

The Honorable Marsha J. Pechman

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**UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE**

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as
President of the United States, et al.,

Defendants.

Case No. 2:17-cv-01297-MJP

**DECLARATION OF SAMANTHA
EVERETT IN SUPPORT OF
PLAINTIFFS’ MOTION FOR
PRELIMINARY INJUNCTION**

NOTE ON MOTION CALENDAR:
October 6, 2017

ORAL ARGUMENT REQUESTED

I, Samantha Everett, swear under penalty of perjury under the laws of the United States to the following:

1. I am counsel of record for Plaintiffs in this action, am over age 18, and competent to be a witness. I am making this Declaration based on facts within my own personal knowledge. I provide this Declaration in support of Plaintiffs’ Motion for Preliminary Injunction.

2. Attached hereto as **Exhibit 1** is a true and correct copy of Department of Defense Press Briefing by Secretary Carter on Transgender Service Policies, dated June 30, 2016, available at <https://www.defense.gov/News/Transcripts/Transcript-View/Article/822347/departement-of-defense-press-briefing-by-secretary-carter-on-transgender-service/>.

3. Attached hereto as **Exhibit 2** is a true and correct copy of a Statement by Secretary Carter on DOD Transgender Policy, dated July 13, 2015, available at

1 <https://www.defense.gov/News/News-Releases/News-Release-View/Article/612778>.

2 4. Attached hereto as **Exhibit 3** is a true and correct copy of a Statement by Chief
3 Pentagon Spokesperson Dana W. White on Transgender Accessions, dated June 30, 2017,
4 available at: <https://www.defense.gov/News/News-Releases/News-Release-View/Article/1236145/statement-by-chief-pentagon-spokesperson-dana-w-white-on-transgender-accessions>.

7 5. Attached hereto as **Exhibit 4** is a true and correct copy of a Politico article
8 entitled “Inside Trump’s snap decision to ban transgender troops,” dated July 26, 2017, available
9 at: <http://www.politico.com/story/2017/07/26/trump-transgender-military-ban-behind-the-scenes-240990>.

11 6. Attached hereto as **Exhibit 5** is a true and correct copy of a New Civil Rights
12 Article entitled “Trump announced his transgender military ban just days after Tony Perkins
13 asked him for it,” dated September 11, 2017, available at:
14 http://www.thenewcivilrights_movement.com/trump_announced_his_transgender_military_ban_just_days_after_tony_perkins_asked_him_for_it.

16 7. Attached hereto as **Exhibit 6** are true and correct copies of tweets posted on July
17 26, 2017, from the Twitter feed of President Trump, available at
18 <https://twitter.com/realDonaldTrump>.

19 8. Attached hereto as **Exhibit 7** is a true and correct copy of the President’s August
20 25, 2017 Memorandum for the Secretary of Defense and the Secretary of Homeland Security
21 regarding “Military Service by Transgender Individuals,” available at
22 <https://www.whitehouse.gov/the-press-office/2017/08/25/presidential-memorandum-secretary-defense-and-secretary-homeland>.

24 9. Attached hereto as **Exhibit 8** are true and correct copies of excerpts from the 2011
25 “A Report of the National Transgender Discrimination Survey,” available at
26 <http://www.transequality.org/issues/resources/national-transgender-discrimination-survey-executive-summary> (highlighting provided).

1 10. Attached hereto as **Exhibit 9** is a true and correct copy of New England Journal
2 of Medicine Article entitled “Caring for Our Transgender Troops – The Negligible Cost of
3 Transition-Related Care,” dated September 17, 2015 (highlighting provided).

4 11. Attached hereto as **Exhibit 10** is a true and correct copy of a RAND Corporation
5 Article entitled “Transgender Troops: Fit to Serve,” dated August 18, 2016, available at
6 <http://www.nejm.org/doi/pdf/10.1056/NEJMp1509230> (highlighting provided).

7 12. Attached hereto as **Exhibit 11** is a true and correct copy of an August 2017 Palm
8 Center Publication entitled “Discharging Transgender Troops Would Cost 960 Million,”
9 available at [http://www.palmcenter.org/wp-content/uploads/2017/08/cost-of-firing-trans-](http://www.palmcenter.org/wp-content/uploads/2017/08/cost-of-firing-trans-troops.pdf)
10 [troops.pdf](http://www.palmcenter.org/wp-content/uploads/2017/08/cost-of-firing-trans-troops.pdf) (highlighting provided).

11 13. Attached hereto as **Exhibit 12** is a true and correct copy of a March 2015 Palm
12 Center Publication entitled “Open Service by Transgender Members of Israel Defense Forces,”
13 available at <http://www.palmcenter.org/wp-content/uploads/2015/05/Israel-Defense-Forces.pdf>
14 (highlighting provided).

15 14. Attached hereto as **Exhibit 13** are true and correct copies of excerpts from a
16 March 2014 Palm Center Publication entitled “Report of the Transgender Military Service
17 Commission,” available at [http://archive.palmcenter.org/files/Transgender%20Military%](http://archive.palmcenter.org/files/Transgender%20Military%20Service%20Report.pdf)
18 [20Service%20Report.pdf](http://archive.palmcenter.org/files/Transgender%20Military%20Service%20Report.pdf) (highlighting provided).

19 15. Attached hereto as **Exhibit 14** is a true and correct copy of a Statement by Fifty-
20 Six Retired Generals and Admirals, dated August 1, 2017, available at
21 <http://www.palmcenter.org/wp-content/uploads/2017/08/56-GOFO-statement-2.pdf>.

22 16. Attached hereto as **Exhibit 15** is a true and correct copy of the Declaration of
23 Margaret C. Wilmoth filed in *Doe v. Trump*, No. 1:17-cv-01597, Dkt. No. 13-13 (D.D.C.), on
24 August 31, 2017. Because Dr. Wilmoth has been ill this week, she has been unable to sign an
25 identical copy of this declaration for use in this litigation.

26 17. Attached hereto as **Exhibit 16** is a true and correct copy of a USA Today Article
27 entitled “Accept transgender troops, allow them medical treatment, Adm. Mike Mullen tells
28 Congress,” dated July 25, 2017, available at <https://www.usatoday.com/story/news/politics/>

1 2017/07/25/accept-treat-transgender-troops-admmike-mullen-tells-congress/508852001.

2 18. Attached hereto as **Exhibit 17** is a true and correct copy of an Article from The
3 Hill entitled “Ex-Joint Chiefs chairman tells Congress to allow medical care for transgender
4 troops,” dated July 25, 2017, available at <http://thehill.com/policy/defense/343658-former-joint-chiefs-chairman-to-congress-dont-ban-medical-care-for-transgender>.

6 19. Attached hereto as **Exhibit 18** is a true and correct copy of the biography
7 webpage for Admiral Michael Mullen on the Joint Chiefs of Staff website, obtained from the
8 website <http://www.jcs.mil/About/The-Joint-Staff/Chairman/Admiral-Michael-Glenn-Mullen/> on
9 September 13, 2017 (highlighting provided).

11 DATED this 14th day of September, 2017 at Seattle, Washington

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14 Samantha Everett

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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that on September 14, 2017, I caused true and correct copies of the foregoing documents to be served by the method(s) listed below on the following interested parties:

By Hand Delivery:

US Attorney’s Office
700 Stewart St., Suite 5220
Seattle, WA 98101-1271

By Registered or Certified Mail:

Attorney General of the United States	Department of Defense
U.S. Department of Justice	1400 Defense Pentagon
950 Pennsylvania Avenue, NW	Washington, DC 20301-1400
Washington, DC 20530-0001	

Secretary of Defense James N. Mattis	President Donald J. Trump
1000 Defense Pentagon	1600 Pennsylvania Ave. NW
Washington, DC 20301-1000	Washington, DC 20500

I hereby certify under the penalty of perjury that the foregoing is true and correct. Executed on September 14, 2017 at Seattle, Washington.

s/Rachel Horvitz
Rachel Horvitz, *Paralegal*

Exhibit 1

Department of Defense Press Briefing by Secretary Carter on Transgender Service Policies in the Pentagon Briefing Room

Press Operations

June 30, 2016

SECRETARY OF DEFENSE ASH CARTER: Good afternoon, everyone. Thanks for being here.

I am here today to announce some changes in the Defense Department's policies regarding transgender service members. And before I announce what changes we're making, I want to explain why.

There are three main reasons, having to do with their future force, our current force and matters of principle. The first and fundamental reason is that the Defense Department and the military need to avail ourselves of all talent possible in order to remain what we are now, the finest fighting force the world has ever known.

Our mission is to defend this country and we don't want barriers unrelated to a person's qualification to serve preventing us from recruiting or retaining the soldier, sailor, airman or Marine who can best accomplish the mission.

We have to have access to 100 percent of America's population for our all-volunteer force to be able to recruit from among them the most highly qualified and to retain them.

Now, while there isn't definitive data on the number of transgender service members, RAND looked at the existing studies out there, and their best estimate was that about 2,500 people out of approximately 1.3 million active-duty service members,

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and about 1,500 out of 825,000 reserve service members are transgender, with the upper end of their range of estimates of around 7,000 in the active component and 4,000 in the reserves.

Although relatively few in number, we're talking about talented and trained Americans who are serving their country with honor and distinction. We invest hundreds of thousands of dollars to train and develop each individual, and we want to take the opportunity to retain people whose talent we've invested in and who have proven themselves.

And this brings me to the second reason, which is that the reality is that we have transgender service members serving in uniform today. And I have a responsibility to them and to their commanders to provide them both with clearer and more consistent guidance than is provided by current policies.

We owe commanders better guidance on how to handle questions such as deployment, medical treatment and other matters. And this is particularly true for small unit leaders, like our senior enlisted and junior officers. Also, right now, most of our transgender service members must go outside the military medical system in order to obtain medical care is judged by doctors to be necessary, and they have to pay for it out of their own pockets. This is inconsistent with our promise to all our troops that we will take care of them and pay for necessary medical treat.

I, and the Defense Department's other senior leaders who have been studying this issue the past year, have met with some of these transgender service members. They've deployed all over the world, serving on aircraft, submarines, forward operating bases and right here in the Pentagon. And while I learned that in most cases, their peers and local commanders have recognized the value of retaining such high-quality people, I also learned the lack of clear guidelines for how to handle this issue puts the commanders and the service members in a difficult and unfair position.

One service member I met with described how some people had urged him to leave the military, because of the challenges he was facing with our policies, and he said he just wouldn't quit. He was too committed to the mission, and this is where he wanted to be. These are the kind of people we want serving in our military.

The third and final reason for the change, also important, is a matter of principle. Americans who want to serve and can meet our standards should be afforded the opportunity to compete to do so. After all, our all-volunteer force is built upon having the most qualified Americans, and the profession of arms is based on honor and trust.

Army Chief-of-Staff General Milley recently reminded us of this when he said, and I quote him, "The United States Army is open to all Americans who meet the standard, regardless of who they are. Embedded within our Constitution is that very principle, that all Americans are free and equal. And we, as an Army, are sworn to protect and defend that very principle. And we are sworn to even die for that principle. So, if we in uniform are willing to die for that principle, then we in uniform should be willing to live by that principle." That's General Milley.

In view of these three reasons to change our policy, last July I directed the commencement of a study to identify the practical issues related to transgender Americans serving openly, and to develop an implementation plan that addresses those issues consistent with military readiness, because our mission -- which is defending the country -- has to come first.

I directed the working group to start with the presumption that transgender persons can serve openly without adverse effect -- impact, excuse me, on military effectiveness and readiness, unless and except where objective, practical impediments are identified.

I think it's fair to say this has been an educational process for a lot of people here in the department, including me. We had to look carefully and deliberately at medical, legal and policy considerations that have been evolving very rapidly in recent years. And we had to take into account the unique nature of military readiness and make sure we got it right.

I'm proud of the thoughtful and deliberate manner in which the department's leadership has pursued this review. I've been guided throughout by one central question. Is someone the best-qualified service member to accomplish our mission?

Let me now describe the process we used to study this over the last year. The leadership of the armed services, the Joint Chiefs of Staff, the service secretaries, myself, together with personnel, training, readiness and medical specialists from across the Department of Defense, studied all the data available to us. We also had the RAND Corporation analyze relevant data and studies to help us with our review. And we got input from transgender service members, from outside expert groups, and from medical professionals outside of the department.

We looked carefully at what lessons could be learned from the outside, including from allied militaries that already allow transgender service members to serve openly. And from the private sector also, because even though we're not a business and are different than a company in important ways, their experience and their practices are still relevant.

It's worth noting, for example, that at least 18 countries already allow transgender personnel to serve openly in their militaries. These include close allies such as the United Kingdom, Israel, and Australia. And we were able to study how they dealt with this issue.

We also saw that among doctors, employers and insurance companies today, providing medical care for transgender individuals is becoming common and normalized in both public and private sectors alike. Today, over a third of Fortune 500 companies, including companies like Boeing, CVS, and Ford, offer employee health insurance plans with transgender-inclusive coverage. That's up from zero such companies in 2002.

Similarly, nondiscrimination policies at two-thirds of Fortune 500 companies now cover gender identity, up from just three percent in 2002.

And for the public sector, all civilian federal employees have access today to a health insurance plan that provides comprehensive coverage for transgender-related care and medical treatment.

Based on its analysis of allied militaries and the expected rate at which American transgender service members would require medical treatment that would impact their fitness for duty or deployability, RAND's analysis concluded that there would be, quote, "minimal readiness impacts from allowing transgender service members to serve openly," end quote.

And in terms of cost, RAND concluded that health care costs would represent, again in their words, "an exceedingly small proportion of DOD's overall health care expenditures."

Now, as a result of this year-long study, I'm announcing today that we're ending the ban on transgender Americans in the United States military.

Effective immediately, transgender Americans may serve openly and they can no longer be discharged or otherwise separated from the military just for being transgender.

Additionally, I have directed that the gender identity of an otherwise qualified individual will not bar them from military service or from any accession program.

In taking the steps, we are eliminating policies that can result in transgender members being treated differently from their peers based solely upon their gender identity, rather than upon their ability to serve and we are confirming that going forward we will apply the same general principles, standards and procedures to transgender service members as we do to all service members.

What I heard from the transgender service members I met with overwhelmingly was that they don't want special treatment. They want to be held to the same standards and be treated like everybody else.

As I directed, the study identified practical issues that arise with respect to transgender service, and it developed an implementation plan to address those issues.

Let me briefly describe that implementation plan. I want to emphasize that in this case, as in the department's decisions on Don't Ask, Don't Tell and women in service, simply declaring a change in policy is not effective implementation.

That is why we have worked hard on the implementation plan and must continue to do so. These policies will be implemented in stages over the next 12 months, starting most immediately with guidance for current service members and their commanders, followed by training for the entire force and then beginning to access new military service members who are transgender.

Implementation will begin today. Starting today, otherwise qualified service members can no longer be involuntarily separated, discharged or denied reenlistment or continuation of service just for being transgender.

Then, no later than 90 days from today, the department will complete and issue both a commander's guidebook for leading currently serving - for leaders of currently serving transgender members and medical guidance to doctors for providing transition-related care, if required, to currently serving transgender service members.

Our military treatment facilities will begin providing transgender service members with all medically necessary care based on that medical guidance. Also starting on that date, service members will be able to initiate the process to officially change their gender in our personnel management systems.

Next, over the nine months that follow, based on detailed guidance and training materials that will be prepared, the services will conduct training of the force and commanders to medical personnel, to the operating force and recruiters.

When the training is complete, no later than one year from today, the military services will begin accessing transgender individuals who meet all standards, holding them to the same physical and mental fitness standards as everyone else who wants to join the military.

Our initial accession policy will require an individual to have completed any medical treatment that their doctor has determined as necessary in connection with their gender transition and to have been stable in their identified gender for 18 months, as certified by their doctor before they can enter the military.

I have directed that this succession standard be reviewed no later than twenty-four months from today to ensure it reflects what we learn over the next two years as this is implemented as well as the most up-to-date medical knowledge.

I've discussed the implementation plan with our senior military leaders, including Chairman Dunford. The chief sent specific recommendations about the timeline, and I made adjustments to the implementation plan timeline to incorporate those recommendations. The chairman has indicated the services support the final implementation timeline that I've laid out today.

Overall, the policies we are issuing today will allow us to assess -- excuse me, access talent of transgender service members to strengthen accomplishment of our mission, clarify guidance for commanders and military medical providers, and reflect better the department's and our nation's principles.

I want to close by emphasizing that deliberate and thoughtful implementation will be key. I, and the senior leaders of the department will therefore be ensuring all issues identified in this study are addressed in implementation.

I'm confident they can and will be addressed in implementation. That's why we are taking the step-by-step approach I've described. And I'm 100 percent confident in the ability of our military leaders and all men and women in uniform to implement these changes in a manner that both protects the readiness of the force and also

I'm also confident that we have reason to be proud today of what this will mean for our military, because it is the right thing to do, and it's another step in ensuring that we continue to recruit and retain the most qualified people.

And good people are the key to the best military in the world. Our military and the nation it defends will be stronger.

Thank you. And now, I'll take some questions. And -- Phil, you want to start?

Q: Sure. Mr. Secretary, could you talk a bit about -- I know you spoke about the costs for health care. Are there other costs associated with this implementation plan? And could you elaborate a bit on the timing issue, the adjustments in timing you spoke to?

SEC. CARTER: Sure. With respect to cost -- by the way, I will mention that Peter Levine will be here later and will be prepared to answer questions in detail.

But the reason that RAND concluded the costs would be minimal is that the medical treatment that service members who are currently transgender requires fairly straightforward, well-understood -- they were able to make those estimates. And that was, as they said, minimal.

And with respect to accessing new members as I indicated, they will have already completed and been stable in their transition for a period of not less than 18 months before they can access service, so there will be no medical costs associated with that.

And with respect to the timetable for implementation, the -- there's -- as I indicated in the stages, there's the -- the preparation of the medical guidance, that is up to the doctors who need to do that, so that doctors at military treatment facilities all have a standard protocol.

I'm giving them 90 days to that. That is what they asked for. The commanders' guidance, the -- as I indicated, the chairman and the chiefs asked for 90 days in that regard -- to prepare that commanders guidance and the training guidance.

And I agreed to that. I think that's reasonable. That's the amount of time it will take them to complete the job. Obviously, they've begun some of that.

And then, the rest of the time is time to train the force, which is comparable to the time we took to train the force say, in Don't Ask, Don't Tell. We do have some experience in this kind of thing, and we're following that template to successful implementation -- change of this kind.

Q: (inaudible) -- on Russia?

SEC. CARTER: Sure.

Q: --On a separate subject -- there's a report today that spoke to a proposal to strengthen coordination -- military coordination with Russia in targeting al-Nusra in Syria. And I'm just wondering is there -- you've been a skeptic in the past about cooperating with Russia militarily in Syria, given that their motives are different than those of the United States. Has something changed? Would you support this proposal?

SEC. CARTER: Well, we do have a professional relationship with the Russian military to make sure that there are no incidents and no safety issues as we both operate in neighboring areas of Syria. But I -- I've said before, the Russians got off on the wrong foot in Syria. They said they were coming in to fight ISIL. And that they would assist the political transition in Syria towards a post-Assad government that

They haven't done either of those things. So I think while I'm still hopeful that they will do both of those things, and I think that's what Secretary Kerry's talks, which are very frequent with the Russians, are all about. But meanwhile, we have a channel which is focused on safety issues, and we maintain that. And that's a very professional working channel between us.

Q: Can I follow up on that and ask you something else? It's a follow-on to Phil's question. You're well known to be skeptical of the Russians and some of the things that they have -- their military has done. So, really straight up, are you willing -- are you in favor now of an expanded effort for military cooperation with the Russians inside Syria?

Because most people in this town think you are not.

SEC. CARTER: If the Russians would do the right thing in Syria, and that's an important condition, as in all cases with Russia, we're willing to work with them. That's what we've been urging them to do since they came in. That's the objective that Secretary Kerry's talks are aimed at. And if we can get them to that point, that's a good thing.

Q: But may I follow up on two small items? Are you willing to include an effort for the U.S. to begin airstrikes against al-Nusra? And may I also ask you about Raqqah? As the world has watched what's happened in Istanbul, how urgent now are you, beyond the usual discussion of accelerants, to see the Syrian Arab coalition and the other fighters get to Raqqah? Because --

SEC. CARTER: Oh, very, very eager to get them to Raqqah. This is the same group that we've been working successfully with, that is they have been successful, and we've been enabling and supporting them, in -- to envelop and take, which they will, from ISIL the city of Manbij, which like Raqqah, isn't as well known, but Manbij is

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a city from which external plotting has been conducted by ISIL into Europe and into the United States as well.

And was part of the transit hub from the Turkish border down to ISIL in Syria. So that was an important objective. Those same forces, and that same approach, or really the same approach and some larger forces, actually, are the ones that we plan -- and I just was discussing this with General Votel and General MacFarland the other day, along with General Dunford.

Those are the forces that we are going to position to, again, envelop and collapse ISIL's control of Raqqa.

And the reason I want to do that, Barbara, as soon as possible is that Raqqa is the self-proclaimed capital of the self-proclaimed caliphate of ISIL. And it's important to destroy the ISIL in Iraq and Syria, because that's absolutely necessary.

It's not sufficient to avoid all kinds of radicalization and so forth, but it's necessary in order to eliminate the idea that there can be a state based upon that ideology. That's why we are so intent in our military campaign against ISIL on Iraq and Syria. So we would like to get Raqqa as soon as -- as soon as we possibly can, like everything else.

Chris?

Q: Mr. Secretary, a couple of questions about what this change will mean for the transgender service members. First, can you verify that the health -- the military health care coverage will cover all aspects of transition-related care, including gender reassignment surgery?

And second, will the Pentagon add gender identity or transgender status to the military equal opportunity policy in the event that a transgender service member feels like they're experiencing discrimination?

SEC. CARTER: The answer to the first one is the medical standards don't change. The transgender individual, like all other servicemembers, will get all medical care their doctors deem necessary.

They will have to do that with their -- subject to, if it's non-urgent medical care, subject to their commanders. Because, you know, if they need to be deployed, they need to be deployed. And it's normal that if you -- if you have, say, a procedure which is not urgent, that you have to defer that if you are being deployed.

So we don't have any -- we're not going to have any different medical policy for transgender service members than others. Our doctors will treat them -- give them medically necessary treatment according to the protocols that are determined by the medical profession.

Q: (inaudible) -- MEO policy? Will you add transgender status for the MEO?

SEC. CARTER: You know, I don't know the specific answer to that. I certainly assume the answer is yes, and Peter is telling me yes, that certainly stands to reason that we would. That makes sense.

Let's see. Cory. Cory is not here. How about Paul?

Q: I wanted to follow-up on that question. So there's been some debate on whether the military would only cover hormone therapy versus covering full reassignment surgery. So will reassignment surgery be covered?

SEC. CARTER: This is for currently serving members. Again, that's going to be a matter that the doctors will determine in accordance with what is medically necessary. That's a decision that they make with their physician.

And the timing of it -- of any treatment, of any kind, like any other non-urgent medical care, will be something that their commanders will have a voice in for the very simple reason that we -- we as, in this matter as in all matters, readiness and deployability are critical. Tom?

