of sex reassignment surgery, such an amendment would significantly improve the physical and mental health of . . . transgender veterans with gender dysphoria.” *See id.* In short, SRS is an effective and medically necessary treatment for certain patients for whom psychotherapy and hormone therapy are insufficient treatment for gender dysphoria.

IV. Case-By-Case Assessment And Appropriate Treatment Of Veterans With Gender Dysphoria Is Necessary To Prevent Physical And Emotional Harm

a. Medical And Mental Health Organizations, Courts, And The Federal Government Have All Recognized The Importance Of Individualized Care

Because not all patients require the same therapeutic care, medical and mental health professionals must make treatment decisions on a case-by-case basis. This is a fundamental principle of the WPATH Standards of Care, which state: “While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria.” *See WPATH, Standards of Care*, at 54.

Recognizing the importance of individualized care for transgender patients, major medical and mental health organizations have called for an end to blanket exclusions in health insurance coverage for treatment of gender dysphoria:

- “The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender health care services and provide all covered services to transgender persons as they would all other beneficiaries.” Daniel & Butkus, 163 *Annals of Internal Med.* 135, 136.

- In its Standards of Care, WPATH “urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria.” WPATH, *Standards of Care*, at 33.
- The American Medical Association (“AMA”) “supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient’s physician.” AMA Policy H-185.950, <https://policysearch.ama-assn.org/policyfinder/detail/H-185.950?uri=%2FAMADoc%2FHOD.xml-0-1128.xml>.
- “The American College of Obstetricians and Gynecologists opposes discrimination on the basis of gender identity and urges public and private health insurance plans to cover the treatment of gender identity disorder.” American College of Obstetricians & Gynecologists, Committee Opinion of the Committee on Healthcare for Underserved Women, No. 512, *Health Care for Transgender Individuals* (Dec. 2011).
- The American Psychiatric Association “[a]dvocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment” and “[o]pposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician.” Am. Psychiatric Ass’n, *Position Statement on Access to Care for Transgender and Gender Variant Individuals* (2012), <https://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2012-transgender-gender-variant-access-care.pdf>.
- The American Psychological Association “recognizes the efficacy, benefit, and necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments.” Am. Psychol.

Ass'n, *Resolution on Transgender, Gender Identity, & Gender Expression Non-Discrimination* (Aug. 2008), <http://www.apa.org/about/policy/transgender.pdf>.

- The American Nurses Association “is committed to the elimination of health disparities and discrimination based on sexual orientation, gender identity, and/or expression within health care. LGBTQ+ populations face significant obstacles accessing care such as stigma, discrimination, inequity in health insurance, and denial of care because of an individual’s sexual orientation or gender identity.” American Nurses Association, *Position Statement on Nursing Advocacy for LGBTQ+ Populations* (2018), <https://www.nursingworld.org/~49866e/globalassets/practiceandpolicy/ethics/nursing-advocacy-for-lgbtq-populations.pdf>.

Moreover, courts have recognized the importance of individualized assessment and treatment and the harm that can result from blanket prohibitions. For example, in *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011), the Seventh Circuit affirmed the district court’s decision striking down on Eighth Amendment grounds a Wisconsin statute that prohibited the Wisconsin Department of Corrections from providing transgender inmates with hormone therapy and SRS. *Id.* at 559. The Seventh Circuit held that such a blanket policy is unacceptable because “[t]he feelings of dysphoria can vary in intensity [t]he accepted standards of care dictate a gradual approach to treatment.” *Id.* at 553-54. Thus, “[f]or some number of patients,” psychotherapy “will be effective in controlling feelings of dysphoria,” but for others, “a doctor can prescribe hormones, which have the effect of relieving the psychological distress.” *Id.* at 554. Following this individualized course of treatment depending on an individual’s needs, “[i]n the most severe cases, sexual reassignment surgery may be appropriate.” *Id.*; see also *Fields v. Smith*, *Amicus*

Br. of Medical and Mental Health Professionals 12-16 (arguing case-by-case assessment is necessary for prisoners with gender dysphoria).

