No. 17-2398

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

BROCK STONE, Petty Officer First Class, *et al.*,

Plaintiffs-Appellees,

v.

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

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

SUPPLEMENTAL ADDENDUM IN SUPPORT OF APPELLEES' OPPOSITION TO APPELLANTS' EMERGENCY MOTION FOR ADMINISTRATIVE STAY AND PARTIAL STAY PENDING APPEAL

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[*] Before the Court is a pending motion to waive the Individual Plaintiffs' obligation under Local Rule 102.2(a) to provide addresses, and to permit Plaintiff Doe to proceed anonymously.

HEATHER WILSON
in her official capacity as Secretary of the
U.S. Department of the Air Force
1690 Air Force Pentagon
Washington, D.C. 20330

Defendants.

FIRST AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

NATURE OF THE ACTION

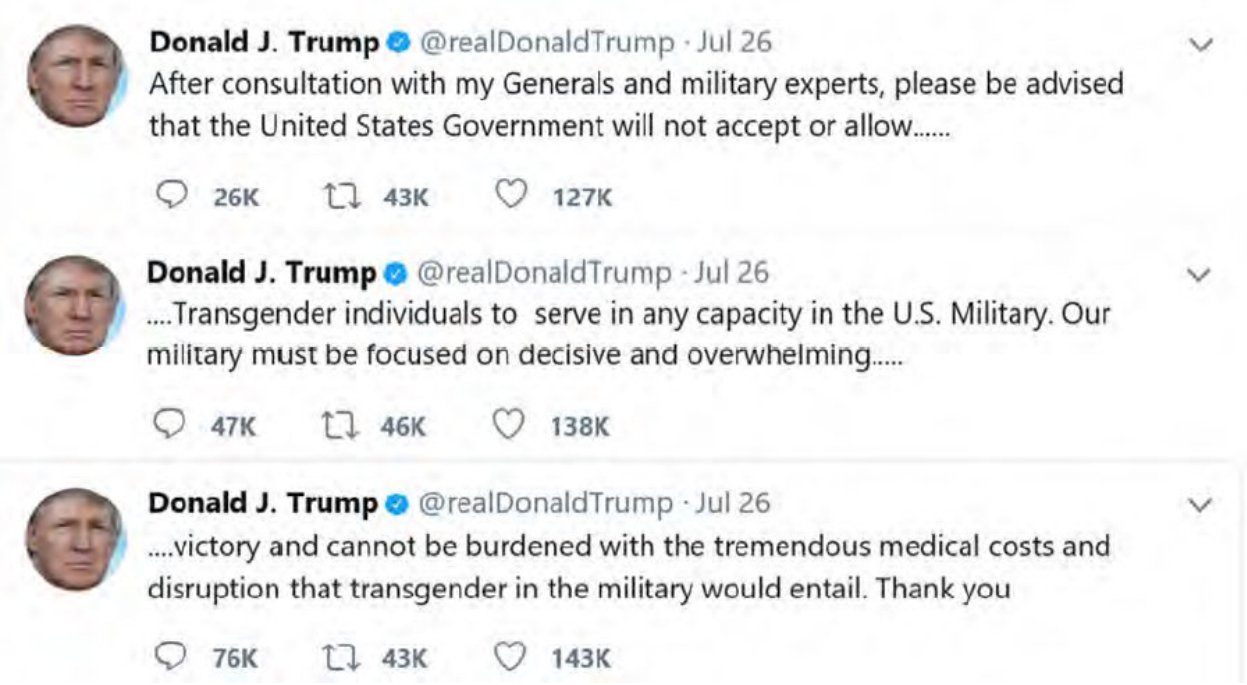
1. Thousands of transgender service members are serving honorably in this country's Armed Forces. Some perform critical roles in intelligence analysis, disaster relief, medical care, and pre-deployment training at bases in the United States. Others have deployed to combat zones in Iraq and Afghanistan. Many transgender service members have received awards for their service, and some have served for decades. All have answered the selfless call of service to our nation by putting themselves in harm's way to protect the rights and freedoms fundamental to this country.

2. The individual plaintiffs in this case ("Individual Plaintiffs") are just some of those transgender service members. Petty Officer Stone has served in the U.S. Navy for 11 years, including a nine-month deployment to Afghanistan, and is currently assigned to a unit at Fort Meade, in Maryland. Staff Sergeant Cole has served in the U.S. Army for almost ten years, including a one-year deployment to Afghanistan where she served as a team leader and designated marksman. Senior Airman Doe has served for approximately six years on active duty in the U.S. Air Force, where he was awarded "Airman of the Year" for his flight. Airman First Class George has been enlisted in the Air National Guard since 2015. He is training as a nurse, and intends to seek a commission in the U.S. Army. Petty Officer Gilbert has served in the U.S. Navy for 13 years, including a one-year deployment to Afghanistan, and currently serves as an

information and space systems technician. Technical Sergeant Parker served in the Marine Corps for four years and has served in the Air National Guard for 26 years, now working as a fuel technician.

3. At the culmination of a thorough process of research and analysis, the Department of Defense ("DoD") concluded in 2016 that there was no basis for the military to exclude men and women who are transgender from openly serving their country, subject to the same fitness requirements as other service members. This review process carefully considered and rejected the notion that medical costs, military readiness, or other factors presented any plausible reason to discriminate against service members who are transgender, many of whom had already been serving with honor in silence for decades. Accordingly, the Secretary of Defense issued a directive (the "Open Service Directive") that service members who are transgender be permitted to serve openly without fear of discharge; that these service members receive medically necessary health care, as do others who serve their country; and that, beginning on July 1, 2017, men and women who are transgender be permitted to enlist in the military subject to stringent enlistment standards.

4. On the morning of July 26, 2017, President Trump declared on Twitter that the Individual Plaintiffs and all other men and women who are transgender would no longer be allowed to continue serving in the military "in any capacity." This pronouncement was posted under the handle @realDonaldTrump:



5. The Trump Administration has provided no evidence that this pronouncement was based on any analysis of the actual cost and disruption allegedly caused by allowing men and women who are transgender to serve openly. News reports indicate that the Secretary of Defense and other military officials were surprised by President Trump's announcement, and that his actual motivations were purely political, reflecting a desire to accommodate legislators and advisers who bear animus and moral disapproval toward men and women who are transgender, with a goal of gaining votes for a spending bill that included money to build a border wall with Mexico.

6. On August 25, 2017, President Trump formalized his ban in a Memorandum for the Secretary of Defense and the Secretary of Homeland Security, with the subject "Military Service by Transgender Individuals" (the "Transgender Service Member Ban"). President Trump directed the Secretary of Defense to "return to" the pre-2016 policy of banning service by men and women who are transgender, which he described as "generally prohibit[ing] openly transgender individuals from accession into the United States military and authoriz[ing] the

discharge of such individuals." President Trump further banned the use of government resources to fund "sex-reassignment surgical procedures" for service members regardless of cost or medical necessity.

7. President Trump delayed the operation of his directives, but its impacts are already being felt today. Planned medical treatment and procedures are being canceled, treatment plans are being modified, and recommendations and requests for new treatment are being denied to service members who are transgender. The six-month preparation period only serves as a brief delay to the full implementation of President Trump's unequivocal policy pronouncement. The many harms and impacts are being felt already.

8. As a consequence of the Transgender Service Member Ban, thousands of Americans already serving their country—many of whom publicly revealed that they are transgender after DoD formally welcomed their service in June 2016—have been told that they are no longer welcome. At a minimum, the Transgender Service Member Ban deprives them of their currently-recognized right not to be discharged on the basis of their transgender status, instead authorizing their discharge at any time after March 23, 2018. While the Pentagon develops a plan to involuntarily terminate their military service, men and women who are transgender will be singled out from other service members and denied medically necessary health care that is provided to everyone else. Other men and women who are transgender will be denied the opportunity to serve altogether, even if they could satisfy the stringent standards for enlistment applicable to all others seeking to serve.

9. Without input from the Department of Defense and Joint Chiefs of Staff, and without any deliberative process, President Trump cast aside the rigorous, evidence-based policy

of the Open Service Directive, and replaced it with discredited myths and stereotypes, uninformed speculation, and animus against people who are transgender.

10. Plaintiffs bring this action to right this unconstitutional wrong.

THE PARTIES

Plaintiff Stone

11. Petty Officer First Class Brock Stone is a 34-year-old man.

12. Petty Officer Stone is assigned to a unit at Fort Meade, Maryland through at least August 2020, and resides off-base with his wife in Anne Arundel County.

13. Petty Officer Stone has served in the U.S. Navy for 11 years, including a nine-month deployment to Afghanistan. Petty Officer Stone was awarded an achievement medal in connection with his deployment, and he has received multiple other commendations, including a flag letter of commendation and multiple recommendations for early promotion. He has received extensive and costly training and is skilled in his field.

14. Petty Officer Stone is transgender.

15. Petty Officer Stone publicly revealed his transgender status to military personnel in reliance upon DoD's June 2016 Open Service Directive.

16. Pursuant to his evaluation by DoD medical personnel, Petty Officer Stone is undergoing hormone therapy as a medically necessary part of his gender transition.

17. Since arriving at Fort Meade in July 2017, Petty Officer Stone has received medically necessary treatment related to his gender transition at Walter Reed National Military Medical Center in Bethesda, Maryland. He was close to finalizing a medical treatment plan that included surgery at the time he was transferred to Fort Meade. Before President Trump issued his Transgender Service Member Ban, Petty Officer Stone planned and expected that his treatment plan at Fort Meade would include medically necessary surgery in 2018.

18. Petty Officer Stone is a member of the ACLU of Maryland.

Plaintiff Cole

19. Staff Sergeant Kate Cole is a 27-year-old woman.

20. Staff Sergeant Cole is stationed at Fort Polk, Louisiana.

21. Staff Sergeant Cole has served in the U.S. Army for almost ten years, including a one-year deployment to Afghanistan where she served as a team leader and designated marksman. Staff Sergeant Cole currently works as a Cavalry Scout, where she operates with a tank unit.

22. Staff Sergeant Cole is transgender.

23. Staff Sergeant Cole publicly revealed her transgender status to military personnel following, and in reliance upon, DoD's June 2016 Open Service Directive.

24. Pursuant to her evaluation by DoD medical personnel, Staff Sergeant Cole is undergoing hormone therapy as a medically necessary part of her gender transition.

25. Staff Sergeant Cole was scheduled to receive medically necessary surgery related to her gender transition in or around September 2017. On September 8, 2017, she was informed that approval of her medically-indicated surgical treatment was denied and her pre-surgical consultation for an orchiectomy was cancelled as part of a stop to all surgical care related to gender transition in the wake of the President's directive.

Plaintiff Doe

26. Senior Airman John Doe is a 25-year-old man.

27. Senior Airman Doe is stationed at Little Rock Air Force Base, Arkansas.

28. Senior Airman Doe has served for approximately six years on active duty in the U.S. Air Force, where he is pursuing cryogenics certification. He was awarded "Airman of the Year" for his flight.

29. Senior Airman Doe has deployed to Qatar for a six-month deployment.

30. Senior Airman Doe is transgender.

31. Senior Airman Doe publicly revealed his transgender status to military personnel following, and in reliance upon, DoD's June 2016 Open Service Directive.

32. Pursuant to his evaluation by DoD medical personnel, Senior Airman Doe is undergoing hormone therapy as a medically necessary part of his gender transition and had planned to receive medically necessary surgery in the summer of 2017.

33. Following President Trump's July 2017 tweets announcing the forthcoming Trump Transgender Service Member Ban, Senior Airman Doe was informed by e-mail from the medical command at the base where he was scheduled to undergo surgery that all gender transition-related surgeries, including his own, had been put on hold pending further DoD guidance.

Plaintiff George

34. Airman First Class Seven Ero George is a 41-year-old man.

35. Airman First Class George is stationed at the Selfridge Air National Guard Base, Michigan.

36. Airman First Class George is in the Air National Guard, where he serves in the base security force. He is also a member of the base Honor Guard, performing military funeral honors for deceased veterans, retirees, and active duty members; providing dignified transfers; and performing color guard details.

37. Airman First Class George is transgender.

38. Airman First Class George publicly revealed his transgender status to military personnel following, and in reliance upon DoD's June 2016 Open Service Directive.

39. Airman First Class George is undergoing hormone therapy as a medically necessary part of his gender transition and has undergone medically necessary surgery.

40. Airman First Class George intends to pursue a commission in the U.S. Army Nurse Corps and is finishing a civilian degree in nursing. This effort to seek a commission in a different service would subject Airman First Class George to the Army's accession policies, including the ban on accessions included in President Trump's Transgender Service Member Ban.

Plaintiff Gilbert

41. Petty Officer First Class Teagan Gilbert is a 31-year-old woman.

42. Petty Officer Gilbert is a reservist stationed in Phoenix, Arizona.

43. Petty Officer Gilbert has served in the U.S. Navy for more than 13 years, including a one-year deployment to Afghanistan. She is currently in the Naval Reserve working as an information and space systems technician.

44. Petty Officer Gilbert is transgender.

45. Petty Officer Gilbert publicly revealed her transgender status to military personnel following, and in reliance upon, DoD's June 2016 Open Service Directive.

46. Pursuant to her evaluation by DoD medical personnel, Petty Officer Gilbert is undergoing hormone therapy as a medically necessary part of her gender transition and plans to seek approval for medically indicated surgical treatment in the future.

47. Petty Officer Gilbert has one year of course work left in her undergraduate degree at Arizona State University, after which she intends to apply to Officer Candidate School and return to active duty status.

48. Petty Officer Gilbert's goal is to serve in the military for at least 20 years.

Plaintiff Parker

49. Technical Sergeant Tommie Parker is a 54-year-old woman.

50. Technical Sergeant Parker is stationed at Stewart Air National Guard Base, New York and has served in the Marine Corps for four years and the Air National Guard for 26 years, including deployments to Okinawa (with the Marine Corps) and Germany (with the Air National Guard). Her Air National Guard service time includes twelve years and counting on active duty. It is Technical Sergeant Parker's goal to serve in the military for at least 20 years of active duty service time. She now works as a fuel technician.

51. Technical Sergeant Parker is transgender.

52. Technical Sergeant Parker publicly revealed her transgender status to military personnel following, and in reliance upon, DoD's June 2016 Open Service Directive.

53. Pursuant to her evaluation by DoD medical personnel, Technical Sergeant Parker is undergoing hormone therapy as a medically necessary part of her gender transition.

Plaintiff ACLU of Maryland

54. Plaintiff American Civil Liberties Union of Maryland, Inc. ("ACLU of Maryland") is an affiliate of the American Civil Liberties Union, a non-profit, nationwide, nonpartisan membership organization with over 1,500,000 members.

55. Plaintiff ACLU of Maryland's growing membership comprises over 42,000 Maryland members, including one or more men and women who are transgender who are currently serving in the U.S. military or who intend to volunteer for service in the U.S. military.

56. The ACLU of Maryland litigates cases in which government officials have attempted to discriminate against men and women who are transgender, and therefore the ACLU of Maryland has a direct interest in challenging the ban at issue in this case.

57. The ACLU of Maryland's interest in protecting both its members and other men and women who are transgender from discrimination on the basis of sex and transgender status is both germane and fundamental to the organization's purpose of furthering the principles of liberty and equality embodied in the Constitution and the nation's civil rights laws.

Defendants

58. Defendant Donald J. Trump is the President of the United States. He is sued in his official capacity. In that capacity, on August 25, 2017, he issued the Transgender Service Member Ban.

59. Defendant James Mattis is the Secretary of Defense and is sued in his official capacity. DoD is responsible for providing the military forces needed to deter war and protect the security of the United States. At all times relevant to this Complaint, Defendant Mattis was acting as an employee and agent of the United States. In that capacity, Defendant Mattis is responsible for supervising the branches of the U.S. Armed Forces; for promulgating, implementing, and enforcing the policies and regulations that govern military service in all branches of the U.S. Armed Forces; and for ensuring the legality of these policies and regulations. In this role, he is responsible for the maintenance and enforcement of Department of

Defense Instruction ("DoDI") 1300.28, which establishes DoD policies regarding transgender service members.

60. Defendant Ryan McCarthy is the Acting Secretary of the Army and is sued in his official capacity. The Department of the Army is the DoD branch that defends the land mass of the United States, its territories, commonwealths, and possessions. At all times relevant to this Complaint, Defendant McCarthy was acting as an employee and agent of the United States. In that capacity, Defendant McCarthy has overall responsibility for the Army and for the Army's development, administration, and enforcement of policies and regulations that affect service by transgender service members. These policies and regulations include Army publications and directives implementing DoD policy governing transgender service members.

61. Defendant Richard Spencer is the Secretary of the Navy and is sued in his official capacity. The Department of the Navy is the DoD branch that maintains, trains, and equips combat-ready maritime forces. At all times relevant to this Complaint, Defendant Spencer was acting as an employee and agent of the United States. In that capacity, Defendant Spencer has overall responsibility for the Navy and Marine Corps and for those services' development, administration, and enforcement of policies and regulations that affect service by transgender service members. These policies and regulations include Navy and Marine Corps publications and directives implementing DoD policy governing transgender service members.

62. Defendant Heather Wilson is the Secretary of the Air Force and is sued in her official capacity. The Department of the Air Force is the DoD branch that provides the U.S. military with air and space capability. At all times relevant to this Complaint, Defendant Wilson was acting as an employee and agent of the United States. In that capacity, Defendant Wilson has overall responsibility for the Air Force and for the Air Force's development, administration, and

enforcement of policies and regulations that affect service by transgender service members. These policies and regulations include Air Force publications and directives implementing DoD policy governing transgender service members.

JURISDICTION AND VENUE

63. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 because the action arises under the United States Constitution, the laws of the United States, and the Declaratory Judgment Act, 28 U.S.C. §§ 2201–02.

64. Venue is proper in this judicial district pursuant to 28 U.S.C. § 1391(e)(1) because Plaintiff Stone and Plaintiff ACLU of Maryland reside in this District, and because a substantial part of the events or omissions giving rise to this action occurred and are occurring in this District.

FACTUAL ALLEGATIONS

A. Current Military Service by Men and Women Who Are Transgender

65. Transgender Americans have served, and continue to serve, in the military with distinction, including in combat. As of May 2014, the Williams Institute at UCLA School of Law estimated that men and women who are transgender account for approximately 8,800 active members of the U.S. Armed Forces. This figure may be even higher today in light of DoD's June 2016 Open Service Directive regarding transgender service.

66. Men and women who are transgender also serve openly in civilian roles supporting the U.S. military, including as contractors in combat zones.

B. Medical Treatment for Transgender Service Members

67. Pursuant to DoDI 1300.28 (§ 1.2(a)), "[t]ransgender persons . . . are subject to the same standards and procedures as other members with regard to their medical fitness for duty, physical fitness, uniform and grooming standards, deployability, and retention."

68. The American Psychiatric Association and every other major mental health organization recognize that being transgender is not a mental disorder and implies no impairment in judgment, stability, reliability, or general social or vocational capabilities.

69. Some men and women who are transgender, however, experience "gender dysphoria," a diagnostic term used to describe the incongruence between a person's gender identity and the gender that they were assigned at birth where such incongruence is accompanied by clinically significant distress.

70. As with all medical conditions, varying courses of treatment for gender dysphoria may be medically necessary depending on the needs of the individual, as determined in consultation with medical professionals. These treatments, often referred to as transition-related care, may include social role transition, hormone therapy, and surgery (sometimes called "sex reassignment surgery" or "gender confirmation surgery"). The goal of the treatment is to align an individual's outward expression of gender, body, and biochemistry with the person's gender identity in order to eliminate the clinically significant distress.

71. According to every major medical organization and the overwhelming consensus among medical experts, treatments for gender dysphoria, including surgical procedures, are effective, safe, and medically necessary when clinically indicated to alleviate the distress caused by the condition.

72. In accordance with that medical consensus and contemporary standards of care, Medicare, Medicaid, and private insurance policies across the country routinely cover transition-related care as medically necessary treatment.

73. The medical needs of transgender service members with gender dysphoria are not materially different from those of other service members. For example, the military provides

routine psychological care to all service members around the globe, including men and women who are transgender. It also provides long-term hormone treatments for persons with diabetes and other endocrine disorders, and stocks cross-sex hormones in its dispensaries in the United States and abroad. The military further provides medically-indicated surgery to all service members, including chest and breast reconstruction, hysterectomy, and genital reconstruction, among other procedures that might be prescribed to treat gender dysphoria.

C. History of DoD Policy on Transgender Military Service

1) Historical Regulatory Ban

74. Starting some time before 1981, DoD maintained and enforced a policy barring men and women who are transgender from enlisting or being retained in the U.S. Armed Forces.

75. That policy prohibited men and women who are transgender from serving openly, whether or not they required any ongoing medical treatment and even if they were fit to serve. In contrast, non-transgender individuals, including those requiring medical interventions, were allowed to remain in military service if they could demonstrate their fitness to serve.

76. Notably, in order to establish medical fitness, service members do not have to prove that they are universally deployable. According to the policy, "[i]nability 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."

77. Neither the policy nor the various service branch regulations that implemented it articulated a rationale for presuming that being transgender renders a service member administratively unfit.

2) DoD Revisits and Studies the Regulations Regarding Transgender Military Service

78. On July 13, 2015, then-Secretary of Defense Ashton Carter issued two directives aimed at updating DoD's existing transgender service member regulations, which the Secretary described as "an outdated, confusing, inconsistent approach that's contrary to our value of service and individual merit [and that is] causing uncertainty that distracts commanders from our core missions." *Statement by Secretary of Defense Ash Carter on DOD Transgender Policy*, DoD (July 13, 2015), https://www.defense.gov/News/News-Releases/News-Release-View/Article/612778/.

79. The Secretary's first directive established a working group to study "the policy and readiness implications of welcoming transgender persons to serve openly." The Acting Under Secretary of Defense for Personnel and Readiness led the group, which was comprised of leaders from the armed services; the Joint Staff; the service secretaries; and personnel, training, readiness and medical specialists from across DoD (with input from transgender service members, outside expert groups, and medical professionals outside the department).

80. The Secretary's second directive ordered that "decision authority in all administrative discharges for those diagnosed with gender dysphoria or who identify themselves as transgender be elevated to" the Under Secretary, "who will make determinations on all potential separations."

81. From July 2015 to June 2016, members of the working group and other senior leaders in DoD met with transgender service members deployed throughout the world, including individuals serving on aircrafts, submarines, and operating bases, as well as at the Pentagon. These individuals were determined to be high-quality additions to the U.S. Armed Forces, and DoD leaders observed that the ambiguity of existing regulations regarding the service of

transgender individuals put both the service members and their commanders in a difficult and fundamentally unfair position.

82. The DoD working group also carefully examined medical, legal, and policy considerations associated with permitting transgender service members to serve openly in the Armed Forces. The working group reviewed data, studied the many allied militaries that already permit transgender service members to serve openly, and considered analogous examples from the public and private sectors in the United States. DoD observed, among other things, that the provision of medical care for men and women who are transgender is becoming common and normalized in public and private sectors alike.

83. In conjunction with its working group efforts, DoD commissioned the RAND Corporation to analyze relevant data and studies to assist with DoD's own review. RAND's work was "sponsored by the Office of the Under Secretary of Defense for Personnel and Readiness and conducted within the Forces and Resources Policy Center of the RAND National Defense Research Institute, a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community." Agnes Gereben Schaefer et al., *Assessing the Implications of Allowing Transgender Personnel to Serve Openly*, RAND Corporation, at iii–iv (2016) (hereinafter, "RAND Report," attached as **Exhibit A** to Plaintiffs' original Complaint).

84. Based on various factors, including 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 concluded that there would be "minimal" readiness impacts from allowing transgender service members to serve openly. *See id.*

at xii, 2–3. Specifically, RAND estimated that 10 to 130 active component members each year could have reduced deployability as a result of gender transition-related treatments. This amount is negligible relative to the 102,500 non-deployable soldiers in the Army alone in 2015, 50,000 of them in the active component. *Impact of Transgender Personnel on Readiness and Health Care Costs in the U.S. Military Likely to Be Small*, RAND Press Room (June 30, 2016), https://www.rand.org/news/press/2016/06/30.html.

85. RAND concluded that health care costs would represent "an exceedingly small proportion" of both Active Component and overall DoD health care expenditures. RAND Report, at xi–xii, 31. In so concluding, RAND observed that "[b]oth psychotherapy and hormone therapies are [already] available and regularly provided through the military's direct care system," and "[s]urgical procedures quite similar to those used for gender transition are already performed within the MHS for other clinical indications." *Id*. at 8. For instance, "[r]econstructive breast/chest and genital surgeries are currently performed on patients who have had cancer, been in vehicular and other accidents, or been wounded in combat." *Id*.

3) Decision to Permit Transgender Service Members to be Subject to the Same Fitness Standards as Other Service Members

86. Based on input from the DoD's working group and the RAND Corporation, including information and recommendations from the service secretaries and other Pentagon officials, Secretary Carter issued a directive and memorandum to all military departments regarding military service for transgender service members on June 30, 2016. The Open Service Directive announced that, "[e]ffective immediately, no otherwise qualified Service member may be involuntarily separated, discharged or denied reenlistment or continuation of service, solely on the basis of their gender identity." Further, "[t]ransgender Service members will be subject to the same standards as any other Service member of the same gender." Thus, "[a] Service

member whose ability to serve is adversely affected by a medical condition or medical treatment related to their gender identity should be treated, for purposes of separation and retention, in a manner consistent with a Service member whose ability to serve is similarly affected for reasons unrelated to gender identity or gender transition." The Open Service Directive is attached as **Exhibit B** to Plaintiffs' original Complaint.

87. Citing the RAND Report, the Secretary of Defense explained the three principal reasons underlying the Open Service Directive: (1) the military's need to "avail ourselves of all talent possible" in order to remain "the finest fighting force the world has ever known"; (2) the Secretary's duty to transgender service members and their commanders to "provide them both with clearer and more consistent guidance than is provided by current policies"; and (3) as a matter of principle, "Americans who want to serve and can meet our standards should be afforded the opportunity to compete to do so." *Department of Defense Press Briefing by Secretary Carter on Transgender Service Policies in the Pentagon Briefing Room* (June 30, 2016), https://www.defense.gov/News/Transcripts/Transcript-View/Article/822347/departmentof-defense-press-briefing-by-secretary-carter-on-transgender-service/.

88. The Open Service Directive was to be implemented over the course of a 12-month period, from June 2016 to June 2017. Although transgender service members already in the military on June 30, 2016 were allowed to serve openly as soon as the Open Service Directive took effect, accession of transgender personnel—that is, the process of bringing new enlisted recruits and officer candidates into the military—did not begin immediately. The Policy gave the Department of Defense and the military services approximately one year to conduct training, and to start accepting transgender members into the military beginning on July 1, 2017.

89. The enlistment requirements were stringent, providing, inter alia, that a history of gender dysphoria was disqualifying unless a licensed medical provider certified that the applicant had been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months.

90. On September 30, 2016, DoD issued an "Implementation Handbook" to "assist our transgender Service members in their gender transition, help commanders with their duties and responsibilities, and help all Service members understand Department policy allowing the open service of transgender Service members." *Transgender Service in the U.S. Military: An Implementation Handbook*, DoD, at 8 (Sept. 30, 2016), *available at* https://www.defense.gov/Portals/1/features/2016/0616_policy/DoDTGHandbook_093016.pdf?ver=2016-09-30-160933-837. The Handbook explained to transgender service members that DoD's revised transgender service member policy "ensures your medical care is brought into the military health system (MHS), protects your privacy when receiving medical care, and establishes a structured process whereby you may transition gender when medically necessary." *Id*. at 17. The Handbook encouraged transgender service members to be "open and honest with your leadership when discussing the gender transition process," and further encouraged transgender service members to disclose their transgender status to colleagues. *Id*. at 20.

91. The Handbook also provided guidance to commanders and non-transgender service members. *Id*. at 25–33. The topics in the Handbook include an overview of the gender transition approval process; guidance specific to transgender service members, commanders, and non-transgender service members, including communication, medical care, deployment and physical fitness, and privacy; frequently asked questions and answers; various potential scenarios and guidance on how to address them; and resources for further information. *See generally id*.

92. Implementation training began shortly after the policy was announced. This training involved commanders, medical personnel, the operating forces, and recruiters. The training was directed to the entire joint force, in the United States and around the world.

93. During this same timeframe, each of the service branches conducted a comprehensive review of regulations governing medical care, administrative separations, and manpower management, in order to ensure that service-level issuances were consistent with the DoD instructions.

D. Twitter Announcement of Categorical Ban on Service by Men and Women Who Are Transgender

94. On the morning of July 26, 2017, President Trump posted the following announcement on Twitter, under the handle @realDonaldTrump:

95. The Trump Administration has provided no evidence that this about-face in policy was supported by any study of the issue or any consultation with military officers, DoD officials, other military experts, or medical or legal experts.

96. Press reports indicate that President Trump's motivations in abruptly announcing a transgender ban were largely political, reflecting a desire to placate legislators and advisers who bear animus and moral disapproval toward men and women who are transgender in order to gain votes to pass a defense spending bill that included money to build a border wall with Mexico—a well-known priority for President Trump. Rachel Bade & Josh Dawsey, *Inside Trump's Snap Decision to Ban Transgender Troops*, Politico (July 26, 2017, 2:07 PM), http://www.politico.com/story/2017/07/26/trump-transgender-military-ban-behind-the-scenes-240990; *see also, e.g.*, Tom Porter, *Transgender Military Ban: The Rise of Anti-LGBT Hate Groups in Trump's White House*, Newsweek (July 26, 2017, 12:47 PM), http://www.newsweek.com/anti-lgbt-hate-groups-transgender-military-ban-trump-642218; Asawin Suebsaeng et al., *Trump Bows to Religious Right, Bans Trans Troops*, The Daily Beast (July 26, 2017, 12:33 PM), http://www.thedailybeast.com/trump-bows-to-religious-right-bans-trans-troops.

97. According to subsequent media reports, "President Donald Trump's White House and Defense Department lawyers had warned him against the transgender military ban for days" and were "startl[ed]" when they "learned of the change in a series of tweets." Josh Dawsey, *John Kelly's Big Challenge: Controlling the Tweeter in Chief*, Politico (Aug. 4, 2017, 6:03 PM), http://www.politico.com/story/2017/08/04/trump-john-kelly-challenge-twitter-241343.

98. President Trump's actions immediately caused the Individual Plaintiffs and other transgender service members to fear for their careers, the well-being of their family members and dependents, their health care and, in some cases, their safety.

99. The President's actions were also experienced by the Individual Plaintiffs as a betrayal, in light of their actions to come out publicly to military personnel in reliance on the June 2016 directive.

100. Close to 60 retired generals and flag officers from various military branches also found President Trump's tweet to undermine national security and military readiness, stating:

> 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 . . . The military conducted a thorough research process on this issue and concluded that inclusive policy for transgender troops promotes readiness. . . . We could not agree more.

Fifty-Six Retired Generals and Admirals Warn that President Trump's Anti-Transgender Tweets, if Implemented, Would Degrade Military Readiness, Palm Ctr. (Aug. 1, 2017), http://www.palmcenter.org/fifty-six-retired-generals-admirals-warn-president-trumps-antitransgender-tweets-implemented-degrade-military-readiness/.

101. Members of Congress were similarly "troubled" by President Trump's tweet on a bipartisan basis, with one Republican lawmaker (and former Navy SEAL) issuing the following statement:

> I am troubled that [DoD] seemed to be unaware of this potential policy change and how it was made public. I understand the DoD is in the middle of a review of relevant policies and I believe this ban is premature. There are heroic military members willing to put their lives on the line and give the ultimate sacrifice on our behalf, regardless of their gender identity. I support the ability for those who meet all military requirements, medical and otherwise, to have the opportunity to serve our great country.

See Rep. Scott Taylor (R-Va.), *Statement on Trump Transgender Ban* (July 26, 2017), https://taylor.house.gov/media/press-releases/statement-trump-transgender-ban.

102. Senator John McCain, Chairman of the Senate Committee on Armed Services; also repudiated President Trump's announcement, stating:

> The Department of Defense has already decided to allow currently-serving transgender individuals to stay in the military, and many are serving honorably today. Any American who meets current medical and readiness standards should be allowed to continue serving. There is no reason to force service members who are able to fight, train, and deploy to leave the military—regardless of their gender identity. We should all be guided by the principle that any American who wants to serve our country and is able to meet the standards should have the opportunity to do so—and should be treated as the patriots they are.

See Sen. John McCain (R-Ariz.), *Statement by SASC Chairman John McCain on Transgender Americans in the Military* (July 26, 2017), https://www.mccain.senate.gov/public/index.cfm/2017/7/statement-by-sasc-chairman-john-mccain-on-transgender-americans-in-the-military.

103. The Department of Defense declined comment on President Trump's policy announcement, referring questions to the White House.

104. The Secretary of Defense was on vacation at the time of President Trump's announcement on Twitter.

E. The Transgender Service Member Ban

105. Early Friday evening on August 25, 2017, President Trump issued his Transgender Service Member Ban in the form of a Memorandum for the Secretary of Defense and Secretary of Homeland Security. A copy is attached as **Exhibit C** to Plaintiffs' original Complaint.

106. The Transgender Service Member Ban states that in President Trump's own "judgment," DoD's decision to adopt the Open Service Directive "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."

107. The Transgender Service Member Ban therefore "direct[s]" the Secretary of Defense and the Secretary of Homeland Security "to return to the longstanding policy and practice on military service by transgender individuals that was in place prior to June 2016," until President Trump is personally persuaded that a change is warranted. Transgender Service Member Ban § 1(b).

108. The Transgender Service Member Ban orders that the policy banning enlistment of men and women who are transgender be extended, until a recommendation to the contrary is made "that I find convincing." *Id.* § 2(a). The Transgender Service Member Ban further orders a "halt" to the use of DoD 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." *Id.* § 2(b).

109. The Transgender Service Member Ban specifies that provisions banning men and women who are transgender from enlisting will take effect on January 1, 2018 (the date Defendant Mattis's directive delaying accessions will expire). It further provides that the provisions banning existing transgender service members from continued service and banning medically necessary health care will take effect on March 23, 2018. *Id.* § 3.

110. The Transgender Service Member Ban further directs the Secretary of Defense, in consultation with the Secretary of Homeland Security, to submit to President Trump by February 21, 2018, a plan to implement the Transgender Service Member Ban and "determine how to address transgender individuals currently serving in the United States military." *Id.* § 3.

111. The Transgender Service Member Ban gives the Secretary of Defense discretion to determine how to implement the Ban, but it does not leave discretion for the Secretary of Defense to allow currently serving members who are transgender to continue to serve indefinitely. At a minimum, on March 23, 2018, transgender service members will be subject to discharge or discontinuation of service on the basis of their transgender status alone. And whatever plan the Secretary submits to implement the Ban, the required end result is the fulfillment of President Trump's avowed goal: a military with no transgender service members "in any capacity."

F. Fundamental Contradiction Between Transgender Service Member Ban and DoD's Own Considered Conclusions

112. Although the Transgender Service Member Ban purports to be based on President Trump's "judgment," that judgment appears to reflect nothing more than uninformed speculation, myths, and stereotypes that have already been rebutted by an extensive and rigorous evidence-based process.

113. For example, as justification for the Transgender Service Member Ban, President Trump stated that allowing men and women who are transgender to continue serving would be disruptive. But the 2016 study commissioned by DoD found that a transgender service member's care would have a substantial impact on readiness *only* if (1) that service member worked in an "especially unique" military occupation, (2) that occupation was "in demand at the time of transition," *and* (3) the service member needed to be available for "frequent, unpredicted mobilizations." RAND Report, at 43. "Having completed medical transition, a service member could resume activity in an operational unit if otherwise qualified." *Id*. Upon information and belief, the DoD's own working group reached similar conclusions. The American Medical

Association similarly adopted a resolution that "there is no medically valid reason to exclude transgender individuals from service in the [United States] military."

114. Further, high-ranking military personnel have indicated that the Transgender Service Member Ban—not the Open Service Directive—will cause serious disruption to the Armed Forces. *See Fifty-Six Retired Generals and Admirals Warn that President Trump's Anti-Transgender Tweets, if Implemented, Would Degrade Military Readiness, supra* ("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*[.]") (emphases added)).

115. President Trump has similarly invoked alleged concerns about "unit cohesion." The RAND study noted that "[t]he underlying assumption [of these alleged concerns] is that if service members discover that a member of their unit is transgender, this could inhibit bonding within the unit, which, in turn, would reduce operational readiness." *Id*. at 44.

116. To study the validity of this argument, RAND looked to, among other things, the experiences of foreign countries that permit open transgender military service. There are 18 such countries: Australia, Austria, Belgium, Bolivia, Canada, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, the Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom. Observing that "there has been no significant effect of openly serving transgender service members on cohesion, operational effectiveness, or readiness" in foreign militaries that permit open transgender service, and that "direct interactions with transgender individuals significantly reduce negative perceptions and increase acceptance," the RAND study

concluded: "[W]e anticipate a minimal impact on readiness from allowing transgender personnel to serve openly." *Id*. at 44–45, 47. Upon information and belief, the DoD's own working group reached similar conclusions.