Q: Mr. Secretary, if I could follow-up very quickly. You said a current service member --

SEC. CARTER: Only because --

Q: So incoming service members who are transition would not be eligible for that transitional surgery?

SEC. CARTER: It depends, Nick. If someone who is transgender and comes out will need to and be required to have undergone transition and be stable in that state for 18 months before they can enter the military.

Q: But the U.S. military will not provide that surgery. Is that what you're saying?

SEC. CARTER: They won't be in the U.S. military at that time because they won't have accessed until they have undergone transition. Tom --

Q: Just wondering, if I could -- how many transgender troops have been dismissed under the old policy? And also, I'm wondering why Chairman Dunford isn't here to discuss this policy since it affects the uniformed military --

SEC. CARTER: I'll take the second part first. This is my decision. However, I have, we have arrived at it together, the senior leadership of the department. They support this timetable, this implementation plan, as I indicated, I actually made some adjustments in it specifically to take into account some of the desire by some of the chiefs to have a little more time on the front end, particularly for the commanders in

training guidance, and so I agreed to that because I thought that was reasonable. And I have a general principle around here which is very important which is that it's important that the people who have to implement decisions be part of the decision making, and the armed services are the ones that are going to have to implement that, so it's very important that they've been part of this study, but now, they're a critical part of implementation, because they and I all agree, as I said before, that simply declaring the military open to transgender individuals does not constitute effective implementation. We have work to do and we'll do it and we'll do it together.

Q: Mr. Secretary, in light of the events this morning at Andrews Air Force Base, are you getting a little fed up about all these false alarms for an active shooter? And why the communications problems this morning?

SEC. CARTER: Well, I wouldn't say fed up, because I think we have to take these things seriously when they occur, and I'm sure if a mistake was made here, if somebody inadvertently did, they weren't doing that on purpose, and it also shows a high degree of readiness and rapidity of responses. So it does appear, based on the information that I have at this moment, that this was mistaken, and that this was a drill that was going on that was mistaken for a real event, and a response was made, and that is something -- because it has happened before, that I think we need to pay attention to -- how to minimize the chances of false alarms like that. At the same time, I think it's important to have a reasonable level of awareness of the possibility of this kind of event and what to do, and I thought the response was strong and solid. So that's the good news. The bad news is, it appears to have been a mistake, and we'd like to reduce the number of mistakes made in this way, no question about it. David --

Q: Mr. Secretary, I'm still confused by your answer to Mik's question. Someone who is already in the military, if he is -- he or she is deemed medically -- if sex change surgery is deemed medically necessary, the military will pay for it?

SEC. CARTER: That's correct.

Q: What happens now -- and then you explained the 18 month stable before you commit, but what happens to a service man or woman who joins --

SEC. CARTER: They'll receive --

(CROSSTALK)

Q: They join as a man or woman and then decide at some point after they've joined the service that they need --

SEC. CARTER: Any medical treatment in that instance, that is determined to be medically necessary by their doctors, will be provided like any other medical care. However, and I emphasize this, they're subject to the normal readiness requirements that are imposed upon any military serviceman.

Q: So, this is not a one-time -- one-time offer? It -- this is going to --

SEC. CARTER: No, I think our -- our offer in this is an all medical -- because there is no change in medical policy. Medically-necessary policy to serving service -- medically-necessary care to -- as determined by doctors, which is appropriate, will be provided to service members in -- as is part of our promise about medical care in general.

Can I -- one -- one more?

Q: Reaction to the response from Capitol that's, of course, already come in. This is the way things work and this electronic age as -- Chairman Mac Thornberry of the House Armed Services Committee has already reacted to your announcement, even as you're still making it.

And I -- if I could just read a tiny bit of his statement, and just get your response. He says, quote, "This is the latest example of the Pentagon and the president

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prioritizing politics over policy. Our military readiness, and hence, our national security, is dependent on our troops being medically ready and deployable. The administration seems unwilling or unable to assure the Congress and the American people that transgender individuals will meet these individual readiness requirements."

Can you --

SEC. CARTER: Well, the chair -- the chairman is right -- that is Chairman Thornberry -- is right to emphasize readiness. That is a key part of our -- was a key part of our study, and will be a key part of implementation.

And the chairman and other members of the committee and I -- committees and -- I've actually heard a variety of opinions on this, some urging us to move even faster than we have moved, and some wanting -- and this is very legitimate -- to understand what the effects on readiness and so forth are.

But we have some principles here. We have a necessity here. And we're going to act upon that. We're going to do it in a deliberate, and thoughtful and step-by-step manner. But it's important that we do it.

(CROSSTALK)

Q: One question. Is that in Afghanistan -- (inaudible)?

SEC. CARTER: Thank you very much.

-END-

Exhibit 2

IMMEDIATE RELEASE

Statement by Secretary of Defense Ash Carter on DOD Transgender Policy

Press Operations

Release No: NR-272-15

July 13, 2015

Over the last fourteen years of conflict, the Department of Defense has proven itself to be a learning organization. This is true in war, where we have adapted to counterinsurgency, unmanned systems, and new battlefield requirements such as MRAPs. It is also true with respect to institutional activities, where we have learned from how we repealed "Don't Ask, Don't Tell," from our efforts to eliminate sexual assault in the military, and from our work to open up ground combat positions to women. Throughout this time, transgender men and women in uniform have been there with us, even as they often had to serve in silence alongside their fellow comrades in arms.

The Defense Department's current regulations regarding transgender service members are outdated and are causing uncertainty that distracts commanders from our core missions. At a time when our troops have learned from experience that the most important qualification for service members should be whether they're able and willing to do their job, our officers and enlisted personnel are faced with certain rules that tell them the opposite. Moreover, we have transgender soldiers, sailors, airmen, and Marines - real, patriotic Americans - who I know are being hurt by an outdated, confusing, inconsistent approach that's contrary to our value of service and individual merit.

Today, I am issuing two directives to deal with this matter. First, DoD will create a working group to study over the next six months the policy and readiness implications of welcoming transgender persons to serve openly. Led by (Acting) Under Secretary of Defense for Personnel and Readiness Brad Carson, and composed of military and civilian personnel representing all the military services and the Joint Staff, this working group will report to Deputy Secretary of Defense Bob Work. At my direction, the working group will start with the presumption that transgender persons can serve openly without adverse impact on military effectiveness and readiness, unless and except where objective, practical impediments are identified. Second, I am directing that decision authority in all administrative discharges for those diagnosed with gender dysphoria or who identify themselves as transgender be elevated to Under Secretary Carson, who will make determinations on all potential separations.

As I've said before, we must ensure that everyone who's able and willing to serve has the full and equal opportunity to do so, and we must treat all our people with the dignity and respect they deserve. Going forward, the Department of Defense must and will continue to improve how we do both. Our military's future strength depends on it.

Exhibit 3

IMMEDIATE RELEASE

Statement by Chief Pentagon Spokesperson Dana W. White on Transgender Accessions

Press Operations

Release No: NR-250-17

June 30, 2017

Secretary Mattis today approved a recommendation by the services to defer accessing transgender applicants into the military until Jan. 1, 2018.

The services will review their accession plans and provide input on the impact to the readiness and lethality of our forces.

Exhibit 4

POLITICO



President Donald Trump's sudden decision was, in part, a last-ditch attempt to save a House proposal full of his campaign promises that was on the verge of defeat, numerous congressional and White House sources said. | Andrew Harnik/AP Photo

DEFENSE

Inside Trump's snap decision to ban transgender troops

A congressional fight over sex reassignment surgery threatened funding for his border wall.

By **RACHAEL BADE** and **JOSH DAWSEY** | 07/26/2017 02:07 PM EDT | Updated 07/26/2017 09:49 PM EDT

After a week sparring with his attorney general and steaming over the Russia investigation consuming his agenda, President Donald Trump was closing in on an important win.

House Republicans were planning to pass a spending bill stacked with his campaign promises, including money to build his border wall with Mexico.

But an internal House Republican fight over transgender troops was threatening to blow up the bill. And House GOP insiders feared they might not have the votes to pass the legislation because defense hawks wanted a ban on Pentagon-funded sex reassignment operations — something GOP leaders wouldn't give them.

They turned to Trump, who didn't hesitate. In the flash of a tweet, he announced that transgender troops would be banned altogether.

Trump's sudden decision was, in part, a last-ditch attempt to save a House proposal full of his campaign promises that was on the verge of defeat, numerous congressional and White House sources said.

The president had always planned to scale back policies put in place during the administration of President Barack Obama welcoming such individuals in combat and greenlighting the military to pay for their medical treatment plans. But a behind-the-scenes GOP brawl threatening to tank a Pentagon funding increase and wall construction hastened Trump's decision.

Numerous House conservatives and defense hawks this week had threatened to derail their own legislation if it did not include a prohibition on Pentagon funding for gender reassignment surgeries, which they deem a waste of taxpayer money. But GOP leaders were caught in a pinch between those demands and those of moderate Republicans who considered the proposal blatantly discriminatory.

ADVERTISING

“There are several members of the conference who feel this really needs to be addressed,” senior House Appropriations Committee member Robert Aderholt (R-Ala.) said Tuesday. “This isn’t about the transgender issue; it’s about the taxpayer dollars going to pay for the surgery out of the defense budget.”

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That’s why House lawmakers took the matter to the Trump administration. And when Defense Secretary James Mattis refused to immediately upend the policy, they went straight to the White House. Trump — never one for political correctness — was all too happy to oblige.

“[P]lease be advised that the United States Government will not accept or allow Transgender individuals to serve in any capacity in the U.S. Military,” Trump tweeted Wednesday morning. “Our military must be focused on decisive and overwhelming victory and cannot be burdened with the tremendous medical costs and disruption that transgender in the military would entail.”

The president’s directive, of course, took the House issue a step beyond paying for gender reassignment surgery and other medical treatment. House Republicans were never debating expelling all transgender troops from the military.

“This is like someone told the White House to light a candle on the table and the WH set the whole table on fire,” a senior House Republican aide said in an email. The source said that although GOP leaders asked the White House for help on the taxpayer matter specifically, they weren’t expecting — and got no heads up on — Trump’s far-reaching directive.

While Democrats and centrist Republicans are already blasting the move, one White House official said the decision would be “seen as common-sense” by millions — though likely vociferously protested by others. White House officials also noted that conservatives had pushed for the ban, including in a May letter that was signed by dozens of right-leaning

groups.

"It's not the worst thing in the world to have this fight," the administration official said.

The announcement, multiple sources said, did not sit well with Mattis, who appeared to be trying to avoid the matter in recent weeks. An extensive Defense Department review of the policy was already underway, but a decision wasn't expected for months.

Insiders said Mattis felt there was no need to rush upending the policy, arguing the Pentagon needed time to study the issue. Its decision would affect at least 2,450 transgender active-military personnel, according to a Rand report — though military LGBT activist groups say as many as 15,000 soldiers fall into that category.

That timeline, however, wasn't good enough for House Republicans. Rep. Vicky Hartzler (R-Mo.), the original author of the House's transgender proposal, attempted to reach Mattis by phone numerous times in recent weeks to discuss the transgender issue.

What to know about Trump's transgender military ban

By JACQUELINE KLIMAS, MATTHEW NUSSBAUM and CONNOR O'BRIEN

Mattis only got back to her the day she forced the matter on the House floor in mid-July. And, according to Rep. Tom MacArthur (R-N.J.), who opposed the Hartzler proposal, Mattis asked Hartzler to withdraw her amendment and give him space to maneuver.

Lawmakers, including Hartzler, went around Mattis to engage the White House. Mattis knew the ban was being considered and was consulted before the announcement, according to several White House officials. But the decision ultimately came down from Trump and was "White House-driven," Trump aides said.

The president was also annoyed by the Pentagon delay, one person said. A different official said the White House had gotten positive reaction from conservatives, an important factor amid their displeasure with Trump's recent bashing of Attorney General Jeff Sessions.

The transgender fight first surfaced in the House a few weeks ago. With the backing of almost the entire GOP Conference, Hartzler offered an amendment to a defense authorization bill that would ban funding for gender reassignment surgeries and treatments for transgender active-duty personnel.

Republican supporters were shocked when a group of 24 mostly moderate Republicans teamed up with 190 Democrats to kill the effort in a 209-214 vote.

Republicans spent much of a closed-door GOP Conference meeting the next morning steaming about what happened.

"It's not so much the transgender surgery issue as much as we continue to let the defense bill be the mule for all of these social experiments that the left wants to try to [foist] on government," Rep. Trent Franks (R-Ariz.), a conservative supporter of the Hartzler proposal, said last week.

He added: "It seems to me, and all due respect to everyone, that if someone wants to come to the military, potentially risk their life to save the country, that they should probably decide whether they're a man or woman before they do that."

Ernst opposes Trump's ban on transgender troops

By **BURGESS EVERETT**

Supporters of Hartzler's proposal were determined to try again. Last week, they began pushing GOP leadership to use a procedural trick to automatically include the controversial proposal in a Pentagon spending package set for a floor vote this week. The idea was to tuck the provision into a rules package governing the legislation, sidestepping a second potentially unsuccessful amendment vote and adding it to the bill without a floor fight.

Under intense pressure from moderates in the Tuesday Group to reject the idea, Speaker Paul Ryan (R-Wis.) and his team shied away from the strategy, worried that it would make them look hypocritical for circumventing regular order.

"Leadership should respect the will of the House — and that's already been expressed," said Rep. Carlos Curbelo (R-Fla.), a centrist who opposed the amendment. "These transgender service-people are serving our country and have signed up and agreed to risk their lives for this country, so we want to honor that commitment as well."

That's when lawmakers turned to the White House for help. They figured the administration could speed up a decision and settle the dispute once and for all.

"Conservatives were telling [the] White House they didn't want money in a spending bill to go to transgender health services," said one senior administration official, noting that it accelerated Trump's decision.

Their argument fell on sympathetic ears, White House sources said. Chief strategist Steve Bannon encouraged Trump to deal with the matter now.

Now, some Republicans are having buyer's remorse. They didn't realize Trump was going to ban transgender people from serving in the military altogether.

Franks, the Hartzler amendment supporter, told POLITICO that his push was more narrowly tailored to the medical procedures issue — not an all-out ban on transgender people. He wasn't sure what he thought about the broader prohibition, saying he needed to look into it further.

Still, some, like Hartzler, were elated.

"This was the right call by our commander in chief, to make sure every defense dollar goes toward meeting the threats that we are facing in the world," she said in an interview. "The entire [Obama-era transgender] policy... is a detriment to our readiness."

Exhibit 5



Source: Rodney & Adonica Howard-Browne/Facebook

Trump Announced His Transgender Military Ban Just Days After Tony Perkins Asked Him for It



by **DAVID BADASH**

September 11, 2017 11:10 AM



Report: 'Within Days of the Meeting, Mr. Trump Took Action, Announcing His Transgender Military Ban'

ADVERTISEMENT

On July 11 Family Research Council president Tony Perkins asked President Donald Trump to ban transgender service members from the U.S. military. Just 15 days later, on July 26, the president took to Twitter to announce he was [instituting a total ban](#) on all transgender military service members

A Sunday [New York Times article](#) detailing how the religious right has gained extraordinary access to and influence over the Trump administration refers to a six-hour meeting in July between the Christian conservatives and the White House.

At that meeting, "Tony Perkins, president of the Family Research Council, a conservative religious lobbying group, broached the topic of banning transgender people from the military," reports the Times, citing an account from the Trump administration's religious advisor, Johnnie Moore.

"Some Republican members of Congress had been pushing for a similar prohibition, pointing to the medical costs of supporting transgender people. Again, within days of the meeting, Mr. Trump took action, announcing his transgender military ban."

That meeting (photo above), as [NCRM reported](#) at the time, was held July 11. It concluded with an Oval Office group prayer, with the conservative faith leaders laying their hands on the President. Here's a photo of that event in the Oval Office, which Moore posted to Twitter:



Johnnie Moore 

@JohnnieM

[Follow](#)

Such an honor to pray within the Oval Office for [@POTUS](#) & [@VP](#) .

9:08 PM - Jul 11, 2017

5,739

3,361

7,801

Pat Robertson's CBN religious news network posted a list of the attendees, which looks like a who's who of the anti-gay Christian right.

Tony Perkins, President of the Family Research Council (FRC); Pastor John Hagee, founder and senior pastor of Cornerstone Church in San Antonio; Paula White, senior pastor of New Destiny Christian Center in Apopka, Florida; former Congresswoman Michele Bachmann; Ralph Reed, chairman of the Faith and Freedom Coalition; Gary Bauer, president of American Values; Robert Jeffress, senior pastor of First Baptist Church in Dallas, Jack Graham, pastor of Prestonwood Baptist Church in Plano, Texas; Jim Garlow, senior pastor of Skyline Church in La Mesa, California; Rodney Howard-Browne, senior pastor at the River at Tampa Bay Church, Mike Evans, the founder of Friends of Zion Museum in Jerusalem, and Richard Land, president of the Southern Evangelical Seminary in Charlotte and others.

President Trump had told the American people in his tweets that he had consulted with his generals before making the decision but that claim has been debunked. The Pentagon, according to multiple reports, is not happy about the ban and was not consulted or informed prior to the announcement. If implemented, Trump's possibly unconstitutional ban could lead to the eviction of up to 15,000 transgender troops.

As with his Muslim travel ban, several civil rights groups are suing the Trump administration in federal court in an attempt to block it.

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Image via Rodney & Adonica Howard-Browne/[Facebook](#)

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The New Civil Rights Movement, LLC



Exhibit 6



Donald J. Trump  @realDonaldTrump · 4h 

...victory and cannot be burdened with the tremendous medical costs and disruption that transgender in the military would entail. Thank you

 39K  25K  73K 



Donald J. Trump  @realDonaldTrump · 4h 

....Transgender individuals to serve in any capacity in the U.S. Military. Our military must be focused on decisive and overwhelming.....

 24K  27K  71K 



Donald J. Trump  @realDonaldTrump · 4h 

After consultation with my Generals and military experts, please be advised that the United States Government will not accept or allow.....

 14K  26K  66K 

Exhibit 7

THE WHITE HOUSE
Office of the Press Secretary
FOR IMMEDIATE RELEASE
August 25, 2017

MEMORANDUM FOR THE SECRETARY OF DEFENSE
THE SECRETARY OF HOMELAND SECURITY

SUBJECT: Military Service by Transgender
Individuals

Section 1. Policy. (a) Until June 2016, the Department of Defense (DoD) and the Department of Homeland Security (DHS) (collectively, the Departments) generally prohibited openly transgender individuals from accession into the United States military and authorized the discharge of such individuals. Shortly before President Obama left office, however, his Administration dismantled the Departments' established framework by permitting transgender individuals to serve openly in the military, authorizing the use of the Departments' resources to fund sex-reassignment surgical procedures, and permitting accession of such individuals after July 1, 2017. The Secretary of Defense and the Secretary of Homeland Security have since extended the deadline to alter the currently effective accession policy to January 1, 2018, while the Departments continue to study the issue.

In my judgment, the previous Administration failed to identify a sufficient basis to conclude that terminating the Departments' longstanding policy and practice would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources, and there remain meaningful concerns that further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects.

(b) Accordingly, by the authority vested in me as President and as Commander in Chief of the Armed Forces of the United States under the Constitution and the laws of the United States of America, including Article II of the Constitution, I am directing the Secretary of Defense, and the Secretary of Homeland Security with respect to the U.S. Coast Guard, to return to the longstanding policy and practice on military service by transgender individuals that was in place prior to June 2016 until such time as a sufficient basis exists

upon which to conclude that terminating that policy and practice would not have the negative effects discussed above. The Secretary of Defense, after consulting with the Secretary of Homeland Security, may advise me at any time, in writing, that a change to this policy is warranted.

Sec. 2. Directives. The Secretary of Defense, and the Secretary of Homeland Security with respect to the U.S. Coast Guard, shall:

(a) maintain the currently effective policy regarding accession of transgender individuals into military service beyond January 1, 2018, until such time as the Secretary of Defense, after consulting with the Secretary of Homeland Security, provides a recommendation to the contrary that I find convincing; and

(b) halt all use of DoD or DHS resources to fund sex-reassignment surgical procedures for military personnel, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex.

Sec. 3. Effective Dates and Implementation. Section 2(a) of this memorandum shall take effect on January 1, 2018. Sections 1(b) and 2(b) of this memorandum shall take effect on March 23, 2018. By February 21, 2018, the Secretary of Defense, in consultation with the Secretary of Homeland Security, shall submit to me a plan for implementing both the general policy set forth in section 1(b) of this memorandum and the specific directives set forth in section 2 of this memorandum. The implementation plan shall adhere to the determinations of the Secretary of Defense, made in consultation with the Secretary of Homeland Security, as to what steps are appropriate and consistent with military effectiveness and lethality, budgetary constraints, and applicable law. As part of the implementation plan, the Secretary of Defense, in consultation with the Secretary of Homeland Security, shall determine how to address transgender individuals currently serving in the United States military. Until the Secretary has made that determination, no action may be taken against such individuals under the policy set forth in section 1(b) of this memorandum.

Sec. 4. Severability. If any provision of this memorandum, or the application of any provision of this memorandum, is held to be invalid, the remainder of this

memorandum and other dissimilar applications of the provision shall not be affected.

Sec. 5. General Provisions. (a) Nothing in this memorandum shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This memorandum shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(d) The Secretary of Defense is authorized and directed to publish this memorandum in the *Federal Register*.

DONALD J. TRUMP

###

Exhibit 8



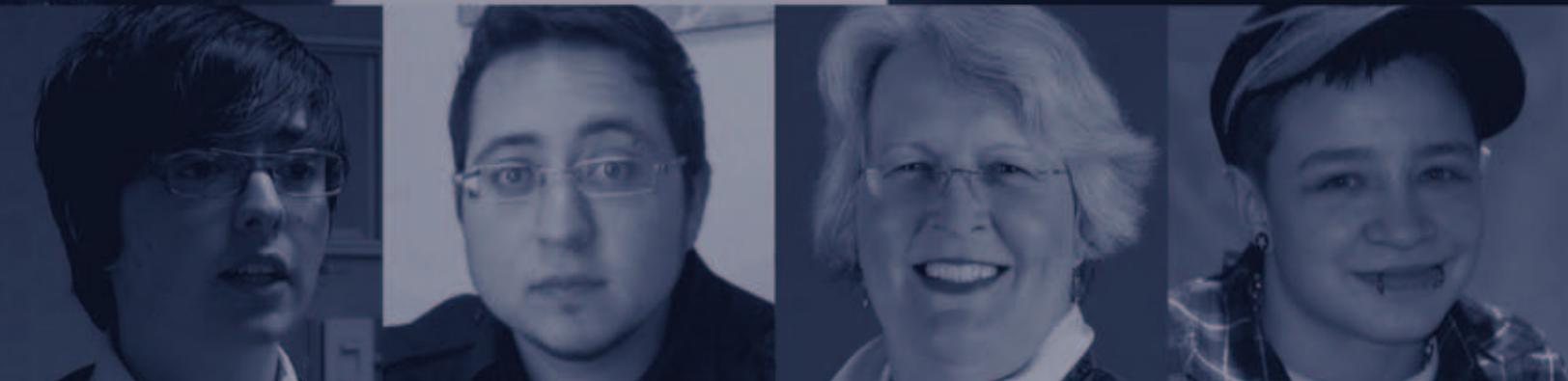
Injustice at Every Turn

A Report of the National Transgender Discrimination Survey

Lead authors in alphabetical order:

Jaime M. Grant, Ph.D.
Lisa A. Mottet, J.D.
Justin Tanis, D.Min.

with Jack Harrison
Jody L. Herman, Ph.D.
and Mara Keisling



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About the National Center for Transgender Equality

The National Center for Transgender Equality is a national social justice organization devoted to ending discrimination and violence against transgender people through education and advocacy on national issues of importance to transgender people. By empowering transgender people and our allies to educate and influence policymakers and others, NCTE facilitates a strong and clear voice for transgender equality in our nation's capital and around the country.