Similarly, in *De'lonta v. Johnson*, 708 F.3d 520 (4th Cir. 2013), the Fourth Circuit reversed the district court's dismissal of a transgender prisoner's Eighth Amendment claim based on the prison's refusal to refer the plaintiff for assessment for SRS because she was already receiving counseling and hormone therapy to treat her gender dysphoria. In so ruling, the Fourth Circuit observed that "the [WPATH] Standards of Care . . . indicate that [SRS] may be necessary for individuals who continue to present with severe [gender dysphoria] after one year of hormone therapy." *Id.* at 525; *see also Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1118 (N.D. Cal. 2015) (plaintiff, who was an inmate, stated an Eighth Amendment claim for denial of SRS, characterizing it as "necessary medical treatment" for this inmate); *cf. O'Donnabhain v. Commissioner*, 134 T.C. 34, 65-70 & n.45 (2010) (SRS is "well-recognized and accepted treatment[] for severe" gender dysphoria).

Adding to the weight of authority, the U.S. Department of Health and Human Services ("HHS") has recognized the need for individualized assessment and treatment: HHS overturned a blanket ban on providing Medicare coverage for SRS. *See In re NCD 140.3, Transsexual Surgery*, DAB Dec. No. 2576, Docket No. A-13-87 (HHS, Appeals Bd., May 30, 2014), <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf>. In May 2014, the HHS Appeals Board determined that the blanket denial of "Medicare coverage of all transsexual surgery as a treatment for transsexualism" failed the Board's "reasonableness standard." *Id.* at 1. The Board found that SRS "is an effective treatment option in appropriate cases," *id.* at 15, and that the WPATH Standards of Care, which have "attained widespread acceptance," *id.* at 23, include "criteria for the use of" SRS, *id.* at 15 n.22.

Empirical studies of individuals who have undergone the full treatment prescribed by medical and mental health professionals for their diagnosis further demonstrate that gender dysphoria “is not a homogenous phenomenon,” and that it requires “a more varied treatment approach.” P.T. Cohen-Kettenis & L.J.G. Gooren, *Transsexualism: A Review of Etiology, Diagnosis and Treatment*, 46 *J. Psychosomatic Res.* 315, 328 (1999) (reviewing empirical studies on those with gender dysphoria).

Further, despite actuarial fears of over-utilization and a potentially expensive benefit, programs that have expanded to include coverage of SRS have found the economic costs to be minimal compared to other insurance costs. See Jody L. Herman, The Williams Institute, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans: Findings From a Survey of Employers* 2, 11, 15, 16 (Sept. 2013), <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Cost-Benefit-of-Trans-Health-Benefits-Sept-2013.pdf>; Human Rights Campaign, *San Francisco Transgender Benefit: Actual Cost & Utilization (2001-2006)*, <http://www.hrc.org/resources/entry/san-francisco-transgender-benefit-actual-cost-utilization-2001-2006> (last visited June 19, 2017).

b. The VA’s Blanket Ban On Sex Reassignment Surgery Denies Individualized Care And Disrupts Continuity Of Patient Care

Blanket bans on SRS—such as the VA’s ban—disrupt continuity of patient care. Continuity of care for transgender patients is an important principle in the WPATH Standards of Care. The Standards of Care advise that “[h]ealth professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.” See WPATH, *Standards of Care*, at 3, 65. In conflict with this important standard of care, the VA covers all medically necessary care for transgender veterans *except* for SRS:

It is VHA policy that medically necessary care is provided to enrolled or otherwise eligible intersex and transgender Veterans, including hormonal therapy, mental health care, preoperative evaluation, and medically necessary post-operative and long-term care following sex reassignment surgery. Sex reassignment surgery cannot be performed or funded by VA.

see VHA Directive 2013-003, *Providing Health Care for Transgender and Intersex Veterans*, Feb. 8, 2013, *revised* Jan. 9, 2017, https://www.birmingham.va.gov/docs/LGBT_Healthcare.pdf, at § 3; *see also* Department of Veterans Affairs, *Presidential Transition Briefing Book*, Nov. 1, 2016, <https://www.oprm.va.gov/docs/foia/2016PresidentialTransitionUserGuide.pdf>, at 88 (“VA currently provides many services for transgender Veterans to include hormone therapy, mental health care, preoperative evaluation, and long-term care following sex reassignment surgery.”). Transgender veterans may receive a bundle of pre- and post-operative care from their VA providers but must obtain—and pay for—the critical operative care on their own.