117. Senator Tammy Duckworth—an Iraq War Veteran, Purple Heart recipient and former Assistant Secretary of the Department of Veterans Affairs—has explained that the Transgender Service Member Ban, not the Open Service Directive, would "harm our military readiness":

> When I was bleeding to death in my Black Hawk helicopter after I was shot down, I didn't care if the American troops risking their lives to help save me were gay, straight, transgender, black, white or brown. All that mattered was they didn't leave me behind. If you are willing to risk your life for our country and you can do the job, you should be able to serve—no matter your gender identity or sexual orientation.

See Sen. Tammy Duckworth (D-Ill.), *Duckworth Statement on Reports Trump Administration Directing DOD to Discriminate Against Transgender Servicemembers* (Aug. 24, 2017), https://www.duckworth.senate.gov/content/duckworth-statement-reports-trump-administration-directing-dod-discriminate-against.

118. Finally, President Trump claimed that allowing transgender service members to continue service would be too expensive. The RAND Report's study found to the contrary. Namely, "even in the most extreme scenario that we were able to identify using the private health insurance data, we expect only a 0.13-percent ($8.4 million out of $6.2 billion) increase in [active component] health care spending." RAND Report, at 36. By contrast, total military spending on erectile dysfunction medicines amounts to $84 million annually—ten times the cost of annual transition-related medical care for active duty transgender service members. Patricia Kime, *DoD Spends $84M a Year on Viagra, Similar Meds*, Military Times (Feb. 13, 2015),

http://www.militarytimes.com/pay-benefits/military-benefits/health-care/2015/02/13/dod-spends-84m-a-year-on-viagra-similar-meds/.

119. An August 2017 report by the Palm Center concluded that implementing the Transgender Service Member Ban will cost $960 million. *See* Aaron Belkin et al., *Discharging Transgender Troops Would Cost $960 Million*, Palm Center (Aug. 2017), *available at* http://www.palmcenter.org/wp-content/uploads/2017/08/cost-of-firing-trans-troops.pdf.

G. Immediate and Irreparable Harm from the Transgender Service Member Ban

120. The Individual Plaintiffs and other transgender service members face immediate and irreparable harm as a result of the Transgender Service Member Ban.

121. Each Individual Plaintiff and other transgender service members suddenly face the reality that, despite their years of commitment and training, their careers will prematurely end and various benefits will be permanently unavailable. Terminating the active service of Plaintiffs and other transgender service members would also adversely affect their retirement benefits, and could in some cases preclude eligibility for retirement benefits altogether.

122. Plaintiff Petty Officer Stone has served in the U.S. Navy for 11 years, which included a nine-month deployment to Afghanistan. Petty Officer Stone was awarded an achievement medal in connection with his deployment, and he has received multiple other commendations, including a flag letter of commendation and multiple recommendations for early promotion. Despite this lengthy service and deployment, and the fact that he has received extensive and costly training in his field, he faces the prospect that he will be forced out of the U.S. Navy pursuant to the Transgender Service Member Ban.

123. Plaintiff Staff Sergeant Cole has served in the U.S. Army for nearly a decade, which included a one-year deployment to Afghanistan. Despite her lengthy service, experience

as a team leader, designated marksman, and Cavalry Scout, she faces the prospect that she will be forced out of the U.S. Army pursuant to the Transgender Service Member Ban.

124. Plaintiff Senior Airman Doe has served for approximately six years in the U.S. Air Force, which included a deployment to Qatar. Despite his service and the fact that he was awarded "Airman of the Year" for his flight, he faces the prospect that he will be forced out of the U.S. Air Force pursuant to the Transgender Service Member Ban.

125. Plaintiff Airman First Class George has served in the Air National Guard for two and a half years and intends to pursue a commission in the U.S. Army. Despite his service as base security force, he will be prohibited from commissioning in the U.S. Army and faces the prospect that he will be forced out of the Air National Guard pursuant to the Transgender Service Member Ban.

126. Plaintiff Petty Officer Gilbert has served in the U.S. Navy for 13 years, which included a one-year deployment to Afghanistan. Despite her lengthy service and her specialized knowledge as an information and space systems technician, she faces the prospect that she will be forced out of the U.S. Navy pursuant to the Transgender Service Member Ban.

127. Plaintiff Technical Sergeant Parker has served in the U.S. Marine Corps for four years and the Air National Guard for 26 years, which included deployments to Japan and Germany. Despite her lengthy service, she faces the prospect that she will be forced out of the Air National Guard pursuant to the Transgender Service Member Ban.

128. In addition, many transgender service members, including Plaintiffs Stone, Cole, Doe, Gilbert, and Parker, will be denied medically necessary surgical treatment that, in many cases, has already been recommended by military medical professionals.

129. Scheduled medical procedures for Plaintiffs Doe and Cole have already been cancelled.

130. Each transgender service member who is denied medically necessary surgical treatment will suffer serious harm.

131. The Individual Plaintiffs will also face irreparable harm to their education as a result of the Transgender Service Member Ban.

132. Plaintiff Cole currently benefits from the Army's tuition assistance, which permits her to take college classes through the University of Maryland - University College. If she is discharged, she will no longer be eligible for tuition assistance.

133. The Transgender Service Member Ban will prevent Plaintiff Gilbert from being accepted to Officer Candidate School after finishing her coursework at Arizona State University.

134. The Individual Plaintiffs and other transgender service members also face extraordinary stress, uncertainty, and stigma based on the decision to ban transgender individuals from service and single out their medical care for a ban on coverage. Effective March 23, 2018, the Open Service Directive's policy that transgender status is not a basis for discharge will be rescinded, and the military will be "authorized to discharge" every transgender service member. Even as Plaintiffs wait for their status to be "addressed" as the Trump Transgender Service Member Ban is implemented, they face significant uncertainty and concern about their careers and their futures, must plan for potential discharge, and experience the stigma of being told their service to their country is not valued or wanted, and that their medical care needs are not real or necessary. Upon information and belief, some service members are already being told that they may not reenlist.

LEGAL CLAIMS

COUNT I (Against All Defendants)

VIOLATION OF THE EQUAL PROTECTION COMPONENT OF THE FIFTH AMENDMENT'S DUE PROCESS CLAUSE

135. Plaintiffs re-allege and incorporate by reference as if fully set forth herein the allegations in all preceding paragraphs.

136. The equal protection component of the Due Process Clause of the Fifth Amendment to the United States Constitution protects all persons, including members of the Armed Forces.

137. President Trump issued the Transgender Service Member Ban, directing that: (i) current policy providing that transgender status is not a basis for discharge is rescinded, and service members who are transgender are barred from serving in the U.S. Armed Forces, irrespective of their ability to demonstrate their fitness to serve (§ 1(b)); (ii) enlistment in the military or commissioning as an officer by men and women who are transgender is prohibited, irrespective of their ability to demonstrate their fitness to serve, including the strict accession requirements adopted by DoD (§ 2(a)); and (iii) currently serving transgender service members are denied medically necessary surgical care, including in cases where individuals are stable in their gender transition and able to demonstrate their fitness to serve on the same basis as other service members (§ 2(b)).

138. Each of these three policies—and the Transgender Service Member Ban as a whole—violates Plaintiffs' right to equal protection.

i. Rescission of Protection Against Discharge of Existing Service Members (Directive Section 1(b))

139. Section 1(b) of the Transgender Service Member Ban directs the Secretary of Defense to "return to the longstanding policy and practice on military service by transgender

individuals that was in place prior to June 2016," indefinitely. Section 1(a) describes the policy being reinstated as one under which the military is "authorized to discharge" service members on the basis of their transgender status.

140. Section 1(b) thus establishes a broad ban on service by men and women who are transgender, with immediate and longer-term impacts on those currently serving.

141. Section 3 of the Transgender Service Member Ban requires the Secretary of Defense, in implementing the Transgender Service Member Ban, to determine by February 21, 2018 how to "address" currently serving transgender men and women. Although these service members are permitted to continue serving until this determination is made, transgender service members are immediately impacted by the Transgender Service Member Ban.

142. All service members who are transgender immediately have grave reason to fear for their careers, and must reevaluate career plans that were premised on the Open Service Directive. Individual Plaintiffs and other service members who are transgender experience significant stress and psychological harm caused by this impending threat to their military service.

143. Service members who are transgender are also immediately injured by the stigma created by the Transgender Service Member Ban. Even if some transgender service members are permitted to continue serving beyond March 23, 2018, they now serve in a military where the Commander-in-Chief has announced that their service is unwanted and unwelcome, they are subject to discharge at any time on the basis of their transgender status, and their medical care will be withheld. Any transgender service member permitted to remain in his or her position will necessarily be treated as, and experience the harms associated with, a form of second-class status.

ii. Ban on New Enlistments and Commissions (Directive Section 2(a))

144. Section 2(a) of the Transgender Service Member Ban directs the Secretary of Defense to "maintain the currently effective policy regarding accession of transgender individuals into military service beyond January 1, 2018."

145. In so stating, Section 2(a) prohibits men and women who are transgender from enlisting and serving openly in the United States Armed Forces. The Open Service Directive had determined that men and women who are transgender would not be disqualified, subject to rigorous accession criteria, at the end of a phase-in period on July 1, 2017. Defendant Mattis delayed new enlistments for a further six months on the asserted basis that further study was warranted. President Trump has now acted to ban enlistment without awaiting the results of any study.

146. DoD treats commissioning as an officer as a new accession. Thus, candidates who would otherwise be eligible for commissions on January 1, 2018, will not be eligible as a result of President Trump's indefinite ban on new accessions.

iii. Ban on Medically Necessary Care (Directive Section 2(b))

147. Section 2(b) of the Transgender Service Member Ban directs the Secretary of Defense to "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."

148. Transgender service members who require medically necessary care to treat gender dysphoria are entitled to care on an equal basis to what is provided to non-transgender service members with medical conditions requiring comparable medically necessary care.

149. Many of the same or substantially equivalent surgical procedures banned by the Transgender Service Member Ban are covered by the military when used to treat other serious medical conditions. The Transgender Service Member Ban singles out transgender service members for different treatment by denying them coverage for medically necessary care that is inherently related to their transgender status and gender nonconformity.

* * *

150. The Defendants' actions of adopting, implementing, and enforcing each of the three policies in the Transgender Service Member Ban discriminates against Individual Plaintiffs and other men and women who are transgender on the basis of sex, which is subject to, and fails, heightened scrutiny under the Fifth Amendment.

151. The Defendants' actions of adopting, implementing, and enforcing each of the three policies in the Transgender Service Member Ban discriminates against the Individual Plaintiffs and other men and women who are transgender on the basis of their transgender status, which is independently subject to, and fails, heightened scrutiny under the Fifth Amendment.

a. Men and women who are transgender, as a class, have historically been subject to discrimination.

b. Men and women who are transgender, as a class, have a defining characteristic that frequently bears no relation to an ability to perform or contribute to society.

c. Men and women who are transgender, as a class, exhibit immutable or distinguishing characteristics that define them as a discrete group.

d. Men and women who are transgender, as a class, are a minority with relatively little political power.

152. The Defendants' actions of adopting, implementing, and enforcing each of the three policies in the Transgender Service Member Ban discriminates against Plaintiffs and other transgender individuals on the basis of invidious stereotypes, irrational fears, and moral disapproval, which are not permissible bases for differential treatment under any standard of review.

153. As a result of the policies, practices, and conduct of the Defendants, men and women who are transgender, including Individual Plaintiffs and members of Plaintiff ACLU of Maryland, have suffered, or imminently will suffer, harm, including stigma, humiliation and/or emotional distress, loss of liberty, loss of salary and benefits on which they and their dependents rely, loss of access to medically necessary care, threatened disruption of their military service (including loss of promotion and other career opportunities), and violations of their constitutional right to equal protection. Defendants' conduct continues to violate the equal protection rights of men and women who are transgender on a daily basis and is the proximate cause of widespread harm among Plaintiffs.

154. Plaintiffs seek declaratory and injunctive relief because they have no adequate remedy at law to prevent future injury caused by Defendants' violation of their Fifth Amendment rights to equal protection.

COUNT II (Against All Defendants)

VIOLATION OF SUBSTANTIVE DUE PROCESS

155. Plaintiffs re-allege and incorporate by reference as if fully set forth herein the allegations in all preceding paragraphs.

156. The substantive component of the Fifth Amendment's Due Process Clause includes not only the privileges and rights expressly enumerated by the Bill of Rights, but also includes the fundamental rights implicit in the concept of ordered liberty.

157. The Fifth Amendment bars certain government actions regardless of the fairness of the procedures used to implement them, particularly conduct that is so arbitrary as to constitute an abuse of governmental authority.

158. As a result of the Transgender Service Member Ban, men and women who are transgender, including Individual Plaintiffs, have suffered, or will imminently suffer, a violation of their right to substantive due process because, due to their transgender status, and without any reasoned basis, they are denied an opportunity to demonstrate their continued fitness for duty; the ability to enlist in the U.S. Armed Forces despite being fit to serve; and/or the opportunity to receive medical care on an equal basis as service members who are not transgender. Moreover, the Transgender Service Member Ban unfairly and indefensibly strips Individual Plaintiffs of opportunities and benefits previously recognized by DoD's Open Service Directive, on which they relied.

159. President Trump issued the Transgender Service Member Ban, directing that: (i) transgender status is a basis for discharge, and current service members who are transgender are barred from serving in the U.S. Armed Forces, irrespective of their ability to demonstrate their fitness to serve (§ 1(b)); (ii) enlistment in the military or commissioning as an officer by men and women who are transgender is prohibited, irrespective of their ability to demonstrate their fitness to serve (§ 2(a)); and (iii) currently serving transgender service members are denied medically necessary surgical care, including in cases where individuals are stable in their gender transition and able to demonstrate their fitness to serve on the same basis as other service members (§ 2(b)). Each of these three policies—and the Transgender Service Member Ban as a whole—violates Plaintiffs' rights to substantive due process.

160. The Defendants directly and proximately caused, and continue to cause, the violation of Plaintiffs' rights to substantive due process under the law.

161. As a result of the policies, practices, and conduct of the Defendants, men and women who are transgender, including Individual Plaintiffs and members of Plaintiff ACLU of Maryland, have suffered, or imminently will suffer, harm, including stigma, humiliation and/or emotional distress, loss of liberty, loss of salary and benefits on which they and their dependents rely, loss of access to medically necessary care, disruption of their military service (including loss of promotion and other career opportunities), and violations of their constitutional right to substantive due process. Defendants' conduct continues to violate the substantive due process rights of men and women who are transgender on a daily basis and is the proximate cause of widespread harm among Plaintiffs.

162. Plaintiffs seek declaratory and injunctive relief because they have no adequate remedy at law to prevent future injury caused by Defendants' violation of their Fifth Amendment rights to substantive due process.

COUNT III (Against All Defendants)

VIOLATION OF 10 U.S.C. § 1074

163. Plaintiffs re-allege and incorporate by reference as if fully set forth herein the allegations in all preceding paragraphs.

164. Pursuant to 10 U.S.C. § 1074(a)(1), members of the United States armed services, including active duty and reserve members, are entitled to medical care in military treatment facilities.

165. Surgery that is medically necessary and indicated for the treatment of a diagnosis of gender dysphoria is "medical care" that is covered by the statutory right under 10 U.S.C. §

1074(a)(1). As a result of the Transgender Service Member Ban, transgender service members, including Individual Plaintiffs, have suffered, or will imminently suffer, a violation of this statutory right.

166. Section 2(b) of the Transgender Service Member Ban "halt[s] 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." Section 2(b) takes effect on March 23, 2018, but DoD has already cancelled planned medical procedures for transgender service members, including for Plaintiffs Cole and Doe.

167. The Defendants directly and proximately caused, and continue to cause, the violation of Plaintiffs' right to medical care under 10 U.S.C. § 1074(a)(1).

168. As a result of the policies, practices, and conduct of the Defendants, transgender service members, including Individual Plaintiffs, have suffered, or imminently will suffer, harm, including denial of and lack of access to medical benefits. Defendants' conduct continues to violate Individual Plaintiffs' rights under 10 U.S.C. § 1074(a)(1). Plaintiffs seek declaratory and injunctive relief because they have no adequate remedy at law to prevent future injury caused by Defendants' violation of 10 U.S.C. § 1074(a)(1).

169. Defendants, including the President, cannot act in contravention of a validly enacted statute. Their actions in establishing, implementing, and enforcing the ban on surgical care are *ultra vires*. Moreover, DoD's actions in implementing and enforcing the ban are not in accordance with law under the Administrative Procedure Act, 5 U.S.C. § 706(2).

RELIEF REQUESTED

Wherefore, Plaintiffs respectfully request that this Court:

A. Issue a declaratory judgment that the policies and directives encompassed in President Trump's Memorandum for the Secretary of Defense and the Secretary of Homeland Security, dated August 25, 2017 and entitled "Military Service by Transgender Individuals" violates the equal protection component of the Fifth Amendment to the U.S. Constitution, and is invalid on its face and as applied to Plaintiffs;

B. Issue a declaratory judgment that the policies and directives encompassed in President Trump's Memorandum for the Secretary of Defense and the Secretary of Homeland Security, dated August 25, 2017 and entitled "Military Service by Transgender Individuals," violates the Fifth Amendment's guarantee of substantive due process, and is invalid on its face and as applied to Plaintiffs;

C. Issue an Order preliminarily and permanently enjoining the Defendants from implementing and enforcing the policies and directives encompassed in President Trump's Memorandum for the Secretary of Defense and the Secretary of Homeland Security, dated August 25, 2017 and entitled "Military Service by Transgender Individuals."

D. Award reasonable attorneys' fees and allowable costs of court; and

E. Award such other and further relief as it may deem appropriate and in the interests of justice.

Dated: September 14, 2017

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 14th day of September, 2017, a copy of the foregoing was served via electronic mail, pursuant to agreement, on the following counsel:

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., Plaintiffs, v. DONALD J. TRUMP, et al., Defendants.	Case No. 1:17-cv-02459

MEMORANDUM IN SUPPORT OF
PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

Men and women who are transgender have long served this country in the U.S. Armed Forces. They have seen combat in distant theaters and performed critical roles at home. Many have devoted their careers to service and developed mission-critical skills on which our national defense relies. And since June 30, 2016, these transgender individuals have been able to serve their country openly, when, after extensive study and review, the Department of Defense ("DoD") concluded that there was no justification to exclude from service someone who is ready, willing, and fit to serve simply because he or she is transgender.

President Donald J. Trump has now overridden DoD's reasoned determination. Acting without further study and catching DoD by surprise, President Trump announced on Twitter that "the United States Government will not accept or allow Transgender individuals to serve in any capacity in the U.S. Military." One month later, President Trump issued a directive formalizing this change (the "Transgender Service Member Ban" or "Ban"). The directive reverses DoD policy allowing transgender people to serve without fear of being discharged based on their transgender status, bars the military from providing surgical care needed to treat some transgender service members, and blocks new enlistments by transgender individuals who otherwise meet rigorous criteria developed by DoD.

Plaintiffs are service members who are transgender and, at DoD's encouragement, came out to their commanding officers and colleagues. Some have plans to seek commissions as officers, which the Ban has disrupted. Some have a medical need for surgery the military will now refuse to provide. All have been told by their Commander-in-Chief that despite years of honorable service, they are not wanted in the Armed Forces "in any capacity."

The Transgender Service Member Ban violates the Constitution's equal protection guarantee. Although discrimination based on transgender status is subject to heightened

scrutiny, President Trump's purported justifications for the Ban fail even rational basis review. The cost of providing health care to transgender service members is negligible and no different than the kind of expenses the military incurs in providing other types of medical care to service members. Military effectiveness is *enhanced*, not threatened, by the open service of transgender men and women.

Indeed, the remarkable context of this case is that President Trump's asserted military justifications have already been studied at length and rejected *by the military itself*. The Ban reflects a decision to single out a disfavored group and withdraw legal protection based not on evidence but animus, moral disapproval, and crass political calculation.

In addition to violating the Equal Protection Clause, the Ban violates substantive due process, denying individual dignity on wholly irrational grounds. It also violates a federal statute, 10 U.S.C. § 1074, which creates a right to medical care for active-duty service members.

Unless this Court issues a preliminary injunction to restore the status quo, Plaintiffs will suffer irreparable harm. On January 1, 2018, Plaintiffs and others who otherwise meet DoD's strict accession and fitness standards will be denied the opportunity to commission as officers or enlist, simply because they are transgender. No later than March 23 (and in some cases now), Plaintiffs and others with a medical need for surgery will be denied care, simply because they are transgender. On that same day, Plaintiffs and others will lose legal protection and become subject to discharge, simply because they are transgender. And each day that President Trump's unconstitutional directive remains in effect, Plaintiffs and their families continue to grapple with the stress and uncertainty of having their careers, their livelihoods, and their medical care jeopardized by a Commander-in-Chief who rejects their service and their sacrifice.

Plaintiffs ultimately will prevail in this challenge to President Trump's abrupt, irrational, and unconstitutional decision. Until then, this Court should issue a preliminary injunction to prevent Defendants from enforcing this facially unconstitutional ban and restore the status quo as it existed the morning of July 26, 2017, before President Trump upended thousands of lives with three tweets.

FACTUAL BACKGROUND[1]

The military welcomed the open service of transgender service members on June 30, 2016. It did so at the conclusion of an exhaustive review by high-ranking DoD and military officials, who held numerous discussions with military leaders and personnel, commissioned an independent report, and studied the experiences of allied militaries. *See* Expert Decl. of Hon. Brad R. Carson ("Carson") ¶¶ 8–27. Determining that there was no justification to exclude qualified men and women from service solely because they are transgender, the Secretary of Defense issued DTM 16-005 (the "Open Service Directive"). *See* Decl. of Marianne F. Kies ("Kies"), Ex. 1.[2] This case arises because President Trump abruptly rescinded the Open Service Directive and replaced it with the Transgender Service Member Ban.

A. Transgender Status and Gender Dysphoria

Men and women who are transgender have a gender different from the one assigned to them at birth. *See* Expert Decl. of Dr. George R. Brown ("Brown") ¶ 20; Agnes Gereben Schaefer et al., *Assessing the Implications of Allowing Transgender Personnel to Serve Openly*,

[1] On a motion for preliminary injunction, the uncontroverted facts alleged in accompanying declarations and the Complaint must be taken as true. *See Elrod v. Burns*, 427 U.S. 347, 350 n.1 (1976). Additionally, "district courts may look to and, indeed, in appropriate circumstances rely on, hearsay or other inadmissible evidence when deciding whether a preliminary injunction is warranted." *G.G. ex rel. Grimm v. Gloucester Cty. Sch. Bd.*, 822 F.3d 709, 725–26 (4th Cir. 2016), *vacated on other grounds*, 137 S. Ct. 1239 (2017) (Mem.).

[2] Unless otherwise noted, the exhibits cited herein are all attached to the Kies Declaration.

RAND Corporation, at 6 (2016) ("RAND Report") (Brown, Ex. C). Being transgender is not a mental disorder. Brown ¶ 25. Men and women who are transgender have no impairment in judgment, stability, reliability, or general social or vocational capabilities solely because they are transgender. *Id.* They lead productive and successful lives, making substantial contributions to their communities and country.

Because of the incongruence between their actual gender and the gender assigned to them at birth, some (but not all) transgender individuals experience clinically significant distress. Brown ¶¶ 26–28 & Ex. C (RAND Report) at 6. The diagnostic term for such distress is "gender dysphoria." Brown ¶ 26. There are well-established standards for treatment of gender dysphoria, and this treatment is highly effective at curing all symptoms. *Id.* ¶¶ 32–33. The goal of treatment is to enable the individual to live all aspects of life consistent with his or her gender identity, thereby eliminating the distress associated with the incongruence. *Id.* ¶ 36.

Treatment for gender dysphoria varies depending on the needs of the individual. It can include a "social transition," whereby the person begins to live in their actual gender. Brown ¶ 36 & Ex. C (RAND Report) at 6. Some may require hormone therapy, *e.g.*, estrogen for a woman who is transgender, or testosterone for a man who is transgender. Brown ¶¶ 36–37 & Ex. C (RAND Report) at 6. And some may undergo one or more surgeries to align their body with their actual gender. *Id.* The greater medical community, including the American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association, accepts all of these courses of treatment as standard, medically

necessary care. Brown ¶ 34. Medicare, state Medicaid programs, and private insurers routinely cover transition-related care as medically necessary treatment.[3]

B. The Open Service Directive

Starting some time before 1981, DoD enforced a policy barring men and women who are transgender from enlisting or being retained in the Armed Forces. This policy categorically excluded individuals who had had a "change of sex" from enlisting and prohibited persons who are transgender from serving openly, regardless of whether they required any ongoing medical treatment and regardless of their fitness to serve. Brown ¶¶ 39–58 & Ex. C (RAND Report) at 1. During this time, the military treated "Sexual Gender and Identity Disorders" as a condition rendering a service member "administratively unfit," and allowed these members no opportunity to demonstrate fitness to serve. Brown ¶¶ 48–56. At the same time, DoD permitted individuals who were not transgender — including persons requiring medical interventions for various physical and psychological conditions — to remain in service if they could demonstrate their fitness. Brown ¶ 57.

Despite this policy, for years men and women who are transgender served our country honorably in the Armed Forces, including in combat. As of May 2014, transgender persons accounted for an estimated 8,800 active-duty service members, as well as 134,300 veterans and retirees from Guard or Reserve service. *See* Gates & Herman, *Transgender Military Service in the United States*, Williams Inst., at 1, 4 (May 2014) (Ex. 4).

[3] *See, e.g.*, DHS, Dep't Appeals Board, *NCD 140.3, Transsexual Surgery*, No. A-13-87 (May 30, 2014) (Ex. 2); Code of Md. Regs. 10.09.67.26-3 (requiring Maryland Medicaid providers to cover "medically necessary gender reassignment surgery and other somatic specialty care for members with gender identity disorder"); Transcend Legal, *Transgender Insurance Medical Policies* (Ex. 3) (examples of insurance policies covering surgery for gender dysphoria).

On July 13, 2015, then-Secretary of Defense Ashton Carter acknowledged that existing regulations were "an outdated, confusing, inconsistent approach that's contrary to our value of service and individual merit [and that is] causing uncertainty that distracts commanders from our core missions." *Statement by Secretary of Defense Ash Carter on DoD Transgender Policy* (July 13, 2015) (Ex. 28). Secretary Carter created a working group to study "the policy and readiness implications of welcoming transgender persons to serve openly." *Id.*

The DoD working group included representatives of the leadership of the Armed Forces; the Joint Chiefs of Staff; the service secretaries; and personnel, training, readiness, and medical specialists from across the Department. *See id.*; Carson ¶¶ 1, 8–10. Over the next year, the working group performed a systematic review — including meeting with transgender service members deployed throughout the world, and consulting with outside experts, medical professionals, and others. *See* Carson ¶ 10; *DoD Press Briefing by Secretary Carter on Transgender Service Policies in the Pentagon Briefing Room* (June 30, 2016) (Ex. 5).

The working group also commissioned a study by the Forces and Resources Policy Center of the non-partisan RAND National Defense Research Institute ("RAND"). RAND conducted an "extensive literature review"; examined data from inside and outside DoD; studied policies of foreign militaries that permit open service by persons who are transgender; and reviewed DoD's instructions on enlistment, retention, separation, and deployment. Brown, Ex. C (RAND Report) at 2–3. RAND concluded that the impact on military readiness from open service would be "negligible," and that associated health care costs would represent "an exceedingly small proportion" of DoD's overall health care expenditures. *Id.* at xi–xii, 31, 70.

RAND's findings were consistent with the medical and anecdotal evidence that the working group collected, including evidence related to combat experience. For example, the

working group found that the Military Health System already has an effective process for providing prescribed medications and medical services to deployed service members across the globe, including those in combat settings. Carson ¶ 24; Expert Decl. of Maj. Gen. Margaret C. Wilmoth (U.S. Army, Ret.) ("Wilmoth") ¶¶ 14–18, 20. The group further concluded that the short periods of non-deployability that *some* transgender service members *might* experience would be comparable to the non-deployability associated with medical conditions the military does not consider a basis for discharge, such as pregnancy, orthopedic injuries, and appendicitis. Carson ¶ 22; Wilmoth ¶ 19. For these and additional reasons, the working group ultimately concluded that "[o]pen service by transgender service members would not impose any significant burdens on readiness, deployability, or unit cohesion." Wilmoth ¶ 23.

The Secretary of Defense agreed, determining that "open service by transgender Service members while being subject to the same standards and procedures as other members with regard to their medical fitness for duty, physical fitness, uniform and grooming, deployability, and retention, is consistent with military readiness and with strength through diversity." Ex. 1 (Open Serv. Dir.). On June 30, 2016, the Secretary issued a directive rescinding the historical policy of discriminating against men and women who are transgender.

The Open Service Directive had three main components. *First*, it provided that "no otherwise qualified Service member may be involuntarily separated, discharged or denied reenlistment or continuation of service, solely on the basis of their gender identity." Ex. 1 at Attach. § 1(a). Men and women who are transgender are "subject to the same standards as any other Service member of the same gender." *Id.* § 1(b). Medical conditions affecting transgender service members are treated "in a manner consistent with a Service member whose ability to serve is similarly affected for reasons unrelated to gender identity or gender transition." *Id.*

§ 1(c). Pursuant to this policy change, transgender service members were encouraged to disclose their gender identity to colleagues and leadership. DoD, *Transgender Service in the U.S. Military: An Implementation Handbook*, at 20 (Sept. 30, 2016) (Ex. 6).

Second, the Open Service Directive provided that "transgender Service members may transition gender while serving" pursuant to contemporaneously-issued guidance. Ex. 1 at Attach. § 3(a). "Any medical care and treatment provided to an individual Service member in the process of gender transition [is] provided in the same manner as other medical care and treatment." *DoD Instruction 1300.28*, § 1.2(d) (June 30, 2016) (Ex. 7). "Any determination that a transgender Service member is non-deployable at any time w[ould] be consistent with established Military Department and Service standards, as applied to other Service members whose deployability [wa]s similarly affected in comparable circumstances unrelated to gender transition." *Id.* § 1.2(e).[4]

Third, the Open Service Directive announced that individuals wishing to join the military (a process, applicable to both new enlistees and officer candidates, known as "accession") would not be prohibited from doing so solely because they are transgender. *See generally* Ex. 1 (Open Serv. Dir.), at Attachment. At the same time, the Directive set out stringent accession requirements beyond those applicable to those already serving, to "ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty." *Id.* § 2(a). Thus, "[a] history of gender dysphoria" was disqualifying, "**unless**, as

[4] Surgeries necessary for the treatment of gender dysphoria are comparable to surgeries performed for service members who are not transgender, including chest and breast reconstruction, hysterectomies, and genital reconstruction. Brown ¶ 85; Wilmoth ¶ 20. All of the medications that may be used to treat a service member's gender dysphoria are used by other service members for conditions unrelated to gender dysphoria. Brown ¶¶ 38, 62–63, 75, 78–79, 81–85. Military policy allows service members to take a range of medications, including hormones, while deployed in combat settings. *Id.* ¶¶ 62, 78–83.

certified by a licensed medical provider, the [prospective enlistee] ha[d] been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for [at least] 18 months." *Id.* § 2(a)(1) (emphasis in original). "A history of sex reassignment or genital reconstruction surgery" was also disqualifying unless at least 18 months had passed since the surgery, no further surgery was required, and "no functional limitations or complications persist[ed]." *Id.* § 2(a)(3). Finally, a history of any medical treatment "associated with gender transition" was disqualifying, unless the enlistee had "completed all medical treatment" associated with the transition; had been "stable" in the transition for 18 months; and had been stable on any hormones for 18 months. *Id.* § 2(a)(2). To ensure proper training for those administering the new criteria, DoD provided a period before new enlistments would begin, "[n]ot later than July 1, 2017." *Id.* § 2(a).

On June 30, 2017 — the day before new enlistments were scheduled to begin — the current Secretary of Defense announced that it was "necessary to defer the start of accessions for six months." *See* Jim Mattis, *Memorandum for Secretaries of the Military Departments, Chairman of the Joint Chiefs of Staff: Accession of Transgender Individuals into the Military Services* (June 30, 2017) (Ex. 8). Secretary Mattis wished to "personally" receive the views of newly arriving military and civilian leadership. *Id.* He directed the Under Secretary of Defense for Personnel and Readiness to lead a review of the accession policy and to report the results by December 1, 2017. Secretary Mattis stressed that he was "in no way presuppos[ing] the outcome of the review"; that his announcement did not otherwise change the Open Service Directive; and that "we will continue to treat all Service members with dignity and respect." *Id.*

C. President Trump's Transgender Service Member Ban

Less than a month after Secretary Mattis announced this review, President Trump abruptly announced a categorical ban on transgender individuals serving in the military. On July 26, 2017, President Trump published three tweets under the handle @realDonaldTrump:

Ex. 19. President Trump later claimed that his Twitter announcement did the military a "great favor" by ending the "confusing issue" of transgender service. Cooper, *Trump Says Transgender Ban Is a 'Great Favor' for the Military*, N.Y. Times (Aug. 10, 2017) (Ex. 9).

President Trump's tweets "startl[ed]" DoD. Dawsey, *John Kelly's Big Challenge: Controlling the Tweeter in Chief*, Politico (Aug. 4, 2017) (Ex. 10). There is no indication that President Trump consulted with any experts on this issue or that the announcement was based on any new evidence questioning DoD's previous determinations. Rather, the announcement was made in the context of legislative politics; anti-transgender Members of Congress had tried and failed to defund medical care for transgender service members, and appealed directly to President Trump to intervene. Bade & Dawsey, *Inside Trump's Snap Decision to Ban*

Transgender Troops, Politico (July 26, 2017) (Ex. 11). It was reported that President Trump hoped the ban would appeal to members of his "base."[5]

President Trump's announcement drew swift criticism. Fifty-six retired generals and admirals pointed out that "[t]housands 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." *Fifty-Six Retired Generals and Admirals Warn that President Trump's Anti-Transgender Tweets, if Implemented, Would Degrade Military Readiness*, Palm Center (Aug. 1, 2017) (Ex. 14).

Senator John McCain, Chairman of the Senate Armed Services Committee, stated that "[t]here is no reason to force service members who are able to fight, train, and deploy to leave the military – regardless of their gender identity." *Statement by SASC Chairman John McCain on Transgender Americans in the Military* (July 26, 2017) (Ex. 15). Senator Tammy Duckworth, an Iraq War veteran, noted that "[i]f you are willing to risk your life for our country and you can do the job, you should be able to serve." *Duckworth Statement on Reports Trump Administration Directing DoD to Discriminate Against Transgender Servicemembers* (Aug. 24, 2017) (Ex. 16). More than 100 Members of Congress expressed strong "process" concerns, criticizing President Trump's "refusal to appropriately consult with relevant advisors, experts, or military leaders." *See* Letter from McEachin, et al. to President Trump (Aug. 29, 2017) (Ex. 17).

President Trump nonetheless formalized the Transgender Service Member Ban in a Memorandum for the Secretary of Defense and the Secretary of Homeland Security, entitled "Military Service by Transgender Individuals." Ex. 18. The memorandum states that President

[5] *See, e.g.*, Ex. 11 (*Inside Trump's Snap Decision*); Miller, *Trump's Evangelical Advisers Discussed Transgender Ban at White House Meeting*, Religion News Service (July 27, 2017) (Ex. 12); Peoples, *Trump Transgender Ban Nod to Christian Conservatives*, U.S. News & World Report (July 27, 2017) (Ex. 13).

Trump exercised his own "judgment" to determine that DoD had "failed to identify a sufficient basis to conclude" that the Open Service Directive "would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources." *Id.* § 1(a). The memorandum addressed, and rescinded, each component of the Open Service Directive.

First, the memorandum directed the military to treat transgender service members as subject to discharge, effective March 23, 2018. *Id.* §§ 1, 3. Specifically, President Trump directed the military to "return to the longstanding policy and practice on military service by transgender individuals that was in place prior to June 2016," a policy he described as "generally prohibit[ing] openly transgender individuals from accession into the United States military and authoriz[ing] the discharge of such individuals." *Id.* § 1. Discharges pursuant to this policy are temporarily delayed while the Secretary of Defense submits a plan to President Trump, by February 21, 2018, concerning "how to address transgender individuals currently serving in the United States military." *Id.* § 3. Whatever plan the Secretary submits, the required end result is the fulfillment of President Trump's avowed goal: a military with no transgender service members "in any capacity." Ex. 19 (tweets).