About the National Gay and Lesbian Task Force

The mission of the National Gay and Lesbian Task Force is to build the grassroots power of the lesbian, gay, bisexual and transgender (LGBT) community. We do this by training activists, equipping state and local organizations with the skills needed to organize broad-based campaigns to defeat anti-LGBT referenda and advance pro-LGBT legislation, and building the organizational capacity of our movement. Our Policy Institute, the movement's premier think tank, provides research and policy analysis to support the struggle for complete equality and to counter right-wing lies. As part of a broader social justice movement, we work to create a nation that respects the diversity of human expression and identity and creates opportunity for all.

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ACKNOWLEDGEMENTS

This study was undertaken with the dogged commitment of the National Center for Transgender Equality and the National Gay and Lesbian Task Force to bring the full extent of discrimination against transgender and gender non-conforming people to light. Executive directors Mara Keisling and Rea Carey committed considerable staff and general operating resources to this project over the past three years to create the original survey instrument, collect the data, analyze thousands of responses and, finally, present our findings here.

Key Task Force and NCTE staff, as well as our data analyst, are credited on the masthead of this report but many former staff, pivotal volunteers and visiting fellows put their unflinching effort and best thinking to this enormous task.

We are deeply grateful to Dr. Susan (Sue) Rankin of Pennsylvania State University, a nationally recognized LGBT researcher, for hosting our study through Penn State's Consortium on Higher Education. This allowed the survey to go through the Institutional Review Board process, to ensure the confidentiality and humane treatment of our survey participants. We are most grateful to M. Somjen Frazer who first as a volunteer and then later as a staff analyst made a crucial contribution in the questionnaire development, data cleaning and variable development phase of the research. Former Task Force Policy Institute staff member Nicholas Ray also did a wonderful job convening and guiding the many staff and volunteers who participated in developing the questionnaire.

A number of Vaid Fellows at the Task Force made crucial contributions to this work in the data cleaning, field work and early analytical stages of this report including Morgan Goode, Amanda Morgan, Robert Valadéz, Stephen Wiseman, Tey Meadow and Chloe Mirzayi. Morgan's work interfacing with staff at homeless shelters, health clinics and other direct service programs serving transgender and gender non-conforming people greatly increased participation in the study by transgender people often shut out of research projects.

Transgender community leaders made a major contribution to our thinking in developing the survey and field work, including Marsha Botzer, Moonhawk River Stone, M.S., LMHC and Scout, Ph.D. All of these leaders made important suggestions in the development of the questionnaire and our data collection process. We are grateful to Marsha, as the Task Force board chair, and Hawk, a member of the Task Force board, for championing this work institutionally.

Our organizations are especially grateful to the Network for LGBT Health Equity, formerly the Network for LGBT Tobacco Control, for providing \$3,000 in funding for health and outreach workers to reach underserved racial and ethnic populations in this endeavor.

Both organizations would also like to thank their foundation funders for their support in making this work possible: Arcus Foundation, Gill Foundation, Open Society Institute, as well as an Anonymous donor. In addition, the Task Force would like to thank additional foundation funders who supported this work, including the David Bohnett Foundation, Evelyn and Walter Haas, Jr. Fund, Ford Foundation, Kicking Assets Fund of the Tides Foundation, and the Wells Fargo Foundation.

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Finally, we thank Steven K. Aurand, who has volunteered at the Task Force for over 20 years, using his expertise in statistics to greatly increase our capacity to work with a very complex data set.

This study has obviously been a labor of love by a community of dedicated advocates, and we are honored to be able to offer the collective fruits of our labor to the community.

EXECUTIVE SUMMARY

This study brings to light what is both patently obvious and far too often dismissed from the human rights agenda. Transgender and gender non-conforming people face injustice at every turn: in childhood homes, in school systems that promise to shelter and educate, in harsh and exclusionary workplaces, at the grocery store, the hotel front desk, in doctors' offices and emergency rooms, before judges and at the hands of landlords, police officers, health care workers and other service providers.

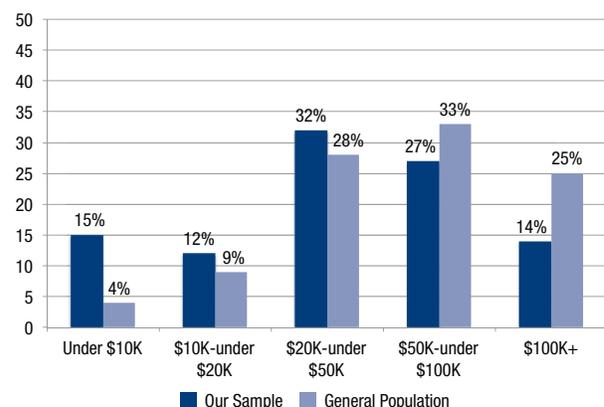
The National Gay and Lesbian Task Force and the National Center for Transgender Equality are grateful to each of the 6,450 transgender and gender non-conforming study participants who took the time and energy to answer questions about the depth and breadth of injustice in their lives. A diverse set of people, from all 50 states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands, completed online or paper surveys. This tremendous gift has created the first 360-degree picture of discrimination against transgender and gender non-conforming people in the U.S. and provides critical data points for policymakers, community activists and legal advocates to confront the appalling realities documented here and press the case for equity and justice.

KEY FINDINGS

Hundreds of dramatic findings on the impact of anti-transgender bias are presented in this report. In many cases, a series of bias-related events lead to insurmountable challenges and devastating outcomes for study participants. Several meta-findings are worth noting from the outset:

- Discrimination was pervasive throughout the entire sample, yet **the combination of anti-transgender bias and persistent, structural racism was especially devastating**. People of color in general fare worse than white participants across the board, with African American transgender respondents faring worse than all others in many areas examined.
- Respondents **lived in extreme poverty**. Our sample was nearly four times more likely to have a household income of less than \$10,000/year compared to the general population.¹
- A staggering **41% of respondents reported attempting suicide** compared to 1.6% of the general population,² with rates rising for those who lost a job due to bias (55%), were harassed/bullied in school (51%), had low household income, or were the victim of physical assault (61%) or sexual assault (64%).

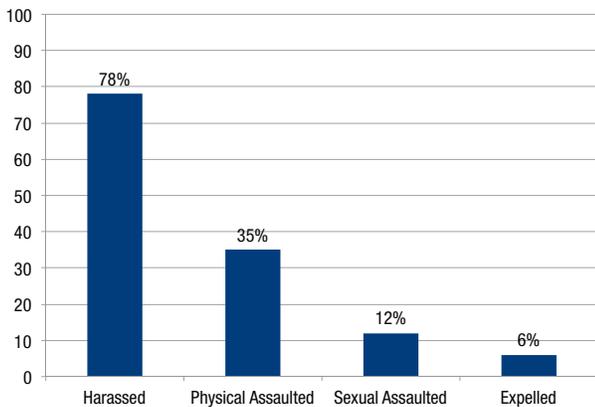
Household Incomes of Respondents³



HARASSMENT AND DISCRIMINATION IN EDUCATION

- Those who expressed a transgender identity or gender non-conformity while in grades K-12 reported **alarming rates of harassment (78%), physical assault (35%) and sexual violence (12%)**; harassment was so severe that it led **almost one-sixth (15%) to leave a school** in K-12 settings or in higher education.
- Respondents who have been **harassed and abused by teachers** in K-12 settings showed dramatically worse health and other outcomes than those who did not experience such abuse. Peer harassment and abuse also had highly damaging effects.

Harassment, Assault and Discrimination in K-12 Settings



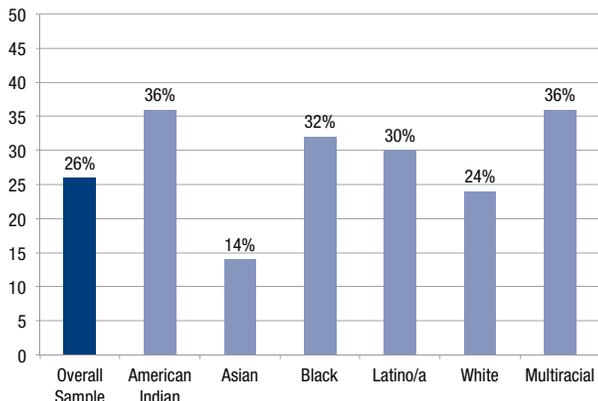
Respondents Income by Mistreatment in School⁴

	General Population	No school mistreatment	Mistreated in school
Under \$10K	4%	12%	21%
\$10K - under \$20K	9%	11%	15%
\$20K - under \$50K	28%	31%	33%
\$50k - under \$100k	33%	30%	21%
\$100k+	25%	16%	9%

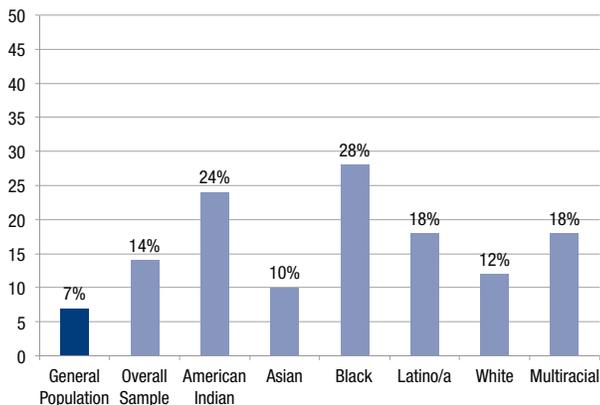
EMPLOYMENT DISCRIMINATION AND ECONOMIC INSECURITY

- **Double the rate of unemployment:** Survey respondents experienced unemployment at twice the rate of the general population at the time of the survey,⁵ with rates for people of color up to four times the national unemployment rate.
- **Widespread mistreatment at work: Ninety percent (90%) of those surveyed reported experiencing harassment, mistreatment or discrimination on the job or took actions like hiding who they are to avoid it.**
- **Forty-seven percent (47%) said they had experienced an adverse job outcome, such as being fired, not hired or denied a promotion because of being transgender or gender non-conforming.**
- **Over one-quarter (26%) reported that they had lost a job due to being transgender or gender non-conforming and 50% were harassed.**
- **Large majorities attempted to avoid discrimination by hiding their gender or gender transition (71%) or delaying their gender transition (57%).**
- **The vast majority (78%) of those who transitioned from one gender to the other reported that they felt more comfortable at work and their job performance improved, despite high levels of mistreatment.**
- Overall, **16% said they had been compelled to work in the underground economy** for income (such as doing sex work or selling drugs).
- **Respondents who were currently unemployed experienced debilitating negative outcomes**, including nearly double the rate of working in the underground economy (such as doing sex work or selling drugs), twice the homelessness, 85% more incarceration, and more negative health outcomes, such as more than double the HIV infection rate and nearly double the rate of current drinking or drug misuse to cope with mistreatment, compared to those who were employed.
- **Respondents who had lost a job due to bias also experienced ruinous consequences such as four times the rate of homelessness, 70% more current drinking or misuse of drugs to cope with mistreatment, 85% more incarceration, more than double the rate working in the underground economy, and more than double the HIV infection rate, compared to those who did not lose a job due to bias.**

Loss of Job by Race



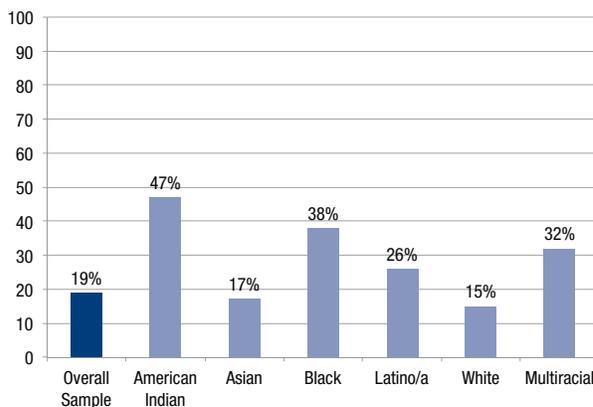
Unemployment Rates including by Race



HOUSING DISCRIMINATION AND HOMELESSNESS

- Respondents reported various forms of direct housing discrimination — 19% reported having been refused a home or apartment and 11% reported being evicted because of their gender identity/expression.
- One-fifth (19%) reported experiencing homelessness at some point in their lives because they were transgender or gender non-conforming; the majority of those trying to access a homeless shelter were harassed by shelter staff or residents (55%), 29% were turned away altogether, and 22% were sexually assaulted by residents or staff.
- Almost 2% of respondents were currently homeless, which is almost twice the rate of the general population (1%).⁶
- Respondents reported less than half the national rate of home ownership: 32% reported owning their home compared to 67% of the general population.⁷
- Respondents who have experienced homelessness were highly vulnerable to mistreatment in public settings, police abuse and negative health outcomes.

“I was denied a home/apartment” by Race



DISCRIMINATION IN PUBLIC ACCOMMODATIONS

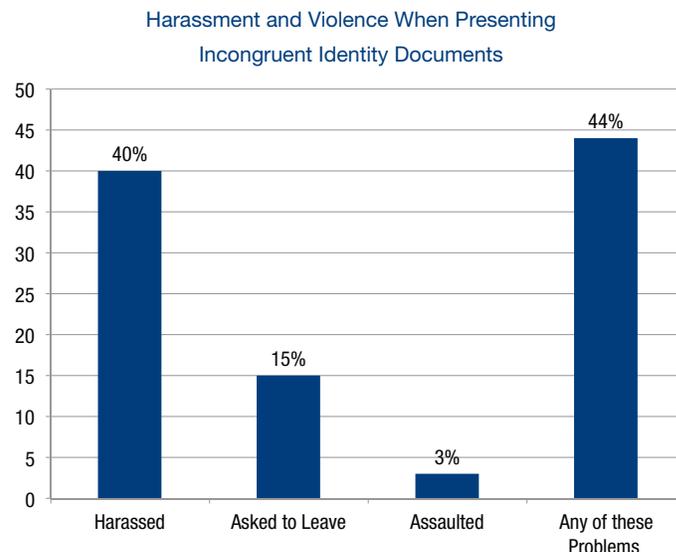
- **Fifty-three percent (53%) of respondents reported being verbally harassed or disrespected in a place of public accommodation, including hotels, restaurants, buses, airports and government agencies.**
- **Respondents experienced widespread abuse in the public sector, and were often abused at the hands of “helping” professionals and government officials. One fifth (22%) were denied equal treatment by a government agency or official; 29% reported police harassment or disrespect; and 12% had been denied equal treatment or harassed by judges or court officials.**

Experiences of Discrimination and Violence in Public Accommodations

Location	Denied Equal Treatment	Harassed or Disrespected	Physically Assaulted
Retail Store	32%	37%	3%
Police Officer	20%	29%	6%
Doctor’s Office or Hospital	24%	25%	2%
Hotel or Restaurant	19%	25%	2%
Government Agency/Official	22%	22%	1%
Bus, Train, or Taxi	9%	22%	4%
Emergency Room	13%	16%	1%
Airplane or Airport Staff/TSA	11%	17%	1%
Judge or Court Official	12%	12%	1%
Mental Health Clinic	11%	12%	1%
Legal Services Clinic	8%	6%	1%
Ambulance or EMT	5%	7%	1%
Domestic Violence Shelter/Program	6%	4%	1%
Rape Crisis Center	5%	4%	1%
Drug Treatment Program	3%	4%	1%

BARRIERS TO RECEIVING UPDATED ID DOCUMENTS

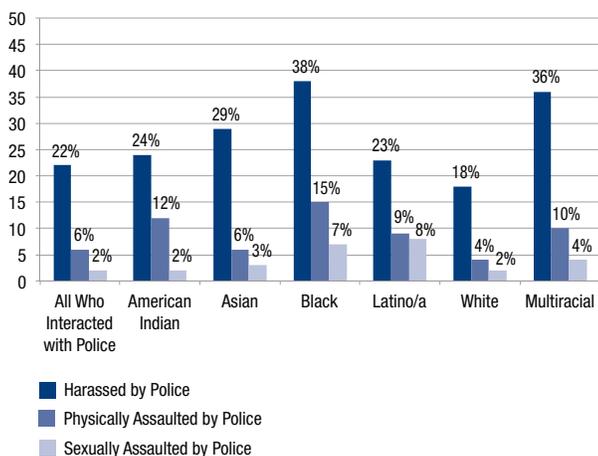
- Of those who have transitioned gender, **only one-fifth (21%) have been able to update all of their IDs and records with their new gender.** One-third (33%) of those who had transitioned had updated *none* of their IDs/records.
- Only 59% reported updating the gender on their driver’s license/state ID, meaning **41% live without ID that matches their gender identity.**
- **Forty percent (40%) of those who presented ID** (when it was required in the ordinary course of life) that did not match their gender identity/expression **reported being harassed, 3% reported being attacked or assaulted, and 15% reported being asked to leave.**



ABUSE BY POLICE AND IN PRISON

- **One-fifth (22%) of respondents** who have interacted with police **reported harassment by police**, with much higher rates reported by people of color.
- Almost half of the **respondents (46%) reported being uncomfortable seeking police assistance.**
- **Physical and sexual assault in jail/prison is a serious problem:** 16% of respondents who had been to jail or prison reported being physically assaulted and 15% reported being sexually assaulted.

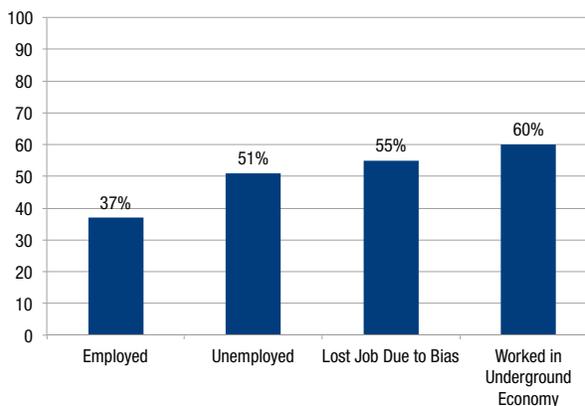
Police Harassment and Assault, Due to Bias, by Race



DISCRIMINATION IN HEALTH CARE AND POOR HEALTH OUTCOMES

- **Health outcomes for all categories of respondents show the appalling effects of social and economic marginalization**, including much higher rates of HIV infection, smoking, drug and alcohol use and suicide attempts than the general population.
- **Refusal of care: 19% of our sample reported being refused medical care** due to their transgender or gender non-conforming status, with even higher numbers among people of color in the survey.
- **Uninformed doctors: 50% of the sample reported having to teach their medical providers** about transgender care.
- **High HIV rates:** Respondents reported **over four times the national average of HIV infection, with rates higher among transgender people of color.**⁸
- **Postponed care:** Survey participants reported that when they were sick or injured, **many postponed medical care due to discrimination (28%)** or inability to afford it (48%).

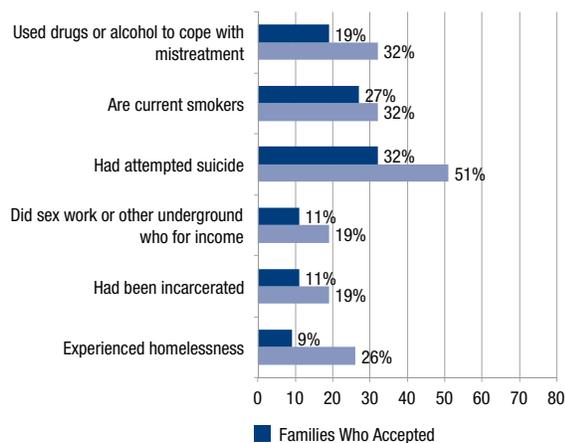
Suicide Attempt by Employment



FAMILY ACCEPTANCE OF GREAT IMPORTANCE

- **Forty-three percent (43%) maintained most of their family bonds**, while 57% experienced significant family rejection.
- In the face of extensive institutional discrimination, **family acceptance had a protective affect against many threats to well-being** including health risks such as HIV infection and suicide. Families were more likely to remain together and provide support for transgender and gender non-conforming family members than stereotypes suggest.

Impact of Family Acceptance

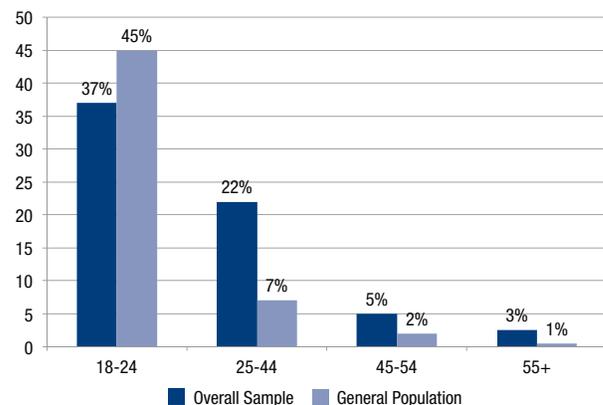


RESILIENCE

Despite all of the harassment, mistreatment, discrimination and violence faced by respondents, study participants also demonstrated determination, resourcefulness and perseverance:

- Although the survey identified major structural barriers to obtaining health care, 76% of transgender respondents have been able to receive hormone therapy, indicating a determination to endure the abuse or search out sensitive medical providers.
- Despite high levels of harassment, bullying and violence in school, many respondents were able to obtain an education by returning to school. Although fewer 18 to 24-year-olds were currently in school compared to the general population, respondents returned to school in large numbers at later ages, with 22% of those aged 25-44 currently in school (compared to 7% of the general population).¹⁰
- Over three-fourths (78%) reported feeling more comfortable at work and their performance improving after transitioning, despite reporting nearly the same rates of harassment at work as the overall sample.
- Of the 26% who reported losing a job due to bias, 58% reported being currently employed and of the 19% who reported facing housing discrimination in the form of a denial of a home/apartment, 94% reported being currently housed.

Status as a Student by Age⁹



CUMULATIVE DISCRIMINATION

Sixty-three percent (63%) of our participants had experienced a serious act of discrimination — events that would have a major impact on a person's quality of life and ability to sustain themselves financially or emotionally. These events included the following:

- Lost job due to bias
- Eviction due to bias
- School bullying/harassment so severe the respondent had to drop out
- Teacher bullying
- Physical assault due to bias
- Sexual assault due to bias
- Homelessness because of gender identity/expression
- Lost relationship with partner or children due to gender identity/expression
- Denial of medical service due to bias
- Incarceration due to gender identity/expression

Almost a quarter (23%) of our respondents experienced a catastrophic level of discrimination — having been impacted by at least three of the above major life-disrupting events due to bias. These compounding acts of discrimination — due to the prejudice of others or lack of protective laws — exponentially increase the difficulty of bouncing back and establishing a stable economic and home life.