This disruption of continuity of care runs contrary to the healthcare needs of transgender veterans, which the VA well understands. The VA has been providing some transition-related care for veterans since 2011 and, since 2015, the VA has opened clinics in Cleveland, Ohio and Tucson, Arizona that specialize in providing medical care to transgender veterans. *See* Brian Albrecht, *All Things Considered: VA Transgender Clinic Opens in Cleveland*, Cleveland.com (Nov. 12, 2015, 4:07 PM), http://www.cleveland.com/metro/index.ssf/2015/11/vas_first_transgender_clinic_o.html; Jimmy Jenkins, *New VA Clinic Opens for Transgender Vets*, NPR (Dec. 29, 2015), <http://www.npr.org/2015/12/29/460955296/new-va-clinic-opens-for-transgender-vets>. But although veterans are able to receive comprehensive pre- and post-operative care from the VA, they must seek out their medically-necessary surgeries elsewhere. Jenkins, *New VA Clinic Opens for Transgender Vets*.

This can lead to terrible and absurd results. For example, when one transgender veteran was denied coverage of her medically-necessary SRS, she went to Tijuana, Mexico to obtain that surgery. She did this because the VA's denial of coverage required her to pay for the surgery out-of-pocket and had she obtained the surgery in the U.S. it would have been three times as expensive. After the Mexican doctor botched her surgery, she was forced to undergo years of post-operative care, including corrective surgeries, through the VA. *See, e.g.,* Nicole Comstock, California Veteran Shares Story of Gender Transition, FOX40 (May 11, 2015), <http://fox40.com/2015/05/11/california-veteran-shares-story-of-gender-transition/>. Had the VA provided coverage of the veteran's surgery at the outset, her operation would have been conducted correctly, sparing the patient years of pain and, likely, saving taxpayers money.

The VA's refusal to cover such care has no basis in medicine. In fact, the VA has repeatedly recognized that surgical care is medically necessary. The VA's former Under Secretary for Health unequivocally stated that “[i]ncreased understanding of both gender dysphoria and surgical techniques in this area has improved significantly and is now widely accepted as medically necessary treatment.” *See* Attachment 2 (Letter from David J. Shulkin, M.D., Former Under Secretary for Health, Department of Veterans Affairs to Sen. Elizabeth Warren, Nov. 10, 2016); *see also* Department of Veterans Affairs, 38 CFR Part 17, Removing Gender Alterations Restriction from the Medical Benefits Package (Spring 2016), <http://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201604&RIN=2900-AP69> (making same statement).

In addition, the VA provides these very surgeries to other veterans. The VA's Directive is clear that its ban on SRS does not apply to intersex veterans. *See* VHA Directive 2013-003, *Providing Health Care for Transgender and Intersex Veterans*, Feb. 8, 2013, revised Jan. 9,