Second, President Trump directed the military to "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." *Id.* § 2(b). According to the memorandum, the ban on surgical care takes effect on March 23, 2018. *Id.* § 3. In practice, the military has already ceased providing surgical care to some transgender service members, including Plaintiffs. *See infra* § D.

Third, President Trump directed the military to "maintain the currently effective policy regarding accession of transgender individuals into military service," *i.e.*, banning such

accessions, until he is provided with a recommendation to the contrary "that I find convincing." Ex. 18 § 2(a). The indefinite ban on new enlistments and commissions takes effect on January 1, 2018 (the day after Secretary Mattis's six-month delay of new accessions expires). *Id.* § 3.

Secretary Mattis confirmed that he "will carry out the [P]resident's policy direction" and develop an implementation plan "[a]s directed." *Statement by Secretary of Defense Jim Mattis on Military Service by Transgender Individuals* (Aug. 29, 2017) (Ex. 20).

D. Plaintiffs' Military Service

Plaintiffs include men and women who are transgender and who serve in the U.S. military, and the American Civil Liberties Union of Maryland, Inc. on behalf of its members.

Plaintiff Stone. Brock Stone, a 34-year-old man, is a Petty Officer First Class in the U.S. Navy. He has served for over 11 years, including a nine-month deployment to Afghanistan. Stone ¶ 1. Petty Officer Stone is stationed at Fort Meade, Maryland, where he works as a computer analyst. *Id.* He revealed his transgender status to military personnel in connection with and in reliance upon the Open Service Directive. *Id.* ¶ 2. Petty Officer Stone is eligible for promotion to Chief Petty Officer, a promotion in which he would take great pride, and which would result in a significant pay increase and additional housing allowance. *Id.* ¶ 13. The Transgender Service Member Ban threatens that promotion. *Id.*

Petty Officer Stone is currently undergoing hormone therapy as a part of his gender transition, supervised by DoD medical personnel. *Id.* ¶¶ 4, 9. He plans to receive transition-related surgical care as part of his treatment. *Id.* ¶ 10. The Transgender Service Member Ban immediately jeopardizes Petty Officer Stone's medically necessary treatment, and compromises his career and financial future. Petty Officer Stone has planned his finances around remaining with the military through retirement and receiving the future retirement benefits to which he

would be entitled; the Ban also compromises his ability to support his wife as she starts a new business. *Id.* ¶¶ 9, 11, 12.

Plaintiff Cole. Kate Cole, a 27-year-old woman, is a Staff Sergeant in the U.S. Army. Cole ¶ 2. She enlisted in the Army at age 17, and has deployed to Afghanistan and also spent two years stationed in Germany, where she rotated through Estonia, Latvia, Lithuania, and Poland. *Id.* Staff Sergeant Cole revealed her transgender status to military personnel following the Open Service Directive. *Id.* ¶ 3. Pursuant to an evaluation and recommendation by DoD medical personnel, she is currently undergoing hormone therapy. *Id.* ¶ 4. Staff Sergeant Cole was scheduled for gender confirmation surgery and reported for a DoD medical consultation for that surgery on September 8, 2017. *Id.* ¶ 11. DoD personnel informed Staff Sergeant Cole that there is no transition-related surgery at this time, and it is not certain if, or when, such surgery will be allowed. *Id.* Staff Sergeant Cole also fears for her career and the financial hardships that discharge would inevitably cause her. *Id.* ¶¶ 12–13.

Plaintiff Doe. John Doe, a 25-year-old man, is a Senior Airman in the U.S. Air Force, in which he has served for almost six years, including a six-month deployment to Qatar. Doe ¶ 2. He is currently pursuing cryogenics certification and is the suicide prevention and interpersonal violence instructor for his base. *Id.* Senior Airman Doe revealed his transgender status to military personnel following the Open Service Directive. *Id.* ¶ 4. After evaluation and recommendation by DoD medical personnel, he has begun medically necessary hormone therapy. *Id.* ¶ 5. Senior Airman Doe was scheduled to undergo a medically recommended hysterectomy in August 2017. *Id.* ¶ 12. He received an e-mail from medical officials at the base where he was to receive treatment stating that all gender transition-related surgeries, including

his own, were on hold; his previously prescribed surgery was apparently deleted from his treatment plan. *Id.*

Senior Airman Doe had planned to serve in the Air Force for the remainder of his career, but now fears discharge. *Id.* ¶ 10. After achieving his current rank, he submitted paperwork to reenlist for another five years. His reenlistment is currently pending. *Id.* He is financially dependent upon military income and related military benefits, including health care. *Id.* ¶ 11. Because of the Ban, he is now unable to plan for his future. *Id.* ¶ 12.

Plaintiff George. Seven Ero George, a 41-year-old man, is an Airman First Class in the Air National Guard. George ¶ 2. He currently works in the security force at Selfridge Air National Guard Base in Michigan. *Id.* Airman First Class George revealed his transgender status to military personnel following the Open Service Directive. *Id.* ¶ 3. Pursuant to an evaluation and recommendation by his civilian healthcare provider, he began to undergo medically necessary hormone therapy. *Id.* ¶¶ 3–4. He has successfully undergone a double mastectomy and chest reconstruction surgery as part of his treatment. *Id.* ¶ 4. He has provided the Air National Guard with documentation of his treatment, and the Air National Guard confirmed that he still met all criteria for service, including deployability. *Id.*

Airman First Class George has been planning to pursue a commission in the U.S. Army Nurse Corps. *Id.* ¶ 5. That career path is foreclosed by President Trump's indefinite ban on new accessions by men and women who are transgender. Ex. 18 (Ban). Airman First Class George is concerned about both his future financial security and military career opportunities. George ¶¶ 5, 9–13.

Plaintiff Gilbert. Teagan Gilbert, a 31-year-old woman, is a Petty Officer First Class in the U.S. Navy, where she has served for more than 13 years, including a one-year deployment to

Afghanistan. Gilbert ¶ 2. Petty Officer Gilbert has received specialized military training and education, including experience with DoD space systems. *Id.* ¶ 4. She is currently serving in the Naval Reserve as an information and space systems technician. *Id.* Petty Officer Gilbert revealed her transgender status to military personnel following the Open Service Directive. *Id.* ¶ 5. Pursuant to an evaluation and recommendation by DoD medical personnel, she is currently undergoing medically necessary hormone therapy and plans to seek approval of medically-indicated surgical treatment, including gender confirmation surgery. *Id.* ¶ 6.

Petty Officer Gilbert planned to serve in the U.S. military for at least 20 years. *Id.* ¶ 7. The Transgender Service Member Ban is already hindering her career; she perceives increased difficulty in receiving new reservist assignments as a result of the Ban. *Id.* ¶ 11. If discharged, Petty Officer Gilbert will lose not only her own military health care but also health care for her six-year-old son, of whom she has sole custody. *Id.* ¶ 12. Petty Officer Gilbert has plans to apply to Officer Candidate School after completing her college degree, but the accession ban would bar her from receiving a commission. *Id.* ¶ 7; *see* Ex. 18 (Ban).

Plaintiff Parker. Tommie Parker, a 54-year-old woman, is a Technical Sergeant in the Air National Guard. Parker ¶ 2. She has served in the military for over 30 years, including over 16 years on active duty, and currently works as a fuel technician at Stewart Air National Guard Base in New York. *Id.* Technical Sergeant Parker revealed her transgender status to military personnel following the Open Service Directive. *Id.* ¶ 3. Pursuant to an evaluation and recommendation by DoD medical personnel, she began hormone therapy. *Id.* ¶ 4. She intends to serve in the Air National Guard for her entire career, through the next 3.5 years. *Id.* ¶ 5. Now, she fears that she will be discharged and will lose the retirement benefits she would earn with completion of 20 years on active duty. *Id.* ¶ 9. Technical Sergeant Parker is financially

dependent on her military income and other significant benefits, as are her wife and three children. *Id.* ¶ 10.

LEGAL STANDARD

A plaintiff seeking preliminary injunctive relief must show: (1) a clear likelihood of success on the merits; (2) a clear likelihood that he or she will suffer irreparable harm in the absence of such relief; (3) that the balance of equities tips in plaintiff's favor; and (4) that an injunction is in the public interest. *United States v. South Carolina*, 720 F.3d 518, 533 (4th Cir. 2013).

ARGUMENT

I. Plaintiffs Are Likely to Succeed on the Merits of Their Claims.

The Transgender Service Member Ban violates the equal protection and substantive due process guarantees of the U.S. Constitution, as well as service members' statutory right to medical care. Plaintiffs are likely to succeed on the merits of each of these claims.

A. The Transgender Service Member Ban Violates Equal Protection.

"The liberty protected by the Fifth Amendment's Due Process Clause contains within it the prohibition against denying to any person the equal protection of the laws." *United States v. Windsor*, 133 S. Ct. 2675, 2695 (2013). This equal protection guarantee applies to men and women who serve in the Armed Forces. *See, e.g.*, *Frontiero v. Richardson*, 411 U.S. 677, 690–91 (1973); *Emory v. Sec'y of Navy*, 819 F.2d 291, 294 (D.C. Cir. 1987) (per curiam).

While President Trump's action singling out transgender service members for unequal treatment is subject to heightened scrutiny, the Transgender Service Member Ban cannot survive *any* level of scrutiny. President Trump's abrupt decision to bar men and women who are transgender from serving in the military defies rational explanation. All of the justifications advanced in defense of the Ban are either demonstrably false or "ma[k]e no sense in light of how

the [military] treat[s] other groups similarly situated in relevant respects." *Bd. of Trs. of Univ. of Ala. v. Garrett*, 531 U.S. 356, 366 n.4 (2001). The anomalous process — in which a surprise Twitter announcement overrode the military's extensive evidence-based review — confirms that the Transgender Service Member Ban is "inexplicable by anything but animus toward the class it affects." *Romer v. Evans*, 517 U.S. 620, 632 (1996).

1. Heightened Scrutiny Applies to the Transgender Service Member Ban.

The Constitution's equal protection guarantee "stands to ensure that the line drawn between . . . two groups has some modicum of principled validity, through its scrutiny of both the purpose animating the statute as well as the way the line is set." *Smith Setzer & Sons, Inc. v. S.C. Procurement Review Panel*, 20 F.3d 1311, 1321 (4th Cir. 1994). A classification will be "strictly scrutinized" when it "operates to the peculiar disadvantage of a suspect class." *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 172 (4th Cir. 2000). Courts assess whether a classification is suspect based on whether the class: (i) has historically "been subjected to discrimination," *Bowen v. Gilliard*, 483 U.S. 587, 602 (1987); (ii) has a defining characteristic that "frequently bears no relation to ability to perform or contribute to society," *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440–41 (1985) (superseded by statute on other grounds); (iii) exhibits "obvious, immutable, or distinguishing characteristics that define [the members of the class] as a discrete group," *Bowen*, 483 U.S. at 602; and (iv) is politically "vulnerable," *id.* at 629; *see Windsor v. United States*, 699 F.3d 169, 181 (2d Cir. 2012) (applying these considerations), *aff'd,* 133 S. Ct. 2675 (2013). "The presence of *any* of the factors is a signal that the particular classification is 'more likely than others to reflect deep-seated prejudice rather than legislative rationality in pursuit of some legitimate objective,' thus

requiring heightened scrutiny." *Golinski v. OPM*, 824 F. Supp. 2d 968, 983 (N.D. Cal. 2012) (emphasis added) (quoting *Plyler v. Doe*, 457 U.S. 202, 216 n.14 (1982)).

Discrimination based on transgender status implicates all of the traditional heightened-scrutiny factors. "[T]ransgender people as a class have historically been subject to discrimination or differentiation"; "they have a defining characteristic that frequently bears no relation to an ability to perform or contribute to society"; "as a class they exhibit immutable or distinguishing characteristics that define them as a discrete group"; and "as a class, they are a minority with relatively little political power." *Evancho v. Pine-Richland Sch. Dist.*, 237 F. Supp. 3d 267, 288 (W.D. Pa. 2017); *see also Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1051 (7th Cir. 2017) ("There is no denying that transgender individuals face discrimination, harassment, and violence because of their gender identity."); *G.G. v. Gloucester Cty. Sch. Bd.*, 853 F.3d 729, 730 (4th Cir. 2017) (Davis, J., concurring) (transgender individuals are "a vulnerable group that has traditionally been unrecognized, unrepresented, and unprotected"); *Bd. of Educ. of the Highland Local Sch. Dist. v. U.S. Dep't of Educ.*, 208 F. Supp. 3d 850, 873–74 (S.D. Ohio 2016), *appeal docketed*, No. 16-4107 (6th Cir. Sept. 28, 2016); *Adkins v. City of N.Y.*, 143 F. Supp. 3d 134, 139–40 (S.D.N.Y. 2015); *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1119 (N.D. Cal. 2015).

Furthermore, discrimination against transgender individuals requires heightened scrutiny because, for at least three reasons, it is a form of discrimination on the basis of sex. First, a person's transgender status is an inherently sex-based characteristic; discrimination "on the basis of being transgender" is "literally discrimination 'because of sex.'" *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509, 527 (D. Conn. 2016).

Second, discrimination against people because they have undergone a gender transition is also inherently based on sex. Just as discrimination based on religion includes discrimination against people who convert from one religion to another, sex discrimination includes discrimination against men or women who have undergone a gender transition from the sex assigned to them at birth. *See Schroer v. Billington*, 577 F. Supp. 2d 293, 306–07 (D.D.C. 2008); *see also Glenn v. Brumby*, 663 F.3d 1312, 1314 (11th Cir. 2011) (firing employee because of her "intended gender transition" is sex discrimination); *Dawson v. H&H Elec., Inc.*, 2015 WL 5437101, at *3 (E.D. Ark. Sept. 15, 2015).

And third, discrimination against transgender individuals inherently involves discrimination based on sex stereotypes. "A person is defined as transgender precisely because of the perception that his or her behavior transgresses gender stereotypes. . . . There is thus a congruence between discriminating against transgender . . . individuals and discrimination on the basis of gender-based behavioral norms." *Glenn*, 663 F.3d at 1316. Accordingly, "any discrimination against transsexuals (as transsexuals) — individuals who, by definition, do not conform to gender stereotypes — is . . . discrimination on the basis of sex." *Finkle v. Howard Cty.*, 12 F. Supp. 3d 780, 788 (D. Md. 2014); *see also Whitaker*, 858 F.3d at 1049–50; *Smith v. City of Salem*, 378 F.3d 566, 569, 572 (6th Cir. 2004).

2. The Transgender Service Member Ban Fails Any Level of Scrutiny.

Although discrimination against transgender service members is subject to heightened scrutiny, the Transgender Service Member Ban cannot withstand any level of review. Even under rational basis review, justifications must have a "footing in the realities of the subject addressed," *Heller v. Doe by Doe*, 509 U.S. 312, 321 (1993), and the government "may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational," *Cleburne*, 473 U.S. at 446. Moreover, "the disadvantage

imposed" on a discrete group of individuals may not be "born of animosity toward the class of persons affected." *Romer*, 517 U.S. at 634. Unequal treatment "motived by an improper animus or purpose" is unconstitutional under any standard. *Windsor*, 133 S. Ct. at 2693.

President Trump's abrupt decision to bar men and women who are transgender from serving in the military defies rational explanation. The sweeping ban "outrun[s] and belie[s] any legitimate justifications that may be claimed for it." *Romer*, 517 U.S. at 635; *see also USDA v. Moreno*, 413 U.S. 528, 535–36 (1973) (invalidating law on rational-basis review because "even if we were to accept as rational the Government's wholly unsubstantiated assumptions concerning [hippies] . . . we still could not agree with the Government's conclusion that the denial of essential federal food assistance . . . constitutes a rational effort to deal with these concerns").

a) The Ban is not rationally related to military effectiveness.

Open service by transgender individuals does nothing to "hinder military effectiveness and lethality." Ex. 18 (Ban) § 1(a). President Trump provided no explanation of what specific concerns he harbors on this score, and the experience of Plaintiffs — who have served for years or even decades, deployed overseas, and received specialized, mission-critical training — alone refutes any uninformed assumption that transgender status is somehow incompatible with effectiveness in the field.

The military already has generally applicable standards and procedures for assessing the medical fitness and deployability of all service members, and for discharging those who are not fit. Transgender service members are held to those same standards, and are dischargeable on the same basis if they fail to meet them. *See* Ex. 1 (Open Serv. Dir.) at Attach. § 1. The military also has an effective system for distributing prescribed medications, including hormones, to deployed service members across the globe, even in combat settings. Wilmoth ¶¶ 14–16; Brown

¶¶ 62, 78–83. Only a few medications "are inherently disqualifying for deployment," and none of them are used to treat gender dysphoria. Brown ¶ 81. The only people affected by President Trump's categorical ban are transgender service members who would otherwise qualify as medically fit and deployable under these generally applicable standards. *See City of L.A. v. Patel*, 135 S. Ct. 2443, 2451 (2015) ("The proper focus of the constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant.").

To the extent that President Trump assumes that transgender service members who undergo transition-related surgery would be generally non-deployable, that assumption has no basis in fact. Under the strict accessions policy of the Open Service Directive, men and women who are transgender must generally have completed all transition-related surgery 18 months *before* initial enlistment, eliminating any foreseeable need for additional surgery. Ex. 1 at Attach. § 2. Some (but not all) transgender service members who have already enlisted may require medically necessary surgery, but any impact on availability for deployment is "negligible and significantly smaller than the lack of availability due to [other] medical conditions." Brown, Ex. C (RAND Report) at 46. For example, in 2015 in the Army alone, 14% of active-duty service members were ineligible to deploy for legal, medical, or administrative reasons. *Id.* In comparison, RAND estimates that between eight and 43 labor-years would be unavailable for deployment due to transition-related care in a given year — out of 1.2 million labor-years total in the active component — with a reduction of at most just 0.0015 percent of available deployable labor-years across both the active and reserve components. Brown, Ex. C (RAND Report) at 42.

These *de minimis* deployability constraints plainly cannot justify the sweeping Ban in light of the military's broader treatment of non-deployability. Brown ¶ 91. Courts long ago struck down an analogous military regulation requiring discharge based on pregnancy — holding

that the regulation was not rationally related to the asserted military objectives of mobility, readiness, and administrative convenience. *See, e.g.*, *Crawford v. Cushman*, 531 F.2d 1114, 1121–25 (2d Cir. 1976). A military that accepts individuals with myriad conditions limiting deployability cannot cite the "negligible" limitations on deployability that a subset of transgender service members may experience as even a rational justification for banning them. *Cf. Cleburne*, 473 U.S. at 450 ("[T]he expressed worry about fire hazards, the serenity of the neighborhood, and the avoidance of danger to other residents fail rationally to justify singling out a home [for people with disabilities] for the special use permit, yet imposing no such restrictions on the many other uses freely permitted in the neighborhood."); *Bostic v. Schaefer*, 760 F.3d 352, 382 (4th Cir. 2014) (rejecting justification that is "so underinclusive" that its real motivation "must have 'rest[ed] on an irrational prejudice'" (quoting *Cleburne*, 473 U.S. at 450)).

Far from compromising readiness, the experience from other countries has shown that open service for transgender individuals "*improved* readiness by giving units the tools to address a wider variety of situations and challenges." Brown, Ex. C (RAND Report) at 61 (emphasis added). An illustrious group of retired generals and admirals underscored this point. *See* Ex. 14 (*Fifty-Six Retired Generals and Admirals*) ("This proposed ban . . . would . . . deprive the military of mission-critical talent . . . . [T]ransgender troops have been serving honorably and openly for the past year, and have been widely praised by commanders. . . . The military conducted a thorough research process on this issue and concluded that inclusive policy for transgender troops promotes readiness. . . . We could not agree more.").[6]

[6] President Trump has not explained his stray reference to "unit cohesion" (Ex. 18 (Ban) § 1(a)), a rationale he did not mention when he announced the Transgender Service Member Ban on Twitter. To the extent President Trump is speculating that other service members harbor prejudice against people who are transgender and would have difficulty serving with them, this assumption has no factual basis. *See* Carson ¶ 19 ("no evidence that permitting openly

b) The Ban is not rationally related to an interest in avoiding "tremendous costs" to the military.

President Trump also defended the ban by claiming that the cost of providing medical care to transgender service members would be "tremendous" and "tax military resources." Ex. 19 (tweets); Ex. 18 (Ban) § 1(a). That is simply untrue. Surgeries that treat gender dysphoria are not particularly expensive when compared with surgeries for other conditions. Brown, Ex. C (RAND Report) at 33–37, 70. Indeed, the types of surgeries used to treat gender dysphoria are routinely provided to non-transgender service members. *See id.* at 8–9; Brown ¶¶ 84–85; Wilmoth ¶ 20. The Military Health System already possesses the surgical expertise to perform genital and chest reconstructive surgeries for patients who, *e.g.*, have been in vehicular accidents or wounded in combat. Brown ¶ 85 & Ex. C (RAND Report) at 8; Wilmoth ¶¶ 20–21.

Moreover, because surgeries are not medically necessary for all men and women who are transgender, *see* Brown ¶¶ 26–28, 32–33, and because such surgeries are not foreseeable for new enlistees (who must generally have completed their surgical care), the number of surgeries the military would need to perform to treat gender dysphoria is "overwhelmingly small," Brown, Ex. C (RAND Report) at 31.

Thus, RAND found that "even in the most extreme scenario," providing care for men and women who are transgender would entail only a 0.13% increase in active component health care spending — a mere one one-hundredth of one percent of the military's annual health care budget. Brown, Ex. C (RAND Report) at 33–37, 70. In real terms, the highest-range estimate of

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transgender people to serve in the military would disrupt unit cohesion"). This speculation may be based in President Trump's own misunderstanding of military service and stereotypes about the character of the men and women who serve. *Cf.* Mehta, *Trump Stands by Tweet Blaming Sexual Assaults in Military on Men and Women Serving Together*, L.A. Times (Sept. 7, 2016) (Ex. 21) (statement by President Trump that sexual assault is the inevitable result of allowing women to serve alongside men in the military).

providing health care to transgender service members would be $8.4 million, out of $6.2 *billion* in active component health expenditures. *Id.* at 33–37. This is "little more than a rounding error" in the military's $47.8 billion annual health care budget. Belkin, *Caring for Our Transgender Troops*, New Eng. J. Med., at 1 (Aug. 12, 2015) (Ex. 22).[7]

Even if a "cost" justification had any factual basis, reducing costs is not a sufficient governmental interest to justify unequal treatment of similarly situated groups. *See, e.g.*, *Diaz v. Brewer*, 656 F.3d 1008, 1014 (9th Cir. 2011) (where interest in "cost savings and reducing administrative burdens" "depend[s] upon distinguishing between homosexual and heterosexual employees, similarly situated," it "cannot survive rational basis review"); *Bassett v. Snyder*, 59 F. Supp. 3d 837, 854 (E.D. Mich. 2014) ("Although a state has a valid interest in preserving the fiscal integrity of its programs and may legitimately attempt to limit its expenditures," it "may not accomplish such a purpose by invidious distinctions between classes of its citizens." (internal quotation marks omitted)). Because medical conditions resulting in similar or higher costs for the military are not bases for discharge or denial of care, cost savings does not explain the exclusion of transgender service members with comparable or even less costly medical needs. *Cf. Cleburne*, 473 U.S. at 450; *Bostic*, 760 F.3d at 382.

3. President Trump's Decision to Single Out Transgender Service Members Is Impermissibly Rooted in Animus and Moral Disapproval.

President Trump's sweeping and categorical ban is "inexplicable by anything but animus toward the class it affects." *Romer*, 517 U.S. at 632. It is "a classification of persons undertaken for its own sake, something [the Fifth Amendment] does not permit." *Id.* at 635. "[A] court applying rational-basis review under the Equal Protection Clause must strike down a government

[7] For example, the military spends at least 10 times more on medication to treat erectile dysfunction than it would to care for transgender service members. *See* Kime, *DoD Spends $84M a Year on Viagra, Similar Meds*, Military Times (Feb. 13, 2015) (Ex. 23).

classification that is clearly intended to injure a particular class of private parties, with only incidental or pretextual public justifications." *Kelo v. City of New London*, 545 U.S. 469, 491 (2005) (Kennedy, J., concurring); *Vance v. Bradley*, 440 U.S. 93, 97 (1979) (rational-basis review not deferential when there is "some reason to infer antipathy").

"In determining whether a law is motived by an improper animus or purpose, [d]iscriminations of an unusual character especially require careful consideration." *Windsor*, 133 S. Ct. at 2693 (internal quotation marks omitted). The extraordinary context of this case is that DoD went through a careful and exhaustive process that *rejected* as factually baseless all of the justifications President Trump now asserts. One would expect, at a minimum, that such a significant policy reversal would have been based on some new evidence casting doubt on the military's earlier conclusions. But President Trump cited no such evidence, and apparently did not even discuss his plan to ban transgender service members with senior DoD leadership, including Secretary Mattis, who had just instituted an evidence-based assessment of the military's enlistment policies. Ex. 10 (*John Kelly's Big Challenge*). This extraordinary procedural irregularity belies the legitimacy of any governmental interest Defendants may assert. *See Int'l Refugee Assistance Project ("IRAP") v. Trump*, 857 F.3d 554, 596 (4th Cir. 2017) (en banc) (proffered national security interest "is belied by evidence in the record that President Trump issued the First Executive Order without consulting the relevant national security agencies"); *Waste Mgmt. Holdings, Inc. v. Gilmore,* 252 F.3d 316, 336 (4th Cir. 2001) (discriminatory purpose shown by "the specific sequence of events leading up to the particular decision being challenged, including any significant departures from normal procedures" (internal quotation marks omitted)).

If President Trump had wanted an orderly study of the consequences of the open service policies already in place, he could have allowed the six-month study Secretary Mattis had just announced to run its course. *See* Ex. 8 (*Memorandum for Secretaries*). Indeed, the difference between Secretary Mattis's action and President Trump's Ban is stark. Whereas Secretary Mattis announced a six-month study that would "in no way presuppose the outcome of the review," *id.*, President Trump abruptly went on Twitter to preempt and prejudge his own DoD's review process. He even claimed to be "doing the military a great favor" by "coming out and just saying it." Ex. 9.

The haphazard nature of President Trump's decisionmaking is compounded by the political context in which it occurred. There was no urgency as a matter of *policy* to announce a ban on transgender service on July 26, 2017, given the past and pending studies. The urgency was entirely political: Members of Congress, bearing animus and moral disapproval toward transgender service members, tried to defund transgender medical care, but lacked the votes. *See* Ex. 11 (*Inside Trump's Snap Decision*).[8] President Trump made his abrupt announcement on Twitter immediately after direct outreach from these legislators, as this issue threatened to disrupt a spending bill that included funds for the President's desired border wall with Mexico.

[8] Even the views expressed publicly by these Members of Congress betrayed their moral disapproval and stereotype-driven views of transgender individuals. Rep. Vicky Hartzler, for example, referred to transgender service members as presenting "disturbing distractions." *House Armed Services Committee Holds Markup on the Fiscal 2018 Defense Authorization Bill,* Cong. Quarterly (June 28, 2017) (Ex. 24). Rep. Steve King referred to open service as "promoting a transgender agenda." Fraley, *Iowa Rep. Wants to Strip Military Funding for Transgender Service Members*, KCRG-TV9 (July 12, 2017) (Ex. 25). Rep. Duncan Hunter referred to service by persons who are transgender as "social experimentation" at odds with the military's "warrior culture." *Hunter Statement on Transgender Military Service Decision*, Rep. Hunter Newsroom (July 26, 2017) (Ex. 26). Rep. Trent Franks inappropriately suggested that individuals who want to serve "should probably decide whether they're a man or a woman" first. *See* Ex. 11 (*Inside Trump's Snap Decision*).

Id. This backdrop reinforces the conclusion that President Trump's "judgment," Ex. 18 (Ban) § 1(a), reflected nothing more than a desire to cater to "negative attitudes," "fear," and "irrational prejudice." *Cleburne*, 473 U.S. at 448, 450; *cf. IRAP*, 857 F.3d at 592 (stated national security interest was provided in bad faith, as pretext for religious purpose).

B. The Transgender Service Member Ban Violates the Substantive Due Process Rights of Men and Women Who Are Transgender.

The "substantive component" of due process "includes not only the privileges and rights expressly enumerated by the Bill of Rights, but [also] includes the fundamental rights 'implicit in the concept of ordered liberty.'" *Kallstrom v. City of Columbus*, 136 F.3d 1055, 1060 (6th Cir. 1998) (quoting *Roe v. Wade*, 410 U.S. 113, 152 (1973)). Government action that "shocks the conscience," *Rochin v. California*, 342 U.S. 165, 172 (1952), or "arbitrar[ily]" and "outrageous[ly]" infringes a liberty interest, violates substantive due process, *Natale v. Town of Ridgefield*, 170 F.3d 258, 262 (2d Cir. 1999).

The Transgender Service Member Ban embodies such unconstitutional conduct. "Equality of treatment and the due process right to demand respect for conduct protected by the substantive guarantee of liberty are linked in important respects." *Lawrence v. Texas*, 539 U.S. 558, 575 (2003). Singling out a group of Americans for special disfavor based solely on a matter intertwined with their "personal identity" offends their "individual dignity." *Obergefell v. Hodges*, 135 S. Ct. 2584, 2597 (2015). An arbitrary decision plainly inconsistent with all available data to exclude men and women who are transgender from military service serves no legitimate interest, and cannot be reconciled with the liberty and equality protected by the Constitution. "[T]he Fifth Amendment itself withdraws from Government the power to degrade or demean," as President Trump has done. *Windsor*, 133 S. Ct. at 2695.

President Trump's abrupt and unconsidered policy change seriously offends another basic element of due process: the right to rely on the Government's promises. Due process "may constrain the extent to which government can upset settled expectations when changing course and the process by which it must implement such changes." *Cleburne*, 473 U.S. at 471 n.22. Following the Open Service Directive, Plaintiffs and numerous other service members revealed their transgender status to their commands. The military actively encouraged them to do so in its 2016 Implementation Handbook. *See* Ex. 6 at 20. These decisions to come out as transgender, made in reliance on government assurances, cannot now be undone. President Trump's Ban breaks faith with service members who took their commanders at their word and heeded the encouragement to come forward. Using that decision as the basis for destroying these service members' careers offends the basic notions of justice that the Due Process Clause guards. *Cf. Watkins v. U.S. Army*, 875 F.2d 699, 708 (9th Cir. 1989) (finding "affirmative misconduct" by military in admitting and retaining gay service member and then attempting to discharge him on that basis); *Bartko v. SEC*, 845 F.3d 1217, 1227 (D.C. Cir. 2017) (noting that estoppel against the Government is based on egregious misconduct that "rise[s] to a constitutional level"). To hold otherwise would effectively sanction government entrapment. *See Moser v. United States*, 341 U.S. 41, 47 (1951).

C. President Trump's Ban on Surgical Care Violates 10 U.S.C. § 1074.

President Trump's decision to ban the provision of surgical care for transgender service members is unlawful for the additional reason that it violates an act of Congress. In order "to create and maintain high morale in the uniformed services," 10 U.S.C. § 1071, Congress dictated that "a member of a uniformed service . . . is entitled to medical and dental care in any facility of any uniformed service," *id.* § 1074(a)(1). Section 1074 imposes on the United States a "statutory obligation" to provide medical services. *United States v. Gov't Emps. Ins. Co.*, 461 F.2d 58, 60

(4th Cir. 1972). Surgical procedures are sometimes medically necessary for the treatment of transgender individuals who have been diagnosed with gender dysphoria. Brown ¶¶ 36–37. When that is the case, the surgery constitutes "medical care," and service members are entitled to it, just as they and other service members are entitled to and receive necessary medical care for the treatment of other conditions (*e.g.*, gall bladder surgery, laminectomy, and myriad other operations the military performs).

"When the President takes measures incompatible with the expressed or implied will of Congress, his power is at its lowest ebb." *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 637 (1952). The President cannot override a duly enacted statute by denying necessary medical care to a group of service members he happens to disfavor. *See generally Ancient Coin Collectors Guild v. U.S. Customs & Border Prot., Dep't of Homeland Sec.*, 698 F.3d 171, 179 (4th Cir. 2012); *Chamber of Commerce v. Reich*, 74 F.3d 1322, 1327 (D.C. Cir. 1996).[9]

II. Plaintiffs and Other Transgender Service Members and Transgender Persons Who Wish to Serve Will Be Irreparably Harmed Absent Grant of the Requested Relief.

President Trump's unconstitutional Ban is currently causing irreparable harm, and will cause even greater harm when its mandates take full effect on January 1 and March 23, 2018. *Cf. Nevada v. U.S. Dep't of Labor*, 218 F. Supp. 3d 520, 525, 532 (E.D. Tex. 2016) (issuing preliminary injunction during six-month delay between publication of final rule and its effective date). Without a preliminary injunction to preserve the status quo, Plaintiffs' health and careers — and the health and careers of thousands of other transgender service members and qualified individuals who wish to serve — will be irreparably harmed.

[9] Like any federal agency, DoD may not take actions that are "not in accordance with law" under the Administrative Procedure Act. 5 U.S.C. § 706(2).

a. Prior to the Ban, the military provided necessary medical care, including in some cases appropriate surgery, to service members diagnosed with gender dysphoria. Under President Trump's directive, no later than March 23, 2018, the military may not generally fund surgical care for transgender service members. *See* Ex. 18 (Ban) § 2(b) (Secretary of Defense "shall . . . halt" use of DoD resources for such surgeries); *id.* § 3 (specifying effective date of § 2(b)). In fact, this prohibition appears already to be in place: planned surgeries for Plaintiffs Cole and Doe have been cancelled. Cole ¶ 11; Doe ¶ 12.

The denial of "medical services" is "exactly the sort of irreparable harm that preliminary injunctions are designed to address." *Fishman v. Paolucci*, 628 F. App'x 797, 801 (2d Cir. 2015). Research supports the intuitive conclusion that denial of necessary medical care for individuals diagnosed with gender dysphoria leads to "adverse health outcomes." Brown, Ex. C (RAND Report) at 9–10. Plaintiffs Stone, Cole, Doe, and Gilbert, as well as other similarly situated transgender service members, are irreparably harmed by this denial of medical care. *See supra* Facts § D.

b. Prior to the Ban, DoD had established policies for the accession of new enlistees and candidates for commissions, and these new accessions were to begin on January 1, 2018. Ex. 1 (Open Serv. Dir.); Ex. 8 (*Memorandum for Secretaries*). President Trump's memorandum changes the status quo by directing that the Secretary of Defense "shall . . . maintain" the ban on "accession of transgender individuals . . . beyond January 1, 2018." Ex. 18 (Ban) § 2(a); *see also id.* § 3 (specifying effective date of § 2(a)).

Plaintiffs George and Gilbert, like numerous others who want to serve their country and are qualified to join a service, are irreparably harmed by the accession ban. Airman First Class George intends to pursue a commission as an officer in the U.S. Army Nurse Corps, George ¶ 5,

and Petty Officer Gilbert is pursuing a degree with the goal of applying to Officer Candidate School, Gilbert ¶ 7. DoD treats commissioning as a new accession under the applicable regulations and guidance. *See, e.g.*, Ex. 6 (*Handbook*) at 40–41; Brissett, *Transgender Academy Cadets Can Graduate, but Not Commission*, Air Force Magazine (May 19, 2017) (Ex. 27). Denying Plaintiffs this opportunity to further their careers and serve their country in these new capacities is irreparable injury. *See Ariz. Dream Act Coal. v. Brewer*, 855 F.3d 957, 978 (9th Cir. 2017) ("[L]oss of opportunity to pursue one's chosen profession constitutes irreparable harm.").

c. Prior to the Ban, DoD policy was that "no otherwise qualified Service member may be involuntarily separated, discharged or denied reenlistment or continuation of service, solely on the basis of their gender identity." Ex. 1 (Open Serv. Dir.); *see also* Ex. 8 (*Memorandum for Secretaries*). President Trump's memorandum rescinds this policy effective March 23, 2018. Ex. 18 (Ban) § 1(a) (describing previous policy against open service); *id.* § 1(b) (directing return to previous policy); *id.* § 3 (specifying effective date of § 1(b)). At a minimum, the military will be "authorized [to] discharge" them based on their transgender status. *Id.* § 1(a). And while DoD has been directed to submit an implementation plan concerning "how to address transgender individuals currently serving," *id.* § 3, President Trump has already dictated the endpoint of that plan: "the United States Government will not accept or allow Transgender individuals to serve in any capacity in the U.S. military." Ex. 19.

"The unconstitutional discharge of even one servicemember perpetuates a harm to that person that is irreparable." *Log Cabin Republicans v. United States*, 2012 WL 12952732, at *10 (C.D. Cal. Mar. 15, 2012). A service member facing involuntary discharge suffers at least loss of "medical benefits," as well as "the stigma of being removed from active duty . . . and labeled

as unfit for service." *Elzie v. Aspin*, 841 F. Supp. 439, 443 (D.D.C. 1993). He or she may also face the loss of retirement pay. *Id.* Here, Plaintiffs' careers would be irreparably destroyed if they are barred from continuing their service. They also face the loss of important benefits, including eligibility for promotion and health care for themselves and their dependents. *See, e.g.*, Doe ¶ 11; Gilbert ¶ 12; Stone ¶¶ 12–13.