CONCLUSION

It is part of social and legal convention in the United States to discriminate against, ridicule, and abuse transgender and gender non-conforming people within foundational institutions such as the family, schools, the workplace and health care settings, every day. Instead of recognizing that the moral failure lies in society's unwillingness to embrace different gender identities and expressions, society blames transgender and gender non-conforming people for bringing the discrimination and violence on themselves.

Nearly every system and institution in the United States, both large and small, from local to national, is implicated by this data. Medical providers and health systems, government agencies, families, businesses and employers, schools and colleges, police departments, jail and prison systems—each of these systems and institutions is failing daily in its obligation to serve transgender and gender non-conforming people, instead subjecting them to mistreatment ranging from commonplace disrespect to outright violence, abuse and the denial of human dignity. The consequences of these widespread injustices are human and real, ranging from unemployment and homelessness to illness and death.

This report is a call to action for all of us, especially for those who pass laws and set policies and practices, whose action or continued inaction will make a significant difference between the current climate of discrimination and violence and a world of freedom and equality. And everyone else, from those who drive buses or teach our children to those who sit on the judicial bench or write prescriptions, must also take up the call for human rights for transgender and gender non-conforming people, and confront this pattern of abuse and injustice.

We must accept nothing less than a complete elimination of this pervasive inhumanity; we must work continuously and strenuously together for justice.

Endnotes

- 1 U.S. Census Bureau, "Current Population Survey," Annual Social and Economic Supplement (Washington, DC: GPO, 2008).
- 2 "U.S.A. Suicide: 2002 Official Final Data," prepared for the American Association of Suicidology by John L. McIntosh, Ph.D. Official data source: Kochanek, K.D., Murphy, S.L., Anderson, R.N., & Scott, C. (2004). Deaths: Final data for 2002. National Vital Statistics Reports, 53 (5). Hyattsville, MD: National Center for Health Statistics DHHS Publication No. (PHS) 2005-1120. Population figures source: table I, p.108. of the National Center for Health Statistics (Kochanek et al., 2004), see http://www.sprc.org/library/event_kit/2002datapg1.pdf.
- 3 General population data is from U.S. Census Bureau, "Current Population Survey," Annual Social and Economic Supplement (Washington, DC: GPO, 2008).
- 4 See note 3. "Mistreatment" includes harassment and bullying, physical or sexual assault, discrimination, or expulsion from school at any level based on gender identity/expression.
- 5 Seven percent (7%) was the rounded weighted average unemployment rate for the general population during the six months the survey was in the field, based on which month questionnaires were completed. See seasonally unadjusted monthly unemployment rates for September 2008 through February 2009. U.S. Department of Labor, Bureau of Labor Statistics, "The Employment Situation: September 2008," (2008): http://www.bls.gov/news.release/archives/empsit_10032008.htm.
- 6 1.7% were currently homeless in our sample compared to 1% in the general population. National Coalition for the Homeless, "How Many People Experience Homelessness?" (July 2009): http://www.nationalhomeless.org/factsheets/How_Many.html.
- 7 U.S. Department of Housing and Urban Development, "U.S. Housing Market Conditions, 2nd Quarter, 2009" (Washington, DC: GPO, 2009): http://www.huduser.org/portal/periodicals/ushmc/summer09/nat_data.pdf.
- 8 The overall sample reported an HIV infection rate of 2.6% compared to .6% in the general population. United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO), "2007 AIDS Epidemic Update" (2007): http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf. People of color in the sample reported substantially higher rates: 24.9% of African-Americans, 10.9% of Latino/as, 7.0% of American Indians, and 3.7% of Asian-Americans in the study reported being HIV positive.
- 9 U.S. Census Bureau, "Current Population Survey: Enrollment Status of the Population 3 Years Old and Over, by Sex, Age, Race, Hispanic Origin, Foreign Born, and Foreign-Born" (Washington, DC: GPO, October 2008): Table 1. <http://www.census.gov/population/www/socdemo/school/cps2008.html>. The last category, over 55, was not rounded to its small size.
- 10 See note 9.

“My mother disowned me. I was fired from my job after 18 years of loyal employment. I was forced onto public assistance to survive. But still I have pressed forward, started a new career, and rebuilt my immediate family. You are defined not by falling, but how well you rise after falling. I’m a licensed practical nurse now and am studying to become an RN. I have walked these streets and been harassed nearly every day, but I will not change. I am back out there the next day with my head up.”

—Survey Respondent



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Exhibit 9

After the revocation, some written information about prescription drugs was produced by a patchwork of organizations, including the AMA, the U.S. Pharmacopeia, and the American Association of Retired Persons.³ When the FDA began in 1985 to allow drug companies to advertise in mass-market magazines and newspapers so long as they included a “fair balance of information,” as required for ads in medical journals, companies began developing their own “patient information sheets,” which often simply reprinted the text of the package insert written for physicians and pharmacists. This information provision had little to do with educating consumers and much to do with expanding marketing opportunities. The medical terminology, dense verbiage, and tiny fonts of these inserts have made them inscrutable to the average consumer and virtually useless as information sources.⁴

The FDA’s Medication Guide program, proposed in 1995 and launched in 1999, aimed to mitigate this problem for some outpatient prescription products, with user-friendly information to be distributed at the point of sale. The most effective of these guides might serve as templates for risk

communication in DTCA. Moreover, in 2015, companies could harness the power of communications technologies such as smartphone-scannable QR codes to link such information to print ads or online materials for interested consumers.

Yet the primary risk-communication challenges the FDA has faced are not technological but social. In the case of the Pill, the PPI’s opponents were able to dilute and delay efforts to provide patients with clear, comprehensive risk information. The U.S. medical consumer’s voice has grown stronger since the 1970s, and the FDA increasingly relies on social scientific research in its decisions. Nonetheless, the success or failure of the current proposal depends on the agency’s ability to capture the interests of all stakeholders.

For all its capacity to encourage overdiagnosis and overmedication, DTCA’s virtue is that it treats consumers as people who deserve to know something about the compounds they take into their bodies. After 30 years of DTCA, it’s not clear that advertising is the best medium for communicating risk information,⁵ but marketers should at least be required to try to communicate risk

information as effectively as they do their promotional messages.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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1. Brief summary and adequate directions for use: disclosing risk information in consumer-directed print advertisements and promotional labeling for prescription drugs: guidance for industry. Rockville, MD: Food and Drug Administration, August 2015 (<http://www.fda.gov/downloads/drugs/guidancecomplianceregulatoryinformation/guidances/ucm069984.pdf>).
2. Greene JA, Watkins ES, eds. *Prescribed: writing, filling, using, and abusing the prescription in modern America*. Baltimore: Johns Hopkins University Press, 2012.
3. Nightingale SL. Written patient information on prescription drugs: the evolution of government and voluntary programs in the United States. *Int J Technol Assess Health Care* 1995;11:399-409.
4. Shrank WH, Avorn JA. Educating patients about their medications: the potential and limitations of written drug information. *Health Aff (Millwood)* 2007;26:731-40.
5. Mintzes B. Advertising of prescription-only medicines to the public: does evidence of benefit counterbalance harm? *Annu Rev Public Health* 2012;33:259-77.

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Caring for Our Transgender Troops — The Negligible Cost of Transition-Related Care

Aaron Belkin, Ph.D.

On July 13, 2015, U.S. Defense Secretary Ashton Carter announced that the military anticipates lifting its ban on service by transgender persons, those whose gender identity does not match the sex that they were assigned at birth. Although an es-

timated 12,800 transgender personnel currently serve in the U.S. armed forces (see table for explanations of estimates), they must conceal their gender identity because military policy bans them from serving and prohibits military doctors from providing tran-

sition-related care. Although some transgender people do not change their bodies to match their gender identities, government agencies, courts, and scientists agree that for many, transition-related care (gender-affirming surgery, cross-sex hormone therapy, or

Estimating the Cost to the U.S. Military of Providing Transition-Related Care for Transgender Personnel.*			
Variable	Estimate for U.S. Military	Calculation	Australian Military (accuracy check)
No. of transgender troops	12,800	2,136,799 (2015 force size) ÷ 2,581,000 (2012 force size) × 15,500 (estimated no. of transgender troops in 2012) = 12,832	
Overrepresentation of transgender persons in the military	×2	12,800 ÷ 2,136,799 = 0.6%; among U.S. civilian adults, 700,000, or 0.3% of the population, are transgender; 0.6 ÷ 0.3 = 2	
No. expected to utilize transition-related care per yr	188	0.000044 (employee utilization rate for transition-related care at large civilian employers) × 2,136,799 × 2 (overrepresentation of transgender persons in the military)	13 (persons receiving transition-related care) over 30 mo = 5.2 persons per yr; 5.2 ÷ 58,000 (total force size) = 1 person per 11,154 troops; 2,136,779 ÷ 11,154 = 192
Cost			
Per person receiving transition-related care	\$29,929	Cost per University of California claimant receiving transition-related care	
Total	\$5.6 million per yr	\$29,929 × 188	\$287,710 (cost over 30 mo) ÷ 30 × 12 = \$115,084; 2,136,779 (U.S. troops) ÷ 58,000 (Australian troops) × \$115,084 = \$4.2 million per year
Per transgender service member	\$438 per yr	\$5.6 million ÷ 12,800	
Per member of the military	\$2.62 per yr (22 cents per mo)	\$5.6 million ÷ 2,136,779	

* Data are from the Defense Manpower Data Center; Gates and Herman¹; Herman²; 9News³; and State of California Department of Insurance.⁴

both) is medically necessary, and state regulators have found medical exclusions to be indefensible and in some cases unlawfully discriminatory. Yet in response to Carter’s announcement, opponents in the Pentagon and beyond expressed concerns about the costs of providing such care.

Having analyzed the cost that the military will incur by providing transition-related care, I am convinced that it is too low to warrant consideration in the current policy debate. Specifically, I estimate that the provision of transition-related care will cost the military \$5.6 million annually, or 22 cents per member per month. Of course, the cost will depend on how many transgender personnel serve and utilize care, and estimates are sensitive to certain assumptions, such as the expectation that the military will not become a “magnet” employer

for transgender people seeking health care benefits. Though my utilization and cost estimates are quite close to actual data provided by an allied military force, it seems clear that under any plausible estimation method, the cost amounts to little more than a rounding error in the military’s \$47.8 billion annual health care budget.

My calculations are as follows. In 2014, scholars estimated that 15,500 transgender personnel served in the military out of a total force of 2,581,000, but they included troops who were ineligible for health benefits.¹ Moreover, the military has become smaller in recent years: as of May 31, 2015, a total of 2,136,779 troops served in the Active and Selected Reserve components and were thus eligible for health benefits. Assuming that the number of transgender personnel

has declined along with the overall force size, and excluding those serving in Reserve components whose members are ineligible for medical benefits, I estimate that 12,800 transgender troops serve currently and are eligible for health care.

As for the expected utilization of transition-related care, the latest research suggests that among large civilian employers whose insurance plans offer transition-related care including surgery and hormones, an average of 0.044 per thousand employees (one of every 22,727) file claims for such care annually.² On the basis of this utilization rate, the military could expect that 94 transgender service members will require transition-related care annually. However, transgender persons are overrepresented in the military by a factor of two — possibly in part because, before attaining self-

acceptance, many transgender women (people born biologically male who identify as female) seek to prove to themselves that they are not transgender by joining the military and trying to fit into its hypermasculine culture.⁵

If transgender people are twice as likely to serve in the military as to work for the civilian firms from which the 0.044 figure was derived, then an estimated 188 transgender service members would be expected to require some type of transition-related care annually. It is not possible, on the basis of the available data, to estimate how many will require hormones only, surgery only, or hormones plus surgery.

As an accuracy check, consider the Australian military, which covers the cost of transition-related care: over a 30-month period, 13 Australian troops out of a full-time force of 58,000 underwent gender transition — an average of 1 service member out of 11,154 per year.³ If the Australian rate were applicable to the U.S. military, the Pentagon could expect 192 service members to undergo gender transition annually.

To estimate the cost of care, note that under insurance plans offered to University of California employees and their dependents, the average cost of transition-related care (surgery, hormones, or both) per person needing treatment was \$29,929 over 6.5 years.⁴ This estimate was derived from 690,316 total person-years of coverage, a sample arguably large enough to justify extrapolation to other settings.⁴ By comparison, over a 30-month period, the Australian military paid U.S. \$287,710 for transition-related care for 13 service members, or \$22,132 per person requiring care.³

Under these utilization-rate and cost-per-claimant estimates, pro-

viding transition-related care to the 188 military personnel expected to require it annually would cost an estimated \$5.6 million per year, or \$438 per transgender service member per year, or 22 cents per member per month. If the Australian military's annual cost of transition-related care were applied to the U.S. armed forces, the Pentagon could expect to pay \$4.2 million per year to provide such care.

Actual costs could be lower than expected, because transition-related care has been proven to mitigate serious conditions including suicidality that, left untreated, impose costs on the military, and addressing symptoms might conceivably improve job performance as well. There are costs, in other words, of *not* providing transition-related care, due to potential medical and psychological consequences of its denial, paired with the requirement to live a closeted life. In addition, the \$29,929 cost-per-claimant estimate was derived from private-sector care, but the military provides care more efficiently than civilian systems do. Although the military might outsource some transition surgeries to private providers, many transition surgeries are well within the skill set of its reconstructive surgeons. Finally, transgender service members may be less likely than civilians to seek transition-related care, owing to hostile command climates or an unwillingness to interrupt military service.

In contrast, actual costs will be higher if the military covers more procedures than the insurance plans from which the \$29,929 estimate was derived. In addition, costs will be higher if transition-related care is offered to family members and dependents. Finally, if transgender civilians join the

military in order to obtain care, costs will be higher than estimated. Military recruiters have used the promise of health care benefits to entice civilians to enlist, and if transition-related coverage motivates outstanding transgender candidates to serve, that is not necessarily problematic. That said, civilian insurance plans increasingly cover transition-related care, which reduces the incentive to join the armed forces to obtain care. And low utilization rates reported by civilian firms offering such care may suggest that few transgender persons obtain civilian employment for that purpose. If so, it would be difficult to imagine that large numbers would seek to join the military to obtain such care, given the multiyear service obligations they would incur.

Some observers may object to the concept that the military should pay for transition-related care, but doctors agree that such care is medically necessary. And though costs can be high per treated person, they are low as a percentage of total health spending, similar to the cost of many other treatments that the military provides. Even if actual costs exceed these estimates on a per-capita basis for persons requiring care, the total cost of providing transition-related care will always have a negligible effect on the military health budget because of the small number treated and the cost savings that the provision of such care will yield. The financial cost of transition-related care, in short, is too low to matter.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Exhibit 10



OBJECTIVE ANALYSIS.
EFFECTIVE SOLUTIONS.



RAND > The RAND Blog > RAND Review >



ESSAY

August 18, 2016

Transgender Troops: Fit to Serve

U.S. Army Capt. Jennifer Peace poses near her home in Spanaway, Washington, August 18, 2015. Photo by Drew Perine/The News Tribune via AP

Army Capt. Jennifer Peace felt like she could finally exhale. On the television in Peace's office, Defense Secretary Ashton Carter was announcing that she could serve openly as herself. It's over, she realized. Finally over.

No more male uniforms or close-cropped male hair regulations; no more subordinates awkwardly saluting her as "Sir" instead of "Ma'am." For Peace, an intelligence officer and veteran of two combat tours, Carter's announcement opening the military to transgender people like her meant an official end to years of living in limbo.

"I really thought that I would just feel a sense of relief, that it wouldn't be as emotional as it was," said Peace, a career soldier with a dog tag tattooed onto her left shoulder, along with the blue, pink, and white stripes of the transgender pride flag.

"I've had to put being transgender at the top of my list of who I am," she said. "Now I can be a soldier and an officer and a wife and everything else first, and let being transgender kind of fade into the background."



Army Capt. Jennifer Peace with Secretary of Defense Ash Carter a week before the military lifted its ban on transgender service members serving openly.

Photo courtesy Capt. Peace

Topics

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[Gender Equity in the Workplace](#)
[Gender Integration in the Military](#)
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Breaking Down Barriers

The Pentagon's decision in late June to open the ranks to transgender service members was informed by months of RAND research into the costs and numbers involved.

Between 1,320 and 6,630 transgender men and women already serve in active duty, the researchers estimated—a fraction of one percent of the total force. The costs of letting them serve openly and access military health care would be "overwhelmingly small" as a percentage of military spending.

No more than 140 active-duty service members a year would likely seek gender-transition hormone treatments, for example; even fewer would seek transition-related

surgeries. That would add between \$2.4 million and \$8.4 million to an annual military health care budget of more than \$6 billion, the researchers estimated.

“If an out group can do the job, that’s really what counts. If people think you can do the job, you earn their respect, and they feel like you have their back.”

- Agnes Gereben Schaefer, senior political scientist

Those medical treatments would also limit when and where between 25 and 130 active-duty service members could deploy in any given year. For comparison, the Army alone has 50,000 active-duty soldiers who cannot deploy for other reasons.

“So we’re talking really small numbers—really small,” said Agnes Gereben Schaefer, the lead author of the study and a senior political scientist at RAND.

The study was the latest commissioned from RAND by the military as it seeks to break down long-standing barriers to service. RAND research on opening the ranks to gay and lesbian service members led to the repeal of the military’s “don’t ask, don’t tell” policy in 2011. More recently, a series of RAND reports have helped inform the Pentagon’s decision to integrate women into combat positions.

“All of our work across these areas has demonstrated that if an out group can do the job, that’s really what counts,” said Schaefer, who has been involved in all three lines of research. “If people think you can do the job, you earn their respect, and they feel like you have their back.”

Performance, Not Pronouns

That is what drove Shane Ortega.

He served two combat tours in Iraq, as a Marine, as a woman—and then one more in Afghanistan, as a soldier, as a man. His transition earned him a desk job; he believes his willingness to work harder and march farther kept him in the military as one of the first openly transgender people in active duty. Seventy pushups? He’d knock out 90, chest to the floor.

“It becomes exhausting to fight every single day to just be identified by the correct pronoun,” he said—and then pointed for an example to what happened when he was invited to speak at the Pentagon. His commanding officers at first ordered him to squeeze into a woman’s blouse, citing Army regulations and the gender still listed on his military ID. It was so tight he couldn’t lift his arm to salute.



U.S. Army Sergeant Shane Ortega shaves at home at Wheeler Army Airfield, March 26, 2015
Photo by Kent Nishimura/The Washington Post via Getty Images

“This is something they can’t mess up,” said Ortega, who ended up wearing a camouflage field uniform to his meetings at the Pentagon, and has since left the military. Lifting the ban, he added, “has to be fluid. This isn’t just, ‘You have to get a new uniform.’ This is people’s lives.”

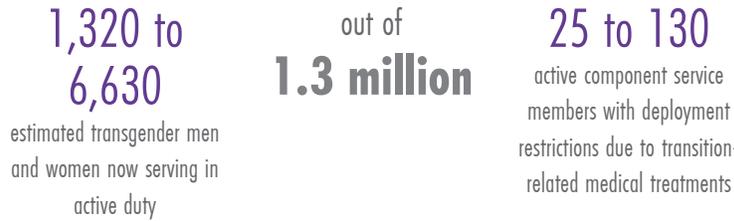
Eighteen other countries already allow transgender people to serve in the military, including such close U.S. allies as Australia, Canada, Israel, and the United Kingdom. They have seen “no significant effect” on unit cohesion, operational effectiveness, or overall readiness since they opened their ranks, RAND researchers found.

But their experiences—and especially the challenges they faced—offer some hard-learned lessons for the American military leaders now charged with implementing transgender service rules.

Some of the foreign militaries RAND studied reported instances of bullying or harassment of transgender troops, for example, underscoring the need for zero-tolerance leadership and training. Researchers also found that it was easy to stumble on the details: Could medals and commendations earned pre-transition, for example, be reissued under a new name post-transition?

Transgender Service: By the Numbers

RAND research provided the Pentagon the most rigorous and impartial estimates available of the costs and implications of allowing transgender men and women to serve openly.



18 other countries already allow transgender people to serve in the military

- | | | | |
|-----------|----------------|-------------|----------------|
| Australia | Czech Republic | France | Norway |
| Austria | Denmark | Germany | Spain |
| Belgium | Estonia | Israel | Sweden |
| Bolivia | Finland | Netherlands | United Kingdom |
| Canada | | New Zealand | |

Focus on Mission

The Pentagon released an 18-page policy memorandum as it lifted the transgender ban that started to answer some of those questions. It says, for example, that service members will use the uniforms, housing, and bathrooms that correspond with the gender on their military ID cards, which can be changed with a doctor's order. Defense Secretary Carter also said the military will spend the next year refining its policies and training its troops.

“Our mission is to defend this country,” he said in announcing the end of the ban, “and we don't want barriers unrelated to a person's qualifications to serve preventing us from recruiting or retaining the soldier, sailor, airman, or Marine who can best accomplish the mission.”

Someone, in other words, like Phyllis Frye. In 1970, she looked like the ideal Army officer: educated under an elite ROTC scholarship, trained as an engineer, committed to a military career—and male.

When the military learned she was transgender, it sent her to a hypnotist who made her vomit when she wore women's clothes. It tried drugs that were so powerful they blurred her vision. In the end, she negotiated an honorable discharge, went back to school, studied law, and is now widely recognized as the grandmother of the transgender rights movement.

“You're going to get someone who loves the military, who wants to be a patriot, who wants to serve their country,” she says now. “What else do you want out of a person?”

“The military wasted me,” she adds. It paid for her education and training, gave her housing and health care—“and all you got out of it was about 19 months of active duty.” She figures she would have retired as a lieutenant colonel after 30-plus years of military service if she had been allowed to stay. Instead, her military career ended in 1972.

Forty-four years later, another Army officer, Capt. Peace, watched live on the television in her office as Secretary Carter lifted the ban that had threatened to bring her career, too, to a standstill. She and another transgender service member embraced when Carter spoke the words they had waited so long to hear: “Effective immediately...”

She talks about her commitment to the Army, about the relief of knowing she can make it a career now; she says she hopes to earn a promotion to major soon. And then she asks: Did you see the press conference after Carter's announcement? One of the first questions he got was not about health care costs or bathroom use—not about transgender people at all—but about the civil war in Syria.

“That's exactly how it should be,” she says. “The ban may be lifted, but we've got more important things to worry about.”

— Doug Irving



Phyllis Randolph Frye, the first openly transgender judge in the United States, poses at her office in Houston, Texas, July 22, 2015
Photo by Brandon Thibodeaux/The New York Times

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Nov 18, 2010 | [National Defense Research Institute](#), [Bernard Rostker](#), et al.