2017, § 3. Moreover, the VA provides the same kind of surgical benefits to non-transgender veterans with other medical needs, whether because of cancer or a genital injury during service. *Id*; see also, Mimi Leong *et al.*, *Effective Breast Reconstruction in Female Veterans*, 198 Am. J. Surg. 658 (2009) (addressing outcomes of breast reconstruction performed at VA hospitals); *Shimansky v. West*, 17 Vet. App. 90, 90, 1999 WL 757054 (1999) (unpublished table decision) (patient received a penile prosthesis at the Wilmington, Delaware VA Medical Center); *Brewer v. Nicholson*, 21 Vet. App. 420, 420, 2006 WL 3007323 (2006) (unpublished table decision) (patient received a penile prosthesis at the Jackson, Mississippi VA Medical Center); Board of Veteran's Appeals, Docket No. 96-07-121 (Sept. 26, 1997), <https://www.va.gov/vetapp97/files4/9732876.txt> (stating patient received a "testicular prosthetic implantation" at a VA hospital); Carolyn Gardella *et al.*, *Prevalence of Hysterectomy and Associated Factors in Women Veterans Affairs Patients*, 50 J. Reprod. Med. 166, 167-72 (2005) (estimating prevalence of hysterectomies provided by the VA Puget Sound Health Care System); Denise Hynes *et al.*, *Breast Cancer Surgery Trends and Outcomes: Results from a National Department of Veterans Affairs Study*, 198 J. Am. College of Surgeons, 707, 707-16 (2004) (examining trends in breast cancer surgery performed at VA hospitals); *Norvell v. Peake*, 22 Vet. App. 194, 195 (2008) (noting that the patient underwent a bilateral orchiectomy at Lexington, Kentucky, VA Medical Center), *aff'd sub nom. Norvell v. Shinseki*, 333 F. App'x 571 (Fed. Cir. 2009); J.M. Corman *et al.*, *Fournier's Gangrene in a Modern Surgical Setting: Improved Survival with Aggressive Management*, 84 BJU Int'l, 85, 85-88 (July 1999) (noting that all patients covered in the survey had received scrotoectomies for Fournier's Gangrene and that some of the patients had been treated at West Los Angeles Veterans Administration Hospital); Board of Veterans Appeals, Docket No. 05-31 519 (Oct. 25, 2007), <https://www.va.gov/vetapp07/files4>

/0733550.txt (noting that the patient had undergone a total penectomy at a VA hospital due to cancer).

In sum, because of the individual nature of gender dysphoria and its treatment, medical and mental health professionals must evaluate each patient with gender dysphoria on a case-by-case basis to prescribe the proper therapeutic treatment. Some transgender veterans require SRS, and the VA's blanket policy of denying SRS precludes case-by-case assessment and treatment of individuals with gender dysphoria. Thus, this blanket ban prevents medical and mental health professionals from prescribing the proper treatment and places veterans at substantially greater risk of physical and emotional harm.

Regards,



Scott Wilkens
Jenner & Block LLP

CC: The American Academy of Nursing, the American Medical Association, the American Medical Student Association, American Medical Women's Association, the American Nurses Association, the Association of LGBTQ Psychiatrists, the Association of Nurses in AIDS Care, GLMA: Health Professionals Advancing LGBT Equality, the HIV Medicine Association, the LGBT Caucus of Public Health Professionals of the American Public Health Association, the Lesbian, Bisexual, Gay and Transgender Physician Assistant Caucus of the American Academy of PAs, Inc., the National Association of Social Workers, and the World Professional Association for Transgender Health.

ATTACHMENT 1

AFFIDAVIT OF EVAN YOUNG

I, Evan Young, declare as follows:

1. I am the National President and a current board member of the Transgender American Veterans Association (“TAVA”). I am 45 years old and I reside in Dover, Arkansas. I have personal knowledge of the matters stated in this declaration and could and would so testify if called as a witness.

2. I have over fourteen years of active service in the U.S. military. I retired as a Major. I received a Bachelor of Arts from Northwestern State University of Louisiana, where I majored in English, and a Master of Science in Management Information Systems from Nova Southeastern University.

3. During my enlisted service, I was stationed in Illesheim, Germany, Fort Story, Virginia, and Fort Polk, Louisiana. Following my commission, I was selected to serve as a recruiter and held positions at the 369th Adjutant General Battalion as a company executive officer and at the Adjutant General School as a special project officer. I served in the Hawaii Army National Guard as Communications-Electronics Officer for the 29th Support Battalion, Information Officer for the 29th Separate Infantry Brigade, Public Affairs Officer for the State Area Command, and Commander of the 117th Mobile Public Affairs Detachment. After transferring to the United States Army Reserves, I served as Broadcast Officer for the 209th Broadcast Public Affairs Detachment in Rome, Georgia. I was a public affairs officer for NORAD and USNORTHCOM from 2008-2011, as well as the recruiting officer for the University of Michigan Reserve Officers’ Training Corps department from 2011-2013.