Even if Plaintiffs are not immediately discharged on March 23, the basis of their service will fundamentally change: rather than serve under a guarantee that their transgender status will not be used against them, they will serve (if at all) under the constant threat of discharge because of that status. Plaintiffs are already experiencing significant uncertainty and stress due to the changed nature of their relationship with the military. Cole ¶ 13; Doe ¶ 12; George ¶ 15; Gilbert ¶ 13; Parker ¶ 13; Stone ¶ 14. Regardless of how Secretary Mattis fills in the details, Plaintiffs face irreparable injury both now and after March 23, 2018.

In addition to all of these harms, the violation of Plaintiffs' constitutional rights "unquestionably constitutes irreparable injury." *Elrod v. Burns*, 427 U.S. 347, 373 (1976); *see also Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012); *IRAP*, 857 F.3d at 602. President Trump has singled out transgender men and women who are fit to serve for "disparate treatment," an act of discrimination that "itself stigmatizes members of a disfavored group as innately inferior." *Evancho*, 237 F. Supp. 3d at 294. Plaintiffs' experiences of stigma, rejection, and betrayal are ongoing irreparable harms that flow directly from this unconstitutional Ban. *See* Cole ¶ 14; Doe ¶¶ 12–13; George ¶ 16; Gilbert ¶ 14; Parker ¶ 15; Stone ¶¶ 14–15.

III. The Balance of Equities and the Public Interest Favor an Injunction.

The balance of equities in this case points firmly in Plaintiffs' favor. Plaintiffs and other transgender service members have suffered and continue to face significant harm from the Transgender Service Member Ban, as do transgender individuals who otherwise meet the

qualifications to enlist or be commissioned. In light of the serious constitutional defects of the Ban, these harms necessarily take precedence in any balancing. "[T]he Government is in no way harmed by issuance of a preliminary injunction which prevents it from enforcing restrictions likely to be found unconstitutional." *IRAP*, 857 F.3d at 603 (internal quotation marks and alterations omitted).

In any event, Defendants would not be able to point to any harm they would experience if an injunction issued. Plaintiffs simply ask the Court to restore the status quo. The military applies standards to evaluate the medical fitness of all service members, including those who are transgender. An injunction would protect only those who are fit to serve by DoD's own estimation. Harm to military readiness and effectiveness would result only if the Ban were *not* enjoined. As 56 retired generals and admirals have warned, the 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." Ex. 14.

As for the enlistment of new service members, a preliminary injunction would restore the status quo under which the Open Service Directive was scheduled to take effect on January 1. If Secretary Mattis should further delay accessions or change DoD's standards following an independent review, that hypothetical agency action could then be evaluated on its own terms under the Administrative Procedure Act and the Constitution. *Cf. IRAP*, 857 F.3d at 599 n.21 ("Whether a statement continues to taint a government action is a fact-specific inquiry for the court evaluating the statement.").

CONCLUSION

All four factors decisively favor a preliminary injunction. The Transgender Service Member Ban is unconstitutional and invalid on its face, and the Court should enter a preliminary injunction prohibiting Defendants from implementing or enforcing it. *See N.C. State Conf. of*

NAACP v. McCrory, 831 F.3d 204, 238 (4th Cir. 2016) ("When discriminatory intent impermissibly motivates the passage of a law, a court may remedy the injury — the impact of the legislation — by invalidating the law."); *IRAP*, 857 F.3d at 605 (affirming nationwide injunction; "continued enforcement against similarly situated individuals would only serve to reinforce the 'message' that Plaintiffs 'are outsiders, not full members of the political community'").

Dated: September 14, 2017

Respectfully submitted,

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Exhibit 4

Transgender Military Service in the United States

by Gary J. Gates and Jody L. Herman
May 2014

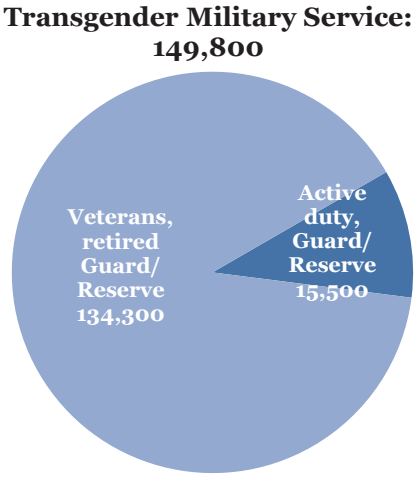
Introduction

This research brief offers analyses from several data sources to estimate the number of transgender individuals who have served in the US armed forces, including the number who are likely on active duty or serving in the Guard or Reserve forces, and the number who are veterans or retired from Guard or Reserve service.

On September 20, 2011, the military policy known as "Don't Ask, Don't Tell" (DADT) ended, allowing gay, lesbian, and bisexual service members to serve openly. Yet, military medical policies still exclude transgender people from serving openly in the US armed forces.[1] These medical policies lay out exclusions for what are deemed to be "psychosexual disorders," including transsexualism, cross-dressing, or a history of gender transition.[2] Therefore, transgender individuals who wish to join the US armed forces are prohibited from doing so if their transgender status is known. Furthermore, those already serving can be medically discharged if suspected of being transgender.

Our estimates suggest that approximately 15,500 transgender individuals are serving on active duty or in the Guard or Reserve forces. We also estimate that there are an estimated 134,300 transgender individuals who are veterans or are retired from Guard or Reserve service (see Figure 1).

Figure 1. Estimates of military service among transgender adults, by type of service.



Data and methodology

The primary data source for the estimates of transgender military service is the National Transgender Discrimination Survey (NTDS), which was conducted by the National Gay and Lesbian Task Force and the National Center for Transgender Equality.[3] This 70-item survey was distributed in cooperation with over 900 organizations across the United States and also was announced through listservs and online communities. It was made available both online and on paper in English and Spanish. The survey was fielded over six months beginning in fall 2008 and resulted in 6,546 valid responses, which is the largest sample of transgender people in the US to date.[4] Respondents answered questions about a broad array of topics, including whether they had served in the US armed forces in the following question:

[1] Kerrigan, M.F. 2012. Transgender discrimination in the military: The new Don't Ask Don't Tell. *Psychology, Public Policy, and Law* 18(3): 500–518.; Harrison-Quintana, J. and Herman, J.L. 2013. Still Serving in Silence: Transgender Service Members and Veterans in the National Transgender Discrimination Survey. *LGBTQ Policy Journal at the Harvard Kennedy School*, Volume 3, 2012-2013.

[2] Witten, T. M. 2007. *Gender identity and the military–Transgender, transsexual, and intersex-identified individuals in the U.S. Armed Forces*. Santa Barbara, CA: Palm Center.; Harrison-Quintana and Herman, *see* note #1.

[3] The NTDS defined "transgender" broadly to include those whose gender identity or expression differs from those traditionally associated with their assigned sex at birth. This includes, but is not limited to, those who self-identify as transgender, transsexual, genderqueer, gender non-conforming, and cross-dressers.

[4] Grant, J.M. et al. 2011. *Injustice at every turn: A report of the National Transgender Discrimination Survey*. Washington, DC: National Gay and Lesbian Task Force and National Center for Transgender Equality.

Have you ever been a member of the armed forces?
- ˜ Yes
- ˜ No
- ˜ I was denied entry because I am transgender/gender non-conforming

As a purposive sample of transgender adults in the US, estimates derived directly from the NTDS could be biased if the true demographic characteristics of the transgender population differ from the characteristics of transgender respondents to the survey. For example, relative to the US population, NTDS respondents are younger and report higher levels of education. Both factors would be associated with lower levels of lifetime military service. Given the lack of demographic data on the transgender population derived from population-based sources, it is not possible to determine if the age and educational attainment levels of NTDS respondents are different from the general US population because younger and more educated transgender individuals were more likely than others to have completed the survey (known as selection bias) or if transgender individuals are, in fact, younger and more likely to have higher levels of education compared to the general population.[5]

More than 93% of NTDS respondents provided information using an online web-based survey. Samples from online surveys are often biased toward more educated respondents. Reisner and colleagues (2014) found that NTDS respondents who used paper survey forms tended to report lower income and educational levels.[6] It is possible that the web-based approach of the NTDS contributed to selection bias toward higher education, which would result in a bias toward lower military service.

To address these possible biases, the estimates of military service among the transgender population in these analyses adjust the characteristics of NTDS respondents such that they have the age and educational attainment patterns of the US population. Military service rates also differ by race and ethnicity. Unfortunately, the race and ethnicity categories used in the NTDS are not consistent with those used in Census Bureau surveys. Educational attainment, like race and ethnicity, captures some of the variation in socio-economic status which may contribute to differences in military service rates.

This adjustment effectively assumes that being transgender is not associated with age or educational attainment. It also leads to estimates of military service rates for the transgender population that are slightly higher than the unadjusted calculations from the NTDS, which includes younger and more educated individuals who are less likely to report military service than older or less educated individuals. Alternatively, if the NTDS age and educational patterns are actually reflective of the transgender population in the US, then the adjustment procedure would produce estimates of transgender military service that may be higher than true military service rates among transgender individuals.

Population age and educational attainment data are derived from analyses of the US Census Bureau's 2011 American Community Survey.

The estimation procedure also assumes that NTDS respondents who report that they were assigned male at birth share the age and educational attainment patterns of the adult male population in the US while NTDS respondents that were assigned female at birth share the patterns of the adult female population. We make this assumption and report differences based on the sex assigned at birth because it is likely that most transgender veterans and service members would have entered and served in the military according to their sex assigned at birth. Estimates for the total number of transgender individuals who are currently or have ever served in the military are derived separately for those assigned male at birth (approximately 60% of the total NTDS sample) and those assigned female at birth (approximately 40% of the total NTDS sample).

Men are substantially more likely than women to serve in the US military. The estimates of transgender military service assume that, consistent with findings from the NTDS, approximately 60% of the transgender population was assigned male at birth while 40% was assigned female at birth. If, in fact, the transgender population is comprised of a larger portion of individuals assigned male at birth, then the estimation procedure likely understates

[5] Several studies have found higher levels of education among transgender individuals. These include: Xavier, J., Hannold, J.A., and Bradford, J. 2007. *The Health, Health-related Needs, and Lifecourse Experiences of Transgender Virginians*. Richmond, VA: Virginia HIV Community Planning Committee and Virginia Department of Health; Hartzell, E., Frazer, M. S., Wertz, K. and Davis, M. 2009. *The State of Transgender California: Results from the 2008 California Transgender Economic Health Survey*. San Francisco, CA: Transgender Law Center; Jenness, V., Sexton, L., Sumner, J. 2011. *Transgender Inmates in California's Prisons: An Empirical Study of a Vulnerable Population*. Report submitted to the California Department of Corrections and Rehabilitation, State of California. Sacramento, California.

[6] Reisner, S.L., Conron, K., Scout, Mimiaga, M.J., Haneuse, S., Austin, S.B. 2014. Comparing In-Person and Online Survey Respondents in the U.S. National Transgender Discrimination Survey: Implications for Transgender Health Research . *LGBT Health* 1(2): 98-106.

transgender military service. Conversely, if those assigned female at birth are actually a larger proportion of the transgender population, then the estimation procedure may overstate transgender military service.

The estimation begins by calculating the percent of NTDS respondents who report military service by their age and educational attainment status. Respondents are separated into five age categories and five educational attainment categories as follows:

- Age (a)
  - 18-24
  - 25-44
  - 45-54
  - 55-64
  - 65 and older
- Education (e)
  - Less than high school
  - High school diploma
  - Some college
  - College degree
  - Graduate degree

The percent of NTDS respondents who report service in the armed forces is calculated for those in each age/education category (mil_{ae}). Data from the 2011 American Community Survey Public Use Microdata Sample (ACS PUMS) are used to calculate the percent of adults age 18 and older who are within each age and education category (p_{ae}).

The adjusted estimate for transgender military service MIL_{adj} determines what the military service patterns of NTDS respondents (separated by sex assigned at birth) would be if they had the same age and educational attainment levels of the male and female population in the US by calculating a weighted average as follows:

$$MIL_{adj} = \sum^{a,e} (mil_{ae} \times p_{ae})$$

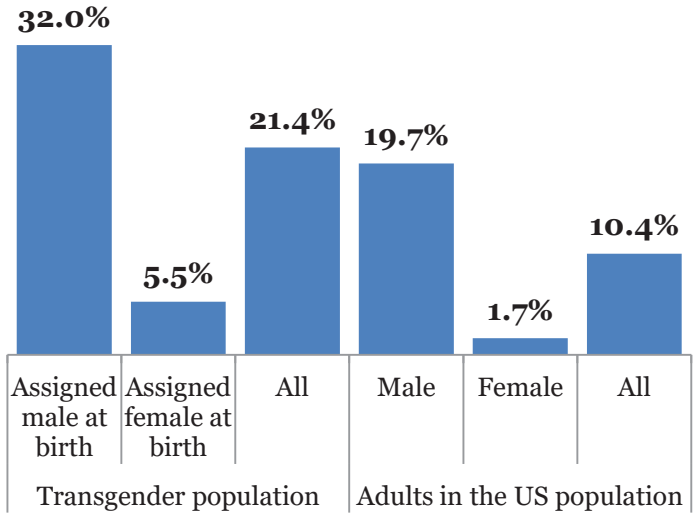
In the US, approximately 5.8% of all adults who have ever served in the armed forces are currently on active duty and 4.4% are now serving in the Guard or Reserve. An estimated 86.8% are veterans who served on active duty in the past and 3.0% are retired from Guard or Reserve service.[7] The number of transgender adults in each category is estimated by applying these same proportions to the estimated number of transgender individuals who report any service in the armed forces.

Transgender military service

Analyses of the unadjusted NTDS data show that 29.6% of respondents assigned male at birth reported that they have served in the armed forces along with 6.0% of those assigned female at birth. In total, 20% of NTDS respondents reported some type of military service.

Assuming NTDS reported rates of military service are true of the transgender population in the US, Figure 2 shows adjusted estimates of military service for the transgender population (separated by sex assigned at birth) and for adult men and women in the US. When figures are adjusted such that the age and educational patterns of the US adult male and female population are applied to the NTDS sample, an estimated 21.4% of transgender individuals have served in the military. The adjusted estimates suggest that 32.0% of those assigned male at birth and 5.5% of those assigned female at birth have served.

Figure 2. Adjusted estimates of service in the armed forces among transgender individuals and estimates of service by adults in the US, by sex or sex assigned at birth.



By comparison, approximately 10.7% of adults in the US have served. This implies that transgender

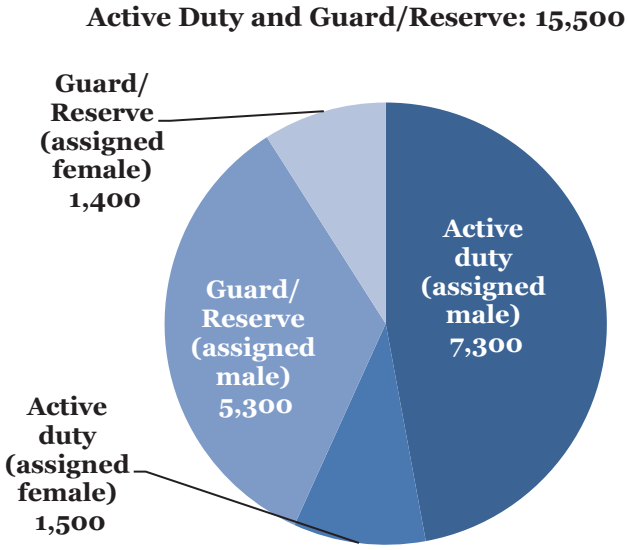
[7] The US Census Bureau's 2012 Statistical Abstract, Table 511 reports that 1,481,000 individuals are on active duty in the US military. Table 513 indicates that approximately 1.1 million individuals are serving in the Ready, Standby, and Retired Reserve forces. Findings from the 2011 American Community Survey, as reported on the US Census Bureau's American Factfinder, Table B21002, show that an estimated 21.5 million Americans are civilian veterans. It should be noted that estimates of the number of veterans and reservists may not be mutually exclusive as some reservists may be veterans with prior service on active duty in the military.

individuals are about twice as likely as adults in the US to have served their country in the armed forces. Transgender individuals assigned female at birth are nearly three times more likely than all adult women and those assigned male at birth are 1.6 times more likely than all adult men to serve.

Gates (2011) estimates that approximately 700,000 adults in the US are transgender.[8] If, like in the NTDS, this group is 60% male assigned at birth and 40% female assigned at birth, then the estimates above imply that there are approximately 150,000 transgender adults in the US who are now serving or who have served in the armed forces.

In the US, 5.4% of men who report any military service are on active duty along with 9.8% of women. Applying these figures to the estimates of transgender military service would imply that approximately 8,800 transgender individuals are currently on active duty, of whom nearly 7,300 are assigned male at birth and about 1,500 are assigned female at birth. The estimates also suggest that 6,700 transgender individuals are serving in the Guard or Reserve forces, of whom 5,300 are assigned male at birth and 1,400 are assigned female at birth (see Figure 3).

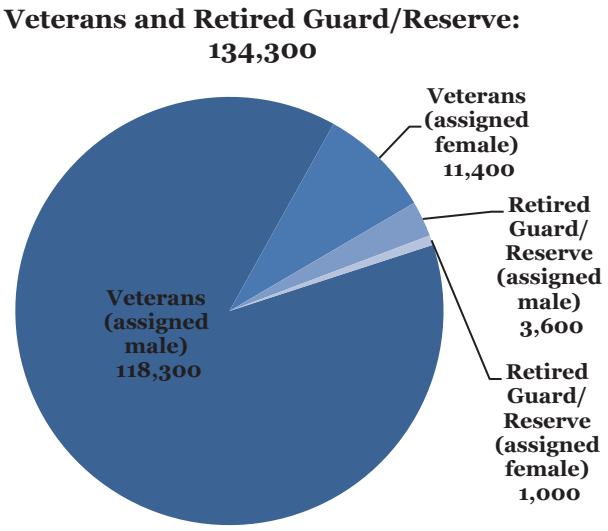
Figure 3. Estimates of active duty and Guard/Reserve service among transgender adults, by type of service and sex assigned at birth.



[8] Estimates of the size of the transgender population from national population-based surveys do not exist. This estimate is based on two state-level population-based surveys in which questions regarding transgender status implied a gender transition or at least discordance between sex at birth and current gender presentation.

The estimates also suggest that there are more than 134,000 transgender individuals in the US who are veterans or have retired from Guard or Reserve service (see Figure 4).

Figure 4. Estimates of veterans and retired Guard/Reserve service among transgender adults, by type of service and sex assigned at birth.



These estimates imply that approximately 0.6% of adults who report service in the armed forces are transgender.

Discussion

Data that allow for a direct tabulation of the number of transgender individuals who serve in the US military simply do not exist. The estimates in this research brief rely on a variety of assumptions that could affect their accuracy.

Men are more likely to serve in the military than are women. If individuals assigned male at birth are, in fact, more than 60% of the transgender population, then transgender military service is likely understated in these estimates. Conversely, if those assigned female at birth represent more than 40% of the transgender population, then estimates of transgender military service are likely overstated.

The estimates also assume that the transgender population shares the age and educational attainment characteristics of the US population. If the true transgender population is younger and more educated than the US population (consistent with the NTDS sample), then the estimates could be overstating transgender military service.

Despite these possible biases, the estimates certainly suggest that transgender individuals are part of the

US armed forces, perhaps in portions that exceed that of the general population.

There is other evidence that transgender individuals represent a larger portion of those in the military than their proportion among adults in the US population. In a survey of transgender people assigned male at birth, Shipherd et al. found that 30 percent had served in the military, which is similar to military service among transgender people assigned male at birth in the NTDS.[9] A recent study by Blosnich et al. reviewed all health records of veterans receiving health care through the Veterans Health Administration (VHA) from 2000 through 2011 and found a prevalence of Gender Identity Disorder (GID) five times that of the US general population.[10] Though individuals with GID diagnoses may or may not identify as transgender, the substantially higher prevalence of GID among veterans in the VHA system provides further evidence that transgender people are over-represented in the US military.

About the authors

Gary J. Gates, PhD is the Williams Distinguished Scholar and a national expert in the demographic, geographic, and economic characteristics of the LGBT population.

Jody L. Herman, PhD, is the Peter J. Cooper Public Policy Fellow and Manager of Transgender Research at the Williams Institute, UCLA School of Law.

Acknowledgements

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[9] Shipherd, J.C., Mizock, L., Maguen, S., and Green, K.E. 2012. Male-to-female transgender veterans and VA health care utilization. *International Journal of Sexual Health* 24(1): 78–87.
[10] Blosnich, J.R., Brown, G.R., Shipherd, J.C., Kauth, M. PhD, Piegari, R.I., and Bossarte, R.M. 2013. Prevalence of Gender Identity Disorder and Suicide Risk Among Transgender Veterans Utilizing Veterans Health Administration Care. *American Journal of Public Health* 103(10): e27-e32. "Gender Identity Disorder" was removed for the *DSM-V*, which now includes "gender dysphoria."

For more information

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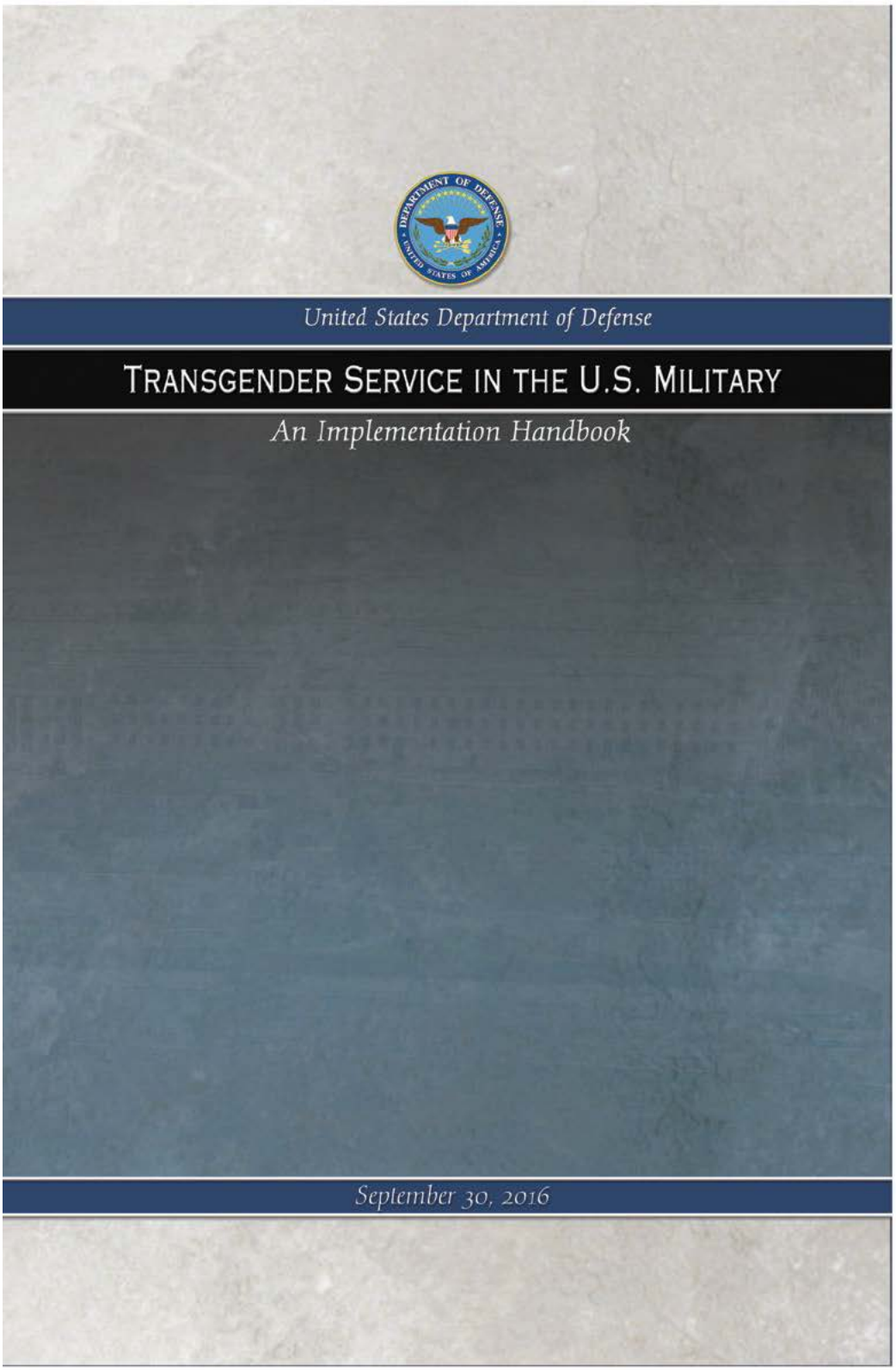
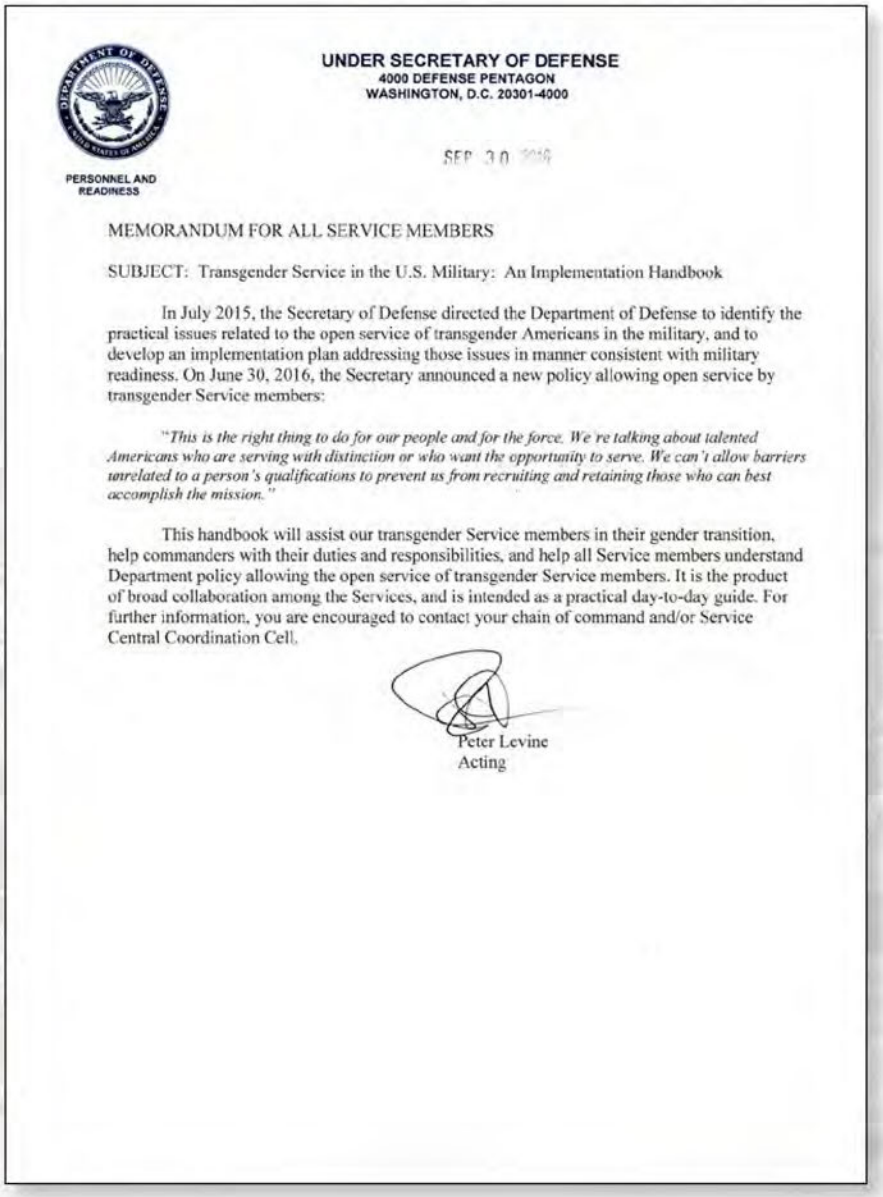
Citation

Gates, GJ and Herman, JL. 2014. Transgender Military Service in the United States. Williams Institute, UCLA School of Law.

Exhibit 6


United States Department of Defense
TRANSGENDER SERVICE IN THE U.S. MILITARY
An Implementation Handbook
September 30, 2016



UNDER SECRETARY OF DEFENSE
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PERSONNEL AND READINESS

SEP 30 2016

MEMORANDUM FOR ALL SERVICE MEMBERS

SUBJECT: Transgender Service in the U.S. Military: An Implementation Handbook

In July 2015, the Secretary of Defense directed the Department of Defense to identify the practical issues related to the open service of transgender Americans in the military, and to develop an implementation plan addressing those issues in manner consistent with military readiness. On June 30, 2016, the Secretary announced a new policy allowing open service by transgender Service members:

"This is the right thing to do for our people and for the force. We're talking about talented Americans who are serving with distinction or who want the opportunity to serve. We can't allow barriers unrelated to a person's qualifications to prevent us from recruiting and retaining those who can best accomplish the mission."

This handbook will assist our transgender Service members in their gender transition, help commanders with their duties and responsibilities, and help all Service members understand Department policy allowing the open service of transgender Service members. It is the product of broad collaboration among the Services, and is intended as a practical day-to-day guide. For further information, you are encouraged to contact your chain of command and/or Service Central Coordination Cell.

Peter Levine
Acting

TRANSGENDER SERVICE IN THE U.S. MILITARY

An Implementation Handbook

September 30, 2016

TABLE OF CONTENTS

TRANSGENDER SERVICE IN THE US MILITARY:

An Implementation Handbook

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…Starting today: Otherwise qualified Service members can no longer be involuntarily separated, discharged, or denied reenlistment or continuation of service just for being transgender.

—Statement by Secretary of Defense Ash Carter[1]

1 U.S. Secretary of Defense Ash Carter, "Secretary of Defense Ash Carter Remarks Announcing Transgender Policy Changes," June 30, 2016.

BACKGROUND

The handbook is designed to assist our transgender Service members in their gender transition, help commanders with their duties and responsibilities, and help all Service members understand new policies enabling the open service of transgender Service members. The handbook includes advice, questions and answers, and scenarios.

This handbook outlines some of the issues faced by commanders, transgender Service members, and the Military Services; it does not have all of the solutions – individual circumstances will vary. It is an administrative management tool, and is not a health management tool or policy document. Additional key parts of this handbook include: Annex A, which contains questions and answers to help with understanding specific terms and words; Annex B, which provides step-by-step details of the gender transition process; Annex C, which highlights situation-based scenarios that may be useful for training situations; and Annex D, which provides links to additional resources. For specific policies refer to Department of Defense Instruction (DoDI) 1300.28,[2] Directive-type Memorandum (DTM) 16-005,[3] Service policies, and/or Service Central Coordination Cells (SCCC).[4]

2 DoD Instruction (DoDI) 1300.28, "In-Service Transition for Service Members Identifying as Transgender," June 30, 2016.

3 Directive-type Memorandum (DTM), 16-005, "Military Service of Transgender Service Members," June 30, 2016.

4 See Annex D for SCCC contact information.

INTRODUCTION

Sex and gender are different. Sex is whether a person is male or female through their biology. Gender is the socially defined roles and characteristics of being male and female associated with that sex. There are a number of people for whom these associations do not match. This feeling may arise in childhood, adolescence or adulthood and may result in gender dysphoria. Sometimes people's gender identity does not match their sex at birth.

Gender dysphoria is a medical diagnosis that refers to distress that some transgender individuals experience due to a mismatch between their gender and their sex assigned at birth. The condition can manifest in a person as strong and persistent cross-gender identification and a discomfort with their biological sex, or a sense of inappropriateness in the gender role of that sex. Transgender Service members may face challenges centered on their own personal situation and/or others' unfamiliarity with gender identity issues.

POLICY

In July 2015, the Secretary of Defense directed the Department of Defense to identify the practical issues related to transgender Americans serving openly in the military and to develop an implementation plan that addresses those issues consistent with military readiness. On June 30, 2016, the Secretary announced a new policy[5] allowing open service of transgender Service members and outlined three reasons[6] for this policy change:

- The Army, Navy, Air Force, Marine Corps, and Coast Guard need to avail themselves of all available talent in order to remain the finest fighting force the world has ever known. The mission to defend this country requires that the Services do not have barriers unrelated to a person's qualification to serve or preventing the Department of Defense (DoD) from recruiting or retaining Service members.
- There are transgender Service members in uniform today. DoD has a responsibility to them and their commanders to provide clearer and more consistent guidance.
- Individuals who want to serve and can meet the Department's standards should be afforded the opportunity to compete to do so.

This handbook will explain the framework by which transgender Service members may transition gender while serving.

5 DoDI 1300.28 and DTM 16-005.

6 U.S. Secretary of Defense Ash Carter Remarks, June 30, 2016.

TERMS AND DEFINITIONS

The following terms are associated with open service by transgender individuals. The list is not all-inclusive. The definitions are consistent with those in the new policy.

Cross-sex hormone therapy. The use of feminizing hormones in an individual assigned male at birth based on traditional biological indicators or the use of masculinizing hormones in an individual assigned female at birth. A common medical treatment associated with gender transition.

Gender dysphoria. A medical diagnosis that refers to distress that some transgender individuals experience due to a mismatch between their gender and their sex assigned at birth.

Gender identity. One's internal or personal sense of being male or female.

Gender marker. Data element in the Defense Enrollment Eligibility Reporting System (DEERS) that identifies a Service member's gender. A Service member must meet all military standards associated with the member's gender marker in DEERS and use military berthing, bathroom, and shower facilities in accordance with the DEERS gender marker.[7]

Gender transition is complete. A Service member has completed the medical care identified or approved by a military medical provider in a documented medical treatment plan as necessary to achieve stability in the preferred gender.

Gender transition process. Gender transition in the military begins when a Service member receives a diagnosis from a military medical provider indicating that the member's gender transition is medically necessary, and concludes when the Service member's gender marker in DEERS is changed and the member is recognized in the preferred gender.

Human and functional support network. Support network for a Service member that may be informal (e.g., friends, family, co-workers, social media.) or formal (e.g., medical professionals, counselors, clergy).

---

7 While the gender marker change is reflected in DEERS, the Services' personnel data systems are the means to input gender; as such, the remainder of this handbook refers to 'Services' personnel data systems'.

Medically necessary. Those health care services or supplies necessary to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medical care.

Non-urgent medical care. The care required to diagnose and treat problems that are not life or limb threatening or that do not require immediate attention.

Preferred gender. The gender of a transgender Service member when gender transition is complete and the gender marker in DEERS is changed.

Real life experience (RLE). The phase in the gender transition process when the individual commences living socially in the gender role consistent with their preferred gender. RLE may or may not be preceded by the commencement of cross-sex hormone therapy, depending on the individual gender transition medical treatment plan. The RLE phase is also a necessary precursor to certain medical procedures, including gender transition surgery. RLE generally encompasses dressing in the new gender, as well as using preferred gender berthing, bathroom, and shower facilities.[8]

Service Central Coordination Cell (SCCC). Service-level cell of experts created to provide multi-disciplinary (e.g., medical, legal) advice and assistance to commanders with regard to service by transgender Service members and gender transition in the military.[9]

Stable in the preferred gender. Medical care identified or approved by a military medical provider in a documented medical treatment plan is complete, no functional limitations or complications persist, and the individual is not experiencing clinically significant distress or impairment in social, occupational, or other important areas of functioning. Continuing medical care, including but not limited to cross-sex hormone therapy, may be required to maintain a state of stability.

Transgender Service member. A Service member who has received a medical diagnosis indicating that gender transition is medically necessary, including any Service member who intends to begin transition, is undergoing transition, or has completed transition and is stable in the preferred gender.

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8 RLE intended to occur off duty; however, exceptions to policy may be granted. Consult Service policy for specifics.

9 A complete listing with SCCC contact information can be found at Annex D.

THE BASICS

Sex and gender are different. Sex is the assignment made at birth as male or female, based on anatomy. Gender identity is an individual's internal sense of being male or female. Gender role or expression is the socially defined roles and characteristics of being male and female associated with that sex. For most people, gender identity and expression are consistent with their sex assigned at birth. However, in transgender individuals, gender identity and/or expression differs from their sex assigned at birth.

Gender dysphoria is a medical diagnosis that refers to distress that some transgender individuals experience due to a mismatch between their gender and their sex assigned at birth.