Exhibit 11

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

Discharging Transgender Troops Would Cost \$960 Million

Aaron Belkin, PhD
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August 2017

EXECUTIVE SUMMARY

- 1) President Trump has tweeted that transgender individuals cannot serve in the armed forces because our military “cannot be burdened with the tremendous medical costs,” which we presume refers to the cost of providing medically necessary transition-related health care to transgender personnel.
- 2) We are not aware of any full-scale analysis of the costs of discharging transgender personnel from the armed forces, although scholars have addressed financial costs associated with the provision of transition-related health care to transgender service members.
- 3) If decisions about whether to allow military service by transgender personnel are based on financial considerations, policymakers should take into account the costs of discharging transgender service members, not just the costs of retaining them.
- 4) We estimate that the financial cost of fully implementing President Trump’s ban on transgender service members would be \$960 million.
- 5) We derive our estimate by multiplying the number of transgender service members (12,800) by the average per-person cost of recruiting and training a replacement for each service member who is discharged (\$75,000).
- 6) By comparison, the RAND Corporation has found that the military’s total annual cost of providing transition-related health care is, at most, \$8.4 million.
- 7) The average annual cost of providing transition-related care for the entire population of transgender troops is \$656 per transgender service member per year, because most transgender personnel do not require transition-related care during their military careers.
- 8) The upshot of our analysis is that implementing President Trump’s transgender service ban would cost \$75,000 per person in order to accrue an annual savings of \$656 per person. For the military as a whole, fully implementing President Trump’s ban would cost \$960 million in pursuit of saving \$8.4 million per year.

Introduction

On July 26, 2017, President Donald Trump tweeted that, “the United States government will not accept or allow transgender individuals to serve in any capacity in the U.S. Military.” According to the President, “Our military ... cannot be burdened with the tremendous medical costs,” presumably referring to the cost of providing medically necessary transition-related health care to transgender personnel.¹ While commentators and scholars have addressed financial costs associated with the provision of such care, we are not aware of any analysis of the costs of discharging transgender personnel from the armed forces. If decisions concerning whether to allow transgender personnel to serve are based on financial considerations, then policymakers should take into account the costs of discharging the service members, not just the costs of retaining them under a policy of equal treatment.

In this policy memo, we estimate that the financial cost of fully implementing President Trump’s ban on transgender service members would be \$960 million. In addition, we compare the cost of fully implementing the ban to the cost of providing medically necessary transition-related health care to transgender personnel. Given that the total annual cost of providing such care is, at most, \$8.4 million, the \$960 million price tag of fully implementing President Trump’s ban is more than 100 times greater than the annual cost of retaining transgender service members and providing for their health care needs.²

Methodology

Several standard methodological approaches can be used to estimate the cost of discharging service members, each with specific data needs and each well-documented in the research and policy literature. For this analysis, we use a replacement-cost method that assumes the military must pay to recruit and train one replacement service member for each individual who is discharged. To derive the estimate reported here, we multiply the number of service members who will be discharged by the cost of recruiting and training one replacement. In the next section of our report, we review several approaches for calculating implementation costs and explain why we utilize the replacement-cost approach.

Lost-value method

In 2006, a Blue Ribbon Commission consisting of a former Secretary of Defense as well as experts in military personnel policy estimated the financial cost of implementing the “don’t ask, don’t tell” policy over a ten-year period, from FY 1994 through FY 2003. According to the Commission, the cost of discharging 9,359 service members for homosexuality during this period was \$363.8 million, or \$38,872 per person. Unlike the studies described below that emphasize the cost of replacing each service member who was discharged, the Commission’s focus was the value that the military would have accrued from each service member who was discharged “had they not been discharged prematurely.” The Commission’s emphasis, in other words, was lost-benefit costs, or

“costs associated with losses to the military because a trained person is not in the services anymore.”³

To estimate the lost value for each premature discharge, and based on its access to individual-level data on training courses that had been completed by service members who were discharged, the Commission estimated the cost of recruiting and training almost every individual who was discharged for homosexuality during the ten-year period under consideration. Then, the Commission estimated “how much of that investment the military recovered from each individual during a ‘cost recovery period.’”⁴ Finally, the Commission subtracted the amount of recovered value from the initial investment.⁵ The Commission’s methodology recognized that the military lost a great deal of value from service members who were discharged shortly after initial skills training—that is, after a significant investment had been made in their training but before they had returned any value to the armed forces. In other cases, when service members were discharged after they had served a great deal of time, the military recovered much of its investment. To use this approach, the Commission required training and length of service data for individuals who had been discharged. These more precise data are not available for this analysis at this time.

Replacement-cost method (Service-specific data)

In 2011, the Government Accountability Office (GAO) issued a report on costs associated with implementing the “don’t ask, don’t tell” policy over a six-year period, from FY 2004 through FY 2009.⁶ According to GAO, the cost of discharging 3,664 service members for homosexuality during this period was \$193.3 million, or \$52,800 per separation. To arrive at its estimate, GAO added the cost of replacing service members who had been discharged (\$185.6 million) to the administrative costs of separation (\$7.3 million).⁷ GAO defined replacement cost in terms of the cost to recruit and train new service members who would replace those who had been discharged.

For recruiting costs, GAO calculated the average per-person recruiting cost for each Service during each fiscal year under consideration, and then “multiplied each of these averages by the number of separated servicemembers for each service.”⁸ For training costs, “GAO included variable costs, such as recruiting bonuses, and excluded fixed costs, such as salaries and buildings ... because ... there would likely be no significant increase in fixed costs when recruiting and training a relatively small number of replacement personnel” (executive summary). Because GAO had access to Service-specific training cost data, as well as individual-level data about the occupational specialties of service members who had been discharged for homosexuality, it was able to estimate the average cost of recruit training for each Service in each fiscal year. GAO was also able to estimate the cost of initial skills (occupational) training in relevant occupations and then multiply those costs “by the number of service members who held that occupation in the year of their separation.”⁹

As is the case with any estimation technique, GAO’s methodology had limitations. For example, unlike the Army and Marine Corps, “the Navy was not able to fully

disaggregate fixed and variable costs, and so our Navy recruiting calculations include some fixed costs.”¹⁰ Nevertheless, GAO took extraordinary measures to assess the reliability of its data, and its estimate is supported by GAO’s access to Service-specific cost data as well as occupational data associated with specific service members who had been discharged.

Replacement-cost method (non-Service-specific data)

In this report, we rely on a replacement-cost approach that is similar to GAO’s methodology, but without Service-specific data about the cost of recruiting and training or individual-level data about occupational specialties. We cannot use the Blue Ribbon Commission’s lost-value methodology because we lack individual data about the length of service or training courses completed by transgender service members currently serving in the armed forces. Thus, we cannot distinguish the military’s initial investment in recruiting and training from one transgender service member to another. Nor can we use GAO’s replacement-cost methodology, since we do not know how the population of transgender service members is distributed across the Services.

As a result, we use a replacement-cost approach that depends on average, DOD-wide per-person training and recruiting costs. Consistent with this approach, we multiply the number of transgender persons currently serving in the U.S. armed forces times the average cost of recruiting and training one replacement. Because the President has said that the military “will not accept or allow transgender individuals to serve in any capacity,” our estimation technique is premised on the assumption that, if the President’s order were fully implemented, the armed forces would be required to replace every transgender service member who is discharged. Thus, the cost of implementing the order is the number of individuals who would be discharged multiplied by the cost of recruiting and training each replacement.

Variables

Average, per-person cost of recruiting and training

According to a 2015 estimate by Accession Medical Standards Analysis and Research Activity (AMSARA), “Recruiting, screening and training costs are approximately \$75,000 per enlistee.”¹¹ While the AMSARA estimate is not explained in available documents, our confidence in the estimate derives from three factors. First, a number of reputable sources rely on the estimate for their own calculations.¹² For example, a July 2017 GAO report on military personnel states that, “From fiscal year 2005 through fiscal year 2015, the military services enlisted over 1.7 million servicemembers at an estimated cost of approximately \$75,000 per enlistee, according to the Department of Defense (DOD).”¹³ GAO then cites the AMSARA data, indicating in a footnote that, “This is an estimated cost to recruit, screen and train an enlistee as reported by the Accession Medical Standards Analysis and Research Activity (AMSARA).”¹⁴

Second, the range of available per-person recruiting and training estimates is not large, and the AMSARA estimate is a middle-range estimate compared with other figures. For example, a higher-bound estimate is derived from the 2006 Blue Ribbon Commission, which reported that the cost to train one Soldier in 2004 was \$56,400, or \$70,766 in 2015 dollars, and that the per-person cost of recruiting was \$10,193, or \$11,984 in 2015 dollars: $\$11,984 + \$70,766 = \$82,750$.¹⁵ A lower-bound estimate is derived from GAO, which estimated in 1998 that the DOD-wide average per-person cost of enlisted training was \$28,800, or \$41,878 in inflation-adjusted figures.¹⁶ Adding the inflation-adjusted per-person recruiting cost of \$11,984 + to \$41,878 yields a lower-bound estimate of \$53,862.

Third, the AMSARA estimate is consistent with current cost estimates provided by two independent experts in military budgeting and personnel policy. In August 2017, a former senior Pentagon official with expertise in budgeting and personnel told us that the average, DOD-wide cost of recruiting and training, from entry to reporting to first duty station, is \$60,000, not including salary and benefits during training. With the addition of salary and benefits, the official's \$60,000 estimate would be quite close to the AMSARA estimate. A War College faculty member with expertise in budgeting and personnel told us in August 2017 that, in his Service, the average cost from arrival at recruit training to graduation is approximately \$76,000, including all overhead. Further, this figure increases to approximately \$83,000 to \$107,000 depending on the type of initial-skills training and the time of the year.¹⁷

Population of currently serving transgender service members

While media reports on military service by transgender personnel frequently mention that 15,000 transgender troops currently serve in the U.S. armed forces, “no studies have directly measured the prevalence or incidence of transgender individuals currently serving in the active or reserve component.”¹⁸ In the absence of opportunities to measure the population directly, scholars have relied on estimates instead. Gary Gates and Jody Herman at UCLA Williams Institute published a 2014 study estimating that 15,500 transgender troops serve in the armed forces.¹⁹ Professor Aaron Belkin published a 2015 *New England Journal of Medicine* study in which he estimated that 12,800 transgender troops serve in the armed forces.²⁰ Additionally, the RAND Corporation published a 2016 study that included five estimates of the population of transgender service members, ranging from a low of 2,150 to a high of 10,790.²¹

Gates and Herman are widely recognized as leading experts in estimating LGBT populations whose sizes are difficult to ascertain. Based on surveys that include questions about military service, they begin by estimating that approximately 21.4 percent of transgender adults have served in the armed forces.²² Gates has estimated that there are approximately 700,000 transgender adults in the U.S.²³ With these two data points, Gates and Herman calculated that approximately 150,000 transgender adults serve or have served in the military. Gates and Herman then determined that among *non-transgender* American adults, “5.4% of men who report any military service are on active duty along with 9.8% of women.”²⁴ Assuming that the ratio of currently serving troops to veterans is

the same for transgender and non-transgender populations, Gates and Herman then apply the ratios above (5.4% of men and 9.8% of women) to the estimated population of transgender veterans and estimate that 15,500 transgender Americans serve currently in the military.²⁵ In 2015, Belkin adjusted the Gates/Herman estimate downward to reflect the downsizing of the armed forces in recent years as well as the fact that Gates and Herman had included troops in the Individual Ready Reserve. Belkin thus arrived at the estimate of 12,800.²⁶

In 2016, the RAND Corporation calculated five estimates of the number of currently serving transgender personnel in the Active and Reserve components. RAND “applied measures of population prevalence to DOD force size estimates to estimate the prevalence in the U.S. military” of transgender individuals.²⁷ In other words, RAND identified distinct estimates of the percentage of transgender civilian adults in the U.S. and then multiplied these percentages by the size of the U.S. military. For example, RAND multiplied the estimated percentage of transgender adults in California (.1%) by the size of the military, including Active and Reserve components, to derive its lower bound estimate of 2,150, and the estimated percentage of transgender adults in Massachusetts (.5%) by the size of the military to derive its upper bound estimate of 10,790. RAND multiplied a weighted California and Massachusetts estimate (.16%) by the size of the military to derive a middle-range estimate of 3,450. RAND then multiplied the size of the military force by “an adjustment of this population-weighted approach based on the natal male/female distribution in the military, yielding a prevalence estimate of 0.19 percent; and ... a doubling of the population-weighted, gender-adjusted value, yielding a prevalence estimate of 0.37 percent.”²⁸ These gender-adjusted calculations yielded middle-range estimates of the population of transgender service members of 3,960 and 7,830.

In our calculations, we rely on Belkin’s estimate of 12,800 because it falls between the lower- and higher-bound estimates of RAND and Gates/Herman, and because the military downsized after the latter published their data. Belkin’s 2015 calculations reflect this reduction.

Cost of care and utilization rates

Belkin estimated in 2015 that 188 transgender service members would require transition-related care (surgery and/or hormones) in any given year and that the total cost to provide such care would be \$5.6 million.²⁹ In 2016, RAND estimated that between 49 and 420 transgender service members would require transition-related care (surgery and/or hormones) in any given year and that the total cost to provide such care would be between \$2.4 million and \$8.4 million.³⁰

U.S. Representative Vicky Hartzler estimated recently that the cost of providing transition-related care to transgender service members would be \$1.3 billion over the next ten years.³¹ Rep. Hartzler erred, however, in assuming that every transgender service member who requires surgery needs “the full catalog of surgical options,” rather than relying on data about the actual utilization of transition-related care, as Belkin and RAND

did.³² Moreover, Rep. Hartzler’s estimate that 30 percent of transgender service members require surgery is not based on data reflecting actual utilization rates. By contrast, the Belkin and RAND estimates are based on actual utilization rates from insurance pools consisting of, at minimum, hundreds of thousands of insurance-years. Unlike Belkin’s study, which was published in one of the pre-eminent peer-reviewed medical journals in the world, Rep. Hartzler’s estimates were calculated by her office staff, whose scholarly credentials are unknown.³³

Family Research Council Senior Fellow Peter Sprigg estimated recently that the cost of providing transition-related care to service members will be \$3.7 billion over the next ten years.³⁴ Sprigg errs, however, in assuming “that every transitioning service member would request a one-year leave of absence at a 10-year cost of \$1.8 billion,” an assumption that is inconsistent with scholarship on gender transition as well as the experiences of foreign militaries that allow transgender personnel to serve.³⁵ Similar to Hartzler, Sprigg wrongly assumes that every transgender service member who requires surgery needs a “comprehensive package” of treatment (\$110,450 for transgender men and \$89,050 for transgender women), rather than relying on data about actual utilization rates and the actual average cost of transition-related care (\$31,931).³⁶ Finally, Sprigg’s estimate that 6,900 transgender service members will require surgery is based on non-random survey data concerning the percent of transgender individuals who say that they plan to have surgery. Scholars have confirmed, however, that actual utilization rates are lower than self-reports of an intent to have surgery.³⁷

Given the numerous errors in Hartzler’s and Sprigg’s calculations—measured against the scholarly and peer-reviewed research on cost of care that Belkin and the RAND authors have published—we rely on RAND’s higher-bound cost estimate of \$8.4 million per year.

Cost of discharging all transgender personnel

Our estimate is that the cost of discharging all transgender personnel from the military would be \$960 million. We arrived at our estimate by multiplying the per-person cost of recruiting and training replacements by the number of currently serving transgender service members: $\$75,000 \times 12,800 = \960 million.

In addition, we compare the cost of fully implementing the President’s ban with two related figures. First, according to analysts at the RAND Corporation, and as addressed above, the cost of providing medically necessary transition-related health care to transgender personnel is, at most, \$8.4 million per year.

Second, as mentioned above, the average total per-person cost of transition-related health care *for those service members who need it* is \$31,931. The average total per-person cost of care for those who need it (\$31,931) is higher than the average annual per-person cost of providing care for the entire population of transgender service members (\$656) because most transgender personnel do not require transition-related care during their military careers.³⁸ Thus, even when focusing exclusively on those transgender service

members who need transition-related care, President Trump's announced ban does not make financial sense. On a per-person basis, the military would spend \$75,000 to achieve a savings of \$31,931.

Lower- and higher-bound estimates

The actual cost of implementing the President's order may be lower than our estimate if the actual cost of training and recruiting is less than \$75,000, and/or if the actual population of transgender personnel is less than 12,800. To estimate this lower-bound amount, we use the lowest training and recruiting cost estimate that we identified (\$53,862), and the lowest population estimate (2,150), to arrive at an estimated total cost of \$115 million ($\$53,862 \times 2,150 = \115 million). Another possibility is that the military may be unable to identify all transgender personnel, and may instead discharge only those transgender service members who revealed their gender identity following the June 30, 2016 announcement of an inclusive policy. The Coast Guard Commandant reported on August 1, 2017 that 13 transgender members of the Coast Guard have revealed their gender identity. With a total Active and Selected Reserve force of 47,992, this means that .00027 of Coast Guard members have revealed that they are transgender.³⁹ If applied to the entire U.S. military, this would mean that $.00027 \times 2,165,000 = 585$ transgender service members have revealed their gender identity. If President Trump discharges all of the estimated 585 transgender service members who have acknowledged their gender identity, and using the lower-bound cost estimate for recruiting and training, the total cost of implementing the ban would be \$32 million ($\$53,862 \times 585 = \32 million).

By contrast, the actual cost of implementing the President's order may exceed our estimate if the actual cost of training and recruiting is more than \$75,000, and/or if the actual population of transgender personnel is greater than 12,800. To estimate this higher-bound amount, we use the highest training and recruiting cost estimate that we identified (\$82,750), and the highest population estimate (15,500), to arrive at a projected total cost of \$1.3 billion ($\$82,750 \times 15,500 = \1.3 billion). In addition, the \$75,000 average per-person recruiting and training cost that we relied upon in our calculations does not include administrative expenses associated with investigating and discharging transgender personnel, or separation costs (such as separation travel) associated with each discharge. Administrative costs of enforcing the ban could be quite high, as a single trial can cost millions of dollars in staff time. (At the time of writing, the authors are aware of several litigation teams preparing lawsuits to challenge the ban.) Finally, our cost estimates, for the most part, capture the cost of training enlisted personnel, not officers. If the military discharges even a handful of transgender officers performing mission-critical specialties, such as physicians or fighter pilots, the cost of enforcing the ban would exceed our estimates.

Conclusion:

Our analysis, which is intended to support public discussion of an important national policy issue, suggests that the direct and indirect costs associated with implementing an order to discharge all transgender military personnel, as tweeted by President Trump on

July 26, 2017, would be \$960 million. We arrived at our estimate by multiplying the number of currently serving transgender service members by the cost of recruiting and training replacements. Given that the cost of providing medically necessary transition-related care to transgender personnel is, at most, \$8.4 million per year, the \$960 million price tag for fully implementing President Trump's ban is more than 100 times greater than the annual cost of retaining transgender service members and providing for their health care needs.

*The views and findings expressed here are those of the authors and should not be assumed to reflect an official policy, position or decision of the U.S. Naval Postgraduate School or the U.S. Government.

¹ Bowden J, Mattis Appalled by Trump Tweets Announcing Transgender Ban: Report, *The Hill*, July 28, 2017.

² Schaefer A, Iyengar R, Kadiyala S, Kavanagh J, Engel C, Williams K and Kress A, *Assessing the Implications of Allowing Transgender Personnel to Serve Openly*. Santa Monica: RAND Corporation, 2016.

³ All quotes in the paragraph are from Blue Ribbon Commission, *Financial Analysis of “Don’t Ask, Don’t Tell”: How Much Does the Gay Ban Cost?*, 2006, 6.

⁴ Blue Ribbon Commission 2006, 7.

⁵ The Commission included separation travel as well.

⁶ Government Accountability Office 11-170, *Military Personnel: Personnel and Cost Data Associated with Implementing DOD’s Homosexual Conduct Policy*, 2011.

⁷ Administrative costs were “costs associated with certain legal activities, such as board hearings, and nonlegal activities, such as processing separation paperwork.” GAO 2011, executive summary.

⁸ GAO 2011, 33.

⁹ GAO 2011, 35.

¹⁰ GAO 2011, 33.

¹¹ Accession Medical Standards Analysis & Research Activity (AMSARA), <http://www.amsara.amedd.army.mil/Default.aspx>, last modified date April 1, 2015, accessed August 3, 2017.

¹² Brooks SM. Occupational Medicine Model and Asthma Military Recruitment. *Military Medicine* 2015; 180 (11):1140; Tanofsky-Kraff M et al. Obesity and the US Military Family. *Obesity* (Silver Spring) 2013; 21 (11): 2205–2220; Institute of Medicine, *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment*. Washington DC: The National Academies Press, 2014, 90; Defense Health Board, *Implications of Trends in Obesity and Overweight for the Department of Defense*, 2013, 61.

¹³ Government Accountability Office 17-527, *Report on Military Personnel: Improvements Needed in the Management of Enlistees’ Medical Early Separation and Enlistment Information*, 2017, 1.

¹⁴ GAO 2017, 1.

¹⁵ Blue Ribbon 2006, 13.

¹⁶ Government Accountability Office 98-213, *Military Attrition: Better Data, Coupled with Policy Changes, Could Help the Services Reduce Early Separations*, 1998, 27-28.

¹⁷ Private communications with the authors.

¹⁸ Schaefer et. al. 2016, 14.

¹⁹ Gary Gates and Jody Herman, *Transgender Military Service in the United States*. Los Angeles: Williams Institute, 2014.

²⁰ Aaron Belkin, Caring for Our Transgender Troops – The Negligible Cost of Transition-Related Care, *New England Journal of Medicine* 2015; 373: 1089-1092.

²¹ Schaefer et. al. 2016, 16.

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- ²² Gates and Herman 2014.
- ²³ Gary Gates, *How Many People Are Lesbian, Gay, Bisexual, and Transgender*. Los Angeles: Williams Institute, 2011; Gates and Herman 2014, 4.
- ²⁴ Gates and Herman 2014, 4.
- ²⁵ Gates and Herman 2014, 4.
- ²⁶ Belkin 2015.
- ²⁷ Schaefer et. al. 2016, 14.
- ²⁸ Schaefer et. al. 2016, 15.
- ²⁹ Belkin 2015.
- ³⁰ Schaefer et. al. 2016, 31; 36.
- ³¹ Harrington E. Transgender Surgeries Would Cost Pentagon \$1.3 Billion, *Washington Free Beacon* July 27, 2017.
- ³² Sivak D. Fact Check: Do Trans People Add ‘Tremendous Medical Costs’ to Military Budget?, *Daily Caller* August 1, 2017.
- ³³ Harrington 2017.
- ³⁴ Peter Sprigg, *Transgender Policy Could Cost Military Billions Over Ten Years*. Washington: Family Research Council, 2017.
- ³⁵ Sivak 2017; Schaefer et. al. 2016.
- ³⁶ In 2012, California’s Department of Insurance reported that the average cost-per-claimant price of transition-related care (surgery and/or hormones) was \$29,929. Adjusted to 2017 dollars, the price is \$31,931. See State of California Department of Insurance REG-2011-00023, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, 2012.
- ³⁷ Jody Herman, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans*. Los Angeles: Williams Institute, 2013.
- ³⁸ The military’s average annual per-person cost of providing transition-related care is \$656 per transgender service member (\$8.4 million / 12,800 = \$656).
- ³⁹ United States Coast Guard web site, <http://www.overview.uscg.mil/Workforce/>, accessed August 2, 2017.