4. I have received numerous awards and medals including two National Defense Service Medals, the Joint Service Commendation Medal, the Army Commendation Medal, three Army Achievement Medals, and the Alaska Community Service Medal.

5. I have been involved with TAVA since 2013, when I joined as a Board Member at Large. That same year, the board of directors elected me Secretary. In July 2014, I was elected Vice-President, and in December 2014, I was elected President. My duties include building coalitions and developing relationships with organizations and individuals that align with our mission; recruiting, growing, and mentoring our board of directors; influencing policy with the U.S. Department of Veterans Affairs (“VA”); setting public policy goals to assist transgender veterans; and providing support and outreach to transgender veterans on a range of issues, including, but not limited to, health care and identity documents.

6. TAVA is a 501(c)(3) organization that was founded in 2003 to advocate on behalf of transgender veterans within the VA health care system. As the only national organization focused exclusively on advocating and conducting educational outreach on behalf of transgender veterans, TAVA is a leading voice and source of information for the transgender veteran population. Its mission is to work with the VA, Congress, veterans, active-duty military personnel, and LGBT groups to influence the VA and military policy, regulations, and procedures regarding the provision of medical and psychological care to veterans with gender dysphoria to ensure that transgender veterans receive necessary and appropriate care. While TAVA primarily focuses on ensuring the fair and equal treatment of transgender individuals, it is committed to improving the health care of all American veterans.

7. TAVA’s advocacy goals include: open transgender military service; continued improvement in the quality and breadth of health care and other services provided to transgender

service members through the VA system and Tricare; access to name and gender changes, particularly for low-income veterans; and transgender veteran employment, among other goals. TAVA also works with individual transgender service members to assist them in securing benefits for themselves and their spouses and family. TAVA works towards these goals through educating the VA and the Department of Defense and through serving as a liaison between transgender veterans and VA staff to raise members' issues with the staff and to connect members to appropriate resources.

8. TAVA has spent considerable time and resources on educating veterans, policymakers and others about the exclusion of medically necessary transition-related surgeries from the VA's medical benefits package, and on advocating the removal of that exclusion and addressing the needs of transgender veterans affected by it. For example, we have produced "know your rights" materials for transgender veterans to educate them about the VA's exclusion of coverage for transition-related surgery,¹ prepared educational reports that include discussion of the harms caused by the surgery exclusion,² and sponsored community gatherings to discuss strategies to end this exclusion.³ In my capacity as TAVA's President, I have spent considerable time speaking with veterans across the country by phone to educate them about the VA's exclusion of transition-related surgeries and how it affects them. Additionally, several of our

¹ See, e.g., <http://transveteran.org/for-veterans/know-your-rights/>.

² See, e.g., The American Military Partner Association and the Transgender American Veterans Association, "How the Department of Defense Transgender Ban Harms Our Military Families" (March 30, 2015), available at <http://militarypartners.org/wp-content/uploads/2015/03/AMPA-Report-on-Transgender-Military-Ban-1.pdf>.

³ See, e.g., <https://sacvalleyvets.wordpress.com/2011/12/11/aver-tava-sponsors-transgender-service-summit/>.

board members have spent time talking with news outlets across the country in an effort to educate the public about the VA's exclusion of transition-related surgeries and to call for reform.

9. TAVA has approximately 2,268 members throughout the country who have joined our efforts through social media, and even though a significant percentage of such members have low incomes, numerous social-media members have contributed time and resources to help the organization achieve its goals. Other members have joined TAVA outside of social media, through contributing financially to our organization in amounts determined by the individual donors; roughly 80 individuals have become members through this method.

10. According to recent estimates, TAVA represents the interests an estimated 129,700 transgender veterans of the U.S. Military, as well as 4,600 retired transgender members of the U.S. Reserves and National Guard. *See* Gary J. Gates and Jody L. Herman, *Transgender Military Service in the United States (May 2014)*, available at <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Transgender-Military-Service-May-2014.pdf>.