Broadly, the term "transgender person" refers to individuals whose internal sense of being male or female (gender identity) is different from the sex they were assigned at birth. Some transgender individuals feel compelled to align their external appearance with their gender identity and undergo transition to the preferred gender. Gender transition care is individualized and can include psychotherapy, hormone therapy, RLE, and sex reassignment surgery.

Traditionally, society has had little understanding of what it means to transition gender. Many transitioning people have been subjected to hostility, ridicule, and discrimination. Every person has the right to have their gender identity recognized and respected, and all Service members who receive a diagnosis that gender transition is medically necessary will be provided with support and management to transition, within the bounds of military readiness.

Gender transition is the process a person goes through to live fully in their preferred gender. Gender transition in the military may present challenges associated with addressing the needs of the Service member while preserving military readiness. The oversight and management of the gender transition process is a team effort with the commander, the Service member, and the military medical provider (MMP). DoD values the contributions of all Service members and tries to ensure all are as medically ready as possible throughout their service. Individual readiness is a key to Total Force readiness.

Gender Transition Approval Process Overview

Gender transition is highly individualized. Figure 1 outlines the main components. Generally, the gender transition process includes:

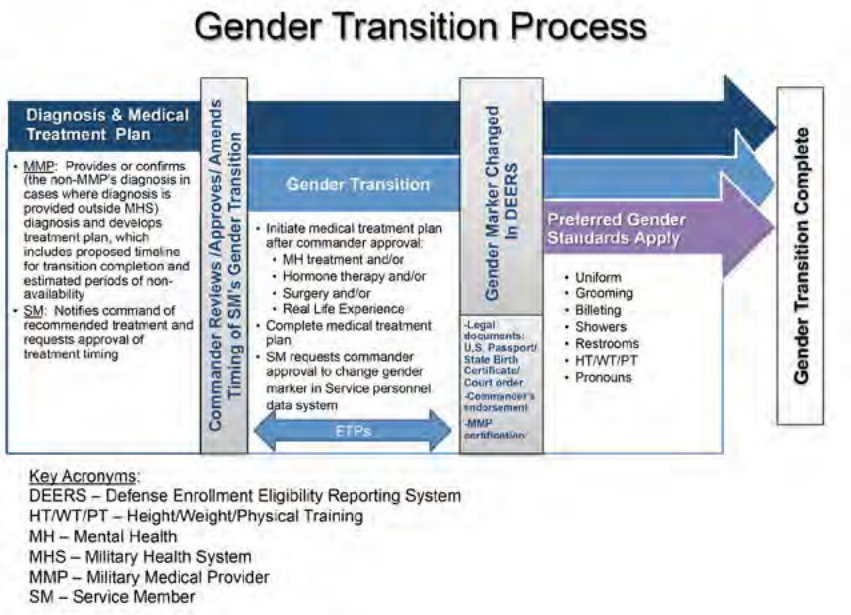
- Diagnosis and medical treatment plan received from or validated by an MMP;
- Gender transition (initiate medical treatment plan, complete medical treatment plan, Service member requesting gender marker change); and
- Compliance with gender standards post-gender marker change.

The process depicted is only a framework and Service members may progress on varying timelines. The commander, informed by the recommendations of the MMP, the SCCC, and others, as appropriate, will respond to the request to transition gender while ensuring readiness by minimizing impacts to the mission (including deployment, operations, training, exercise schedules, and critical skills availability), as well as to the morale and welfare and good order and discipline of the command.

Within this framework, the commander plays a key role in making recommendations and taking action on:

- The timing of medical treatment associated with gender transition;
- Timing of RLE (e.g., non-duty hours, duty hours with an exception to policy (ETP))
- Requested ETPs associated with gender transition; and
- A change to the Service member's gender marker in their Service's personnel data system.

Figure 1: Gender Transition Process



Key Acronyms:
DEERS – Defense Enrollment Eligibility Reporting System
HT/WT/PT – Height/Weight/Physical Training
MH – Mental Health
MHS – Military Health System
MMP – Military Medical Provider
SM – Service Member

FOR THE TRANSGENDER SERVICE MEMBER

"…the reality is that we have transgender Service members serving in uniform today, and I have a responsibility to them and their commanders to provide them both with clearer and more consistent guidance than is provided by current policies."

—Statement by Secretary of Defense Ash Carter[10]

DoD's revised transgender Service member policy ensures your medical care is brought into the military health system (MHS), protects your privacy when receiving medical care, and establishes a structured process whereby you may transition gender when medically necessary.

In-Service Transition

Gender transition in the military begins when you receive a diagnosis from an MMP indicating that gender transition is medically necessary and concludes when you change your gender marker in your Service's personnel data system. Your commander is a critical part of your transition and much of this section will highlight his/her role. The table below outlines responsibilities for both Active and Reserve Component Service members requesting in-service transition. To make a request, you must:

10 U.S. Secretary of Defense Ash Carter Remarks, June 30, 2016.

Active Component & Reserve Component Uniformed Full-Time Support Personnel	Reserve Component (All Others)
1. Secure a medical diagnosis and a medical treatment plan from your MMP. If the diagnosis and treatment plan are from a non-military medical provider (non-MMP), you are required to notify your MMP at the earliest practical opportunity to bring your care into the MHS. Your MMP will review, and if appropriate validate the non-MMP's diagnosis and treatment plan.	1. Secure a medical diagnosis and a medical treatment plan from your non-MMP.
2. Notify your commander of the diagnosis and medical treatment plan indicating that gender transition is medically necessary. Work with your commander and your MMP to develop a transition plan that includes a timeline for treatment and an estimated date for a change of your gender marker in your Service's personnel data system.	2. Notify your commander of the diagnosis and medical treatment plan, indicating that gender transition is medically necessary. Work with your commander to have an MMP validate the non-MMP's diagnosis and treatment plan and develop a transition plan that includes a timeline for treatment and an estimated date for a change of your gender marker in your Service's personnel data system.
3. Notify your commander of any changes to the medical treatment plan, the projected schedule for such treatment, any exceptions to policy (ETP) you may request, and the estimated date on which your gender marker would be changed in your Service's personnel data system.	3. Same as AC.
4. Obtain one of the following to change your gender marker in your Service's personnel data system: ■ A certified true copy of a state birth certificate reflecting your preferred gender; or ■ A certified true copy of a court order reflecting your preferred gender; or ■ A U.S. Passport reflecting your preferred gender.	4. Same as AC.

Active Component & Reserve Component Uniformed Full-Time Support Personnel	Reserve Component (All Others)
5. Obtain your MMP's confirmation that gender transition is complete.[11]	5. Obtain a non-MMP confirmation that your gender transition is complete, then validate with an MMP (in concert with commander).
6. Obtain written approval from your commander to change your gender marker in your service's personnel data system.	6. Same as AC.
7. Submit paperwork to your personnel administrative office once you have all the required documentation and your commander's written approval to obtain your gender marker change.	7. Same as AC.
8. Meet all applicable military standards in your preferred gender (to include using military berthing, bathroom, and shower facilities), when your gender marker is changed in your Service's personnel data system.	8. Same as AC.
9. Adhere to the ongoing medical treatment plan developed by your MMP to address continuing medical needs, including follow-up visits related to continuous hormone treatment and routine health screening.[12]	9. Adhere to the ongoing medical treatment plan developed by your non-MMP to address continuing medical needs, including follow-up visits related to continuous hormone treatment and routine health screening.

11 In DoDI 1300.28, gender transition is complete when a Service member has completed the medical care identified or approved by a military medical provider in a documented medical treatment plan as necessary to achieve stability in the preferred gender.

12 The MMP (or non-MMP, if you are not on active duty) may determine certain aspects of your medical care and treatment to be medically necessary, even after your gender marker is changed in your Service's personnel data system (e.g., cross-sex hormone therapy). A gender marker change does not prohibit you from receiving further care and treatment.

Communication

It is vital that you are open and honest with your leadership when discussing the gender transition process. This will enable you to convey your needs as well as address any questions or concerns from your leadership.

Communication with colleagues is equally important as they may not be familiar or comfortable with gender transition. It is important to remember that while you have had many months, probably years, to understand your need to transition, this may be the first time your colleagues have encountered gender transition. They may have difficulty understanding the reasons and the process.

There are many ways to respectfully disclose your gender identity to your colleagues. How and when you wish to tell your coworkers is something you will need to discuss with your commander and/or your MMP. It is important to state what information you are open to discussing and what information you wish to remain private. Communication strategies could include:

- Ask your leadership to convene a unit meeting and make an announcement on your behalf. Have health professionals and/or chaplains available to answer questions;
- Share a letter from you with your unit;
- Distribute a letter or notification via email; and/or
- Make the announcement in person at a unit meeting.

Finding a Mentor

Similar to seeking a mentor to assist and guide in career/professional development, it may be advisable to seek a mentor to assist you in your transition. A mentor should be someone familiar with the process you are undertaking. If possible, choose someone from your peer group or military pay grade. If you cannot find your own potential mentor(s), consider seeking recommendations from your commander, a chaplain, or medical professional. Below are some areas where a mentor may be beneficial:

- Providing advice on military issues related to the correct wear of your preferred gender uniform and related grooming issues;
- Being a supportive sounding board;

- Providing frank and honest advice; and
- Being a unit point of contact, or conduit, for questions from the workplace related to gender transition.

Considerations

Below are some career considerations that you may wish to take into account.

Period of Adjustment
Early on in your transition you may need to consider that adjusting your appearance and grooming can take some time. During this period of transition, it may be appropriate to discuss periods of authorized absence with your commander and the MMP.

For most of your transition, you should not need to use convalescent leave; however, you may require some time to recover from certain medical or surgical treatments. Accordingly, when convalescent leave is recommended, ensure you have coordinated with your unit leadership, administrative personnel, and medical personnel.

Impact Transitioning May Have on Your Career
Transitioning gender may have an impact on several different aspects of your career including deployability, assignment considerations, medical classification, and aspects of individual readiness (e.g., physical fitness, body composition assessment, and professional military education attendance). Since the impact to your career could be significant, it is strongly recommended you discuss this with your commander and/or mentor.

Assignments
You may need to discuss with your MMP and commander whether you want to transition while in your current unit or upon arrival at a new unit. There are advantages and disadvantages to both. The latter has the advantage of leaving your old life at your last duty station and arriving at your next assignment ready to start your new life. However, the disadvantage is that you will have to re-establish your support network in the new location.

Completing transition within a normal Permanent Change of Station cycle of 3-4 years is possible, but may or may not be desirable depending on your circumstances. Below are some issues to consider:

- Specialized medical care may not be available at all duty locations. Assignments near installations with such care may need to be considered;
- Moving locations means potentially moving away from a stable environment, including medical specialists and social support. However, making a fresh start may be easier for some transitioning members;
- Your duty locations may impact decisions about when to commence RLE in your preferred gender; and
- Not all duty assignments will be able to support a gender transition.

Individual Medical Readiness (IMR)

Medical care for gender transition is managed in the same way as other medical conditions. You may be non-deployable for some periods during your gender transition process. It is your responsibility to inform your leadership regarding your medical condition when, as a result of any medical treatment, you will be or have become non-deployable.[13]

Physical Readiness Testing (PRT)

PRT is a fundamental requirement of your military service. You are required to meet the PRT standards based upon your gender marker in your Service's personnel data system and in accordance with Service regulations. Similar to other circumstances where Service members may not meet standards, it is important that you consult regularly with your MMP to ensure you can meet standards (i.e., fitness). If you are unable to meet the standards, it may be necessary to request an ETP.

Privacy

Maintaining dignity and respect for all is important. You will need to consider both your own privacy needs and the privacy needs of others. This includes, but is not limited to, maintaining personal privacy in locker rooms, showers, and living quarters. One strategy might include adjusting personal hygiene hours. If you have concerns, you are encouraged to discuss them with your chain of command.

Military Records

Your records prior to transition (e.g., awards, performance evaluations) are historical and will not be changed after completion of your gender transition.

13 DoDI 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014.

Your Service has a board process that may consider changes to historical military records.[14] All records generated after your Service's personnel data system gender marker is changed will reflect your preferred gender.

Expectation Management
The military developed a process to allow you to transition gender while you serve. Keep the lines of communication open and be patient with the process. Your timeline may need to be flexible due to operational requirements.

Tips for Transitioning Service Members

The following tips have been provided by Service members from an allied foreign military who have transitioned gender.[15]

- Honesty. "If you wish to be respected you must also give that same respect to your coworkers up and down the chain. How you treat others and inform others will be directly related to the way you are treated. It is incredibly hard to open up and trust people with a personal secret you have probably carried for your entire adult life; however from my experiences if you keep an open-door philosophy and answer honest questions with polite and clear non-emotional detail, most will accept and understand."

- Be professional. "The hormones you may [take] to change will have a varied and perhaps profound effect on not only your physical body, but more importantly your emotional stability. Try not to allow this to cloud or affect your judgement, it will be hard for some to see this happening, trust in your friends when they point out little slips and errors in your emotional well-being, they have your interests at heart!"

- Empower those around you. "Knowledge equals power which equals understanding; empowering those around you to understand will help them feel less threatened and confused, which can assist in being treated with respect and understanding rather than confusion and possibly even contempt and hostility."

- Be confident. "Know yourself, make as much effort as possible to be part of the team and not hide or be hidden away to avoid embarrassment. Stepping

14 See Annex D for a list of Service links to boards for correction of military records.

15 Australian Air Force, Air Force Diversity Handbook: Transitioning Gender in the Air Force, April 2013, 19.

out in to the work arena will be hard, but the sooner you face this challenge the sooner your well-being can return."

- Trust. "Trusting others when you're vulnerable is hard for most serving people. We are proud, strong, and generally rather too stubborn to allow others to take charge of us when we feel we can manage ourselves. The problem is you may not understand all that is happening around you, particularly with your coworkers. So listen and trust in your commanders based on their good sound knowledge."
- Planning. "Map out your transition as best you can, try and forecast as much as possible and pass this on to the relevant commanders. Learn and understand not only what's happening now in your world, but look and think about where you will be and what you may need."

FOR THE COMMANDER

"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."

—Statement by Secretary of Defense Ash Carter[16]

The Commander's Impact

In the course of your duties, you may encounter a transgender Service member who wants to transition gender. It is important that you are aware of your obligations and responsibilities with regard to the support and management of Service members who are transitioning gender. You are responsible and accountable for the overall readiness of your command. You are also responsible for the collective morale and welfare and good order and discipline of the unit and for fostering a command climate where all members of your command are treated with dignity and respect.

Commander's Roles and Responsibilities

In-Service Transition

When you receive a request from a Service member for medical treatment or an ETP associated with gender transition, you must consider the individual needs associated with the request and the needs of your command. The table below outlines your responsibilities for Active and Reserve Component Service members requesting in-service transition. In making a decision on the request, your responsibilities include:

16 U.S. Secretary of Defense Ash Carter Remarks, June 30, 2016.

Active Component & Reserve Component Uniformed Full-Time Support Personnel	Reserve Component (All Others)
1. Complying with the provisions of DoDI 1300.28[17] and with Military Department and Service regulations, policies, guidance, and with your SCCC, as appropriate.	1. Same as AC.
2. Evaluating a Service member's request to transition gender. Ensure, as appropriate, a transition process that: ■ Considers the individual facts and circumstances presented by the Service member; ■ Considers military readiness and impacts to the mission (including deployment, operations, training, and exercise schedules, and critical skills availability), as well as to the morale and welfare and good order and discipline of the unit; ■ Is consistent with the medical treatment plan generated or validated by the MMP; and incorporates consideration of other factors, as appropriate.	2. A Service member will likely provide a diagnosis and medical treatment plan from a non-MMP. In this instance, it still must be validated by the MMP. Consult your chain of command for guidance, if required. You must still evaluate Service member's request in light of the 3 bullets in the active duty column.
3. Reviewing a Service member's request for completeness.[18] If you determine the request to be incomplete, you must return it to the Service member, with written notice of the deficiencies identified, as soon as practicable, but not later than 30 days after receipt.	3. Same as AC.

17 DoDI 1300.28.

18 Refer to Figure 1 and Service policy for completeness determination; in all cases, it will include: completed medical treatment plan and commander approval of request.

Active Component & Reserve Component Uniformed Full-Time Support Personnel	Reserve Component (All Others)
4. Responding to any requests for medical treatment or an ETP[19] associated with gender transition, as soon as practicable, but not later than 90 days after receiving a request determined to be complete. Your response shall: ■ Be in writing; including notice of any actions taken by you; and ■ Be provided to both the Service member and their MMP.	4. Same as AC.
5. At any time prior to the change of the Service member's gender marker in Service's personnel data system, you may modify a previously approved approach to, or an ETP associated with, gender transition.	5. Same as AC.
6. Approving in writing[20] the request to change a Service member's gender marker in your Service's personnel data system upon receipt of the recommendation by the MMP and the requisite legal documentation from the Service member. The Service member is then able to take the approval and the legal documentation to the personnel administrative office to obtain the change to the gender marker.	6. Ensuring non-MMP's statement of completion is validated by an MMP, prior to your approval. The remaining process in active duty column should be followed.
7. When the gender marker in the Service's personnel data system is changed: ■ Apply uniform, grooming, body composition assessment (BCA), PRT, Military Personnel Drug Abuse Testing Program (MPDATP), and other standards reflecting the Service member's gender marker in the Service's personnel data system; and ■ Direct the use of berthing, bathroom, and shower facilities according to the Service member's gender marker as reflected in the Service's personnel data system in facilities that are subject to regulation by the military.	7. Same as AC.

19 Your Service will determine the approval level for ETPs. Refer to Service policy or your SCCC if there are concerns.

20 There is no prescribed format for approving a request to change gender marker. Refer to Service policy or your SCCC if there are concerns.

What You Should Expect From the Military Medical Provider (MMP)

The MMP plays a key role in the gender transition process. The MMP will:

- Provide the medical diagnosis applicable to the Service member; list the medically necessary treatments, including the timing of the proposed treatment and the likely impact of the treatment on the individual's readiness, and deployability; and
- Formally advise you when the Service member's medical treatment plan for gender transition is complete and recommend a time at which the gender marker may be changed in your Service's personnel data system.
- Validate the non-MMP's confirmation that Service member's gender transition is complete.

Policy Implications

You have broad responsibilities to maintain your unit's readiness. Select policy areas that may impact the transition process are highlighted below.

Non-Military Medical Care

If an active duty Service member's diagnosis and/or treatment plan are from a non-MMP, direct the individual to notify the MMP at the earliest practical opportunity to bring the care into the MHS. The MMP must consider, and if appropriate, validate the Service member's diagnosis before initiating any other steps in the transition process. If the request is from a non-active duty Service member, the non-MMP diagnosis and/or treatment plan must still be approved by an MMP.

Military Personnel Uniform and Grooming Standards

Exceptions for uniform and grooming standards may be considered per your Service's policy. You may consider current and preferred gender uniforms, form, fit and/or function, the Service member's professional military image, as well as impact on unit cohesion and good order and discipline. If you have questions, refer to your SCCC.

Deployment

Service members will deploy if they are medically and otherwise qualified to do so. As with any Service member, exceptions may be considered by your Service and must be coordinated with the deployed commander, if unique medical needs exist. Individuals requiring close monitoring or ongoing care may not be available for deployment.

Physical Fitness

There are no separate standards for transgender Service members. Any exceptions to PRT standards will be administered by your Service. Individuals undergoing cross-sex hormone therapy may experience changes to their body shape and physical strength, which may have a notable effect on their ability to maintain standards. If that is the case, consult with the individual and the MMP as you would for any other Service member with a medical condition affecting their ability to meet physical fitness standards.

Privacy Accommodations

If concerns are raised by Service members about their privacy in showers, bathrooms, or other shared spaces, you may employ reasonable accommodations, such as installing shower curtains and placing towel and clothing hooks inside individual shower stalls, to respect the privacy interests of Service members. In cases where accommodations are not practicable, you may authorize alternative measures to respect personal privacy, such as adjustments to timing of the use of shower or changing facilities. This should be done with the intent of avoiding any stigmatizing impact to any Service member. You are encouraged to consult with your SCCC for guidance on such measures.

Military Personnel Drug Abuse Testing Program

The MPDATP[23] requires urinalysis specimens to be collected under the direct supervision of a designated individual of the same sex as the Service member providing the specimen. You have discretion to take additional steps to promote privacy, provided those steps do not undermine the integrity of the program. However, all collections must be directly observed. You are encouraged to use discretion and/or contact your SCCC for additional guidance.

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23 DoDI 1010.16, "Technical Procedures for the Military Personnel Drug Abuse Testing Program (MPDATP)," October 10, 2012.

Tips for Commanders

The below tips are provided by an allied foreign military and may prove useful:[24]

- Protect the service member's privacy. Information management is very important.
- Listen to the Service member's wishes with respect to disclosure to the workplace and the broader community.
- Consider consultation with the chaplain, behavioral health personnel, and medical providers.
- Seek guidance and advice from other commanders and supervisors who have experience with individuals who transitioned gender while serving.
- Encourage the Service member to articulate a plan to include a timeline and strategy for notifying coworkers and other command personnel.
- Assist the Service member with identifying a mentor with whom they are comfortable.
- Encourage open communication. Feel free to ask questions.
- Ensure bullying, bias, harassment, hazing, or any other unacceptable behavior is not tolerated.

24 Australian Air Force Handbook.

FOR ALL SERVICE MEMBERS

"I am 100 percent confident in the ability of our military leaders and all our men and women in uniform to implement these changes in a manner that both protects the readiness of the force and also upholds values cherished by the military—honor, trust, and judging every individual on their merits."

—Statement by Secretary of Defense Ash Carter[25]

The cornerstone of DoD values is treating every Service member with dignity and respect. Anyone who wants to serve their country, upholds our values, and can meet our standards, should be given the opportunity to compete to do so. Being a transgender individual, in and of itself, does not affect a Service member's ability to perform their job. Previous policy, however, required transgender Service members to hide their gender identity and forced them to receive their gender-related medical care outside the MHS.

The June 30, 2016, policy allows transgender Service members to openly acknowledge their gender identity, brings all of their medical care into the MHS, allows transgender Service members to transition their gender when medically necessary, and allows the commander to work with the Service member and an MMP to implement a gender transition plan that meets the individual's medical requirements and unit readiness requirements.

Understanding Gender Transition

The gender transition process is individualized. Gender transition can include social, medical, and legal components. Social transition, in the military context, will generally encompass living in the preferred gender after duty hours. (You may encounter a situation where you know a Service member by one name during duty hours and another after duty hours; this all depends on the individual's transition.) Medical treatment may include behavioral health care, use of hormones (which may change physical appearance), and/or surgery.

25 U.S. Secretary of Defense Ash Carter Remarks, June 30, 2016.

Other aspects of transition includes formally changing one's gender with federal, state, and military documentation.

Some individuals prefer that very few people know they are transgender Service members and hope that after transition they can quietly blend in with their new gender. Others are committed to educating the public about gender identity, are eager to answer questions, and continue to talk openly about being a transgender Service member long after transition.

Revealing gender identity at work may be one of the last steps transgender Service members take to live and work in their preferred gender. By the time they inform their chain of command they plan to change gender, they have often been dealing with this issue for many years. It is also important not to "out" a transgender Service member (i.e., do not talk about someone else's gender identity or status unless they are okay with it.) The bottom line is to treat others with the dignity, respect, and consideration you would like to be treated with by others.

Harassment and Bullying

Everyone plays a role in stopping bullying and harassment. You must be proactive and question behavior that is inappropriate at the time it occurs. You must report inappropriate behavior to your chain of command immediately. Remember, everyone is responsible for fostering the best possible command climate within your unit.

The impact harassment can have on Service members should not be underestimated; it has the potential to affect the member both personally and professionally. Inappropriate jokes, attitudes, or comments that marginalize transgender Service members are damaging to command climate. In an environment that permits inappropriate jokes and behavior, transgender Service members who have not disclosed their status may be unlikely to seek the care they need.

Respect for Personal Information

You are responsible for upholding and maintaining the high standards of the U.S. military at all times and at all places. Out of respect for all Service members, as mentioned earlier, you should not disclose someone's gender identity without their permission, unless the disclosure is made for official use.[26]

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26 Services retain the authority provided by law and Department and Service regulations to counsel, discipline, and involuntarily separate, as appropriate under the circumstances, those Service members who fail to obey established standards.

Tips for Service Members

Your social interactions and developing friendships with peers contribute to a positive work environment. Do not make assumptions about an individual's gender or sexual orientation. Let others volunteer personal information.

Try to ensure planned social activities are inclusive of Service members and their families who may not fit into your perception of what is typical.

If you notice colleagues or peers are expressing opinions that may alienate others, speak up regarding how their statements may impact others. Often people may be unaware of how their statements, questions, and activities may alienate and offend their coworkers, team members, or staff.

You should be sensitive to the use of pronouns when addressing others. This will vary by individual and unit. If there is ever any question about pronoun usage, do not hesitate to ask the Service member how they wish to be addressed.

If you have questions or concerns, you are encouraged to talk with your chain of command.

Privacy

Maintaining dignity and respect for all is important. You will need to consider both your own privacy needs and the privacy needs of others. This includes, but is not limited to, maintaining personal privacy in locker rooms, showers, and living quarters. One strategy might include adjusting personal hygiene hours. If you have concerns, you are encouraged to discuss them with your chain of command.

ACRONYMS

AOR	*Area of Responsibility*
BCA	*Body Composition Assessment*
DEERS	*Defense Enrollment Eligibility Reporting System*
DES	*Disability Evaluation System*
DoD	*Department of Defense*
DoDI	*Department of Defense Instruction*
DTM	*Directive-type Memorandum*
ETP	*Exception to Policy*
HT/WT	*Height/Weight*
IMR	*Individual Medical Readiness*
ING	*Inactive National Guard*
IR	*Individual Readiness*
IRR	*Individual Ready Reserve*
MHS	*Military Health System*
MLOA	*Medical Leave of Absence*
MMP	*Military Medical Provider*
MPDATP	*Military Personnel Drug Abuse Testing Program*
MSA	*Military Service Academy*
MTF	*Military Treatment Facility*
PRT	*Physical Readiness Test*
RLE	*Real Life Experience*
ROTC	*Reserve Officers' Training Corps*
SCCC	*Service Central Coordination Cell*
SELRES	*Selected Reserve*

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ANNEX A:
Questions and Answers

Listed below are responses to frequently asked questions organized by topic and applicable to multiple audiences.

The Basics

1. What does transgender mean?

A. Transgender is a term used to describe people whose sex at birth is different from their sense of being male or female. A transgender male is someone who was born female but identifies as male, and a transgender female is someone who was born male but identifies as female.

2. What is gender identity?

A. Gender identity is one's internal sense of being male or female.

3. What is gender dysphoria?

A. Gender dysphoria is a medical diagnosis that refers to distress that some transgender individuals experience due to a mismatch between their gender and their sex assigned at birth.

4. Is being a transgender person the same as being a transvestite or a cross-dresser?

A. No. "Transvestite" is an outdated term that is considered derogatory. A "cross-dresser" is a person who wears clothing of the opposite sex for reasons other than gender identity (see question #2). A transgender person who dresses according to their gender identity is not "cross-dressing."

5. What is the relationship between sexual orientation and gender identity?

A. There is no relationship between sexual orientation and gender identity.

6. What pronouns should I use with transgender Service members?

A. This will vary by individual and unit. Transgender Service members should work with their unit leadership to establish correct pronoun usage. If there is ever any question about pronoun usage, do not hesitate to ask the Service member how they wish to be addressed.

7. What happens when federal and state laws appear to conflict?

A. When not on federal property, Service members must abide by local laws. If there are any questions or concerns about how state laws may affect Service members and/or their dependents off federal property or in areas of concurrent federal and state jurisdiction, the installation legal assistance office should be consulted.

It is also the commander's responsibility to ensure the safety of unit personnel. This includes reminding Service members of risks through use of safety bulletins, alerts, or briefings regarding off-installation activities. Additionally, judge advocate and SCCC resources are available to enhance risk management strategies.

Health Care Issues

8. What hormones do transgender people need?

A. Not all transgender Service members need cross-sex hormone therapy. Male or female hormones may be prescribed by medical providers in order for transgender Service members to develop the physical characteristics of their preferred gender if that is part of their transition plan.

9. What if a deployed transgender Service member loses his or her medications?

A. In the event that a Service member lost his or her supply of hormones, and for some unlikely reason was not able to obtain replacements, any side effects, like irritability, decreased energy, or hot flashes, would take a few weeks to become evident. None of these side effects would be life threatening.

In-Service Transition Policy Issues

10. Have other countries allowed transgender individuals to serve openly in their militaries?

A. Yes. At least 18 countries: Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, the Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom, allow transgender personnel to serve openly.

11. What about Service members whose beliefs just cannot allow them to accept this as normal?

A. In today's military, people of different moral and religious values work, live, and fight together. This is possible because they treat each other with dignity and respect. This will not change. There will be no changes regarding Service members' ability to freely exercise their religious beliefs, nor are there any changes to policies concerning the Chaplain Corps of the Military Departments and their duties. Service members will continue to treat with respect and serve with others who may hold different views and beliefs.

12. What is the Service Central Coordination Cell (SCCC)?

A. Each Service has an SCCC of medical, legal, and policy experts, primarily to advise field commanders and medical service providers. Contact information for the SCCCs can be found in Annex D of this handbook.

13. Will Reserve Component members receive any kind of medical care or financial assistance to pay for transition-related treatment? Can they be treated in a military treatment facility (MTF) throughout their transition?

A. Reserve Component members typically receive health care through private civilian health insurance. Those enrolled in TRICARE Reserve Select may be able to access mental health and hormone treatment through TRICARE and are eligible for care in MTFs on a space-available basis. Service members are encouraged to contact their civilian provider/TRICARE for eligibility benefits. A civilian diagnosis and medical treatment plan must be submitted to your chain of command and validated by an MMP. This may be accomplished by telemedicine if available or submission of civilian health documentation to an MMP for review per Service policy.

14. How will the military protect the rights of Service members who are not comfortable sharing berthing, bathroom, and shower facilities with a transitioning Service member? Are they forced to just accept a transgender person living and showering with them?

A. To the extent feasible, a commander may employ reasonable accommodations to protect the privacy interests of Service members, while avoiding a stigmatizing impact to any Service member. Commanders are encouraged to consult with their SCCC for guidance.

15. How long will a Service member's deployment eligibility be affected? Is this a way to get out of deployment? Can a Service member in the process of transitioning, which can be a lengthy process, still deploy if called upon?

A. A Service member's period of non-deployability will vary by individual based on the care needed. Availability for deployment and any anticipated duty limitations would be part of the conversation Service members have with their commanders and medical providers as part of a medical treatment plan. Medical recommendations concerning unanticipated calls for deployment would be made in the same way as other medical conditions and as part of the pre-deployment process.

New Accession Policy Issues

Recruiting

16. Does the new policy mean the Military Services will start recruiting transgender applicants immediately?

A. No, policy is being revised to allow the Military Services to recruit new personnel no later than July 1, 2017.[27]

When training of the Force is complete and the new DoDI 6130.03 is effective, the Military Services will begin accessing transgender applicants who meet all standards, holding them to the same physical and mental fitness standards as everyone else who wants to join the military.

Detailed accession policy can be found in in DoD DTM 16-005, "Military Service of Transgender Service Members."[28]

17. What should a recruiter do if a transgender applicant wants to enlist, but the new policy is not in place?

A. A recruiter should ensure the applicant meets all standards (e.g., physical fitness, medical fitness) prior to being accessed. This is also a good time to assist the applicant in understanding the accession requirements so they can prepare themselves for entry once the new policy is in place.

27 DTM 16-005.

28 Ibid.

Military Service Academy (MSA)/ Reserve Officers' Training Corps (ROTC)

18. Does the new accession policy mentioned above apply to the Service Academies and the Reserve Officers' Training Corps (ROTC)?

A. Yes, effective July 1, 2017, the gender identity of an otherwise qualified individual will not bar them from joining the military, from admission to the MSAs, or from participating in ROTC or any other accession program. However, they must adhere to accession standards prior to being commissioned.

19. If ROTC or MSA students seek to transition during college, would they need to be stable for 18 months prior to commissioning?

A. Yes. An individual participant who is transgender is subject to separation from ROTC in accordance with DoDI 1215.08[29] or from an MSA in accordance with DoDI 1322.22,[30] based on a medical condition that impairs the individual's ability to complete such training or to access into the Armed Forces, under the same terms and conditions applicable to participants in comparable circumstances not related to transgender persons or gender transition. ROTC and MSA cadets and midshipmen are required to meet medical accessions standards when they are appointed as commissioned officers.

20. What are the medical requirements that must be met by an MSA cadet or midshipman to be eligible for a commission?

A. Cadets and midshipmen are subject to medical accession standards enumerated in DoDI 6130.03[31] prior to being commissioned.

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29 DoDI 1215.08, "Senior Reserve Officers' Training Corps (ROTC) Programs," June 26, 2006.

30 DoDI 1322.22, "Service Academies," September 24, 2015.

31 DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," September 13, 2011. (Currently under revision to reflect DTM 16-005 changes.)

21. What are the medical requirements that must be met by a ROTC cadet or midshipman to be eligible for a commission?

A. In accordance with DoDI 1215.08,[32] E3.2 (Senior ROTC Programs), complete medical examinations must be conducted before enrollment in the scholarship program or at the time of or immediately before enrollment in Senior ROTC programs of the Army, Navy, and Air Force. Such examinations must, in all respects, be equal to the examination conducted to determine medical qualifications for appointment as a commissioned officer. Provided the cadet or midshipman meets the requirements in DoDI 6130.03,[33] they would be qualified to receive a commission.

22. Would a cadet or midshipman be able to undergo hormone therapy while at one of the MSAs or enrolled in ROTC?

A. It depends. Cadets and midshipmen must continue to meet medical accession standards while at the MSA or enrolled in ROTC. If the standards for appointment into the U.S. Military Services are not maintained, an ROTC cadet or midshipman may be placed on an involuntary Medical Leave of Absence (MLOA) by the Service Secretary or designee. When an MLOA is recommended, a medical record review will determine whether the health-related incapacity or condition presents clear evidence that, following medical treatment, the cadet or midshipman will be unable to meet the physical standards for appointment into the U.S. Armed Forces within a reasonable period of time. Military Service Academy cadets and midshipmen who cannot meet medical accession standards and become medically disqualified may be disenrolled.[34]

32 DoDI 1215.08.

33 DoDI 6130.03.

34 DoDI 1322.22.

ANNEX B:

Gender Transition Roadmap for U.S. Military Personnel

Below is a summary of the gender transition process for a Service member in accordance with the recently implemented DoD Instruction, "In-Service Transition for Transgender Service Members." The roles, responsibilities, and courses of action available to transgender Service members and their commanders are described below.

Service Member Responsibilities

Before Initiating Gender Transition

Request an assessment by an MMP in order to confirm a diagnosis stating gender transition is medically necessary.

- Collaborate with and assist the MMP with developing a medical treatment plan for submission to the commander. This plan should include a projected timeline for completion of gender transition, and estimated periods of non-deployability and absence.
- Notify the commander of the recommended treatment and request approval of the timing of the treatment plan. The written request should include the following:
  - Medical treatment plan outlining all medically necessary care and a projected schedule for such treatment; and an estimated date for the completion of gender transition and a gender marker change in the appropriate Service personnel data system.

Reserve Considerations

- All transgender Reserve Component Service members (except Selected Reserve (SELRES) Full-Time Support personnel who fall under Active Component rules/requirements) will submit to, and coordinate with, their chain of command evidence of a civilian medical evaluation that includes a medical treatment plan.
- To the greatest extent possible, commanders and Service members shall address periods of non-availability for any period of military duty, paid or unpaid, during the Service member's gender transition with a view

to mitigate unsatisfactory participation through the use of rescheduled training or authorized absences.

During Gender Transition

- Initiate gender transition after obtaining the commander's approval.
- Inform the commander of any medical issues that come up in the course of gender transition.
- Notify the commander of any changes to the approved timeline of the medical treatment plan.
- Request the commander process an ETP, if necessary.

When Gender Transition is Complete

- Through your MMP, inform the commander that gender transition is complete, along with a recommended time to change gender marker in the Service personnel data system.
- Request the commander's written approval to change the gender marker in the Service personnel data system. The request must comply with Service policies and must, at a minimum, be accompanied by one of the following legal documents to support gender change:
  - A certified true copy of a State birth certificate reflecting your preferred gender;
  - A certified true copy of a court order reflecting your preferred gender; or
  - A U.S. passport reflecting your preferred gender.
- Upon receipt of the commander's approval, submit supporting documentation to personnel servicing activity to change the gender marker in the Service personnel data system.

After Gender Marker Change in the Service Personnel Data System

- Meet applicable Service standards of the preferred gender, including medical fitness, physical fitness, uniform and grooming, deployability, and retention standards.

- Use military berthing, bathroom, and shower facilities associated with the preferred gender.
- Request ETPs, as needed, from the commander.