Exhibit 12

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

OPEN SERVICE BY TRANSGENDER MEMBERS OF ISRAEL DEFENSE FORCES

March, 2015

Palm Center Research Memo on Open Service by Transgender Members of Israel Defense Forces

Open Policy Enjoys Broad Support; Widely Considered a Success

Overview

The Israel Defense Forces has allowed gay and lesbian Israelis to serve since 1993. A Palm Center Study released in 2000 found that military performance was not impaired as a result of the open policy, which was a further liberalization of a 1983 policy that allowed openly gay service only in certain positions and subject to security restrictions. The IDF never had a written policy on service by transgender personnel, but until recently, individuals were frequently discharged—voluntarily or involuntarily—under the guise of mental health issues when it became known they identified as transgender. In recent years, as more military members were found to be openly transgender, and as transgender identity ceased to be regarded as a mental illness, officials have sought guidance from civilian gender and sexuality experts and groups on how best to accommodate and support transgender service members. Current policy makes all positions open to transgender personnel as long as health, aptitude and security considerations are met; transgender identity is no longer an automatic reason for ending or avoiding service.

Background on Transgender Identity and Health

Transgender is a broad term used to describe individuals who do not identify with the physical gender they were assigned at birth. Identifying as transgender may or may not mean one has transitioned to a different gender, and some who identify this way never do, or intend to, change genders. Research shows that, for some transgender people, changing genders through hormone therapy and/or surgery is medically necessary to obtain optimal health and that depriving individuals of such necessary health care poses serious risks to their wellbeing. Palm Center research has shown that there is “no compelling medical rationale for banning transgender military service,” “there is no medical reason to presume transgender individuals are unfit for duty,” and that eliminating the current U.S. ban on transgender service “would advance a number of military interests, including enabling commanders to better care for their service members.” Currently, 18 foreign militaries, including the IDF, allow transgender personnel to serve openly.

Recent Developments in the IDF

Consultations with press reports and interviews with those knowledgeable about transgender service in the IDF suggest there are at least a dozen and probably more military members who are openly transgender, and the number is growing. Although

transgender individuals have long been allowed to serve, they were not always treated and housed according to their preferred gender. The recent changes, which seek to allow transgender military members to be treated as their preferred gender and to obtain necessary support, were set in motion in 2013 when conversations among officials resulted in allowing a transgender woman who was born male to enlist as a female. Recognizing that supporting its troops was the best path to a strong fighting force, the IDF Medical Corps' Mental Health Division consulted with the Israeli Center for Human Sexuality & Gender Identity in an effort to better understand issues facing the transgender community and to raise awareness within the IDF about how to address their needs. In 2014 a new policy was agreed to that would automatically refer transgender personnel to a support system rather than require them to seek a commander's help to obtain proper uniforms, health care, facilities, etc. Current policy generally calls for treating members according to what their government-issued identification card—which can sometimes reflect a gender transition—says, but the new policy will make it easier for members to obtain needed support and to serve while living as their target gender. Under the new policy, IDF psychologists will work closely with civilian specialists to ensure full support for transgender military members. Tolerance training for senior officers has also been implemented.

How the IDF Handles Sensitive Questions around Transgender Service

- Showers: Attention is generally focused on ensuring the comfort of the transgender individual; most showers are private and many military members serve close enough to home to return there at night, but each situation is accommodated on a case by case basis.
- Housing: Except in combat units, most military members serve close enough to home to return there at night; most transgender individuals have not transitioned genders when they serve in the IDF, and they are housed according to the gender reflected on their government identification card, but special accommodations have been made, including switching to a unit that can offer private rooms or baths.
- Uniforms: Under new policy of referring transgender individuals to a support system comprised of both military and civilian specialists, transgender personnel can obtain uniforms for their desired gender.
- Cost of transitioning: Few if any IDF members transition during their service because of the young age at which they enter the military. Until recently many health insurance policies regarded transitioning genders as an elective process and did not cover it; however, as the medical community has come to view such procedures as medically necessary, military-provided insurance has begun to cover the cost of hormone treatment and can authorize an individual for gender-confirming surgery.
- Fitness: All service members must meet the fitness and aptitude standards required of a given position; if transgender service members are serving as their target gender, they must meet fitness standards applicable to that gender.
- Health needs: The health care needs of transgender individuals are no more difficult or burdensome than a wide range of health care needs of other military members, and no special accommodations or concerns are warranted.

Comments on Transgender Service in the IDF

Brig. Gen. Rachel Tevet-Weisel, advisor for LGBT and women's issues, IDF:

“Some [transgender individuals] come with documents and say they are starting the transitioning process. In those cases, **we think, how we can help them, whether it's with uniforms or a special permit to have long hair.** If there is a soldier who enlists as a man, but along his service wants to be addressed using female terms, then we do that.”

Col. Eyal Fruchter (on leave), former head of Mental Health Department, IDF:

“We had to deal with some problems when the first [openly transgender] people came. We didn't know how to give them the right hormones because they'd never been bought by the medical corps before. But we solved it immediately, and then **no problems occurred.** The commanders were very flexible.”

Dr. Ilana Berger, director, Israeli Center for Human Sexuality and Gender Identity:

“In the past, it wasn't always easy, and protocols weren't always followed; [transgender] people could have a hard time. **But the Army realized it can better use all its people if it individualizes according to the strengths of each person.** This way they don't just discharge them, but figure out how to get the most benefit from each.”

IDF officer Shachar (pseudonym), Israeli Army's first out transgender officer:

“Serving in the army and being recognized for who I really am by my fellow soldiers made me feel like a real man for the first time in my life. It made me feel like myself. **When you feel accepted and happy as who you are, you want to do your best as a soldier, as a person.**”

Lt. Col. Limor Shabtai, Advisor, Deputy Chief of Staff for women's issues, and head of Equal Opportunities Branch, IDF:

“It is important to have growing awareness of the issue in the IDF and we make sure to guide each and every soldier that addresses us in any state of the process. It will be right to form a standard procedure for every applicant and to **find a suitable solution individually for each one according to his or her own needs** and special status.”

Lt. Col. Dr. Rinat Yedidia, clinical head, Mental Health Department, IDF:

“Sometimes there should be no special approach. [Transgender people] mainly need special care because of difficulties they experience during their service. They are not common cases and thus each case should be discussed individually; there is no defined protocol. **If someone needs a mental health treatment, we provide it immediately and in the best manner possible.**”

Dr. Aaron Belkin, director of the Palm Center:

“**Israel's experience with open transgender service as a proven fighting force and a close ally of the U.S. should be instructive to American leaders assessing the current, outdated policy. The IDF has created a supportive and drama-free climate by striking a sensible balance between accommodations where needed and uniformity where possible. The Israeli situation shows that equal treatment and success go hand in hand.**”

Exhibit 13

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

Dr. Joycelyn Elders, MD, former US Surgeon General, Co-Chair
RADM Alan M. Steinman, MD, USPHS/USCG (Ret.), Co-Chair

REPORT OF THE TRANSGENDER MILITARY SERVICE COMMISSION

March, 2014

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

Report of the Transgender Military Service Commission

Commission co-chairs:

Dr. Joycelyn Elders, MD, former US Surgeon General
RADM Alan M. Steinman, MD, USPHS/USCG (Ret.)

Commission members:

Professor George R. Brown, MD, DFAPA
Professor Eli Coleman, PhD
BG Thomas A. Kolditz, PhD, USA (Ret.)

A nonpartisan national commission, comprised of medical and psychological experts, to consider whether Pentagon policies that exclude transgender service members are based on medically sound reasons.

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EXECUTIVE SUMMARY

- 1) This commission has been convened to determine whether US military policies that ban transgender service members are based on medically sound reasons. We find that there is no compelling medical rationale for banning transgender military service, and that eliminating the ban would advance a number of military interests, including enabling commanders to better care for their service members.
- 2) Medical regulations requiring the discharge of all transgender personnel are inconsistent with how the military regulates medical and psychological conditions, and arbitrary in that medical conditions related to transgender identity appear to be the only gender-related conditions requiring discharge irrespective of fitness for duty.
- 3) The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders 5th ed. (DSM-5)* no longer classifies gender non-conformity as a mental illness. While military regulations are updated to reflect revisions of DSM for non-transgender-related conditions, regulations have not been amended to reflect scientific consensus about gender non-conformity.
- 4) The prohibition on medically necessary cross-sex hormone treatment is inconsistent with the fact that many non-transgender military personnel rely on prescribed medications, including anabolic steroids, even while deployed in combat zones, and is based on inaccurate understandings of the complexity, risks and efficacy of such treatments.
- 5) Regulations that prohibit transgender service members from obtaining medically necessary gender-confirming surgery are harmful to the service members and inconsistent with policy concerning other reconstructive surgeries that service members are allowed to have.
- 6) The ban on transgender military service compromises continuity of care between the Military Health Service and Veterans Health Administration, undermining an important goal that officials from both systems have endorsed.
- 7) Military regulations should be stripped of enlistment disqualifications for transgender conditions, whether defined physically or mentally, as well as retention provisions that specify gender identity disorder as grounds for administrative separation. Transgender personnel should be treated in accordance with established medical standards of care, as is done with all other medical conditions.
- 8) Senior leaders should rely on the experiences and standards of other militaries and US federal agencies in formulating administrative policy to address fitness testing, records and identification, uniforms, housing and privacy.

1) OVERVIEW

This Commission came together with the modest goal of assessing whether US military policies that ban transgender service members are based on medically sound rationales.¹ In the process of answering this question, we came to have a deeper appreciation for the consequences of these policies, and we were troubled by what we learned. We determined not only that there is no compelling medical reason for the ban, but also that the ban itself is an expensive, damaging and unfair barrier to health care access for the approximately 15,450 transgender personnel who serve currently in the active, Guard and reserve components.² Medical regulations requiring the discharge of transgender personnel are inconsistent with how the military regulates all other medical and psychological conditions, and transgender-related conditions appear to be the only gender-related conditions that require discharge irrespective of fitness for duty.

Medical standards for enlistment are generally designed to ensure that applicants are free of conditions that would interfere with duty performance, endanger oneself or others, or impose undue burdens for medical care. The regulations, however, bar the enlistment of transgender individuals regardless of ability to perform or degree of medical risk. Unlike other medical disqualifications, which are based on modern medical expertise and military experience, the transgender enlistment bar is based on standards that are decades out of date.

Medical standards for retention are generally designed to identify permanent medical conditions that cannot be corrected and are likely to affect, or have already affected, performance of duty. Existing regulations, however, give commanders complete discretion to separate transgender individuals without medical review (“for the convenience of the government”), regardless of ability to perform or degree of medical risk. As with the enlistment regulations, the retention regulations are inconsistent with modern medical understanding. They include transgender conditions on a list of disqualifying, maladaptive traits assumed to be resistant to treatment and inconsistent with either fitness for duty or good order and discipline. By regulation, service members are simultaneously barred from treatment and also presumed to be unfit, despite the lack of medical evidence to support the policy.

Research shows that depriving transgender service members of medically necessary health care poses significant obstacles to their well-being.³ According to one recent study, “Mental health, medical and substance abuse services obtained outside of the military are supposed to be communicated back to the military, so transgender people who seek these services elsewhere still risk exposure... This leads individuals to go without treatment, allowing symptoms to exacerbate, and causing some to treat symptoms with alcohol or drugs, which could lead to substance abuse or dependence.”⁴ Research has confirmed, as well, that policies that force individuals to conceal their identities can have significant mental health consequences.⁵

Transgender medical care should be managed in terms of the same standards that apply to all medical care, and there is no medical reason to presume transgender individuals are unfit for duty. Their medical care is no more specialized or difficult than other sophisticated medical care the military system routinely provides. Transgender service members should not be required to meet a higher standard of medical self-sufficiency than the military requires of anyone

transition individuals from Canada and the United Kingdom have completed tours in Afghanistan. The US has deployed a post-operative transgender member of the Military Sealift Command repeatedly on Navy ships.⁵⁴

4.c) Gender-Confirming Surgery

The consensus of the medical profession, as reflected in official policies of the American Medical Association, American Psychological Association and Endocrine Society, is that gender-confirming surgeries can be medically necessary for some transgender individuals to mitigate distress associated with gender dysphoria. Surgeries include chest reconstruction and surgeries to create testes (scrotoplasty) and penises (phalloplasty or metoidioplasty, with or without urethral lengthening) for FTM's, and facial feminization, breast augmentation and surgeries to remove testes (orchietomy) and create vaginas (vaginoplasty) for MTF's. That said, other transgender individuals do not want or require surgery to alleviate symptoms. A recent study noted that, "As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither. Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery but not hormones."⁵⁵

In considering the question of gender-confirming surgery among military personnel, it is important to recognize that regulations permit service members to have elective cosmetic surgeries at military medical facilities, and that some of those elective procedures risk post-operative complications that can be more serious than those of medically necessary gender-confirming surgeries.⁵⁶ For example, the LeFort osteotomy procedures and mandibular osteotomies that service members may elect to have are associated with a number of possible complications based upon the technique, surgical level, and anatomic site at which the surgery/osteotomies are performed.⁵⁷ The incidence of complications in craniofacial surgery depends upon the type of surgery and anatomic location at which the procedure is performed, and infection rates may range from approximately 1 to 3 percent.⁵⁸ Additional complications following mandibular osteotomies, such as sensory deficit, may range between 24 to 85 percent, and unfavorable fractures associated with sagittal split osteotomies may range between 3 to 23 percent.⁵⁹ Other studies cite complication rates of LeFort I osteotomies at 6.4 percent, including anatomic complications, bleeding requiring transfusion, infection, ischemic complications such as aseptic necrosis, and insufficient fixation.⁶⁰ Treatment for these complications may require additional surgical or other interventional procedures, antibiotics, and/or local wound care.

Even if the Military Health Service provided gender-confirming surgeries, however, the demand for such procedures would be low. Research on civilian employers whose insurance plans cover transition-related health care has found that very few employees submit claims for such benefits in any given year. If extrapolated to the active, Guard and reserve components of the military, the data suggest that if transgender service members were allowed to serve, and if the military covered medically necessary care related to gender transition, fewer than 2 percent of transgender service members, a total of 230 individuals, would seek gender-confirming surgery

in any particular year.⁶¹ A recent study reported the average cost of transition-related health care at \$29,929.⁶²

As with any surgical procedures, gender-confirming surgeries entail a risk of short-term and chronic post-operative complications.⁶³ Gender-confirming procedures that pertain to the breasts and chest tend to entail low complication rates. MTFs who undergo breast augmentation as a single surgery often are discharged the same day with pain medication and antibiotics. They leave their dressings intact for three days following surgery and the steri-strips along the points of incision are left in place for another week. Patients are generally comfortable within two days and return to regular activities within two weeks, though doctors recommend that they avoid exerting themselves for a month. Surgeries involving the genitourinary system can be riskier. For MTF individuals, surgery on the external genitalia typically entails a penectomy, bilateral orchiectomy, vaginoplasty (including formation of the labia major and minora), clitoroplasty, and urethral shortening. For vaginoplasty, patients are hospitalized for six to eight days. MTFs who have this surgery will start to feel more comfortable after one to two weeks and will be asked to return to the clinic for periodic follow-up visits, though strenuous activity typically is avoided for three months.

Despite the possibility of post-operative complications, research shows that their incidence rate is low. Across 15 studies from 1986 to 2001, 2.1 percent of patients had rectal-vaginal fistula, 6.2 percent with vaginal stenosis, 5.3 percent had urethral stenosis, 1.9 percent with clitoral necrosis, and 2.7 percent with vaginal prolapse.⁶⁴ A follow-up study of 80 women who had vaginoplasties found three post-operative complications and another determined that among 89 vaginoplasties, there was one major complication.⁶⁵ If transgender service members were allowed to serve and to have gender-confirming surgery while in the military, we estimate that ongoing post-operative complications would render ten MTF service members unfit for duty each year.⁶⁶

For FTM individuals, surgery on the genitalia can include a vaginectomy, either metoidioplasty (clitoral lengthening with or without urethral lengthening) or phalloplasty (either pedicled flap or free tissue transfer, with or without urethral lengthening), and scrotoplasty (with placement of testicular prostheses). Additionally, some individuals undergo hysterectomy and bilateral salpingo-oophorectomy. Phalloplasty is a lengthy multiple stage process, and a majority of FTM patients do not undergo any genital surgery except for a hysterectomy and the removal of the fallopian tubes and ovaries. For FTMs who desire both top (chest) and bottom (genital) surgeries, the timeline is more complex than for MTFs. The chest surgery can be completed at the same time as a hysterectomy and oophorectomy, and in most cases patients are discharged the following day. After a mastectomy, FTMs are back to their normal routines in one to two weeks but should avoid strenuous activity for four weeks. FTMs who have had a hysterectomy or oophorectomy can be required to wait four to six months until they can undergo additional genital surgeries, though hysterectomy and oophorectomy may be performed simultaneously with genital reconstruction. Those having urethral lengthening are generally hospitalized five to ten days. Phalloplasty is more complicated, and the expected hospital time can be ten to fourteen days, with a catheter required for up to three weeks.⁶⁷

Research suggests that a minority of individuals having female-to-male genital surgery may expect long-term complications that would require ongoing care.⁶⁸ In a study of 56 FTM patients

in France who had a phalloplasty, 25 percent had complications including infection and hematoma. In the same study, 29 percent of those with a penile prosthesis had mechanical or infective complications.⁶⁹ In another study in the UK of 115 FTMs who underwent total phallic reconstruction from 1998 to 2008, 10.4 percent experienced partial skin necrosis, 4.3 percent had infection, and 2.6 percent had phalluses that were lost.⁷⁰ That said, very few FTMs have genital surgery, and out of 1,594 FTMs who responded to a recent survey, only 48 individuals (3 percent) had genital surgery, including 24 who had metoidioplasty and phalloplasty, 1 who had just phalloplasty, and 23 who had just metoidioplasty.⁷¹ Given such low demand, even using conservative assumptions it is estimated that only 6 post-operative FTM transgender men would become unfit for duty each year as a result of ongoing, post-operative complications following genital surgery.⁷²

In sum, while the risks of genital surgery are real, they are no higher than risks associated with other genitourinary procedures, and they are lower than risks that accompany some elective non-transgender-related surgeries which the military allows and which, unlike genital surgeries for transgender individuals, are cosmetic and not medically necessary. As well, the low rate of demand for genital surgeries would mean that in absolute and relative terms, allowing such procedures would place almost no burden on the military.

4.d) Deployment

In explaining the military's ban on transgender service, and as noted above, spokespersons have emphasized non-deployability, medical readiness and constraints on fitness for duty as reasons why transgender service members should not be allowed to serve. While personnel policy must of course be designed to promote deployability and medical readiness, arguments invoked to oppose transgender service on these grounds do not withstand scrutiny. With few exceptions, transgender service members are deployable and medically ready. As noted in other sections of this report, cross-sex hormone treatment and mental health considerations do not, in general, impede the deployability of transgender service members, and the public record includes instances in which transgender individuals deployed after having undergone transition.⁷³ With two exceptions, all transgender service members who are otherwise fit would be as deployable as their non-transgender peers. The first exception is post-operative transgender service members whose genital surgeries result in long-term complications. Using conservative assumptions, as noted earlier, an estimated 16 post-operative service members (ten MTF transgender women and six FTM transgender men) would become permanently undeployable each year as a result of ongoing post-operative medical complications following genital surgery.

The second exception would be those undergoing surgical transition while in service. But the number of service members undergoing surgical transition in any given period would be low, both in relative and absolute terms, either because they would have already transitioned prior to joining the military, would prefer to wait until the end of military service to transition, or would not want to surgically transition, regardless of the timing. As discussed above, if the military's health care program paid for transition-related coverage, fewer than 2 percent of transgender service members, a total of 230 individuals, would seek gender-confirming surgery each year. With very few exceptions, transgender service members would be deployable and medically ready on a continuous basis.

Straightforward and fair-minded regulatory options are available for managing transgender military service and deployability. According to Army regulations, which, as explained above, do not apply to transgender-related conditions, “Personnel who have existing medical conditions may deploy” if deployment is unlikely to aggravate the condition, if an unexpected worsening of the condition would not pose a grave threat, if health care and medications are immediately available in theater, and if “no need for significant duty limitation is imposed by the medical condition.”⁷⁴ British military policy concerning transgender service and deployability is equally sensible: “Applicants who are about to undergo, or are still recovering from surgery to change the external appearance of their body into that of the acquired gender should be graded P8 [medically unfit], as with any other condition that is being treated or requires surgery at the time of application, until they are fully recovered from the surgery.”⁷⁵

Many non-transgender service members are temporarily or permanently non-deployable, but they are not automatically discharged as a result, and military policies accommodate them within reason. Defense Department regulations confirm that when evaluating a service member’s fitness for duty, non-deployability is not grounds for a determination of unfitness: “Inability to perform the duties of his or her office, grade, rank, or rating in every geographic location and under every conceivable circumstance will not be the sole basis for a finding of unfitness.”⁷⁶ Even service members who are permanently constrained by serious medical conditions and defects are allowed, under some circumstances, to remain in the military. According to DODI 1332.38, “A service member who has one or more of the listed conditions or physical defects is not automatically unfit,” including systemic diseases such as tuberculosis, leprosy, lymphoma, leukemia, or Hodgkin’s disease.⁷⁷ Regulations provide service members suffering from these and other serious, non-transgender-related, medical conditions with opportunities to serve in a limited capacity and to recover: “A member previously determined unfit and continued in a permanent limited duty status...may be determined fit when the member’s condition has healed or improved so that the member would be capable of performing his or her duties in other than a limited duty status.”⁷⁸

Although deployability is a crucial component of readiness, many non-transgender service members are temporarily or permanently non-deployable. According to a 2011 Defense Department study of health-related behaviors, 16.6 percent of active duty service members (244,000 service members) were unable to deploy during the twelve-month period prior to the survey’s administration, including 22.5 percent of Marines. Service members who were temporarily or permanently non-deployable cited a variety of factors including injuries (31.5 percent), illness or medical problems (23.4 percent), pregnancy (9.9 percent), mental health (8.1 percent), family reasons (3.3 percent) and other unspecified reasons (29.9 percent). Another 2.2 percent of the active component returned early from a deployment during the previous year.⁷⁹

Yet non-transgender, non-deployable service members are not automatically banned, and policies accommodate them to the extent possible. Indeed, the services have adopted leave and assignment policies that provide for prolonged absences and restrictions on duty as a result of medical conditions, as well as life choices that service members make. These include ordinary and advance leave. By law, members of the armed forces are entitled to 30 days of paid leave per year (generally referred to as “ordinary” or “annual” leave), accruing at a rate of 2½ days per month.⁸⁰ Service members need not provide any justification in order to take their annual leave. On the contrary, military commanders “shall encourage and assist all Service members to use” their

Appendix – Statement by 16 current and former military university faculty members

We write to endorse the quality of research that informs the Report of the Transgender Military Service Commission, which determined that there is no compelling medical rationale for banning transgender military service. We believe that the Commissioners who completed this study engaged in careful and well-done research, and that their conclusions are based on a reasonable assessment of available evidence.*

LTC Allen B. Bishop, USA (ret.), former assistant professor, US Military Academy
Dr. Allyson A. Booth, professor, US Naval Academy
Lt. Col. David A. Boxwell, Ph.D., USAF (ret.), former professor, US Air Force Academy
Dr. Kathleen Campbell, associate professor, US Military Academy
Dr. Donald Campbell, professor, US Military Academy
Lt. Col. Edith A. Disler, Ph.D., USAF (ret.), former professor, US Air Force Academy
Dr. Barry S. Fagin, professor, US Air Force Academy
Dr. Gregory D. Foster, professor, National Defense University
Dr. Clementine Fujimura, professor, US Naval Academy
Dr. Elizabeth L. Hillman, former instructor, US Air Force Academy
Dr. Janice H. Laurence, former professor, Naval Postgraduate School
Dr. David Levy, professor, US Air Force Academy
Lt. Col. James E. Parco, Ph.D., USAF (ret.), former professor, Air Command and Staff College
Professor Steven M. Samuels, Ph.D., US Air Force Academy
Dr. Richard Schoonhoven, associate professor, US Military Academy
Professor Tammy S. Schultz, Ph.D., US Marine Corps War College

*The views expressed in this statement by current and former faculty at US Government Agencies are those of the individuals and do not necessarily reflect the official policy or position of their respective university, their Service, the Department of Defense or the US Government.