11. Many of TAVA's members are transgender veterans currently enrolled in the VA health care system. Some of those individuals have been diagnosed with gender dysphoria by the VA and have been provided some medical care related to their diagnosis. However, some members who have sought sex reassignment surgery through the VA, or coverage of such surgery by the VA, have been denied such surgery or coverage because of the existing regulatory exclusion of "gender alterations" from covered benefits. Many of those veterans rely on the VA for the provision of their physical and mental health care, and many satisfy all the medical prerequisites for sex reassignment surgery: They have been diagnosed with gender dysphoria (often by VA clinicians), they have spent multiple years living in a gender role consistent with

their gender identity and are currently undergoing hormone therapy to assist in their transition, and they have been prescribed sex reassignment surgery by qualified medical providers as medically necessary treatment for their condition. Nevertheless, these veterans have been unable to obtain medically necessary sex reassignment surgery due to the VA's categorical exclusion of this surgery from its medical benefits package.

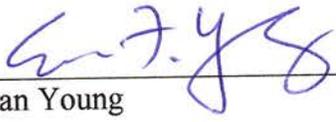
12. TAVA's purpose in submitting this petition is to advocate on behalf of its members who have been denied medically necessary treatment as a result of the VA's regulations. This petition directly advances TAVA's central organizational goal—to achieve reform of the VA's policies regarding coverage of sex reassignment surgery and other medical procedures related to gender dysphoria. If the VA were to amend its regulations to include coverage of sex reassignment surgery, such an amendment would significantly improve the physical and mental health of TAVA members and of other transgender veterans with gender dysphoria.

13. Many TAVA members have been prescribed, and desire to receive, medically necessary transition-related surgeries, but the VA's exclusion of these surgeries from coverage has prevented them from receiving this care. Many members of TAVA have experienced and continue to experience extreme and sometimes life-threatening hardships because they cannot obtain coverage for these health care services that their doctors deem to be medically necessary.

14. These hardships, and the extreme toll they exact, are not hypothetical. For example, in June 2015, a transgender veteran, who was a retired Sergeant, took her own life. In her suicide note, she referenced her inability to have her medical procedures covered as a reason for her desperation and hopelessness.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: May 5th, 2016



Evan Young

ATTACHMENT 2



DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

November 10, 2016

The Honorable Elizabeth Warren
United States Senate
Washington, DC 20510

Dear Senator Warren:

This is in response to your September 22, 2016, letter to the Department of Veterans Affairs (VA) asking for an update on the Notice of Proposed Rulemaking (NPRM) regarding the removal of gender alteration restrictions from VA's medical benefits package. I am responding on behalf of the Department.

VA regularly reviews regulations across the full spectrum of medical services to provide the highest quality health care to our Nation's Veterans. Where there is new data, research, or changes to health care policies across Federal agencies that suggest a need for review, VA makes every effort to examine the circumstances and openly discuss actions that could improve Veteran health care. We note that VA has not published a NPRM to remove the exclusion of gender alterations from VA's medical benefits package, but rather announced it was considering issuance of such a NPRM in the Unified Agenda of Federal Regulatory and Deregulatory Actions, a semiannual compilation of regulatory actions under development in the Federal Government.

VA currently provides many services for transgender Veterans to include hormone therapy, mental health care, preoperative evaluation, and long-term care following sex reassignment surgery. Increased understanding of both gender dysphoria and surgical techniques in this area has improved significantly and is now widely accepted as medically necessary treatment. VA has been and will continue to explore a regulatory change that would allow VA to perform gender alteration surgery and a change in the medical benefits package, when appropriated funding is available. Therefore, this regulation will be withdrawn from the Fall 2016 Unified Agenda. While VA has begun considering factors impacting this rulemaking process, it is not imminent.

Should you have further questions, please have a member of your staff contact Ms. Angela Prudhomme, Congressional Relations Officer, at (202) 461-6471 or by email at Angela.Prudhomme@va.gov.

Thank you for your continued support of our Nation's Veterans.

Sincerely,

A handwritten signature in blue ink that reads "David J. Shulkin MD".

David J. Shulkin, M.D.