Commander Responsibilities

Before Initiating Gender Transition

No later than 30 calendar days after receiving a Service member's request to transition gender:

- Review Service member's request to ensure that it contains the required documentation in accordance with DoD and Service policies, to include a medical treatment plan with a projected timeline for completion of gender transition, estimated periods of non-deployability/absence, and estimated date of gender marker change;
- Coordinate with an MMP. If request to transition gender is from an RC Service member they will likely provide a diagnosis and medical treatment plan from a non-MMP. In this instance, it still must be validated by an MMP;
- Consult with the SCCC; and
- If the Service member's request is incomplete, return it with a written notice of additional required documentation.

No later than 90 calendar days after receiving a Service member's request to transition gender:

- Provide a written response to Service member's request for gender transition or an ETP, with a copy to the MMP; and
- In reviewing the Service member's gender transition request, ensure the decision:
  - Complies with DoD, Service policies, and guidance;
  - Considers the individual facts and circumstances presented by the Service member;

- Considers the needs of the command (including deployment, operations, training, exercise schedules, critical skills availability, morale and welfare, and good order and discipline of the unit);
- Minimizes impacts to the mission and readiness by balancing the needs of the individual with the needs of the command;
- Is consistent with the medical treatment plan; and
- Incorporates input provided by the MMP.

During Gender Transition

In cases where a transitioning Service member is unable to meet standards or requests an ETP during the gender transition, review Service policies outlining the actions a commander may take to balance the needs of the individual Service member and unit readiness. As permitted by Service policies, the commander may:

- Adjust the date on which the Service member's gender transition, or any component of the transition process, will commence;
- Advise the Service member regarding options for extended leave status or participation in other voluntary absence programs during the transition process;
- Arrange for the transfer of the Service member to another organization, command, location, or duty status (e.g., Individual Ready Reserve (IRR)), as appropriate, during the transition process;
- Review and forward ETP requests for application of standards for uniforms and grooming, PRT, and MPDATP participation;
- Establish, or adjust, command policies on the use of berthing, bathroom, and shower facilities;
- Refer for a determination of fitness in the disability evaluation system in accordance with DoDI 1332.18;[35]

35 DoDI 1332.18, "Disability Evaluation System (DES)," August 5, 2014.

- Initiate administrative proceedings, comparable to actions that could be initiated with regard to others whose ability to serve is limited by medical conditions unrelated to gender transition; and
- Consult the SCCC, with regard to:
  - Service by transgender Service members and gender transition in the military;
  - Implementing DoD, Military Department, and Service policies and procedures; and
  - Assessing the means and timing of any proposed medical care or treatment.
- Coordinate with the MMP regarding any medical issues that arise in the course of a Service member's gender transition;
- Ensure that requests for ETPs are processed within 90 days and provide a written response to both the Service member and their MMP; and
- Modify a previously approved timeline for gender transition or an ETP at any time prior to the change in a Service member's gender marker in the Service personnel data system.
  - A determination that modification is necessary and appropriate will be made in accordance with DoD/Service policies and procedures.
  - Notify Service member of such modification under established DoD procedures as described in the 'before intitiating gender transition' section at beginning of 'commander's responsibilities'.

When Gender Transition is Complete

- Review a Service member's request to change gender marker in the Service personnel data system to ensure that it complies with Service requirements, to include at a minimum:
  - A recommendation from the MMP stating that gender transition according to the medical treatment plan is complete and that the Service member is stable in the identified gender; and

- One of the following legal documents to effect gender change:
  - A certified true copy of a State birth certificate reflecting the Service member's preferred gender;
  - A certified true copy of a court order reflecting the Service member's preferred gender; or
  - A U.S. passport reflecting the member's preferred gender.

- If the Service member's request is complete, provide written approval to Service member authorizing gender marker change in the Service personnel data system.

After Gender Marker Change in the Service Personnel Data System

- Apply uniform standards, grooming standards, BCA standards, PRT standards, MPDATP standards, and other standards according to the Service member's identified gender listed in the Service personnel data system.
- Direct the use of military berthing, bathroom, and shower facilities according to the Service member's gender listed in the Service personnel data system.
- Review ETP requests as appropriate.

ANNEX C:
Scenarios

The following fictional cases illustrate scenarios that may be encountered when addressing individual issues.[36] The delineation of responsibilities in each scenario is intended only to provide a general discussion of issues that may arise. The scenarios are not all inclusive, nor are they directive in nature. All personnel are reminded to consult with their Chain of Command, SCCC, Service, and DoD guidelines before determining the best course(s) of action. Commanders are reminded of their responsibility to ensure good order and discipline throughout their entire unit.

Readiness

Scenario 1: Inability to Meet Standards during Transition

A senior officer, Tony, is transitioning to become Tanya. The officer is about halfway through the gender transition timeline agreed upon with his military medical provider (MMP) and commander and is taking feminizing hormone therapy. The officer is aware that male standards (berthing, uniform, BCA, PRT, etc.) will still apply until his transition is complete. However, midway through hormone treatment, it becomes increasingly difficult for Tony to meet the male body composition and physical readiness standards. Tony's commander is supportive, but several key unit training events have been scheduled over the next several months, making immediate accommodation difficult.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to individual medical readiness (IMR) that may impact the ability to meet standards. It is essential that communication among Service member, commander, and the MMP is ongoing.

Service member responsibilities

- If necessary, work with the MMP to obtain proper waiver for male physical readiness standards during the period of gender transition and ensure the commander is informed; and

36 The scenarios presented are fictitious and not intended to represent any actual person or event.

- Discuss alternatives with the commander, such as rescheduled training events or extended leave/absence until gender transition process is complete.

Commander responsibilities

The commander can exercise multiple options listed below, as permitted by DoD and Service policies:

- Advise Tony on the option of taking extended leave/absence during the gender transition process;
- Explore the possibility of transferring Tony to another organization with less rigorous operational requirements;
- Refer Tony for a determination of fitness in the disability evaluation system;[37] or
- Review approved ETPs consistent with Service policies for male physical readiness and male body composition standards and ensure they are followed until the change of gender marker in the Service personnel data system to a female is complete.

Scenario 2: Physical Standards

A Service member has completed their medical treatment plan and is requesting commander approval to change their gender marker in the Service personnel data system. The commander has concerns about the Service member's ability to meet height/weight (HT/WT) and physical readiness training (PRT) standards for the preferred gender.

Key takeaway(s)

This scenario illustrates the importance of ongoing communication among Service member, commander, and the MMP, and the requirement for the commander to approve in writing all gender marker change requests. This communication will assist the commander in determining the timing of the gender marker change in the Service's personnel data system.

37 DoDI 1332.18. (USCG reference is Physical Disability Evaluation System, COMDTINST M1850.2 (series))

Service member responsibilities

- Part of your transition process should include a provision to meet new HT/WT and PRT standards and consider whether an ETP will be required as you progress through the medical treatment plan.
- Continue communicating with your commander and your MMP on your ability to meet HT/WT and PRT standards.

Commander responsibilities

- Part of the Service member's transition process should include a provision to meet new HT/WT and PRT standards as they progress through their medical treatment plan.
- Counsel Service member on HT/WT requirements and personal fitness and the potential negative outcomes should they fail to meet those requirements.
- Consult with the MMP on Service member's ability to meet standards.
- Consider two possible courses of action for gender maker change in Service personnel data system: (1) grant gender marker change with ETPs or (2) delay gender marker change until all standards of the preferred gender are met.
- Consult DoD and Service policy as well as the SCCC.

Scenario 3: Pregnancy

Lieutenant Marty changed his gender marker in the Service personnel data system from female to male after completing an approved transition plan. Lieutenant Marty has not had sex reassignment surgery as part of the transition plan and is working with his MMP on a plan to start a family. Lieutenant Marty approached his commanding officer a few weeks ago and mentioned he was pregnant.

Key takeaway(s)

This scenario illustrates the importance of ongoing communication among Service member, commander, and the MMP with regard to Individual Medical Readiness (IMR). It also emphasizes the importance of understanding

special medical care that may be required and administrative benefits resulting from pregnancy.

Service member responsibilities

- It is your responsibility to notify the chain of command of any change to IMR.[38]
- Though you have changed your gender marker in the Service personnel data system, there are IMR requirements that may be contrary to what is listed in the personnel data system (i.e., gender reflects male, however you have female anatomical characteristics). Health matters specific to anatomical characteristics still require appropriate medical review as they may affect your overall health and readiness, thus you will still require annual female examinations.
- You will receive any/all treatment/check-ups/physicals as it relates to female genitalia, including, in this case, prenatal care. Upon giving birth, you will be entitled to all relevant medical care, administrative entitlements, and leave prescribed under Service policies.
- Be aware that colleagues may find this situation confusing. Consider how and when you would like to discuss the pregnancy with your chain of command and colleagues.

Commander responsibilities

- Comply with Service pregnancy policies.
- Understand and be prepared to address administrative entitlements with Lieutenant Marty (i.e., maternity leave).
- Even though Lieutenant Marty has maintained female anatomy, he must be screened for pregnancy prior to deployment. If Lieutenant Marty became pregnant on deployment he will be transferred in accordance with Service policy.
- Consider workplace communications at the appropriate time with consideration of Lieutenant Marty's wishes.
- Consult with the SCCC.

38 DoDI 6025.19.

Career

Scenario 4: Specialized Career Limitations

A male aviation officer with 12 years of service approaches his commanding officer and requests guidance on how to complete a transition from "Eric" to "Erica." He has been living as a female when not on duty, and has already started hormone therapy, prescribed by a civilian provider, sought consultation for surgical transition, and is about to have a legal name change.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, and the importance of bringing all medical care into the MHS, whether a member of the Active or Reserve Component. Even though the Service member has received gender transition-related treatment with a civilian medical provider, they must have their subsequent care within the military health system. Finally, the scenario highlights how performance of duty may be limited depending on specialty/career field.

Service member responsibilities

- Immediately notify the flight surgeon of care received by a civilian medical provider.
- You are required by policy to inform your commander of medical treatment that may impact your medical readiness status.
- You have a responsibility to maintain your health and fitness, meet IMR requirements,[39] and report medical (including mental health) and health issues that may affect your readiness to deploy or fitness to continue serving in an active/reserve status;
- Receive a diagnosis and a treatment plan from an MMP.
- Provide all medical documentation from your civilian provider to the MMP.
- Develop a transition timeline with the MMP and the commander.

39 Ibid.

Commander responsibilities

- Consider Service policies applicable to Service members regarding unauthorized medical care.
- Direct Service member to an MMP for diagnosis and review of procedures already performed.
- Consult the MMP and/or the SCCC regarding the impact of gender transition on the Service member's readiness status and ability to perform military duties, highlighting the immediate impact to the officer's ability to maintain aviation credentials.
- Consider the timing of medical requirements in the treatment plan and any impacts to the mission (including deployments, operations, training and exercises) as well as the morale and welfare, and good order and discipline of the unit.

Scenario 5: Entry-Level Training

After four months, Private Lee completes recruit and combat training. She then reports to Ft. Sill for Military Occupational Specialty training. Upon arrival, Private Lee tells her Platoon Sergeant she is currently feeling distress as she believes she should be a man. Although she pushed herself through to completion, recruit training increased her distress. Private Lee has expressed reluctance about seeing a mental health specialist and/or medical care provider.

Key takeaway(s)

This scenario illustrates the importance of receiving a proper diagnosis from the MMP prior to other actions being taken. The commander has tools available to facilitate medical care for a Service member's well-being and to ensure Service members complete initial entry training.

Service member responsibilities

- Discuss situation with the commander.
- Obtain an evaluation by an MMP.

Next, Private Lee received a diagnosis of gender dysphoria, and the commander is told her training will be interrupted as treatment is medically necessary. After one month, it is clear Private Lee's medical condition impairs her ability to train.

Commander responsibilities

- Consult with an MMP and determine need for a command-directed mental health evaluation.[40]
- Consult with the SCCC.
- Inform Private Lee potential courses of action may include: withdrawal from training due to her medical condition, a training delay, or an initial entry separation if within 180 days of accession.[41]

Reserve Component

Scenario 6: Individual Ready Reserve

Corporal Kennedy is a member of the IRR and does not have access to an MMP. He has recently completed the transition from female to male. Corporal Kennedy wants to be considered male by his Service. He has a new birth certificate showing his preferred gender.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, whether a member of the Active or Reserve Component. Even though the Service member did all of their gender transition-related treatment with a civilian medical provider, they must still adhere to established military medical and personnel processes.

40 DoDI 6490.04, "Mental Health Evaluations of Members of the Military Services," March 4, 2013.

41 DoDI 1332.14, "Enlisted Administrative Separations," January 27, 2014, as amended.

Service member responsibilities

- All IRR Service members have a responsibility to maintain their health and fitness, meet IMR requirements,[42] and report to their chain of command any medical (including mental health) and health issues that may affect their readiness to deploy or fitness to continue serving.
- Provide medical documentation indicating that transition is complete to their IRR command and ensure it is available to an MMP to confirm the diagnosis.
- Provide legal documentation of gender change (i.e., certified birth certificate, U.S. passport, certified court order) to IRR command.

Commander responsibilities

- Review documentation with an MMP to ensure completeness and compliance with Service instructions and DoD policy.
- If complete, provide letter authorizing gender marker change in the Service personnel database.
- Consult with SCCC.

Scenario 7: Standards and Exceptions to Policy

Sergeant Rich, a Selected Reservist, informs his commanding officer that he has been living as a female when he is not in a drilling status. He requests to be called Meena; to use the female bathroom; to be held to female physical, uniform, and grooming standards; and to have his gender changed in his official military personnel file.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, whether a member of the Active or Reserve Component. Even though the Service member has initiated their gender transition-related treatment with a civilian medical provider, they must still adhere to established military medical and personnel processes.

42 DoDI 1215.13, "Ready Reserve Member Participation Policy," May 5, 2015.

Service member responsibilities

- All Selected Reserve Service members have a responsibility to maintain their health and fitness, meet IMR requirements,[43] and report to their chain of command any medical (including mental health) and health issues that may affect their readiness to deploy or fitness to continue serving.
- Provide medical documentation to the MMP showing diagnosis and medical treatment received from civilian medical provider.
- Upon confirmed diagnosis by the MMP, work with the MMP and commander to develop a transition plan.
- Provide legal documentation of gender change (i.e., certified birth certificate, U.S. passport, certified court order).

Commander responsibilities

- Facilitate Sergeant Rich's consultation with the MMP and discuss need for any ETPs that may be required.
- Upon confirmed diagnosis by the MMP, work with Sergeant Rich and the MMP to develop a gender transition plan consistent with your unit's operational responsibilities.
- When transition is complete, as certified by the MMP, provide a letter authorizing gender marker change in the Service personnel database.
- Ensure your unit is properly trained to accept and understand Sergeant Rich's preferred gender.

Scenario 8: Satisfactory Reserve Participation

Sergeant Williams is a Selected Reserve member with an Army Reserve unit. He has been in consultation with his commander regarding his gender transition. The medical treatment portion of his gender transition will require him to miss up to 2 months of duty. Both the commander and Sergeant Williams are working through potential mitigation strategies to ensure he does not become an unsatisfactory participant.

43 DoDI 6025.19.

Key policy takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, whether a member of the Active or Reserve Component. The commander also has tools available to address the Service member's absence.

Service member responsibilities

- As part of the previously agreed to transition, continued communication with the commander is key to success.
- Be aware of participation requirements to ensure a satisfactory year is achieved.
- Consult with the commander regarding alternative training opportunities.

Commander responsibilities

- You have the necessary tools to develop an initial mitigation strategy; options available to you include: (1) rescheduled training; (2) authorized absences; or (3) alternate training.
- Individual Service policies will detail processes and procedures required to use the above mitigation tools.
- Consult with your SCCC.
- Ensure your unit is properly trained to accept and understand Sergeant Williams' preferred gender.

Scenario 9: Medical Compliance

Airman Bristol, a Selected Reserve member with an Air Force Reserve unit, has an approved transition plan. She has been contemplating an unscheduled medical procedure between unit training assemblies. It is highly unlikely that the surgical procedure will require her to miss training. Airman Bristol is uncertain if she needs to report the procedure to her chain of command.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, whether a member of the Active or Reserve Component. Even though the Service member has initiated their gender transition-related treatment with a civilian medical provider, they must still adhere to established military medical and personnel processes. The commander also has tools available to facilitate the Service member's well-being.

Service member responsibilities

- You have a responsibility to maintain your health and fitness, meet IMR requirements,[44] and report to your chain of command any medical (including mental health) and health issues that may affect your readiness to deploy or fitness to continue serving in an active status.
- Discuss with your commander to address potential adjustments to your transition plan and any readiness implications.

Commander responsibilities

- You should prepare Airman Bristol for any potential periods of non-availability and work with her to mitigate absences. Options available to you include: (1) rescheduled training; (2) authorized absences; or (3) alternate training.
- Consider potential adjustments to Airman Bristol's transition plan based on individual needs as well as readiness.
- Individual Service policies will detail processes and procedures required to use any of these mitigation tools.
- You must also balance the needs of the individual and the unit in terms of readiness. While Airman Bristol may have great flexibility in her Air Force Reserve unit as to the timing of the medical procedure, this may not always be the case. Continued dialogue between you and Airman Bristol is important to individual and unit readiness. For further information, you should consult your chain of command and/or SCCC.

44 Ibid.

Scenario 10: Unauthorized Medical Care

An Active Guard/Reserve (AGR) National Guardsman has completed nearly all aspects of gender transition with the assistance of a civilian medical provider. His gender transition and medical treatment have not been disclosed to the chain of command. He would like to be recognized in his preferred gender.

Key takeaway(s)

This scenario illustrates the importance of notifying the commander of any changes to IMR, whether a member of the Active or Reserve Component. Even though the Service member did all of their gender transition-related treatment with a civilian medical provider, they must still adhere to established military medical procedures.

Service member responsibilities

Even though you have completed nearly all aspects of gender transition by a civilian medical provider, you must:

- By policy, inform your commander of medical treatment that may impact your medical readiness status.
- Maintain your health and fitness, meet IMR requirements, and report medical (including mental health) and health issues that may affect your readiness to deploy or fitness to continue serving in an active/reserve status.
- Request and receive a diagnosis and a treatment plan from an MMP.
- Provide all medical documentation from your civilian provider to the MMP.
- Develop a transition timeline with the MMP and the commander.

Commander responsibilities

- Consider Service policies applicable to Service members regarding unauthorized medical care.
- Direct the Service member to military medical for diagnosis and review of procedures already performed.

- Consult the MMP and/or the SCCC regarding the impact of gender transition on the Service member's readiness status and ability to perform military duties.
- Consider the timing of medical requirements in the treatment plan and any impacts to the mission (including deployments, operations, training and exercises) as well as the morale and welfare, and good order and discipline of the unit.

Privacy and Cohabitation

Scenario 11: Use of Shower Facilities

A transgender Service member has expressed privacy concerns regarding the open bay shower configuration. Similarly, several other non-transgender Service members have expressed discomfort when showering in these facilities with individuals who have different genitalia.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander. It also depicts steps a commander may take to permit privacy, based on Service policy.

Service member responsibilities

- If you have any concerns about privacy in an open bay shower setting, you should discuss this with your chain of command.
- Consider altering your shower hours.

Commander responsibilities

- You may employ reasonable accommodations when/if you have a Service member who voices concerns about privacy. This should be done with the intent of avoiding any stigmatizing impact to any Service member. If permitted by Service policies, some of these steps may include:
  - Facility modifications, such as installing shower curtains and placing towel and clothing hooks inside individual shower stalls.

- In cases where accommodations are not practicable, you may authorize alternative measures to respect personal privacy, such as adjustments to timing of the use of shower or changing facilities.
- Take proactive steps through the chain of command to ensure that expressions of discomfort don't escalate into harassment or hazing.
- Consult the SCCC for guidance on how to institute such measures.

Scenario 12: Urinalysis

A transgender Service member is randomly selected to undergo a urinalysis test at their new command.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander. The commander must adhere to procedures outlined in the Military Personnel Drug Abuse Testing Program (MPDATP)[45] and Service policy.

Service member responsibilities

- Discuss your circumstances with command leadership during sign-in period to determine your options and allow the commander the ability to adjust as required/desired for your comfort and the comfort level of the observer, particularly if you have not undergone full surgical change.

Commander responsibilities

- Depending on Service regulations, you may consider alternate observation options if a request from a transgender Service member or an observer is made. Options could include observation by a different observer or medical personnel.
- You have discretion to take additional steps to promote privacy, provided those steps do not undermine the integrity of the program. However, all collections must be directly observed.

45 DoDI 1010.16.

- Consult with the SCCC; if unable to make special accommodation, spend time discussing with both the observer and the Service member.
- Ensure your observers are properly trained.

Good Order and Discipline

Scenario 13: Living Quarters

You are the leading Chief Petty Officer aboard ship. A high performing Petty Officer, who is transgender and completely transitioned, approaches you and states she can no longer tolerate her roommate. Through positive reinforcement, counseling, and mentorship, you attempt to resolve the issue at the lowest level in the chain of command. However, you notice her performance starting to diminish, and she and her roommate are making derogatory comments to co-workers about each other. The behavior has become disruptive to the entire unit and others are starting to complain. She puts in a request to be re-assigned to another berthing area onboard ship.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander, as well as standards of conduct. It also highlights existing tools available to resolve the situation.

Service member responsibilities

- Respecting each other's rights within a closed space is critical to maintaining good order and discipline.
- Standards of conduct apply equally to all Service members.

Commander responsibilities

- Take an active and positive leadership approach with a focus on conflict resolution and professional obligations to maintain high standards of conduct.
- Counsel the individuals and encourage them to resolve their personal differences. Make clear to both that respecting each other's rights within a closed space is critical to maintaining good order and discipline.

- If the issue cannot be resolved and alternative berthing arrangements can be made within command policy and without degrading good order and discipline of the unit, you may consider alternative arrangements.

Scenario 14: Proper Attire during a Swim Test

It is the semi-annual swim test and a female to male transgender Service member who has fully transitioned, but did not undergo surgical change, would like to wear a male swimsuit for the test with no shirt or other top coverage.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander. It also depicts steps a commander may take to permit privacy, based on Service policy.

Service member responsibilities

- You may be comfortable with your outward appearance; however, there may be a period of adjustment for others. It is courteous and respectful to consider social norms and mandatory to adhere to military standards of conduct.
- Discuss with your chain of command.

Commander responsibilities

- It is within your discretion to take measures ensuring good order and discipline.
- When administering the swim test, counsel the individual and address the unit, if additional options (e.g., requiring all personnel to wear shirts) are being considered.
- Consult with your SCCC.

Scenario 15: Living Quarters

Following her transition (which did not include any sex reassignment surgery) and gender marker change in the Service personnel data system from male to female, Petty Officer Kelleher was assigned to a Coast Guard cutter and

provided quarters in female berthing. Shortly after her arrival aboard the cutter, several females in Petty Officer Kelleher's berthing area complained to the Command Senior Chief about being uncomfortable around Petty Officer Kelleher as she still has male genitalia. The Command Senior Chief approached the commanding officer with these complaints hoping to achieve some sort of resolution.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander, as well as standards of conduct. It also highlights existing tools available to resolve the situation.

Service member responsibilities

- You are not required to modify or adjust your behavior based on the fact you do not "match" the physical appearance of those in your berthing area. You must, however, follow all relevant shipboard and/or Service regulations commensurate with your gender.
- If you suspect others feel uncomfortable, or begin to feel uncomfortable, you should immediately reach out to an appropriate member of your command and note your concern. Should you feel uncomfortable approaching your command, every effort should be made to use resources available through the command senior enlisted leader network (e.g., Command Master Chief, Command Sergeant Major).
- The preservation of personal privacy, dignity, and respect is a responsibility shared by all crew members.

Commander's responsibilities

- Prior to Petty Officer Kelleher's arrival, ensure crew has received baseline training on policy regarding service by transgender personnel.
- Immediately upon the gender marker change in the Service personnel data system, Petty Officer Kelleher will be responsible for meeting all applicable military standards in her preferred gender, and subject to regulation by the military, will use those berthing, bathroom, and shower facilities associated with the preferred gender.

- You are responsible for the collective morale and welfare and good order and discipline of the unit and for fostering a command climate where all members of your command are treated with dignity and respect.
- An initial approach to the complaints may entail meeting with the Command Senior Chief as well as the complaining members of the berthing area to determine the exact nature of their complaints. You should inform them that Petty Officer Kelleher's assignment to female berthing is required regardless of her physical appearance and that their lack of comfort is not reason to prevent Petty Officer Kelleher from residing in female berthing or make her subject to treatment different from others.
- Similarly, as with any other issue taking place in a berthing area that affects the morale and welfare and good order and discipline, you (or Command Senior Chief) may also want to speak with Petty Officer Kelleher to inform her of the perceived problem regarding her physical appearance and its effect on the other members in the berthing area. Such a conversation should be handled very carefully; coordination with the SCCC is advisable to gain assistance on strategies to successfully engage in such communication.
- In every case, you may employ reasonable accommodations to respect the privacy interests of Service members. Avoid stigmatizing actions that may single out any Service members in an attempt to resolve the complaints.

Real Life Experience (RLE)

Scenario 16: Attending a Unit Social Event

A Service member has been undergoing transition for the last three months, from male to female, and his gender marker has not been changed in the Service's personnel data system. Only the immediate chain of command is aware of this transition. The Service member desires to attend an off-post unit event dressed as a female.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander, as well as standards of conduct. It also

highlights existing tools available to resolve the situation, as well as emphasizing the RLE agreement that was discussed when developing the transition plan.

Service member responsibilities

- Your RLE should be conducted in accordance with your approved transition plan. If this specific situation is not addressed, discuss this with your commander and the MMP to potentially modify the transition plan.
- Devise a communication plan with the commander to inform unit members of the transition to your preferred gender prior to attending unit events.

Commander responsibilities

- Maintain good order and discipline.
- During transition planning, discuss and document expected conduct to include RLE and whether ETPs may be necessary.
- If approving the ETP, ensure the unit members are properly trained prior to the event. If granting an ETP is not practicable, discuss with the Service member and advise him not to attend such activities as a female until unit members are properly trained.

Scenario 17: Off Duty

A Service member has been undergoing transition for the last three months, from male to female, and has not yet changed his gender marker in the Service's personnel database system. The unit is aware of his transition. He is preparing to begin his RLE after duty hours (i.e., wearing make-up, wigs, and female clothing) and would like to do so in his barracks room, unit day room, and on the military installation. He is still using the male facilities.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander, as well as standards of conduct. It also highlights existing tools available to resolve the situation, as well as emphasizing the RLE agreement that was discussed when developing transition plan.

Service member responsibilities

- Your RLE should be conducted in accordance with your approved transition plan. If this specific situation is not addressed, discuss this with your commander and the MMP to potentially modify the transition plan (i.e., request an ETP if necessary).

Commander responsibilities

- During transition plan development, discuss and document expected conduct to include RLE.
- Consider ETPs if requested by Service member; ensure your unit is aware and properly trained prior to granting an ETP.
- Only at the Service member's request, consider authorizing extended leave, transfer to IRR, ING, or Career Intermission Program/ Temporary Separation in accordance with Service policy to allow the Service member to live in their preferred gender and conduct RLE. Care should be taken to not apply any undue pressure on the Service member to avail himself of these voluntary options.
- Consider notifying the installation commander that you have a transitioning Service member to mitigate any potential confusion at base access control points.

Overseas

Scenario 18: Liberty Call and Personal Safety

The USS SHIP is about to pull into port for 3 days of liberty. The diverse crew, which includes a transgender Service member, has been working hard in the Arabian Gulf and is excited about a few days off. There is concern for Service member safety ashore due to wide spread anti-LGBT sentiment. Additionally, there are criminal penalties for violations of social norms.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander. Additionally, emphasis is placed on using available tools to evaluate assignments that may be potentially risky for the Service member.

Service member responsibilities

- You must always remember that the laws and what is considered socially normal in the host country may be vastly different than in the U.S.
- Pay attention to any travel warnings given at your command as a pre-arrival brief. You should also consult the Foreign Clearance Guide,[46] Travel Precautions, and Information section for LGBT travel information for that country.
- You should ensure that when you visit the country that you are always accompanied by some of your shipmates and avoid areas that are listed as dangerous. Be cautious of potential risky situations and don't do anything you would not do at home.
- You should avoid all physical displays of affection in public.

Commander responsibilities

- While having a transgender Service member might be unique to your crew, the specific issues and concerns are analyzed similarly to any other safety issues that may be encountered by any member of your crew.
- Conduct a thorough analysis of the country you are visiting prior to arrival. At a minimum, you should review the U.S. State Department's country specific website and DoD Foreign Clearance Guide.
- Tailor your pre-briefs to the crew on the accepted country norms and places to avoid. Ensure a robust buddy system for liberty is prescribed. Educate your non-commissioned officers about any concerns regarding the port.

Scenario 19: Assignment Considerations

A newly reported transgender female Service member arrives in the CENTCOM Area of Responsibility (AOR) to serve as an advise-and-assist mentor to women police officers. The country of assignment specifically requires female trainers for their female police officers.

46 See Annex D.

Key takeaway(s)

This scenario illustrates the importance of open lines of communication between the Service member and the commander, as well as the personnel assignment officer. Additionally, emphasis is placed on using available tools to evaluate assignments that may be potentially risky for the Service member.

Service member responsibilities

- You must be mindful of challenges presented by beliefs and norms in the AOR and how they are different than the accepted norms in the U.S.
- You may need to adjust your expectations in the event that you are asked to shift to a different billet in support of the mission. It is important to maintain a flexible mentality when working with foreign nations to better meet the needs of the overall mission.

Commander responsibilities

- This situation is unique in that close proximity with women and men in foreign countries may be more complicated than in the U.S.
- Some nations view transgender people as culturally unacceptable and will not recognize the individual's preferred gender.
- Conduct a thorough analysis of the country prior to arrival. At a minimum, you should review the U.S. State Department's country specific website and DoD Foreign Clearance Guide.
- You are encouraged to discuss this situation with your chain of command and the SCCC.

Proceed with caution for the safety of the Service member and the possible attention local media interest would generate in assigning this individual to the billet. The individual may need to be reassigned.

ANNEX D:
Additional Resources and Links

DoD Public and CAC-Enabled Websites

Public DoD website, "Department of Defense Transgender Policy":
http://www.defense.gov/transgender

DoD CAC-enabled website:
https://ra.sp.pentagon.mil/DoDCCC/SitePages/HomePage.aspx

Foreign Clearance Guide:

https://www.fcg.pentagon.mil/

Passport

The Department of State has established procedures allowing a person to change the gender on their U.S. Passport. Significantly, an amended birth certificate is not required. Details on this process are contained in the attached information page, found at this link:
http://travel.state.gov/content/passports/english/passports/information/gender.html

Service Boards for Correction of Military Records

Air Force:
http://www.afpc.af.mil/board-for-correction-of-military-records

Army:
http://arba.army.pentagon.mil/abcmr-overview.cfm

Coast Guard:
http://www.uscg.mil/legal/BCMR.asp

Navy and Marine Corps:
http://www.secnav.navy.mil/mra/bcnr/Pages/home.aspx

Service Central Coordination Cells (SCCCs)

Air Force:
usaf.pentagon.saf-mr.mbx.af-central-coordination-cell@mail.mil

Army:
usarmy.pentagon.hqda-dcs-g-1.mbx.sccc@mail.mil

Coast Guard:
SCCC@uscg.mil

Marine Corps:
USMC.SCCC@usmc.mil

Navy:
usn_navy_sccc@navy.mil

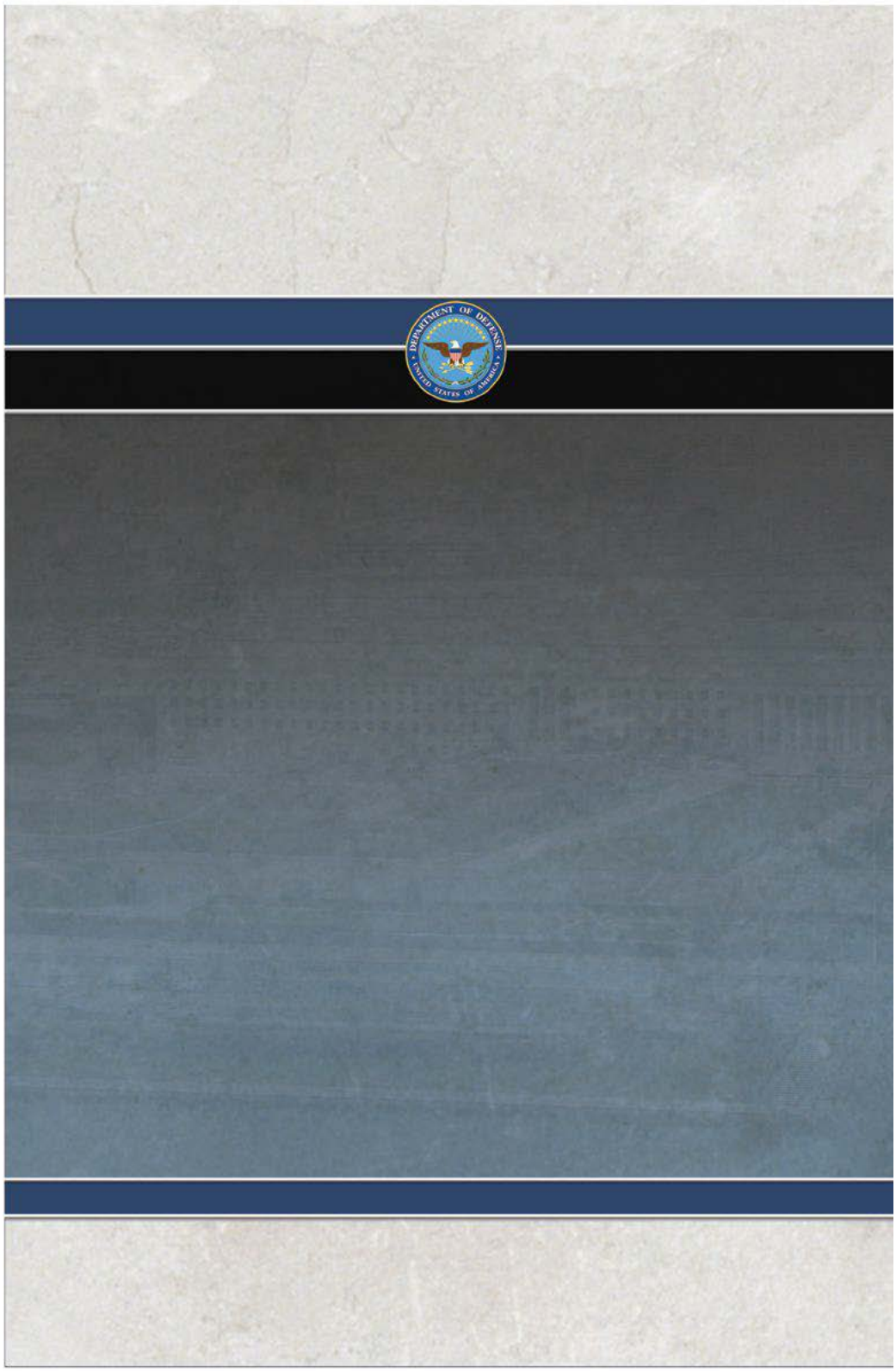

Exhibit 8

SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

JUN 30 2017

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF

SUBJECT: Accession of Transgender Individuals into the Military Services

Since becoming the Secretary of Defense, I have emphasized that the Department of Defense must measure each policy decision against one critical standard: will the decision affect the readiness and lethality of our armed forces? Put another way, how will the decision affect the ability of America's military forces to defend the Nation? It is against this standard that I provide the following guidance on the way forward in accessing transgender individuals into the military Services.

Under existing DoD policy, such accessions were anticipated to begin on July 1, 2017. The Deputy Secretary directed the Services to assess their readiness to begin accessions. Building upon that work and after consulting with the Service Chiefs and Secretaries, I have determined that it is necessary to defer the start of accessions for six months. We will use this additional time to evaluate more carefully the impact of such accessions on readiness and lethality. This review will include all relevant considerations.

My intent is to ensure that I personally have the benefit of the views of the military leadership and of the senior civilian officials who are now arriving in the Department. This action in no way presupposes the outcome of the review, nor does it change policies and procedures currently in effect under DoD Instruction 1300.28, "In-Service Transition for Transgender Service Members." I am confident we will continue to treat all Service members with dignity and respect.

The Under Secretary of Defense for Personnel and Readiness will lead this review and will report the results to me not later than December 1, 2017.

Exhibit 9

The New York Times | https://nyti.ms/2vnTrhQ

POLITICS

Trump Says Transgender Ban Is a 'Great Favor' for the Military

By HELENE COOPER AUG. 10, 2017

WASHINGTON — President Trump said on Thursday that he is doing the United States military a "great favor" by barring transgender people from serving in its ranks — even though the Pentagon has made no move to expel personnel since the commander in chief first tweeted the policy about-face two weeks ago.