Exhibit 14

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

FOR IMMEDIATE RELEASE: Tuesday, August 1, 2017
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Fifty-Six Retired Generals and Admirals Warn That President Trump's Anti-Transgender Tweets, If Implemented, Would Degrade Military Readiness

SAN FRANCISCO, CA — Fifty-six* retired General and Flag Officers provided the following statement to the [Palm Center](#) today:

“The Commander in Chief has tweeted a total ban of honorably serving transgender troops. This proposed ban, if implemented, would cause significant disruptions, deprive the military of mission-critical talent, and compromise the integrity of transgender troops who would be forced to live a lie, as well as non-transgender peers who would be forced to choose between reporting their comrades or disobeying policy. As a result, the proposed ban would degrade readiness even more than the failed ‘don't ask, don't tell’ policy. Patriotic transgender Americans who are serving—and who want to serve—must not be dismissed, deprived of medically necessary health care, or forced to compromise their integrity or hide their identity.

“President Trump seeks to ban transgender service members because of the financial cost and disruption associated with transgender military service. We respectfully disagree, and consider these claims to be without merit. The [RAND Corporation](#), as well as research in the [New England Journal of Medicine](#), found that the financial cost of providing health care to transgender troops would be, at most, \$8.4 million per year. This amounts to one one-hundredth of one percent of the military's annual health care budget. As for ostensible disruptions, transgender troops have been serving honorably and openly for the past year, and have been widely praised by commanders. [Eighteen foreign nations](#), including the UK and Israel, allow transgender troops to serve, and none has reported any detriment to readiness.

“Recently, two former Chairmen of the Joint Chiefs of Staff have taken courageous stands in support of our transgender service members. [General Martin Dempsey](#) said of our transgender troops that, ‘The service of

men and women who volunteer and who meet our standards of service is a blessing, not a burden.’

“And [Admiral Mike Mullen](#) stated that, ‘I led our armed forces under the flawed 'don't ask, don't tell' policy and saw firsthand the harm to readiness and morale when we fail to treat all service members according to the same standards. Thousands of transgender Americans are currently serving in uniform and there is no reason to single out these brave men and women and deny them the medical care that they require. The military conducted a thorough research process on this issue and concluded that inclusive policy for transgender troops promotes readiness.’ Admiral Mullen urged civilian leaders ‘to respect the military’s judgment and not to breach the faith of service members who defend our freedoms.’ We could not agree more.”

General John R. Allen, USMC (Retired)
General Robert W. Sennewald, USA (Retired)
Vice Admiral Donald Arthur, USN (Retired)
Lieutenant General Robert Gard, USA (Retired)
Lieutenant General Walter Gaskin, USMC (Retired)
Vice Admiral Kevin P. Green, USN (Retired)
Lieutenant General Arlen D. Jameson, USAF (Retired)
Lieutenant General Claudia Kennedy, USA (Retired)
Lieutenant General Willie Williams, USMC (Retired)
Major General Juan G. Ayala, USMC (Retired)
Major General Donna Barbisch, USA (Retired)
Rear Admiral Chris Cole, USN (Retired)
Major General Vance Coleman, USA (Retired)
Major General J. Gary Cooper, USMC (Retired)
Major General Paul Eaton, USA (Retired)
Major General Mari K. Eder, USA (Retired)
Rear Admiral F. Stephen Glass, USN (Retired)
Major General Richard S. Haddad, USAF (Retired)
Major General Irv Halter, USAF (Retired)
Rear Admiral Jan Hamby, USN (Retired)
Major General Marcelite J. Harris, USAF (Retired)
Rear Admiral John Hutson, JAGC, USN (Retired)
Major General James R. Klugh, Sr., USA (Retired)
Major General Dennis Laich, USA (Retired)
Major General Randy Manner, USA (Retired)
Major General Dee Ann McWilliams, USA (Retired)
Major General John Phillips, USAF (Retired)
Major General Dana J.H. Pittard, USA (Retired)
Major General Gale Pollock, CRNA, FACHE, FAAN, USA (Retired)

Rear Admiral Harold Robinson, USN (Retired)
Major General Patricia Rose, USAF (Retired)
Rear Admiral Alan Steinman, USPHS/USCG (Retired)
Major General Antonio Taguba, USA (Retired)
Major General Peggy Wilmoth, PhD, MSS, RN, FAAN, USA (Retired)
Major General Maggie Woodward, USAF (Retired)
Rear Admiral Dick Young, USN (Retired)
Rear Admiral Sandra Adams, USN (Retired)
Brigadier General Clara Adams-Ender, USA (Retired)
Brigadier General Ricardo Aponte, USAF (Retired)
Rear Admiral Jamie Barnett, USN (Retired)
Brigadier General David Brahms, USMC (Retired)
Brigadier General Stephen A. Cheney, USMC (Retired)
Brigadier General Julia Cleckley, USA (Retired)
Rear Admiral Jay DeLoach, USN (Retired)
Brigadier General John Douglass, USAF (Retired)
Brigadier General Evelyn "Pat" Foote, USA (Retired)
Brigadier General Judy M. Griego, NMANG (Retired)
Brigadier General David R. Irvine, USA (Retired)
Brigadier General John H. Johns, USA (Retired)
Rear Admiral Gene Kendall, USN (Retired)
Brigadier General Thomas Kolditz, PhD, USA (Retired)
Brigadier General Carlos E. Martinez, USAF (Retired)
Brigadier General Ronald Rokosz, USA (Retired)
Brigadier General John M. Schuster, USA (Retired)
Rear Admiral Michael E. Smith, USN (Retired)
Brigadier Paul Gregory Smith, USA (Retired)
Brigadier General Marianne Watson, USA (Retired)

A 57th Officer, Rear Admiral Sandra Smith, signed this statement after its initial publication.

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Exhibit 15

IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF MARGARET C. WILMOTH
IN SUPPORT OF PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION**

I, Margaret Chamberlain Wilmoth, declare as follows:

Background and Experience

1. I served as Deputy Surgeon General for Mobilization, Readiness and Army Reserve Affairs in the Office of the Surgeon General of the United States Army from July 2014 to May 1, 2017.

2. I received a Bachelor’s degree in Nursing from the University of Maryland in 1975, followed by a Master’s Degree in Nursing from the University of Maryland in 1979. I received a Ph.D. in Nursing from the University of Pennsylvania in 1993. I received a Master’s Degree in Strategic Studies from the United States Army War College in 2001. I am a Registered Nurse.

3. My family’s history of military service dates back to the Revolutionary War. As a small child, I grew up hearing the stories of an aunt who was a nurse and a neighbor who had

served as an Army nurse during World War II. From the time I was 6 or 7 years old, I knew I wanted to be an Army nurse. When I graduated with my nursing degrees at the end of the Vietnam War, the Army was drawing down, so I went into civilian practice. I spent the first seven years of my nursing career as a teacher and researcher.

4. While I was teaching at the University of Delaware, my father, who had joined the Air Force Reserve after serving as a pilot, encouraged me to pursue my dream of serving as an Army nurse by joining the United States Army Reserve (U.S.A.R.). I joined the U.S.A.R. in 1981 and served in various capacities during over thirty-five years in service, achieving the ranks of Captain, Major, Lieutenant Colonel, Colonel, Brigadier General, and Major General, before my retirement from the military on May 1, 2017. When I was promoted to Brigadier General in 2005, I became the first nurse and first woman to command a medical brigade as a general officer. When I was promoted to Major General, I became only the third nurse from the Army Reserve ever to achieve that rank.

5. From July of 2008 through October 2011, I served as Assistant for Mobilization and Reserve Affairs in the Office of the Secretary of Defense for Health Affairs. From October 2011 through July of 2014, I served in the Control Group. In July of 2014, I was appointed Deputy Surgeon General for Mobilization and Reserve Affairs. When I received this appointment, I became the first nurse in the more than 106-year history of the Army Reserve and the first woman to serve in this position. I held this position until my retirement from the military on May 1, 2017.

6. In August of 2014, I was also appointed by the Secretary of the Army to the Army Reserve Forces Policy Committee, where I most recently served as Deputy Chair. This

congressionally-mandated committee's role includes advising the Secretary of the Army on major policy matters directly affecting the reserve components and the mobilization preparedness of the Army. I held this position until my retirement from the military on May 1, 2017.

7. In my more than three-and-a-half decades of service, I received many decorations, including the Distinguished Service Medal, Defense Superior Service Medal, the Legion of Merit Medal, the Meritorious Service Medal, the Army Commendation Medal, and the Army Achievement Medal. I also hold the Expert Field Medical Badge and was awarded the 9A proficiency designation in medical surgical nursing by the Surgeon General, U.S. Army. I am a member of the Order of Military Medical Merit.

8. My civilian professional experience includes academic appointments at Central Missouri State University, University of Kansas, University of North Carolina at Charlotte, and Georgia State University. At Georgia State, I served as Dean of and Professor at the Byrdine F. Lewis School of Nursing and Health Professions at Georgia State University. I also served as a Health Policy Fellow at the Robert Wood Johnson Foundation. I am also a Fellow of the American Academy of Nursing, where I have served as Co-Chair of the Military/Veterans Expert Panel. In August of 2017, I joined the University of North Carolina School of Nursing as the Executive Dean and Associate Dean for Academic Affairs.

9. Throughout my academic and research careers, my practice and research focus has been in psychosocial oncology. My research led to the development of a subspecialty in psychosexual oncology, which focuses on how surgery, chemotherapy, radiation, and immunotherapy impact body image, sexuality, and fertility. I have had more than sixty

psychosexual oncology academic papers published on topics such as comparing the effects of lumpectomy vs. mastectomy on sexual behaviors; and strategies to help nurses become comfortable with psychosexual assessments of patients.

Formation of Working Group

10. On July 28, 2015, Secretary of Defense Ashton Carter directed Brad Carson, Acting Undersecretary of Defense for Personnel and Readiness, to convene a working group (the “Working Group”) to study the policy and readiness implications allowing transgender persons to serve openly in the Armed Forces. The Working Group was asked to determine whether there were any objective, evidence-based impediments to permitting transgender people to serve openly and, if not, to develop an implementation plan for changing the policy to permit open service with the goal of maximizing military readiness. A true and accurate copy of this directive is attached hereto as Exhibit A.

11. When Secretary Carter directed the formation of the Working Group, I was serving as Deputy Surgeon General for Mobilization, Readiness, and Army Reserve Affairs. I was asked by Surgeon General, United States Army to serve as that office’s representative to the Working Group. At the Working Group, I was able to provide the benefit of my medical expertise, my academic research, and my knowledge of the workings of the Military Health System and the Defense Health Agency. I participated in the meetings of the Working Group from its initial meeting in the summer of 2015 though the final meeting in late spring of 2016.

Working Group Process

12. The Working Group addressed many topics, one of which was determining how the medical needs of transgender service members could be met by the military. With respect to that topic, our process involved three steps: (1) Understanding the medical needs of transgender service members; (2) identifying how those needs could be met within the Military Health System; and (3) developing policies and protocols to ensure transgender service members could serve openly and have their medical needs met. The Working Group focused on ensuring that transgender service members' medical needs would be treated in the same manner and under the same framework as the medical needs of other service members, unless that proved unworkable.

13. **Step 1: Understanding Medical Needs.** The first step for the members of the Working Group was to establish a baseline level of knowledge among all Working Group members about the medical needs of transgender service members. We educated ourselves by meeting with experts from the civilian sector so we could begin to understand what being transgender means. We wanted to learn about the full range of medical treatment that might be required for a transgender service member. We sought to understand how an individual might go through a transition process and what the medical components of that process might be. We spoke to internal medicine experts, psychologists, endocrinologists, and surgeons who educated the Working Group regarding all aspects of transgender care including mental health treatment, pharmaceutical treatment, and surgical treatment.

14. **Step 2: Identifying How Medical Needs Could Be Met Within the Military Health System.** After we understood the universe of potential medical needs of transgender

service members, we focused on how the Military Health System (MHS) could meet those needs. For the large majority of medical care needs, we found that MHS was already providing the same or substantially similar services to other service members, and that there would be little, if any, additional burden on MHS from the provision of the required medical services to transgender service members.

15. With respect to hormonal therapy, we learned that MHS already provides this service to service members. Women frequently receive hormonal therapy, as do other service members who have adrenal or pituitary deficiencies that require hormone replacement therapy. The Working Group concluded that providing similar care for transgender individuals from a pharmaceutical perspective would not be a complicating issue or an additional burden.

16. The Working Group also examined whether there were any deployment-related obstacles to providing pharmaceutical care that requires routine doses of medication. We learned that service members with chronic conditions requiring routine medications regularly take with them enough medication to last for at least the first ninety (90) days of their deployment. Examples of such medications would include birth control, hormone replacement therapy, and medications to address low testosterone, hypertension, and osteoporosis, among other conditions. Each Combatant Command sets rules in the form of Personnel Policy Guidance that specifies any special restrictions on deployability of members to that Command, including medical restrictions. For example, a theatre that has only intermittent access to a medical supply train might require service members to bring extra medical supplies or restrict certain service members from serving in particular locations. Such issues are readily addressed in the field through the Personnel Policy

Guidance, and no unique or different issues would be raised by the pharmaceutical needs of transgender service members. The Working Group concluded that no additional burden on deployability would be created by transgender service members who required routine medication.

17. With respect to gynecological care, we learned that MHS already routinely provides this care to its service members. With transgender service members being permitted to serve openly, the concerns about confidentiality that might previously have hindered transgender service members from seeking gynecological care through MHS would no longer be an issue. Transgender service members would now be able to receive all routine medical care including gynecological services through MHS, allowing for more complete and coordinated care for the service members. The Working Group concluded that no additional burden on MHS would be created by the provision of gynecological care to transgender service members.

18. With respect to mental health care, we learned that MHS already routinely provides this care to its service members. With transgender service members being permitted to serve openly, the concerns about confidentiality that might previously have inhibited transgender service members from seeking mental health care through MHS would no longer be an issue. Because transgender service members would now be able to seek such care, if needed, openly through MHS, the Working Group expected that the service members would benefit from more complete and coordinated care. The Working Group concluded that no additional burden on MHS would be created by the provision of mental health care to transgender service members.

19. The Working Group also examined whether there were any deployment or readiness related obstacles associated with addressing the mental health needs of transgender

service members. The Working Group educated itself in part by consulting with our counterparts in Israel, the United Kingdom, and Australia, where open service by transgender individuals is permitted. We learned that those services have seen no reduced ability to serve from transgender service members due to mental health or other gender identity related issues. The Working Group also examined our own military's existing policies and learned that there is a rigorous screening process for all individuals applying to join the military that includes examination of mental health. The Military Entrance Processing Stations (MEPS) (enlistment processing offices) evaluate psychological stability as a component of fitness to serve. Additionally, once individuals are in active or reserve service, mental health is evaluated on an annual basis as part of the Periodic Health Assessment (PHA). The Working Group found that there was no reason to think that these pre-existing military policies, when applied to transgender service members serving openly, would not adequately protect the services from any mental health issues interfering with deployment.

20. With respect to surgical therapy, the Working Group consulted with surgical experts to determine whether there were any aspects of surgical therapy for transgender service members in which MHS did not already have the requisite expertise. We learned that MHS employs general surgeons, urologists who perform urological surgeries, and obstetrician/gynecologists who perform gynecological surgeries. Those skill sets are present in a substantial capacity within MHS, and MHS is able to address most routine surgical needs at or near the location of its service members. We learned, for instance, that surgeries for transgender service members would be relatively rare and that many of those surgeries are already routinely provided to non-transgender service members, such as hysterectomies or chest surgeries. For

surgeries requiring particular expertise, MHS maintains major medical centers that are equipped to provide a broader array of services. For surgeries requiring expertise outside of MHS's capacity, service members are typically referred out to civilian providers. The non-routine surgical needs of a transgender service member could be addressed either through training or contracting with surgeons with the appropriate expertise to MHS, or through the normal process for referring out of MHS to civilian providers. The Working Group concluded that the surgical needs of transgender service members could be addressed through either of these methods without creating additional burden on MHS.

21. The Working Group also learned that the development of gynecology/genitourinary (GYN/GU) surgical expertise within MHS could have an added benefit for MHS beyond the provision of surgical care to transgender service members. MHS struggles with ensuring that their medical providers acquire and retain the skills they need to serve in a wartime scenario. Having surgeons engage in training in the surgical techniques needed to perform sex-reassignment surgery would provide analogous surgical skills required to address, for instance, blast injuries in wartime scenarios. Having the expertise to address genital mutilation from a blast would be a benefit for MHS and all service members.

22. **Step 3: Policy Development.** Throughout this educational process, the Working Group members developed a deep understanding of the medical needs of transgender service members. Next, we turned our focus to developing a policy that would address the psychological and physical needs of transgender individuals and treat those individuals fairly while keeping

readiness and deployability at the forefront. Developing the protocol was an iterative process involving multiple rounds of drafting, gathering input from the services, and redrafting.

23. The Working Group concluded that there were no barriers that should prevent transgender service members from serving openly in the military. Open service by transgender service members would not impose any significant burdens on readiness, deployability, or unit cohesion. For those seeking to join the military, the Working Group recommended that the medical standards for accession into the Military Services by transgender persons be based upon the same standards applied to persons with other medical conditions, which seek to ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty. Based upon that standard, the Working Group recommended that the new accessions policy permit enlistment so long as an applicant with a history of gender dysphoria or of treatment for gender dysphoria has completed all medical treatment associated with the applicant's medical condition and has been stable in the preferred gender for a sufficient period of time.

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24. The Working Group's process for developing the protocol and recommendations was deliberative and thoughtful, involved significant amounts of research and education, and in the end resulted in a policy that all services supported. We were very proud to have developed a policy that treats transgender service members as the equal of their fellow service members, and as soldiers, sailors, marines, cuttermen, and airmen first.

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

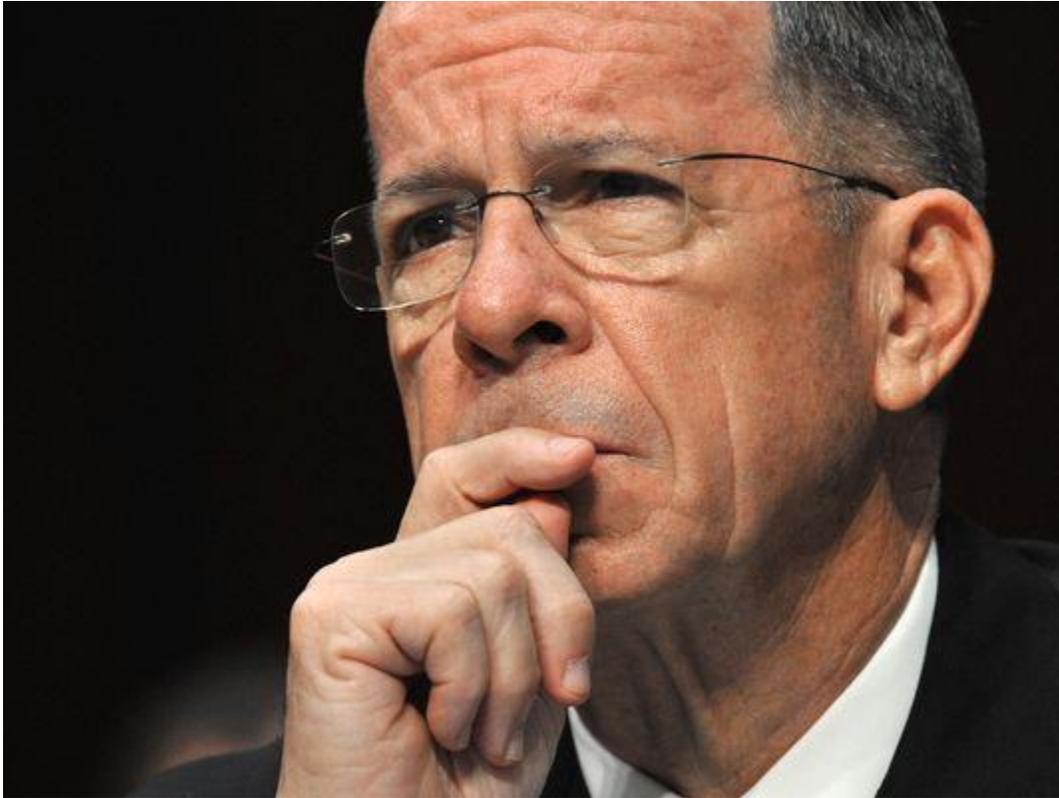
Dated: August 30, 2017


Margaret C. Wilmoth
Margaret C. Wilmoth

Exhibit 16

Accept transgender troops, allow them medical treatment, Adm. Mike Mullen tells Congress

Tom Vanden Brook, USA TODAY Published 1:14 p.m. ET July 25, 2017



(Photo: KAREN BLEIER, AFP/Getty Images)

WASHINGTON — Former Chairman of the Joint Chiefs of Staff Adm. Mike Mullen called on Congress Tuesday to resist dictating policy to the Pentagon on how to treat transgender troops.

Mullen was the highest-profile military leader to oppose the military's policy barring gay troops from serving, lending his considerable prestige to that ultimately successful movement. He oversaw the repeal of "Don't Ask, Don't Tell" in 2011 and compared it today to efforts aimed at limiting funding for medical treatment of transgender troops.

"I led our armed forces under the flawed 'Don't ask, Don't tell' policy and saw firsthand the harm to readiness and morale when we fail to treat all service members according to

the same standards,” Mullen said in a statement to USA TODAY. “Thousands of transgender Americans are currently serving in uniform and there is no reason to single out these brave men and women and deny them the medical care that they require.”

Mullen’s call to limit congressional input into Pentagon policy on transgender troops makes him the highest-ranking former or current officer to speak out on their behalf. Last year, then-Defense Secretary Ash Carter rescinded the policy that prevented transgender troops from serving openly and to allow them to receive medical treatment for their condition.