The White House has yet to make public any formal guidance on how the Defense Department is supposed to turn Mr. Trump's Twitter posts into policy. Last year, many transgender service members came forward after being assured by the Obama administration that they could serve openly in the military. Pentagon officials have said privately that they do not see how to expel current service members, or bar future ones from joining the military, without opening the Defense Department up to lawsuits.

"It's been a very confusing issue for the military, and I think I'm doing the military a great favor," Mr. Trump said during an impromptu news conference at his golf club in Bedminster, N.J.

He declared that he has "great respect" for lesbian, gay, bisexual and transgender people and denied that his ban amounted to a betrayal after pledging to protect them during last year's campaign.

He said the military is "working on it now," adding that "I think I'm doing a lot of people a favor by coming out and just saying it."

The president did not elaborate on exactly what "it" was. But in announcing the ban in three July 26 tweets, Mr. Trump said that the military could not afford the medical costs of supporting transgender people. He also said transgender personnel made it harder for the military to focus on "decisive and overwhelming victory."

The president's announcement drew sharp criticism from L.G.B.T. advocates. This week, two gay rights groups filed a lawsuit to halt the proposed ban before it takes effect. The lawsuit, filed on behalf of five transgender women who are now serving openly, says a ban would violate the women's constitutional rights.

Defense officials said Mr. Trump's announcement two weeks ago took them by surprise. Jim Mattis, the defense secretary, was told about the president's decision only the day before it was posted on Twitter. Shortly after, Gen. Joseph F. Dunford Jr., the chairman of the Joint Chiefs of Staff, the military's highest ranking officer, said in a statement that current personnel policy would remain until the White House and the defense secretary formally issued new guidelines. Mr. Mattis has not yet spoken publicly about the issue.

One administration official said the White House was considering urging transgender service members to retire early. But a defense official, speaking on the condition of anonymity, said on Thursday that doing so might be difficult to defend in court.

Get politics and Washington news updates via Facebook, Twitter and the Morning Briefing newsletter .

A version of this article appears in print on August 11, 2017, on Page A14 of the New York edition with the headline: Transgender Ban Is 'Favor' To Military, Trump Says.

Exhibit 10

POLITICO

WHITE HOUSE

John Kelly's big challenge: Controlling the tweeter in chief

The new chief of staff is already shaking up the West Wing, but can he bring discipline to the president's Twitter bursts?

By **JOSH DAWSEY** | 08/04/2017 06:03 PM EDT

Chief of Staff John Kelly, according to West Wing officials, wants to change the organizational structure in the White House. | Dieu Nalio Chery/AP

President Donald Trump's White House and Defense Department lawyers had warned him against the transgender military ban for days. They were concerned about the ramifications of the policy, how military officials would respond and what legal backlash it could cause, two West Wing officials familiar with last month's discussions said. The lawyers thought there would be plenty of time for more discussions and were analyzing arguments.

Frustrated with being "slow-walked," in the words of one White House official, the president took to Twitter last week — jarring many in the West Wing out of complacency

and startling his lawyers, Defense Department officials and West Wing aides, who learned of the change in a series of tweets.

"After consultation with my Generals and military experts, please 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 began.

The administration had no plan in place, but Trump told others they would have to "get in gear" if he announced the ban first, one White House adviser who spoke to Trump said. He also said the announcement would stop the lawyers from arguing with him anymore. There is still no plan in place, and Defense Department officials have said they won't implement the ban until guidance is given.

That is exactly the kind of situation the new White House chief of staff, John Kelly, has told others he wants to avoid.

Kelly, according to West Wing officials, wants to change the organizational structure in the White House, limit access to the Oval Office, give aides clear lines of command and control what ends up on the president's desk — and who is briefing him.

But he knows, these people said, that he cannot stop the president from tweeting and sees a goal of "pushing the tweets in the right direction," one White House official said, by limiting who encourages them.

Instead, Kelly has said he would like to know what Trump is planning to tweet before he does so and would prefer that big decisions not be announced on Twitter — but has privately conceded there will be late-night or early-morning missives he cannot review.

Kelly is trying to put together a system in which top aides don't learn of decisions on Twitter, one where policy and personnel decisions are not first tweeted without having procedures in place to make them happen.

"You can't have a president who gets up at 5 a.m. and tweets policy," said Leon Panetta, a former chief of staff and a friend of Kelly's. "The best thing would be if the president stopped tweeting, but that's not going to happen."

A White House spokeswoman did not respond to a request for comment.

In many ways, Trump's Twitter feed has caused him more problems than anything else in his administration. He was dragged into weeks of controversy for accusing President Barack Obama — in early-morning tweets, without proof and before setting out to play golf — of tapping his phone; widely decried for attacking a TV host for "bleeding badly" from a face-lift; criticized for lighting into his own attorney general publicly; and discouraged by congressional leaders from damaging legislative discussions with tweets.

"If you can dial back the tweets and the chaos, it is a welcome addition because the chaos has made the first six months a disaster," said Douglas Brinkley, a presidential historian at Rice University.

Trump joins long history of presidents fuming over leaks
By **JOSH GERSTEIN**

Whether Kelly can keep Trump's feed from causing damage, as he has largely done since being sworn in on Monday, remains unclear.

Advisers and friends say Trump is more controlled on Twitter when he is getting good advice and has people around him he trusts — instead of people giving him false information. Several people close to him noted a spate of bad news stories Thursday, including that the special counsel had issued subpoenas and was using a grand jury in Washington, that provoked nothing overnight or in the early-morning hours, when the tweets often flow.

The bursts often come, advisers say, when Trump is frustrated with his staff or news media coverage — or just wants to buck everyone and do it his way, believing he can send the message better than anyone. Or, they say, he takes to Twitter when he wants to keep a tight circle and announce his news for fear of leaks. He also will marvel at how quickly his tweets appear on the television screen and brag about his followers.

"You saw some of that discipline and structure displayed yesterday regarding all of the fake breaking news, and you saw a disciplined response from the attorney," Bryan Lanza, a top

campaign aide who is now a lobbyist, said Friday. “And then you saw a good message from the president at the rally last night.”

Kelly’s predecessor, Reince Priebus, complained privately about the president’s Twitter tactics and was often blindsided by his pronouncements.

WHITE HOUSE
Trump's trip to Bedminster prompts protesters to get creative
By JAKE LAHUT

For example, advisers believed for days that Trump was likely to pick John Pistole as FBI director. Inside the administration, three officials said, there was little initial support for Christopher Wray, the former FBI official who was New Jersey Gov. Chris Christie’s attorney in the bridge-closing controversy. “No one really was pushing for Wray,” one senior administration official said.

After talking extensively with Christie, who sold Trump on the former FBI official’s bona fides as a lawyer, Trump decided to go with Wray without telling others on staff, advisers said. White House officials waking up to the tweet were startled, and hurriedly wrote a news release to correspond to it. Much of the president’s inner circle knew little about Wray. Trump was simply tired of the search, these people said.

Earlier this year, Trump sent a tweet criticizing China while U.S. officials were meeting with a Chinese delegation at the State Department. The Chinese officials were startled by the tweet, as were Trump's advisers. For hours, they pinged one another about what Trump could have meant when he said: “While I greatly appreciate the efforts of President Xi & China to help with North Korea, it has not worked out. At least I know China tried!”

It turned out, later, that Trump was angry over the death of Otto Warmbier, the American student who died in June after being held in North Korea for 18 months, and that his tweets were nothing more than a form of fuming.

Ironically, the announcement of Kelly’s new role foreshadowed the challenges he faces.

Kelly knew he was going to be named chief of staff, officials said. But he didn’t know that Trump, sitting on the tarmac aboard Air Force One on July 28, would announce it on Twitter. Other senior administration officials first learned of the news through a buzzing phone, several officials said.

"I am pleased to inform you that I have just named General/Secretary John F Kelly as White House Chief of Staff," Trump said. "He is a great American."

Exhibit 11

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.

"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."

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 12

Religion News Service | (http://religionnews.com/2017/07/27/evangelical-leaders-discussed-transgender-military-ban-with-trump/)

LGBTQ

Trump's evangelical advisers discussed transgender ban at White House meeting

By Emily McFarlan Miller | July 27, 2017

Johnnie Moore, top right, stands behind President Trump as he talks with evangelical supporters in the Oval Office at the White House. Photo courtesy of Johnnie Moore

(RNS) — President Trump's announcement on Twitter that he was banning transgender people from serving in the military seemed spontaneous and reportedly (https://mobile.nytimes.com/2017/07/26/us/politics/trump-transgender-military.html) caught some administration officials and congressional leaders by surprise.

RELATED: Religious leaders respond to Trump's transgender military ban (http://religionnews.com/2017/07/26/religious-leaders-respond-to-trumps-transgender-military-ban/)

But evangelical Christian leaders who informally advise the president discussed reversing the year-old policy two weeks ago at a meeting arranged by White House staff in Washington, D.C.

The discussion came during a previously-reported (http://religionnews.com/2017/07/12/evangelical-supporters-meet-with-pray-for-trump/) daylong meeting of evangelical leaders — including a number who had been on Trump's evangelical advisory board during the campaign — on July 10 at the Eisenhower Executive Office Building.

The building is next door to the White House and houses the offices of most of the White House staff (https://www.whitehouse.gov/1600/eeob). Various staff members were present throughout the meeting, listening and taking notes, said one of those who attended the meeting, evangelical author and public relations consultant Johnnie Moore.

"It's not the administration propagandizing," he said. "It's religious leaders, it's the administration sitting at the table, taking notes, listening to them, asking questions and vice versa, and attempting to understand the needs of the community."

Moore said the policy on transgender people serving in the military had not been on the agenda for the meeting. It was one of many topics that came up throughout the day, including health care, taxes, religious liberty and judicial appointments.

"We briefly discussed this issue," Moore said.

But earlier this week, the evangelicals followed up with a signed letter (https://twitter.com/TheBrodyFile/status/890381827919228928) asking the president to reverse the Obama era policy allowing transgender people to serve in the military, Moore added.

Moore said the evangelicals were more concerned about the nomination of an ambassador-at-large for international religious freedom.

The White House on Wednesday announced President Trump plans to nominate (http://religionnews.com/2017/07/26/trump-to-nominate-sam-brownback-as-religious-freedom-ambassador/) Kansas Gov. Sam Brownback to fill that position.

Photos shared widely on Twitter showed evangelical leaders laying hands on the president in prayer afterward in the Oval Office.

"When we went to the Oval Office, we didn't discuss a single issue. We just prayed with the president," Moore said.

The letter urging the president to reverse the policy was written by Family Research Council President Tony Perkins, who was also at the meeting, and signed by a number of prominent evangelicals, according to Moore. He did not know if the president had read the letter.

The announcement of the ban on Wednesday (July 26) drew both cheers and condemnation (http://religionnews.com/2017/07/26/religious-leaders-respond-to-trumps-transgender-military-ban/) from leaders of all faiths.

But there will be no change to the military's policy "until the President's direction has been received by the Secretary of Defense and the Secretary has issued implementation guidance," according to internal communication reported on by Politico (http://www.politico.com/story/2017/07/27/trump-transgender-military-ban-no-modification-241029?cid=apn).

The New York Times and other outlets reported the ban came in response to a fight on Capitol Hill over whether taxpayer money should pay for gender transition and hormone therapy for transgender people in the military.

Exhibit 13

usnews.com

Trump Transgender Ban Nod to Christian Conservatives

July 27, 2017, at 4:03 a.m.

Trump Transgender Ban Nod to Christian Conservatives

The Associated Press

New York City Comptroller Scott Stringer speaks to protestors gathered in Times Square, Wednesday, July 26, 2017, in New York. A rally was held in Times Square after President Donald Trump's announcement of a ban on transgender troops serving anywhere in the U.S. military. (AP Photo/Frank Franklin II) The Associated Press

By STEVE PEOPLES, Associated Press

WASHINGTON (AP) — His agenda stalled and his party divided, President Donald Trump veered into the nation's simmering culture wars by announcing plans to ban transgender people from serving in the military.

Much of the political world — prominent conservatives and Trump administration officials, among them — was surprised and confused by the president's sudden social media pronouncement. But on the ground in North Carolina, Tami Fitzgerald was elated.

"It was pretty high up on our wish list," said Fitzgerald, executive director for North Carolina Values Coalition, which has fought for that state's so-called "bathroom bill." Fitzgerald said she found it "ridiculous" that the American taxpayers were being forced to pay for treatment and surgery that violates the conscience of most of the American public."

Trump's abrupt announcement amounted to a direct political lifeline to his most passionate

supporters. In his chaotic first six months in office, Trump has lost sizable support from independents and some Republican voters. But polls show white evangelicals remaining loyal — and essential to stabilizing his political standing.

"Pray for him as he faces critics and opposition," evangelical leader Franklin Graham wrote of the president Wednesday on Facebook, describing the transgender ban as "a bold move."

Trump tweeted earlier in the day his plan to block transgender people from serving in the U.S. military "in any capacity," citing "tremendous medical costs and disruption." The White House did not say what would happen to those thousands of transgender troops already serving. The announcement signals a reversal from President Barack Obama's decision to open the armed services to transgender people, a policy that also required the Pentagon to pay for gender transition surgeries and hormone therapy.

The issue was barely on the radar for some national conservative leaders, who said privately they were far more concerned with de-funding Planned Parenthood, protecting religious freedom, and amending the tax code to allow non-profit religious organizations to engage in politics.

But for Christian conservatives across middle America who make up much of Trump's base, Wednesday's announcement served as a powerful reminder that he remains committed to their values. For emphasis perhaps, Trump followed his morning tweet with an afternoon message in all capital letters: "IN AMERICA WE DON'T WORSHIP GOVERNMENT - WE WORSHIP GOD!"

In Iowa, outspoken social conservative Steve Scheffler praised Trump's decision and lamented the evolution of the LGBT movement.

"Ten years ago, we wouldn't have even been talking about these issues where people can't figure out what gender they are," said Scheffler, a Republican national committeeman. "It's pretty sad we're at this point."

It may not be front and center in Washington, but in city halls and statehouses, debates continue to rage over LGBT rights, particularly as transgender people seek access to bathrooms and locker rooms that match their gender identities.

Trump largely sidestepped the issue before the election, vowing instead to defend LGBT rights. In the spring of 2016, he invited transgender reality star Caitlyn Jenner to use whichever bathroom she chose at Trump Tower.

But after six months in office, he's in desperate need of political momentum.

The Republican president has yet to convince the Republican-led Congress to enact any major legislation. An independent investigation probing Russian interference in the 2016 election has expanded to Trump's closest aides. And the president is publicly quarreling with Attorney General Jeff Sessions, his most loyal Cabinet member.

Trump won over 81 percent of white evangelical voters in the 2016 election, according to exit polls. The Pew Research Center found this spring that Trump's approval rating was twice as high among white evangelical Protestants than the general public.

As his overall approval ratings hover near historic lows, however, he can ill afford to lose the core constituency.

Even before Wednesday's announcement, Trump had been working on his relationship with religious conservatives.

In May, he addressed graduates at Liberty University, the nation's largest Christian college. Earlier in the month, he prayed with more than two dozen evangelical leaders in the Oval Office. And earlier in the week, Christian leaders rallied behind Trump's son-in-law Jared Kushner as he faced congressional investigators.

Caught off-guard by Wednesday's announcement, some evangelical leaders like Liberty University President Jerry Falwell Jr. declined to comment about the transgender ban. Those who did speak out were overwhelmingly supportive.

Robert Jeffress, pastor of the First Baptist Church of Dallas, praised Trump for taking on "the militant liberal agenda." "Thank God for a President who is willing to say, 'Enough is enough!'" he said.

"It is heartening to have a commander-in-chief who puts the expert opinions of his generals and military officials ahead of the destructive forces of political correctness and identity politics," declared Christian evangelist James Dobson.

At the same time, however, Trump's announcement troubled moderate Republicans who hoped the president would treat all Americans equally.

"This came out of nowhere," said Gregory T. Angelo, president of the Log Cabin Republicans.

He said Trump's focus on transgender soldiers "only serve to exacerbate ongoing culture wars around LGBT issues."

Joe Murray, a Mississippi-based attorney who administers the LGBTrump Facebook page, said he's not sure whether the transgender ban "will energize the base or demoralize the base."

"The one thing I know about President Trump is that he's always five steps ahead," Murray said. "I don't know if they're always good steps ahead."

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AP Religion Writer Rachel Zoll contributed to this report.

Exhibit 19

Donald J. Trump @realDonaldTrump · Jul 26

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

26K 43K 126K

Donald J. Trump @realDonaldTrump · Jul 26

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

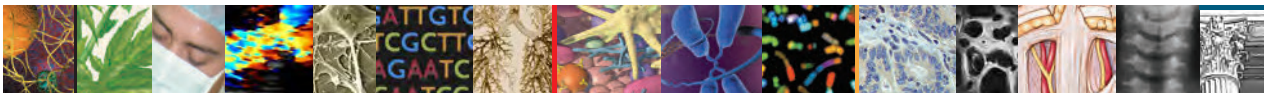
47K 45K 137K

Donald J. Trump @realDonaldTrump · Jul 26

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

76K 43K 142K

Exhibit 22



The NEW ENGLAND JOURNAL of MEDICINE

Perspective

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 estimated 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 transition-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 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

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 Herman[1]; Herman[2]; 9News[3]; and State of California Department of Insurance.[4]

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 cov-

erage, 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, providing 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.

From the University of California, Hastings College of the Law, San Francisco.

This article was published on August 12, 2015, at NEJM.org.

1. Gates G, Herman J. Transgender military service in the United States. Los Angeles: Williams Institute, 2014.
2. Herman J. Costs and benefits of providing transition-related health care coverage in employee health benefits plans: findings from a survey of employers. Los Angeles: Williams Institute, 2013.
3. 9News (NineMSN). Australians hit with $648,000 bill for military's gender reassignment and breast enhancement surgeries. June 9, 2015 (http://www.9news.com.au/national/2015/06/09/05/44/taxpayers-funding-adf-breast-enhancements-and-gender-reassignment).
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DOI: 10.1056/NEJMp1509230

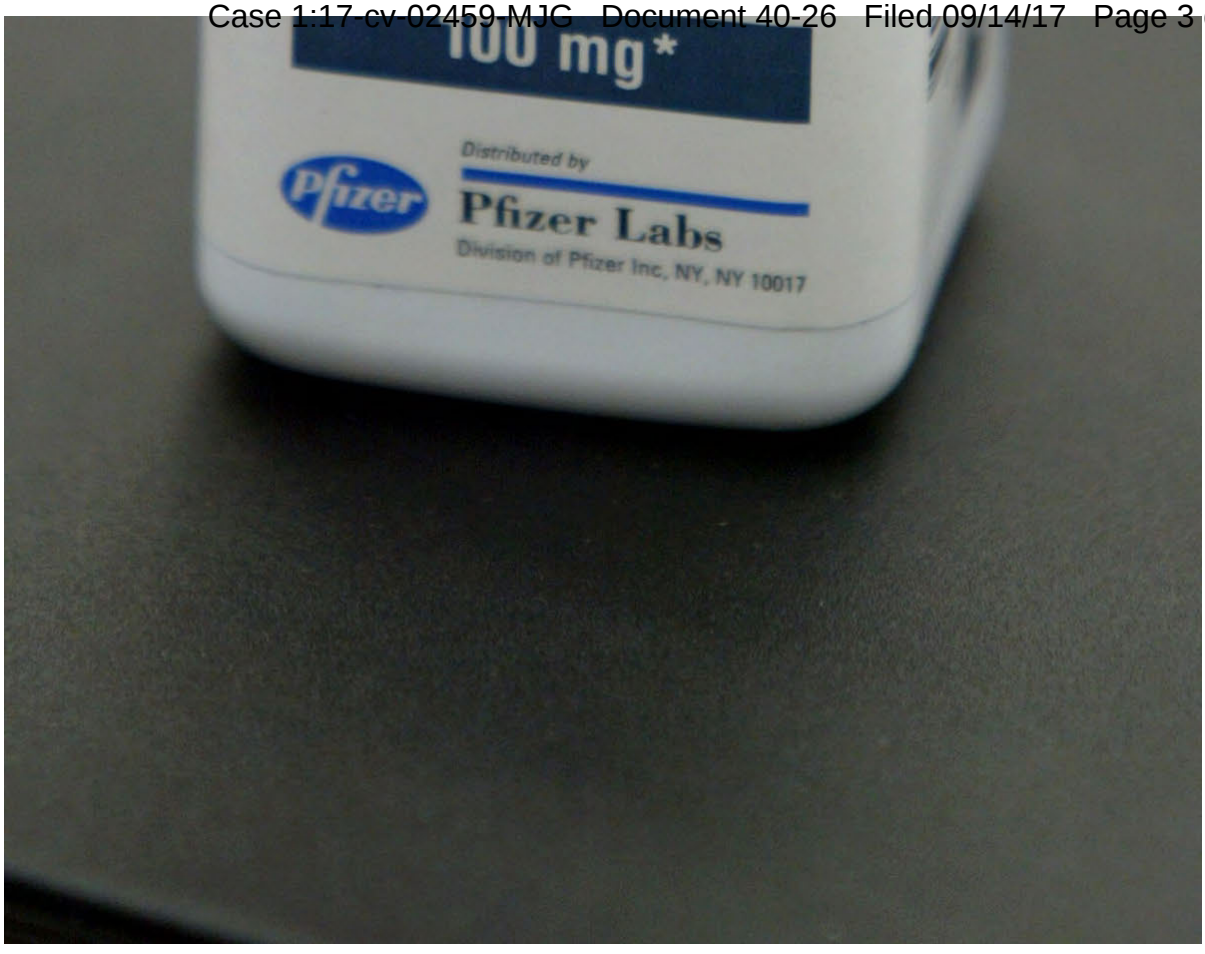
Exhibit 23

Health Care

[http://www.militarytimes.com/pay-benefits/military-benefits/health-care/]

DoD spends $84M a year on Viagra, similar meds

By: Patricia Kime [http://www .militarytimes.com/author/patricia-kime] February 13, 2015



HOLLYWOOD, FL - JUNE 16: A bottle of Viagra sits on the counter of the Post Haste Pharmacy And Surgical Store on June 16, 2003 in Hollywood, Florida. The U.S. Senate is set to debate a new Medicare Bill aimed at reducing the high cost of prescription drugs for the elderly and disabled. The bill, which is estimated to cost $400 billion over ten years, is expected to gain Senate approval. (Photo by Joe Raedle/Getty Images)

A report published online last week by the Washington Free Beacon and picked up by Fox News and the U.K.'s Daily Mail noted that the Pentagon spent more than $500,000 for Viagra in 2014.

That's a lot of money — but the figure wasn't even close to the real amount spent by the Defense Department for that erectile dysfunction drug and others.

According to data from the Defense Health Agency, DoD actually spent $41.6 million on Viagra — and $84.24 million total on erectile dysfunction prescriptions — last year.

And since 2011, the tab for drugs like Viagra, Cialis and Levitra totals $294 million — the equivalent of nearly four U.S. Air Force F-35 Joint Strike Fighters.

The Free Beacon based its analysis on 60 contracts for Viagra to Cardinal Health Inc., according to the article.

But those contracts tell only part of the story: DHA and its pharmacy benefits manager Express Scripts run a vast organization that dispenses medications through military hospitals and clinics, by mail and at retail stores nationwide via multiple contracts.

And according to DHA, military beneficiaries, including active-duty personnel, retirees and eligible family members, filled nearly 1.18 million prescriptions for ED medications through this system in 2014.

While drugs such as Viagra, Cialis, Levitra and other phosphodiesterase type 5 inhibitors are prescribed for other conditions, such as pulmonary arterial hypertension, their most common use is for treating sexual dysfunction in men.

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., *Plaintiffs,* v. DONALD TRUMP, et al., *Defendants.*	Case No. 17-cv-02459 (MJG)

EXPERT DECLARATION OF GEORGE RICHARD BROWN, MD, DFAPA IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

1. I, George Brown, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. The purpose of this declaration is to offer my expert opinion on: (1) the medical condition known as gender dysphoria; (2) the prevailing treatment protocols for gender dysphoria; (3) the U.S. military's pre-2016 ban on the enlistment and retention of men and women who are transgender; (4) the subsequent lifting of that ban; and (5) the unfounded medical justifications for banning individuals who are transgender from serving in the United States military.

3. I have knowledge of the matters stated in this declaration and have collected and cite to relevant literature concerning the issues that arise in this litigation.

4. I am being compensated at an hourly rate for actual time devoted, at the rate of $400 per hour for work that does not involve depositions or court testimony (e.g., review of materials, emails, preparing reports); $500 per hour for depositions (there is a half-day fee for depositions); $600 per hour for in-court testimony; and $4000 per full day spent out of the office

for depositions and $4800 per full day out of the office for trial testimony. Travels days necessary for work are billed at half the "work day" rate plus expenses. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

PROFESSIONAL BACKGROUND

5. I am a Professor of Psychiatry and the Associate Chairman for Veterans Affairs in the Department of Psychiatry at the East Tennessee State University, Quillen College of Medicine. My responsibilities include advising the Chairman; contributing to the administrative, teaching, and research missions of the Department of Psychiatry; consulting on clinical cases at the University and at Mountain Home Veterans Health Administration ("VHA") Medical Center, where I also hold an appointment; and acting as a liaison between the VHA Medical Center and the East Tennessee State University Department of Psychiatry. The majority of my work involves researching, teaching, and consulting about health care in the military and civilian transgender populations.

6. I also hold a teaching appointment related to my expertise with health care for transgender individuals and research at the University of North Texas Health Services Center ("UNTHSC"). My responsibilities include teaching and consultation with UNTHSC and the Federal Bureau of Prisons staff regarding health issues for transgender individuals.

7. In 1979, I graduated *Summa Cum Laude* with a double major in biology and geology from the University of Rochester in Rochester, New York. I earned my Doctor of Medicine degree with Honors from the University of Rochester School of Medicine in 1983. From 1983-1984, I served as an intern at the United States Air Force Medical Center at Wright-Patterson Air Force Base in Ohio. From 1984-1987, I worked in and completed the United States Air Force Integrated Residency Program in Psychiatry at Wright State University and Wright-

Patterson Air Force Base in Dayton, Ohio. A true and correct copy of my Curriculum Vitae is attached hereto as Exhibit A.

8. I first began seeing patients in 1983. I have been a practicing psychiatrist since 1987, when I completed my residency. From 1987-1991, I served as one of the few U.S. Air Force teaching psychiatrists. In this capacity, I performed over 200 military disability evaluations and served as an officer on medical evaluation boards ("MEBs") at the largest hospital in the Air Force.

9. Over the last 33 years, I have evaluated, treated, and/or conducted research in person with 600-1000 individuals with gender disorders, and during the course of research-related chart reviews with over 5100 patients with gender dysphoria. The vast majority of these patients have been active duty military personnel or veterans.

10. For three decades, my research and clinical practice has included extensive study of the health care for transgender individuals, including three of the largest studies focused on the health care needs of transgender service members and veterans. Throughout that time, I have done research with, taught on, and published peer-reviewed professional publications specifically addressing the needs of transgender military service members. *See* Brown Exhibit A (CV).

11. I have authored or coauthored 38 papers in peer-reviewed journals and 19 book chapters on topics related to gender dysphoria and health care for transgender individuals, including the chapter concerning gender dysphoria in Treatments of Psychiatric Disorders (3d ed. 2001), a definitive medical text published by the American Psychiatric Association.

12. In 2014, I coauthored a study along with former Surgeon General Joycelyn Elders and other military health experts, including a retired General and a retired Admiral. The study was entitled "*Medical Aspects of Transgender Military Service*." *See* Elders J, Brown GR,

Coleman E, Kolditz TA, Medical Aspects of Transgender Military Service. Armed Forces and Society, 41(2): 199-220, 2015; published online ahead of print, DOI: 10.1177/0095327X14545625 (Aug. 2014) (the "Elders Commission Report"). The military peer-reviewed journal, Armed Forces and Society, published the Elders Commission Report. A true and correct copy of that report is attached hereto as Exhibit B.

13. I have served for more than 15 years on the Board of Directors of the World Professional Association for Transgender Health ("WPATH"), the leading international organization focused on health care for transgender individuals. WPATH has over 2000 members throughout the world and is comprised of physicians, psychiatrists, psychologists, social workers, surgeons, and other health professionals who specialize in the diagnosis and treatment of gender dysphoria.

14. I was a member of the WPATH committee that authored and published in 2011 the current version of the WPATH Standards of Care ("SoC") (Version 7). The SoC are the operative collection of evidence-based treatment protocols for addressing the health care needs of transgender individuals. I also serve on the WPATH committee that will author and publish the next edition, the Standards of Care (Version 8).

15. Without interruption, I have been an active member of WPATH since 1987. Over the past three decades, I have frequently presented original research work on topics relating to gender dysphoria and the clinical treatment of transgender people at the national and international levels.

16. I have testified or otherwise served as an expert on the health issues of transgender individuals in numerous cases heard by several federal district and tax courts. A true and correct list of federal court cases in which I have served as an expert is contained in the

"Forensic Psychiatry Activities" section of my Curriculum Vitae, which is attached hereto as Exhibit A.

17. I have conducted and continue to provide trainings on transgender health issues for the VHA as well as throughout the Department of Defense ("DoD"). After the DoD announced the policy that allowed for transgender individuals to serve openly in the Armed Forces in 2016, I conducted the initial two large military trainings on the provision of health care to transgender service members. The first training in Spring 2016 was for the Marine Corps. The second training in Fall 2016 was for a tri-service meeting of several hundred active duty military clinicians, commanders, and Flag officers.

18. Since the issuance of DoD Instruction ("DoDI") 1300.28 in October 2016, I have led trainings for a national group of military examiners (MEPCOM) in San Antonio, Texas and for Army clinicians at Fort Knox, Kentucky. Among other things, DoDI 1300.28 implemented the policies and procedures in Directive-type Memorandum 16-005, established a construct by which transgender service members may transition gender while serving, and required certain trainings for the military.

19. I have been centrally involved in the development, writing, and review of all national directives in the VHA relating to the provision of health care for transgender veterans. I also coauthored the national formulary that lists the medications provided by the VHA for the treatment of gender dysphoria in veterans. Finally, I regularly consult with VHA leadership regarding the training of VHA clinicians on transgender clinical care of veterans nationally.

GENDER DYSPHORIA

20. The term "transgender" is used to describe someone who experiences any significant degree of misalignment between their gender identity and their assigned sex at birth.

21. Gender identity describes a person's internalized, inherent sense of who they are as a particular gender (i.e, male or female). For most people, their gender identity is consistent with their assigned birth sex. Most individuals assigned female at birth grow up, develop, and manifest a gender identity typically associated with girls and women. Most individuals assigned male at birth grow up, develop, and manifest a gender identity typically associated with boys and men. For transgender people, that is not the case. Transgender women are individuals assigned male at birth who have a persistent female identity. Transgender men are individuals assigned female at birth who have a persistent male identity.

22. Experts agree that gender identity has a biological component, meaning that each person's gender identity (transgender and non-transgender individuals alike) is the result of biological factors, and not just social, cultural, and behavioral ones.

23. Regardless of the precise origins of a person's gender identity, there is a medical consensus that gender identity is deep-seated, set early in life, and impervious to external influences.

24. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2013) ("DSM-5") is the current, authoritative handbook on the diagnosis of mental disorders. Mental health professionals in the United States, Canada, and other countries throughout the world rely upon the DSM-5. The content of the DSM-5 reflects a science-based, peer-reviewed process by experts in the field.

25. Being transgender is not a mental disorder. *See* DSM-5. Men and women who are transgender have no impairment in judgment, stability, reliability, or general social or vocational capabilities solely because of their transgender status.

26. Gender dysphoria is the diagnostic term in the DSM-5 for the condition that can manifest when a person suffers from clinically significant distress or impairment associated with an incongruence or mismatch between a person's gender identity and assigned sex at birth.

27. The clinically significant emotional distress experienced as a result of the incongruence of one's gender with their assigned sex and the physiological developments associated with that sex is the hallmark symptom associated with gender dysphoria.

28. Only the subset of transgender people who have clinically significant distress or impairment qualify for a diagnosis of gender dysphoria.

29. Individuals with gender dysphoria may live for a significant period of their lives in denial of these symptoms. Some transgender people may not initially understand the emotions associated with gender dysphoria and may not have the language or resources for their distress to find support until well into adulthood.

30. Particularly as societal acceptance towards transgender individuals grows and there are more examples of high-functioning, successful transgender individuals represented in media and public life, younger people in increasing numbers have access to medical and mental health resources that help them understand their experience and allow them to obtain medical support at an earlier age and resolve the clinical distress associated with gender dysphoria.

TREATMENT FOR GENDER DYSPHORIA

31. Gender dysphoria is a condition that is amenable to treatment. *See* WPATH SoC (Version 7); Elders Commission Report at 9-16; Agnes Gereben Schaefer et al., Assessing the Implications of Allowing Transgender Personnel to Serve Openly, RAND Corporation (2016) at 7 ("RAND Report") (a true and correct copy of the report is attached hereto as Exhibit C).

32. With appropriate treatment, individuals with a gender dysphoria diagnosis can be fully cured of all symptoms.

33. Treatment of gender dysphoria has well-established community standards for treatment and is highly effective.

34. The American Medical Association (AMA), the Endocrine Society, the American Psychiatric Association, and the American Psychological Association all agree that medical treatment for gender dysphoria is medically necessary and effective.[1] *See* American Medical Association (2008), Resolution 122 (A-08); American Psychiatric Association, Position Statement on Discrimination Against Transgender & Gender Variant Individuals (2012); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2009); American Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009).

35. The protocol for treatment of gender dysphoria is set forth in the WPATH SoC and in the Endocrine Society Guidelines.[2] First developed in 1979 and currently in their seventh version, the WPATH SoC set forth the authoritative protocol for the evaluation and treatment of gender dysphoria. This approach is followed by clinicians caring for individuals with gender dysphoria, including veterans in the VHA. As stated above, I was a member of the WPATH committee that authored the SoC (Version 7), published in 2011. A true and correct copy of that document is attached hereto as Exhibit D.

36. Depending on the needs of the individual, a treatment plan for persons diagnosed with gender dysphoria may involve components that are psychotherapeutic (i.e., counseling as

[1] Additional organizations that have made similar statements include: the American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Nursing, American College of Nurse Midwives, American College of Obstetrics and Gynecology, American College of Physicians, American Medical Student Association, American Nurses Association, American Public Health Association, National Association of Social Workers, and National Commission on Correctional Health Care.

[2] *Available at* https://www.endocrine.org/guidelines-and-clinical-practice/clinical-practice-guidelines.

well as social role transition – living in accordance with one's gender in name, dress, pronoun use); pharmacological (i.e., hormone therapy); and surgical (i.e., gender confirmation surgeries, like hysterectomy for those transitioning to the male gender and orchiectomy for those transitioning to the female gender). Under each patient's treatment plan, the goal is to enable the individual to live all aspects of one's life consistent with his or her gender identity, thereby eliminating the distress associated with the incongruence.

37. There is a wide range in the treatments sought by those suffering from gender dysphoria. For example, some patients need both hormone therapy and surgical intervention, while others need just one or neither. Generally, medical intervention is aimed at bringing a person's body into some degree of conformity with their gender identity.

38. As outlined further below, treatment protocols for gender dysphoria are comparable to those for other mental health and medical conditions, including those regularly treated within the United States military. *See* RAND Report at 8-9; Elders Commission Report at 13 ("the military consistently retains non-transgender men and women who have conditions that may require hormone replacement").

PRE-2016 MILITARY POLICY

39. Prior to 2016, military policy treated transgender individuals with gender dysphoria differently than people with other curable conditions.

Former Enlistment Policy

40. DoDI 6130.03 established the medical standards for accession/entry into military service. Enclosure 4 of the enlistment instruction contains an extensive list of physical and mental conditions that disqualify a person from enlisting in the military. For instance, persons with autism, schizophrenia, or delusional disorders (or a history of treatment for these conditions) are excluded from enlistment. Prior to 2016, that list also contained "change of sex"

and "transsexualism", which were outdated references to transgender individuals and individuals with gender dysphoria. *See* Elders Commission Report at 7.

41. The enlistment policy allows for the possibility of waivers for a variety of medical conditions. The instruction, however, specifies that entry waivers will not be granted for conditions that would disqualify an individual from the possibility of retention. As discussed further below, because certain conditions related to being transgender ("change of sex") were formerly grounds for discharge from the military, men and women who are transgender could not obtain medical waivers to enter the military. *Id*. at 7-8.

42. Under military instructions, the general purpose of disqualifying applicants based on certain physical and mental conditions is to ensure that service members are: (1) free of contagious diseases that endanger others, (2) free of conditions or defects that would result in excessive duty-time lost and would ultimately be likely to result in separation, (3) able to perform without aggravating existing conditions, and (4) capable of completing training and adapting to military life. *Id*. at 7.