Under the Trump administration, implementation of the policy on recruiting transgender troops has been slowed. The services had been scheduled to begin accepting new transgender troops on July 1, but Defense Secretary Jim Mattis allowed the services another six months to study the issue.

Two weeks ago, the House of Representative narrowly defeated an amendment to the annual National Defense Authorization Act that would have prevented the Pentagon from spending money for surgery on transgender troops. Rep. Vicky Hartzler, R-Mo., introduced the amendment and said it would save taxpayers \$1 billion over 10 years.

“The job of Congress is to ensure that our military is the most effective, efficient and well-funded fighting force in the world,” she said in a statement when her initiative was introduced. “With the challenges we are facing across the globe, we are asking the American people to invest their hard-earned money in national defense.”

RAND Corp. study

Hartzler’s estimate is contradicted by a RAND Corp. study commissioned by the Pentagon last year. The non-profit, non-partisan think tank found that treatment, including hormone and surgery, for transgender troops could cost as much as \$8.4 million per year.

There are as many as 6,630 transgender troops in the active-duty force of 1.3 million, RAND found. The study determined that the effect on treating about 270 transgender troops per year would have a negligible impact on military readiness.

Mullen referred to the RAND report when he said Congress should “not confuse oversight with micromanagement of personnel policy.”

“The military conducted a thorough research process on this issue and concluded that inclusive policy for transgender troops promotes readiness,” Mullen said. “I urge the Congress to respect the military’s judgment and not to breach the faith of service members who defend our freedoms.”

The policy bill approved by the House authorizes nearly \$700 billion in military spending. Another bill to authorize that money contains amendments that would ban the Pentagon from spending money on medical treatment for transgender troops and sensitivity training aimed at promoting their acceptance.

<https://www.usatoday.com/story/news/politics/2017/07/25/accept-treat-transgender-troops-adm-mike-mullen-tells-congress/508852001/>

Exhibit 17

Ex-Joint Chiefs chairman tells Congress to allow medical care for transgender troops

BY REBECCA KHEEL - 07/25/17 01:57 PM EDT [44](#)



© Getty

A former chairman of the Joint Chiefs of Staff is calling on Congress not to legislate on what medical care transgender troops can receive.

“Congressional oversight of the military is vital, but we must not confuse oversight with micromanagement of personnel policy,” retired Adm. [Mike Mullen](#) said in a statement Tuesday reported by [USA Today](#).

“It would be unprecedented for lawmakers to place themselves between loyal service members and their doctors or commanders.”

Mullen, who was the highest-ranking military officer in the country from 2007 to 2011, was speaking out as some Republicans attempt to revive an effort to ban the Pentagon from funding gender reassignment surgeries for troops.

Right now, Pentagon policy allows transgender troops to receive any treatment deemed by their doctors to be medically necessary, including gender reassignment surgery and hormone therapy.

An amendment to the House version of the annual defense policy would have put an end to that by prohibiting funding for all transition-related treatment besides mental healthcare.

But the amendment was voted down 209-214, with 24 Republicans joining with Democrats to defeat it.

Republicans have filed several similar amendments to the "minibus" appropriations bill coming to the House floor this week that folds in defense spending. But it's unclear whether any of those amendments will be advanced by the House Rules Committee and get a vote on the House floor.

In his statement Tuesday, Mullen drew on his experience overseeing the military while "don't ask, don't tell" was still in place. In 2010, Mullen came out in support of repealing the law that banned gays and lesbians from openly serving in the military, helping propel the repeal efforts.

“I led our armed forces under the flawed ‘don't ask, don't tell’ policy and saw firsthand the harm to readiness and morale when we fail to treat all service members according to the same standards,” he said in his statement. “Thousands of transgender Americans are currently serving in uniform and there is no reason to single out these brave men and women and deny them the medical care that they require.”

Mullen also referenced the 2016 RAND Corp. study that found all medical costs for transgender service members would be between about \$2.4 million and \$8.4 million annually and that allowing open service would have “a minimal impact on readiness.”

“The military conducted a thorough research process on this issue and concluded that inclusive policy for transgender troops promotes readiness,” he

said. "I urge the Congress to respect the military's judgment and not to breach the faith of service members who defend our freedoms."

Updated at 4:12 p.m.

<http://thehill.com/policy/defense/343658-former-joint-chiefs-chairman-to-congress-dont-ban-medical-care-for-transgender>

Exhibit 18



(http://www.jcs.mil/) (HTTP://WWW.JCS.MIL/)

JOINT CHIEFS OF STAFF



17TH CHAIRMAN OF THE JOINT CHIEFS OF STAFF

Admiral Michael Glenn Mullen

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Michael Glenn Mullen

Chairman from Oct. 1, 2007 – Sept. 30, 2011



Admiral

Michael Glenn Mullen

High Resolution Version (/portals/36/Images/BiographyPhotos/cjcs/017_mullen.jpg)

In February 1971 Lieutenant (j. g.) Mullen graduated from the Department Head Course 32 at Naval Destroyer School, Newport, Rhode Island. After completing a brief course in nuclear weapons at Norfolk, Virginia, he reported aboard the USS Blandy (DD 943) as Weapons Officer and was promoted to full Lieutenant in July 1971. As part of Destroyer Squadron Twenty-Six, nicknamed "The Mod Squad", the Blandy participated in an experimental program designed to give junior officers more responsibility by assigning them to billets normally held by personnel of greater rank. While serving consecutively as the ship's Weapons and Operations Officer, Mullen participated in NATO operations in the Mediterranean, tracked Soviet ships in the Caribbean, and qualified to command destroyers.

After completing short courses in damage control and fleet petroleum operations in January 1973, Lieutenant Mullen assumed command of the USS Noxbee (AOG 56), a World War II era gasoline tanker, home ported in Little Creek, Virginia. The crew provided replenishment services to the Atlantic Fleet and completed two successful deployments to the Mediterranean, including providing support to US Navy ships in the eastern Mediterranean during the 1973 Arab-Israeli war.

Lieutenant Mullen returned to the US Naval Academy in July 1975. He served two years as a Company Officer for 150 midshipmen, with concurrent assignments as an instructor, a member of the admissions board, and assistant officer-in-charge for summer midshipman training. During his final year at the academy, Mullen was promoted to lieutenant commander in October 1977 and became the Commandant's executive assistant. To prepare for his next assignment, Lieutenant Commander Mullen completed the five-month prospective engineer's course at Idaho Falls, Idaho, and Great Lakes, Illinois. A month after graduation in October 1978, he reported aboard the USS Fox (CG 33), a guided missile cruiser home ported in Bremerton, Washington, as Chief Engineer. Mullen oversaw a fifteen month overhaul of the ship's propulsion system, and his department earned two consecutive awards for engineering excellence. The Fox deployed to the Western Pacific in September 1980 and served briefly as flagship in the Persian Gulf during the continuing crisis with revolutionary Iran. During the deployment, Mullen held concurrent responsibilities as the ship's senior watch officer and force anti-air warfare commander for the USS Ranger Aircraft Carrier Battle Group and combatant forces operating in the Persian Gulf.

In July 1981, after completing a short course in surface ship operations at Newport, Rhode Island, Lieutenant Commander Mullen became the Executive Officer of the USS Sterett (CG 31), home ported in Subic Bay, Republic of the Philippines, while supporting Seventh Fleet operations in the Western Pacific. This involved battle group and multilateral exercises with partner nations, including Japan and the Republic of Korea, and included an encounter with a Vietnamese fishing boat that fired upon the task group. The Sterett also recovered Vietnamese nationals at sea who were fleeing from South Vietnam.

While attending the Naval Postgraduate School at Monterey, California, from January 1983 to March 1985, Lieutenant Commander Mullen advanced in grade to Commander and earned a master of science degree in operations research. After completing a brief refresher course in ship operations at Newport, Rhode Island, Mullen transferred to Pearl Harbor, Hawaii, and took command of the USS Goldsboro (DDG 20) in June 1985. The guided missile destroyer executed Third Fleet operations until August 1986, when it deployed to the Western Pacific and Persian Gulf. As part of the Middle East Force from November to January 1987, the crew conducted maritime security operations under wartime conditions during the Iraq-Iran conflict. In recognition of his performance while commanding afloat, Mullen received the Pacific Fleet's 1987 Vice Admiral Stockdale Leadership Award.

Commander Mullen returned to Newport, Rhode Island, in October 1987. After completing the integrated warfare course for post-command officers at the Naval War College, in December he assumed the duties of Director of the Surface Warfare Division Officer Course. Promoted to captain in September 1989, Mullen transferred to Washington, DC, where he became the Navy's Staff assistant to the Director for Operational Test and Evaluation at the Office of the Secretary of Defense (OSD). He was involved in modernization initiatives such as the Arleigh Burke class (DDG 51) guided missile destroyer, the AEGIS SPY-1B radar testing and evaluation, improvements to the Standard Missile capabilities, Seawolf-class (SSN 21) submarine, and Tomahawk missile programs. As OSD pursued its new "Fly-before-Buy" procurement strategy,

ne proved especially adept at enhancing evaluation methods, granting technical assessments for the Defense Acquisition Board, and briefing members of Congress.

Captain Mullen next completed the 11 week Advanced Management Program at Harvard Business School in November 1991, followed by command refresher training in Rhode Island and Virginia. In April 1992 he assumed command of the AEGIS guided missile cruiser USS Yorktown (CG 48), that year's Atlantic Fleet winner of the Marjorie Sterrett Battleship Fund Award for overall readiness. With the Cold War ended, the ship visited Severomorsk, Russia, and trained with the Romanian and Bulgarian navies. The crew earned another award for battle efficiency during 1993, while conducting counter-drug operations in the Caribbean as part of Joint Task Force (JTF) 4 and maritime interdiction operations off Haiti as part of JTF-120 during Operation SUPPORT DEMOCRACY. In each case Mullen served as the force's air warfare commander. He also embarked women aboard the Yorktown on a temporary basis in an effort to enhance diversity and opportunity in the Navy.

Returning to Washington in February 1994, Captain Mullen served as Director of the Surface Officer Distribution Division at the Bureau of Naval Personnel. This was a tumultuous period, characterized by reductions in personnel, resources, and ultimately the size of the fleet. He implemented changes in personnel assignments to complement the new force structure, including initiatives to realign career paths, increase command opportunities for younger officers, broaden opportunities for joint education and joint assignments, and institutionalize diversity. In August 1995 Mullen became Director of the Surface Warfare Plans, Programs, and Requirements Division in the Office of the Chief of Naval Operations. As the SC-21 (Surface Combatant for the 21st Century) program entered the cost and operational analysis phase of development, he advocated the addition of distributed system networks and extended-range precision weapons to the Arsenal Ship design.

Following his promotion to flag rank on 1 April 1996, Rear Admiral (lower half) Mullen served briefly as the Deputy Director of the Surface Warfare Division and completed refresher training at Oceana, Virginia. Then, in August he took command of Cruiser-Destroyer Group TWO, with concurrent duties as commander of the USS George Washington (CVN 73) Aircraft Carrier Battle Group. The battle group participated in inter-deployment training as part of the Atlantic Fleet until October 1997, when it deployed to the Mediterranean Sea and Persian Gulf. George Washington participated in multi-battle group operations in the Gulf as the cornerstone of US Central Command's military presence in the Middle East. Central Command forces during this time nearly came to blows with the Iraqi military, first in December 1997 and then again in February 1998. The presence and readiness of US forces eventually helped convince Saddam Hussein to allow United Nations weapons inspectors into Iraq.

Newly promoted Rear Admiral (upper half) Mullen returned to the Office of the Chief of Naval Operations in May 1998, this time as Director of the Surface Warfare Division (N-86). Inheriting a reduced force with growing littoral responsibilities, he told Congress, "we can no longer safely mortgage our future readiness by further deferring recapitalization and modernization." Advocating a "measured revolution" that acknowledged fiscal limitations, he addressed retention issues through systems automation, continuation pay, and reduced sea-time. He also sought a modest increase in shipbuilding and installed new technologies aboard existing vessels. Among several key 21st Century initiatives were the tactical Tomahawk cruise missile, theater ballistic missile defense, and the multi-mission DD-21 destroyer programs.

In October 2000 Vice Admiral Mullen accepted concurrent command of the US Second Fleet and NATO Striking Fleet Atlantic, embarked upon the USS Mount Whitney (LCC 20). The Second Fleet operated from the North to the South poles and as far east as Europe. Besides training the Atlantic battle fleet, evaluating new tactics, and maintaining battle group readiness, Mullen could also assemble JTF-120 to address emergent regional crises. The Striking Fleet maintained maritime superiority in the Atlantic and guaranteed NATO's sea lines of communication.

Vice Admiral Mullen returned to Washington in August 2001 as the Deputy Chief of Naval Operations for Resources, Requirements, and Assessments (N-8) in the Office of the Chief of Naval Operations (CNO). During his two-and-a-half-year tenure, Mullen improved the efficiency of the Navy's acquisition process and identified program cuts to recapitalize funding for force modernization and transformation. A principal architect of Sea Power 21, the CNO's strategic vision to address 21st Century threats, he advocated for a Global Concept of Operations that reconfigured naval forces to create additional expeditionary strike groups. This enabled the fleet to expand its geographic scope of influence and enhance the nation's deterrence capability.

Following his promotion to admiral in August 2003, Mullen was appointed the Vice Chief of Naval Operations. He represented Navy interests as a member of the Joint Requirements Oversight Council and led implementation of the CNO's Fleet Response Plan, designed to replace rigid Cold War-era training, maintenance, and deployment cycles with a more flexible timetable that increased the fleet's surge capacity.

In October 2004 Admiral Mullen took concurrent command of US Naval Forces, Europe, and Allied Joint Force Command, situated in Naples, Italy. In this dual role he commanded the Combined and Joint NATO Force in the Balkans (17,000 troops in Kosovo), coordinated ongoing NATO counterterrorism efforts in the Mediterranean during Operation ACTIVE ENDEAVOR, and stood up the first NATO training missions in Iraq (NTM-I). This varied experience provided a fresh understanding of the dynamic global changes and an appreciation of the need for a secure environment to allow democracy and opportunity to flourish.

Eight months later, on 22 July 2005, Admiral Mullen became the 28th Chief of Naval Operations. His initial guidance to the Navy identified three priorities: sustaining combat readiness, building a fleet for the future, and developing 21st Century leaders. Readiness meant maintaining a responsive force—ships and personnel—with a wide range of operational capabilities. Mullen again sought to harness the nation's diversity, empowering sailors to reach their full potential.

Dedicated to developing the Sea Power 21 vision, Admiral Mullen began to "build today a force that is properly sized, balanced, and priced for tomorrow." To bolster the nation's flagging shipbuilding industry, he recommended replacement of aging vessels and expansion of the current fleet to 313 ships by 2020. Much of the fleet's anticipated growth was linked to a new multi-mission littoral combat ship, which would reduce costs and improve the Navy's capability to deal with terrorist threats and humanitarian crises world-wide.

Admiral Mullen also championed revamping the National Fleet Policy between the Navy and Coast Guard and led the naval services to update the united maritime strategy in "A Cooperative Strategy for 21st Century Seapower." The global strategy established dispersed fleet stations to build international relationships and sustain the joint fleet's constant forward presence. Acknowledging growing requirements for interoperability among maritime nations sharing similar interests, Mullen proposed that allies collaborate to form a "Thousand Ship Navy" to secure the "global maritime commons." He envisioned a "free-form, self-organizing network of maritime partners" facilitated by the implementation of an automatic identification system for ships at sea and the creation of a Virtual Regional Maritime Traffic Center.

Based on the recommendation of Dr. Robert M. Gates, the Secretary of Defense, Admiral Mullen became the 17th Chairman of the Joint Chiefs of Staff on 1 October 2007. Mullen arrived in the midst of the Global War on Terrorism and two wars and immediately established three priorities that would resonate throughout his four-year tenure as Chairman. His first priority was to develop a strategy to protect the nation's interests in the Middle East, then dominated by the ongoing campaigns in Iraq and Afghanistan.

As CNO, Admiral Mullen supported President Bush's temporary troop surge in Iraq, support that was made possible through the Chiefs' collective insistence that the surge would be accompanied by economic development and political reconciliation. During his confirmation hearings for Chairman, he testified that America's ground forces were severely strained, but defeat would strengthen the nation's adversaries and further undermine Middle East stability.

Security conditions in Iraq had improved by the fall of 2007, enabling the additional US forces to start to gradually withdraw. Nonetheless, Admiral Mullen made clear that the Iraqi security forces still needed American military assistance to counter insurgent and terrorist violence. A base force would have to remain in place until the Iraqis were sufficiently trained and equipped. In November 2008, after much debate, the Iraqi Parliament accepted a status of forces agreement with the United States that restricted US combat operations and called for an intermediate withdrawal of American forces from major cities by June 2009, followed by their complete departure by the end of 2011.

Relegated by necessity to an economy of force mission, the situation in Afghanistan and neighboring Pakistan worsened during 2007. Frustrated by NATO shortfalls in capability and capacity, Admiral Mullen called for "a well-coordinated counterinsurgency strategy." He also started an effort for alternative logistics supply to reduce reliance on Pakistan. As the Bush administration reassessed its military and diplomatic strategies the following year, Mullen acknowledged that coalition forces were losing ground and advocated recommitment to Afghanistan. He testified before the House Armed Services Committee in December 2007 that the best way to

and advocated greater involvement. "In Afghanistan, we do what we can," he told members of the House Armed Services Committee in December 2007. "In Iraq, we do what we must." He also initiated a long-term diplomatic relationship with General Ashfaq Kayani, the Pakistani Army Chief of Staff, pledging support and soliciting cooperation in combating militants in the country's unruly tribal area. Shortly after his inauguration in 2009, President Obama shifted the military's focus from Iraq to Afghanistan, presented a new counterinsurgency strategy for the region, and increased the number of deployed forces. He pledged collaboration with Pakistan in the fight against terrorism and emphasis on more resources for training security forces, fighting government corruption, and combating drug trafficking in Afghanistan.

By January Admiral Mullen was repeatedly warning about the detrimental effect that poor governance and corruption was having on the population. "Despite a dramatic increase in our civilian presence in Afghanistan this past year," Mullen told members of the House Armed Services Committee in February 2011, "improvements in sub-national governance and reconstruction have not kept pace with progress in improving security. This has impeded our ability to hold, build and transfer."

There were further gains in security—particularly in the south and east over the spring—and a robust effort to continue to grow and develop competent Afghan security forces. Admiral Mullen worked with special operations forces to provide options for the President for operations against Osama bin Laden in the spring of 2011, the execution of which resulted in the killing of Osama bin Laden. Together these developments made it possible for Admiral Mullen to support President Obama's plan to withdraw US troops and turn over security to Afghan forces by 2014. He advised a cautious approach, however, to ensure that the drawdown did not occur too swiftly.

Admiral Mullen's second priority as Chairman was to improve the health of the force by balancing current requirements against future national security threats. The toll taken on US ground forces during protracted wars in Iraq and Afghanistan particularly worried him, and Mullen questioned their readiness to fight a high-intensity war against a major adversary. Besides repairing or replacing worn out equipment, he proposed increasing the interval between deployments, training to full-spectrum operations, and addressing the welfare of service members and their families, especially the needs of the combat wounded and families of the fallen. Mindful of the costs of such initiatives, he suggested that the country devote additional resources to national security and considered a defense budget pegged at 4 percent of its gross domestic product the absolute minimum.

The recession in 2008 challenged modernization efforts, compelling Admiral Mullen to acknowledge that the federal debt represented "the single biggest threat to national security." During the next three years the Chairman and Secretary Gates aggressively trimmed expensive, redundant, or failing programs in order to recapitalize funds for higher priority requirements. They curtailed multiple high-technology items, disestablished US Joint Forces Command, and ultimately reduced the end strength of the Army and Marine Corps to support the all-volunteer force, meet current operational needs, and address the most-likely future threats. Nevertheless, in April 2011 President Obama ordered another \$400 billion in reductions over the next twelve years. Admiral Mullen agreed that the Defense Department should contribute to resolving the nation's deficit crisis and believed that it could responsibly manage a builddown, but he worried that reckless cuts could hollow the military.

Admiral Mullen voiced concern over a widening gulf between the military and the public. Even though the military enjoyed what he called a "Sea of Goodwill" on the part of the American people, only a small percentage of the general population had a personal connection to those in uniform. He and his wife Deborah urged communities to embrace returning veterans, and he called on the military to remember, as well, their own duties of citizenship.

The most controversial issue separating civil and military values was a matter of enlistment criteria. Mullen had been concerned about the issue for years, and in 2008 he ordered his Staff to conduct a serious study about the ramifications to the force. He privately decided to support a change to the "Don't Ask, Don't Tell" policy. During his January 2010 State of the Union Address, President Obama reiterated his pledge to end Don't Ask, Don't Tell, a policy that barred gays and lesbians from serving openly in the military. A week later, Admiral Mullen endorsed the President's plan before members of the Senate Armed Services Committee, testifying, "no matter how I look at the issue, I cannot escape being troubled by the fact that we have in place a policy which forces young men and women to lie about who they are in order to defend their fellow citizens."

When released in late November, the anticipated Pentagon study concluded that allowing gays and lesbians to serve openly would present minimal risk to military effectiveness. President Obama subsequently signed the repeal into law on 22 December and nine months later, after Admiral Mullen, Secretary Leon Panetta, and President Obama "certified" to Congress that the military was ready to execute the new policy, Don't Ask, Don't Tell officially ended on 20 September 2011.

Admiral Mullen's third priority was to balance strategic risk around the globe. His 2011 National Military Strategy envisioned "a 'multi-nodal' world characterized more by shifting interest-driven coalitions based on diplomatic, military, and economic power, than by rigid security competition between opposing blocks." In this dynamic environment, he advocated an interagency approach to foreign policy in which military leaders played a wide range of supporting roles. Chinese military modernization and expansion, and North Korean and Iranian nuclear proliferation, he believed, presented particularly significant risks to regional stability and open access to the global commons. To mitigate these risks he proposed a geographically distributed, operationally resilient, and politically sustainable expeditionary force capable of conducting full-spectrum operations with its international partners. The establishment of US Africa Command in 2007 and US Cyber Command in 2010 reflected the wide range of emerging 21st century challenges.

Admiral Mullen was an active military diplomat and statesman, encouraging improved military-to-military relations throughout the world. He met frequently with the Chief of Staff of the Pakistani Army, leading efforts to establish a more collaborative association with that country. He also led the US delegations that successfully negotiated nuclear arms reductions (New Start Treaty) with the Russians; met with the Chinese, Japanese, and South Korean chiefs to ease tensions in East Asia; and laid the groundwork for increasing America's presence in the Pacific. Perhaps Admiral Mullen's greatest diplomatic challenge occurred near the end of his tenure as Chairman, during the unanticipated Arab Spring of 2011, when a wave of popular uprisings confronted authoritarian regimes throughout the Middle East. He met with senior officials from several Gulf States to encourage tolerance and decry escalating violence. Once President Obama decided to support the U.N. Security Council's resolution to protect civilians in Libya, he led NATO and Arab allies to quickly establish a no-fly zone and supported subsequent operations that resulted in the demise of the Qaddafi regime.

Admiral Mullen left Office on 1 October 2011. He retired one month later, after serving over forty-three years in uniform.

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