43. Because gender dysphoria, as described above, is a treatable and curable condition, unlike other excluded conditions, its inclusion on the list of disqualifying conditions was inappropriate. Individuals with gender dysphoria (or under the language at the time – those who had a "change of sex") were disqualified from joining the military, despite having a completely treatable, or already treated, condition.

44. The enlistment policy treated transgender individuals in an inconsistent manner compared with how the military addressed persons with other curable medical conditions. The result of this inconsistency was that transgender personnel were excluded or singled out for disqualification from enlistment, even when they were mentally and physically healthy.

45. For example, persons with certain medical conditions, such as Attention Deficit Hyperactivity Disorder ("ADHD") and simple phobias, could be admitted when their conditions could be managed without imposing undue burdens on others. Individuals with ADHD are prohibited from enlisting unless they meet five criteria, including documenting that they maintained a 2.0 grade point average after the age of 14. Similarly, individuals with simple phobias are banned from enlisting, unless they meet three criteria including documenting that they have not required medication for the past 24 continuous months.

46. In short, even though the DoD generally allowed those with manageable conditions to enlist, the former regulation barred transgender service without regard to the condition's treatability and the person's ability to serve.

Former Separation Policy

47. The medical standards for retiring or separating service members who have already enlisted are more accommodating and flexible than the standards for new enlistments.

48. Until recently, the medical standards for separation were set forth in DoDI 1332.38. On August 5, 2014, the DoD replaced DoDI 1332.38 with DoDI 1332.18, which permits greater flexibility for the service branches to provide detailed medical standards.

49. The separation instructions divide potentially disqualifying medical conditions into two different tracks. Service members with "medical conditions" are placed into the medical system for disability evaluation. Under this evaluation system, a MEB conducts an individualized inquiry to determine whether a particular medical condition renders a service member medically unfit for service. If a service member is determined to be medically unfit, the service member may receive benefits for medical separation or retirement, or may be placed on

the Temporary Duty Retirement List with periodic reevaluations for fitness to return to duty. While in the U.S. Air Force, I served as an officer on at least 200 MEBs.

50. Under the separation instruction, service members with genitourinary conditions, endocrine system conditions, and many mental health conditions are all evaluated through the medical disability system. *See* DoDI 1332.38 §§ E4.8, E4.11, E4.13; AR 40-501 §§ 2-8, 3-11, 3-17, 3-18, 3-31, 3-32; SECNAVIST 180.50_4E §§ 8008, 8011, 8013; U.S. Airforce Medical Standards Directory §§ J, M, Q.

51. By contrast, under the separation instructions, a small number of medical and psychiatric conditions are not evaluated through the medical evaluation process. Instead, these conditions are deemed to render service members "administratively unfit." Service members with "administratively unfit" conditions do not have the opportunity to demonstrate medical fitness for duty or eligibility for disability compensation.

52. Under DoDI 1332.38, the "administratively unfit" conditions were listed in Enclosure 5 of the instruction. Since August 5, 2014, when DoDI 1332.18 replaced 1332.38, the "administratively unfit" conditions are determined by the service branches, as set forth in AR 40-501 § 3-35; SECNAVIST § 2016; and AFI36-3208 § 5.11.

53. Enclosure 5 of DoDI 1332.38 included, among other conditions, bed-wetting, sleepwalking, learning disorders, stuttering, motion sickness, personality disorders, mental retardation, obesity, shaving infections, certain allergies, and repeated infections of venereal disease. It also included "Homosexuality" and "Sexual Gender and Identity Disorders, including Sexual Dysfunctions and Paraphilias." *See* Elders Commission Report at 8.

54. Similarly, the "administratively unfit" conditions in the service branches included "psychosexual conditions, transsexual, gender identity disorder to include major abnormalities or

defects of the genitalia such as change of sex or a current attempt to change sex," AR 40-501 § 3-35(a); "Sexual Gender and Identity Disorders and Paraphilias," SECNAVIST § 2016(i)(7); and "Transsexualism or Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT)," AFI36-3208 § 5.11.9.5. The service branches retained these bars to service by transgender individuals after DoDI 1332.18 replaced DoDI 1332.38.

55. DoDI 1332.14 controlled administrative separations for enlisted persons. Under the instruction, a service member may be separated for the convenience of the government and at the discretion of a commander for "other designated physical or mental conditions." Before 2016, this particular separation category included "sexual gender and identity disorders." *Id*.

56. Because service members with gender dysphoria were deemed to be "administratively unfit," they were not evaluated by MEBs and had no opportunity to demonstrate that their condition did not affect their fitness for duty. They were disqualified from remaining in the military despite having a completely treatable condition.

57. This was inconsistent with the treatment of persons with other curable medical conditions, who are given the opportunity to demonstrate medical fitness for duty or eligibility for disability compensation. For example, mood and anxiety disorders are not automatically disqualifying for retention in military service. Service members can receive medical treatment and obtain relief in accordance with best medical practices. Mood and anxiety disorders result in separation only if they significantly interfere with duty performance and remain resistant to treatment. In contrast, transgender individuals were categorically disqualified from further service without consideration of their clinical symptoms and any impact on their service.

58. The result of this inconsistency was that transgender personnel were singled out for separation, even when they were mentally and physically healthy, solely because they were transgender.

OPEN SERVICE DIRECTIVE

59. The DoD lifted the ban on open service by transgender military personnel following a June 30, 2016 announcement made by then-Secretary of Defense Ash Carter ("Open Service Directive").

60. Based on my extensive research and clinical experiences treating transgender individuals over decades, the Open Service Directive is consistent with medical science.

61. The Open Service Directive also aligns with the conclusions reached by the RAND National Defense Research Institute, the Elders Commission, and the AMA.

62. The RAND Report concluded that the military already provides health care comparable to the services needed to treat transgender individuals: "Both psychotherapy and hormone therapies are available and regularly provided through the military's direct care system, though providers would need some additional continuing education to develop clinical and cultural competence for the proper care of transgender patients. Surgical procedures quite similar to those used for gender transition are already performed within the [Medical Health System] for other clinical indications." *See* RAND Report at 8.

63. The earlier Elders Commission, on which I served, concluded that "[t]ransgender 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." *See* Elders Commission Report at 4.

64. Additionally, in a unanimous resolution published on April 29, 2015, the AMA announced its support for lifting the ban on open transgender service in the military, based on the AMA's conclusion that there is no grounding in medical science for such a ban.[3]

Enlistment Policy for Transgender Individuals

65. The Open Service Directive's enlistment procedures – which were adopted but never put into effect – are carefully designed to ensure that transgender individuals who enlist in the military do not have any medical needs that would make them medically unfit to serve or interfere with their deployment.

66. First, a "history of gender dysphoria" is considered disqualifying under the Open Service Directive, unless a licensed medical provider certifies that the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months. *See* DTM-16-005 Memorandum and Attachment (June 30, 2016).

67. Second, under the directive, a "history of medical treatment associated with gender transition" is disqualifying, unless a licensed medical provider certifies that: (1) the applicant has completed all medical treatment associated with the applicant's gender transition; (2) the applicant has been stable in his or her gender for 18 months; and (3) if the applicant is receiving cross-sex hormone therapy post-gender transition, the individual has been stable on such hormones for 18 months. *Id.* at 8.

68. Third, a history of "sex reassignment or genital reconstruction surgery" is considered disqualifying under the Open Service Directive, unless a licensed medical provider certifies that: (1) a period of 18 months has passed since any surgical intervention; and (2) no

[3] *Available at* http://archive.palmcenter.org/files/A-15%20Resoultion%20011.pdf.

functional limitations or complications persist and no additional surgical intervention is needed. In other words, under the Open Service Directive, no transgender individual is permitted to enlist, unless the applicant has been stable in his or her gender for a period of 18 months, has waited 18 months since any surgical treatment related to gender transition, and has no medical need for additional surgical care.

Retention Policy for Transgender Individuals

69. Under the Open Service Directive, gender dysphoria is treated like other curable medical conditions. Individuals with gender dysphoria receive medically necessary care. Service members who are transgender are subject to the same standards of medical and physical fitness as any other service member.[4]

70. The Open Service Directive also permits commanders to have substantial say in the timing of any future transition-related treatment for transgender service members. The needs of the military can also take precedence over an individual's need to transition, if the timing of that request interferes with critical military deployments or trainings.

MEDICAL JUSTIFICATIONS FOR BANNING TRANSGENDER SERVICE MEMBERS ARE UNFOUNDED

71. Based upon: (1) my extensive research and experience treating transgender people, most of whom have served this country in uniform, (2) my involvement reviewing the medical implications of a ban on transgender service members, and (3) my participation in implementing the Open Service Directive allowing transgender individuals to serve openly, it is my opinion that any medical objections to open service by transgender service members are

[4] *Available at* https://www.defense.gov/Portals/1/features/2016/0616_policy/Guidance_for_Treatment_of_Gender_Dysphoria_Memo_FINAL_SIGNED.pdf.

wholly unsubstantiated and inconsistent with medical science and the ways in which other medical conditions are successfully addressed within the military.

Mental Health

72. Arguments based on the mental health of transgender persons to justify prohibiting individuals from serving in the military are wholly unfounded and unsupported in medical science. Being transgender is not a mental defect or disorder. Scientists have long abandoned psychopathological understandings of transgender identity, and do not classify the incongruity between a person's gender identity and assigned sex at birth as a mental illness. To the extent the misalignment between gender identity and assigned birth sex creates clinically significant distress (gender dysphoria), that distress is curable through appropriate medical care.

73. Sixty years of clinical experience have demonstrated the efficacy of treatment of the distress resulting from gender dysphoria. *See* Elders Commission Report at 10 ("a significant body of evidence shows that treatment can alleviate symptoms among those who do experience distress"). Moreover, "empirical data suggest that many non-transgender service members continue to serve despite psychological conditions that may not be as amenable to treatment as gender dysphoria." *Id.* at 11.

74. The availability of a cure distinguishes gender dysphoria from other mental health conditions, such as autism, bipolar disorder, or schizophrenia, for which there are no cures. There is no reason to single out transgender personnel for separation, limitation of service, or bars to enlistment, based only on the diagnosis or treatment of gender dysphoria. Determinations can and should be made instead on a case-by-case basis depending on the individual's fitness to serve, as is done with other treatable conditions.

75. The military already provides mental health evaluation services and counseling, which is the first component of treatment for gender dysphoria. *See* RAND Report at 8.

76. Concerns about suicide and substance abuse rates among transgender individuals are also unfounded when it comes to military policy. At enlistment, all prospective military service members undergo a rigorous examination to identify any pre-existing mental health diagnoses that would preclude enlistment. Once someone is serving in the military, they must undergo an annual mental and physical health screen, which includes a drug screen. If such a screening indicates that a person suffers from a mental illness or substance abuse, then that would be the potential impediment to retention in the military. The mere fact that a person is transgender, however, does not mean that person has a mental health or substance abuse problem or is suicidal.

Hormone Treatment

77. The argument that cross-sex hormone treatment should be a bar to service for transgender individuals is not supported by medical science or current military medical protocols.

78. Hormone therapy is neither too risky nor too complicated for military medical personnel to administer and monitor. The risks associated with use of cross-sex hormone therapy to treat gender dysphoria are low and not any higher than for the hormones that many non-transgender active duty military personnel currently take. There are active duty service members currently deployed in combat theaters who are receiving cross-sex hormonal treatment, following current DoD instructions, without reported negative impact upon readiness or lethality.

79. The military has vast experience with accessing, retaining, and treating non-transgender individuals who need hormone therapies or replacement, including for gynecological conditions (e.g., dysmenorrhea, endometriosis, menopausal syndrome, chronic pelvic pain, male hypogonadism, hysterectomy, or oophorectomy) and genitourinary conditions (e.g., renal or

voiding dysfunctions). Certain of these conditions are referred for a fitness evaluation only when they affect duty performance. *See* Elders Commission at 13.

80. In addition, during service when service members develop hormonal conditions whose remedies are biologically similar to cross-sex hormone treatment, those members are not discharged and may not even be referred for a MEB. Examples include male hypogonadism, menstrual disorders, and current, or history of, pituitary dysfunction. *Id*.

81. Military policy also allows service members to take a range of medications, including hormones, while deployed in combat settings. *Id*. Under DoD policy only a "few medications are inherently disqualifying for deployment," and none of those medications are used to treat gender dysphoria. *Id.* (quoting Dept. of Defense, Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications, 2006 at para. 4.2.3). Similarly, Army regulations provide that "[a] psychiatric condition controlled by medication should not automatically lead to non-deployment." *See* AR 40-501 § 5-14(8)(a).

82. Access to medication is predictable, as "[t]he Medical Health Service maintains a sophisticated and effective system for distributing prescription medications to deployed service members worldwide." *See* Elders Commission at 13. At least as to cross-sex hormones, clinical monitoring for risks and effects is not complicated, and with training and/or access to consultations, can be performed by a variety of medical personnel in the DoD, just as is the case in the VHA. This is the military services' current practice in support of the limited medical needs of their transgender troops in CONUS (Continental United States) and in deployment stations worldwide.

83. The RAND Corporation confirms the conclusions I draw from my experience with the military and the Elders Commission. Specifically, the RAND Report notes that the

Medical Health System maintains and supports all of the medications used for treatment of gender dysphoria and has done so for treatment of non-transgender service members. In other words, all of the medications utilized by transgender service members for treatment of gender dysphoria are used by other service members for conditions unrelated to gender dysphoria. *See* RAND Report at 8 ("Both psychotherapy and hormone therapies are available and regularly provided through the military's direct care system, though providers would need some additional continuing education to develop clinical and cultural competence for the proper care of transgender patients"). Part of my role with the DoD over the past 18 months has been to provide this continuing education.

Surgery

84. Nor is there any basis in science or medicine to support the argument that a transgender service member's potential need for surgical care to treat gender dysphoria presents risks or burdens to military readiness. The risks associated with gender-confirming surgery are low, and the military already provides similar types of surgeries to non-transgender service members. *See* Elders Commission Report at 14; RAND Report at 8-9.

85. For example, the military currently performs reconstructive breast/chest and genital surgeries on service members who have had cancer, been in vehicular and other accidents, or been wounded in combat. *See* RAND Report at 8. The military also permits service members to have elective cosmetic surgeries, like LeFort osteotomy and mandibular osteotomy, at military medical facilities. *See* Elders Commission Report at 14. The RAND Report notes that the "skills and competencies required to perform these procedures on transgender patients are often identical or overlapping. For instance, mastectomies are the same for breast cancer patients and female-to-male transgender patients." *See* RAND Report at 8.

86. There is no reason to provide such surgical care to treat some conditions and withhold identical care and discharge individuals needing such care when it is provided to treat gender dysphoria. Based on risk and deployability alone, there is no basis to exclude transgender individuals from serving just because in some cases they may require surgical treatment that is already provided to others.

87. The RAND Report also notes the benefit of military medical coverage of transgender-related surgeries because of the contribution it can make to surgical readiness and training. *Id.* ("performing these surgeries on transgender patients may help maintain a vitally important skill required of military surgeons to effectively treat combat injuries during a period in which fewer combat injuries are sustained").

88. The suggestion by some critics that when it comes to enlistment, individuals would join the military just to receive surgical care, is completely unfounded. The level of commitment and dedication to service makes it unlikely that someone would enlist and complete a years-long term of initial service simply to access health care services. Moreover, because medically-necessary care for gender dysphoria is now increasingly available in the civilian context, there would be limited need to join the military in order to obtain treatment.

Deployability

89. Critics have also cited non-deployability, medical readiness, and constraints on fitness for duty as reasons to categorically exclude transgender individuals from military service. Such arguments are unsubstantiated and illogical. As a general matter and based on the experiences of numerous foreign militaries, transgender service members are just as medically fit for service and deployable as non-transgender service members. *Id*. at 60.

90. Transgender service members – including service members who receive hormone medication – are just as capable of deploying as service members who are not transgender. DoD rules expressly permit deployment, without need for a waiver, for a number of medical conditions that present a much more significant degree of risk in a harsh environment than being transgender. For example, hypertension is not disqualifying if controlled by medication, despite the inherent risks in becoming dehydrated in desert deployment situations. Heart attacks experienced while on active duty or treatment with coronary artery bypass grafts are also not disqualifying, if they occur more than a year preceding deployment. Service members may deploy with psychiatric disorders, if they demonstrate stability under treatment for at least three months. *See* DoDI 6490.07, Enclosure 3.

91. Moreover, although a service member undergoing surgery may be temporarily non-deployable, that is not a situation unique to people who are transgender. Numerous non-transgender service members are temporarily or permanently non-deployable, including pregnant individuals who are not separated as a result. *See* Elders Commission Report at 17.

92. Finally, the RAND Report ultimately concluded that the impact of open service of men and women who are transgender on combat readiness would be "negligible." *See* RAND Report at 70. Based on the available evidence of over 18 foreign militaries, RAND found that open service has had "no significant effect on cohesion, operational effectiveness, or readiness." *Id*. at 60. This includes the experience of Canada, which has permitted open service for over 20 years. *Id*. at 52.

CONCLUSION

93. There is no evidence that being transgender alone affects military performance or readiness. There is no medical or psychiatric justification for the categorical exclusion of transgender individuals from the Armed Forces.

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

Executed this 14th day of September, 2017.

George R. Brown, M.D.

Exhibit C

Assessing the Implications of Allowing Transgender Personnel to Serve Openly

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Preface

U.S. Department of Defense (DoD) policies have rendered both the physical and psychological aspects of "transgender conditions" as disqualifying conditions for accession and allow for the administrative discharge of service members who fall into these categories. However, in July 2015, Secretary of Defense Ashton Carter announced that DoD would "create a working group to study the policy and readiness implications of welcoming transgender persons to serve openly." In addition, he directed that "decision authority in all administrative discharges for those diagnosed with gender dysphoria[1] or who identify themselves as transgender be elevated to the Under Secretary of Defense (Personnel and Readiness), who will make determinations on all potential separations" (DoD, 2015b).

It is against this backdrop that DoD is considering allowing transgender personnel to serve openly. To assist in identifying the potential implications of such a change in policy, the Office of the Under Secretary of Defense for Personnel and Readiness asked the RAND National Defense Research Institute to conduct a study to (1) identify the health care needs of the transgender population, transgender service members' potential health care utilization rates, and the costs associated with extending health care coverage for transition-related treatments; (2) assess the potential readiness implications of allowing transgender service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly. This report documents the findings from that study. This research should be of interest to DoD and military service leadership, members of Congress, and others who are interested in the potential implications of allowing transgender personnel to serve openly in the U.S. armed forces.

This research was sponsored by the Office of the Under Secretary of Defense for Personnel and Readiness and conducted within the Forces and Resources Policy Center of the RAND National Defense Research Institute, a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint

[1] *Gender dysphoria* is "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth" (World Professional Association for Transgender Health, 2011, p. 2).

Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community.

For more information on the RAND Forces and Resources Policy Center, see www.rand.org/nsrd/ndri/centers/frp or contact the director (contact information is provided on the web page).

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Summary

The U.S. Department of Defense (DoD) is reviewing its policy on transgender personnel serving openly and receiving gender transition–related treatment during military service. The prospect of transgender personnel serving openly raises a number of policy questions, including those regarding access to gender transition–related health care, the range of transition-related treatments to be provided, the potential costs associated with these treatments, and the impact of gender transition–related health care needs (i.e., surgical, pharmacologic, and psychosocial) on military readiness—specifically, in terms of the deployability of transgender service members. The Office of the Under Secretary of Defense for Personnel and Readiness asked the RAND National Defense Research Institute to conduct a study to (1) identify the health care needs of the transgender population, transgender service members' potential health care utilization rates, and the costs associated with extending health care coverage for transition-related treatments; (2) assess the potential readiness implications of allowing transgender service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly. This report presents the study findings centered around the following research questions:

- What are the health care needs of the transgender population?
- What is the estimated transgender population in the U.S. military?
- How many transgender service members are likely to seek gender transition–related medical treatment?
- What are the costs associated with extending health care coverage for gender transition–related treatments?
- What are the potential readiness implications of allowing transgender service members to serve openly?
- What lessons can be learned from foreign militaries that permit transgender personnel to serve openly?
- Which DoD policies would need to be changed if transgender service members are allowed to serve openly?

In the following sections, we summarize the findings associated with each research question.

What Are the Health Care Needs of the Transgender Population?

For the purposes of this analysis, we use *transgender* as an umbrella term to refer to individuals who identify with a gender different from the sex they were assigned at birth. Under the recently established criteria and terminology in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the American Psychiatric Association (APA) publication that provides standard language and criteria for classifying mental health conditions, transgender status alone does not constitute a medical condition (APA, 2013). Instead, under the revised diagnostic guidelines, only transgender individuals who experience significant related distress are considered to have a medical condition called *gender dysphoria* (GD). Some combination of psychosocial, pharmacologic (mainly but not exclusively hormonal), or surgical care may be medically necessary for these individuals. Psychotherapy to confirm a diagnosis of GD is a common first step in the process, often followed by hormone therapy and, perhaps, gender reassignment surgery involving secondary or primary sex characteristics. Not all individuals seek all forms of care.

A subset of transgender individuals may choose to *transition*, the term we use to refer to the act of living and working as a gender different from that assigned at birth. For some, the transition may be primarily social, with no accompanying medical treatment; we refer to this as *social transition*. For others, medical treatments, such as hormone therapy and hair removal, are important steps to align their physical body with their target gender. We refer to this as *medical transition*. A subset of those who medically transition may choose to undergo gender reassignment surgery to make their body as congruent as possible with their gender identity. This process of surgical transition is also often referred to as *sex* or *gender reassignment* or *gender confirmation*.

What Is the Estimated Transgender Population in the U.S. Military?

Estimates of the transgender population in the U.S. military and the analyses presented in this report should be interpreted with caution, as there have been no rigorous epidemiological studies of the size or health care needs of either the transgender population in the United States or the transgender population serving in the military. As a result, much existing research relies on self-reported, nonrepresentative survey samples. We applied a range of prevalence estimates from published research to fiscal year (FY) 2014 personnel numbers to estimate the number of transgender individuals serving in the U.S. military. We estimate that there are between 1,320 and

6,630 transgender personnel serving in the active component (AC) and 830–4,160 in the Selected Reserve (SR). Combining survey evidence from multiple states and adjusting for the male/female distribution in the military gave us a midrange estimate of around 2,450 transgender personnel in the AC and 1,510 in the SR.

How Many Transgender Service Members Are Likely to Seek Gender Transition–Related Medical Treatment?

We developed two estimates of demand for gender transition–related medical treatments based on private health insurance data and self-reported data from the National Transgender Discrimination Survey (NTDS). Based on our analyses of available private health insurance data on transition-related health care utilization, we expect only a small number of AC service members to access transition-related health care each year. Our estimates based on private health insurance data ranged from 0.022 to 0.0396 annual claimants per 1,000 individuals. Applied to the AC population, these estimates led to a lower-bound estimate of 29 AC service members and an upper-bound estimate of 129 AC service members annually utilizing transition-related health care, out of a total AC force of 1,326,273 in FY 2014.

We also projected health care utilization using the estimated prevalence of transgender service members and self-reported survey data from the NTDS describing the proportion of the transgender population seeking transition-related treatments by age group. Based on these calculations, we estimated, as an upper-bound, 130 total gender transition–related surgeries and 140 service members initiating transition-related hormone therapy (out of a total AC force of 1,326,273 in FY 2014). To put these numbers in perspective, an estimated 278,517 AC service members accessed mental health services in FY 2014. Hence, we expect annual gender transition–related health care to be an extremely small part of the overall health care provided to the AC population.

What Are the Costs Associated with Extending Health Care Coverage for Gender Transition–Related Treatments?

To determine the budgetary implications of gender transition–related treatment for Military Health System (MHS) health care costs, we again used data from the private health insurance system on the cost of extending coverage for this care to the transgender personnel population. We estimate that AC MHS health care costs will increase by between $2.4 million and $8.4 million annually—an amount that will have little impact on and represents an exceedingly small proportion of AC health care expendi-

tures (approximately $6 billion in FY 2014)[1] and overall DoD health care expenditures ($49.3 billion actual expenditures for the FY 2014 Unified Medical Program; Defense Health Agency, 2015, p. 22). These estimates imply small increases in annual health care costs; results that are consistent with the low prevalence of transgender personnel and the low annual utilization estimates that we identified.

What Are the Potential Readiness Implications of Allowing Transgender Service Members to Serve Openly?

Similarly, when assessing the readiness impact of a policy change, we found that less than 0.0015 percent of the total available labor-years would be affected, based on estimated gender transition–related health care utilization rates.[2] This is because even at upper-bound estimates, less than 0.1 percent of the total force would seek transition-related care that could disrupt their ability to deploy.[3] Existing data also suggest a minimal impact on unit cohesion as a result of allowing transgender personnel to serve openly. However, we caution that these results rely on data from the general civilian population and foreign militaries, as well as previous integration experiences in the military (e.g., gays, lesbians, women), which may not hold for transgender service members.

What Lessons Can Be Learned from Foreign Militaries That Permit Transgender Personnel to Serve Openly?

There are 18 countries that allow transgender personnel to serve openly in their militaries: Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom (Polchar et al., 2014). Our analysis focused on the policies of the four countries—Australia, Canada, Israel, and the United Kingdom—with the most well-developed and publicly available policies on transgender military personnel. Several common themes emerged from our analysis of their experiences:

- The service member's gender is usually considered to have shifted to the target gender in areas such as housing, uniforms, identification cards, showers, and restrooms when a service member publicly discloses an intention to live as the target

[1] AC beneficiaries make up less than 15 percent of TRICARE beneficiaries (Defense Health Agency, 2015).

[2] We define a labor-year as the amount of work done by an individual in a year.

[3] We note that the ability to deploy is not exactly equivalent to readiness. A service member's readiness could be measured by the ability to participate in required training and exercises, which could be affected by treatments as well. Our estimates include days of inactivity due to medical treatments, which could also apply in these settings.

gender and receives a diagnosis of gender incongruence. However, physical fitness standards typically do not fully shift until the medical transition is complete. In many cases, personnel are considered exempt from physical fitness tests during transition.

- Because the gender transition process is unique for each individual, issues related to physical standards and medical readiness are typically addressed on a case-by-case basis. This flexibility has been important in addressing the needs of transgender personnel.
- The foreign militaries we analyzed permit the use of sick leave for gender transition–related medical issues and cover some, if not all, medical or surgical treatments related to a service member's gender transition.
- In no case was there any evidence of an effect on the operational effectiveness, operational readiness, or cohesion of the force.

The case studies also suggested a number of key best practices:

- Ensure strong leadership support.
- Develop an explicit written policy on all aspects of the gender transition process.
- Provide education and training to the entire force on transgender personnel policy, but integrate this training with other diversity-related training and education.
- Develop and enforce a clear anti-harassment policy that addresses harassment aimed at transgender personnel alongside other forms of harassment.
- Make subject-matter experts and gender advisers serving within military units available to commanders seeking guidance or advice on gender identity issues.
- Identify and communicate the benefits of an inclusive and diverse workforce.

Which DoD Policies Would Need to Be Changed if Transgender Service Members Are Allowed to Serve Openly?

We reviewed 20 current accession, retention, separation, and deployment regulations across the services and the Office of the Secretary of Defense to assess the impact of changes that may be required to allow transgender individuals to serve openly. We also reviewed 16 other regulations that have been replaced by more recent regulations or that did not mention transgender personnel.[4] Based on the experiences of foreign militaries, we recommend that DoD issue clear and comprehensive policies.

[4] These additional policies can are listed in Appendix D of this report.

Accession Policy

We recommend that DoD review and revise the language in accession instructions to match the DSM-5 for conditions related to mental fitness, ensuring the alignment of mental health–related language and facilitating appropriate screening and review processes for disorders that may affect fitness for duty. Similarly, physical fitness standards should specify physical requirements (rather than physical conditions). Finally, physical fitness policies should clarify when the service member's target gender requirements will begin to apply.

Retention Policy

We recommend that DoD expand and enhance its guidance and directives to clarify retention standards for review during and after medical transition. For example, evidence from Canada and Australia suggests that transgender personnel may need to be held medically exempt from physical fitness testing and requirements (Canadian Armed Forces, 2012; Royal Australian Air Force, 2015). However, after completing medical transition, the service member could be required to meet the standards of the acquired gender.

Separation Policy

DoD may wish to revise the current separation process based on lessons learned from the repeal of Don't Ask, Don't Tell. The current process relies on administrative decisions outside the purview of the standard medical and physical review process. This limits the documentation and review of discharges, and it could prove burdensome if transgender-related discharges become subject to re-review and redetermination. When medically appropriate, DoD may wish to establish guidance on when such discharge reviews should be handled through the existing medical fitness processes. We also recommend that DoD develop and disseminate clear criteria for assessing whether and how transgender-related conditions may interfere with duty performance.

Deployment Policy

The degree of austerity will differ across deployment environments, and some locations may be able to meet the health care needs of some transgender individuals. Moreover, recent advancements can minimize the invasiveness of treatments and allow for telemedicine or other forms of remote medical care.

Given this, DoD may wish to adjust some of its processes and deployment restrictions in the context of medical and technological advancements (e.g., minimally invasive treatments, telemedicine). Such reforms could minimize the readiness impact of medical procedures that are common among the transgender population. For example, current regulations specifying that conditions requiring regular laboratory visits that cannot be accommodated in a deployed environment can leave service members ineligible for deployment and would affect all individuals receiving hormone treatments

(Office of the Assistant Secretary of Defense for Health Affairs, 2013, p. 3). These treatments require laboratory monitoring every three months for the first year as hormone levels stabilize (Hembree et al., 2009; Elders et al., 2014). To avoid this cost, DoD would need to either permit more flexible monitoring strategies[5] or provide training to deployed medical personnel.[6]

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[5] Some experts suggest that alternatives, such as telehealth reviews, would address this issue for rural populations with limited access to medical care (see, for example, World Professional Association for Transgender Health, 2011).

[6] "Independent duty corpsmen, physician assistants, and nurses can supervise hormone treatment initiated by a physician" (Elders et al., 2014).

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Abbreviations

AC	active component
APA	American Psychiatric Association
DoD	U.S. Department of Defense
DoDI	U.S. Department of Defense instruction
DSM-5	*Diagnostic and Statistical Manual of Mental Disorders*, fifth ed.
FY	fiscal year
GD	gender dysphoria
IDF	Israel Defense Forces
LGBT	lesbian, gay, bisexual, and transgender
MHS	Military Health System
MTF	military treatment facility
NTDS	National Transgender Discrimination Survey
SR	Selected Reserve
VHA	Veterans Health Administration
WPATH	World Professional Association for Transgender Health

CHAPTER ONE

Introduction

U.S. Department of Defense (DoD) policies have rendered both the physical and psychological aspects of "transgender conditions" disqualifying conditions for accession and allowed for the administrative discharge of service members who fall into these categories. However, in July 2015, Secretary of Defense Ashton Carter announced that DoD would "create a working group to study the policy and readiness implications of welcoming transgender persons to serve openly." In addition, he directed that "decision authority in all administrative discharges for those diagnosed with gender dysphoria[1] or who identify themselves as transgender be elevated to the Under Secretary of Defense (Personnel and Readiness), who will make determinations on all potential separations" (DoD, 2015b). It is against this backdrop that DoD is considering allowing transgender service members to serve openly. To assist in identifying the potential implications of such a policy change, the Office of the Under Secretary of Defense for Personnel and Readiness asked the RAND National Defense Research Institute to conduct a study to (1) identify the health care needs of the transgender population, transgender service members' potential health care utilization rates, and the costs associated with extending health care coverage for transition-related treatments; (2) assess the potential readiness impacts of allowing transgender service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly.

Study Approach

Our study approach centered around the following research questions:

- What are the health care needs of the transgender population?
- What is the estimated transgender population in the U.S. military?

[1] *Gender dysphoria*, or GD, is "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth" (World Professional Association for Transgender Health [WPATH], 2011, p. 2).

- How many transgender service members are likely to seek gender transition–related medical treatment?
- What are the costs associated with extending health care coverage for gender transition–related treatments?
- What are the potential readiness implications of allowing transgender service members to serve openly?
- What lessons can be learned from foreign militaries that permit transgender personnel to serve openly?
- Which DoD policies would need to be changed if transgender service members are allowed to serve openly?

We explain our methodological approaches in detail in each chapter of this report, but, here, we present overviews of the various methodologies that we employed. We began our analysis by defining the term *transgender* and then identifying the health care needs of the transgender population. This entailed an extensive literature review of these health care needs, along with treatment standards and medical options—particularly for those who have been diagnosed with gender dysphoria (GD).

We then undertook a review of existing data to estimate the prevalence and likely utilization rates of the transgender population in the U.S. military. Based on our estimates of the potential utilization of gender transition–related health care services, we estimated the Military Health System (MHS) costs for transgender active-component (AC) service members and reviewed the potential effects on force readiness from allowing these service members to serve openly.

We adopted two distinct but related approaches to estimating health care utilization and readiness impact. The first is what we label the *prevalence-based approach*, in which we estimated the prevalence of transgender personnel in the military and applied information on rates of gender transition and reported preferences for different medical treatments to measure utilization and the implied cost and readiness impact. This approach has the benefit of including those who may seek other forms of accommodation, even if they do not seek medical care. It also provides detailed information on the types of medical treatments likely to be sought, which can improve the accuracy of cost and readiness estimates. However, this approach suffers from a lack of rigorous evidence in terms of the rates at which transgender individuals seek treatment and instead relies on the nonscientific National Transgender Discrimination Survey (NTDS). This approach also relies on prevalence measures from only two states, Massachusetts and California, which may not be directly applicable to military populations.

Using our second approach, which we label the *utilization-based approach*, we estimated the rates of utilization of gender transition–related medical treatment. This approach has the benefit of providing real-world measures of utilization, which may be more accurate and more rigorously collected than survey information. However, it suffers from a lack of large-scale evidence and instead relies on several case studies

that may not be directly applicable to the U.S. military. Given the caveats described, these approaches provide the best available estimate of the potential number of transgender service members likely to seek medical treatment or require readiness-related accommodations.[2] In both cases, we applied measures of population prevalence and utilization to fiscal year (FY) 2014 DoD force size estimates to provide estimates of prevalence within the U.S. military.

We also reviewed the policies of foreign militaries that allow transgender service members to serve openly. Our primary method supporting the observations presented in this report was an extensive document review that included primarily publicly available policy documents, research articles, and news sources that discussed policies on transgender personnel in these countries. The information about the transgender personnel policies of foreign militaries came directly from the policies of these countries, as well as from research articles describing the policies and their implementation. Findings on the effects of open transgender service on cohesion and readiness drew largely from research articles that specifically examined this question using interviews and an analysis of studies completed by the foreign militaries themselves. Finally, insights on best practices and lessons learned emerged both directly from research articles describing the evolution of policy and experience and indirectly from commonalities in the policies and experiences of our four in-depth case studies. Recommendations provided in this report are based on these best practices and lessons learned, as well as a consideration of the unique characteristics of the U.S. military.

Finally, for our analysis of DoD policies, we reviewed 20 current accession, retention, separation, and deployment regulations across the services and the Office of the Secretary of Defense. We also reviewed 16 other regulations that have been replaced by more recent regulations or that did not mention transgender personnel.[3] Our review focused on transgender-specific DoD instructions (DoDIs) that may contain unnecessarily restrictive conditions and reflect outdated terminology and assessment processes. However, in simply removing these restrictions, DoD could inadvertently affect standards overall. While we focused on reforms to specific instructions and directives, we note that DoD may wish to conduct a more expansive review of personnel policies to ensure that individuals who join and remain in service can perform at the desired level, regardless of gender identity.

Limitations and Caveats

A critical limitation of such a comprehensive assessment is the lack of rigorous epidemiological studies of the size or health care needs of either the U.S. transgender population or the transgender population serving in the military. Indeed, much of the

[2] We define *accommodations* as adjustments in military rules and policies to allow individuals to live and work in their target gender.

[3] These additional policies are listed in Appendix D of this report.

existing research on the transgender population relies on self-reported, nonrepresentative survey data, along with unstandardized calculations using results from available studies. Because there are no definitive data on this topic, the information presented here should be interpreted with caution and, therefore, we present the full range of estimates.

Organization of This Report

The report is organized around our seven research questions. Chapter Two defines what is meant by the term *transgender*, identifies the health care needs of the transgender population, explains the various treatment options for those diagnosed with GD, and examines the capacity of the MHS to provide treatment options to service members diagnosed with GD. Chapter Three estimates the number of transgender service members in the AC and Selected Reserve (SR). Chapter Four estimates how many transgender service members are likely to seek medical treatment. Chapter Five estimates the costs associated with extending health care coverage for gender transition–related treatments. Chapter Six assesses the potential readiness implications of allowing transgender service members to serve openly. Chapter Seven identifies lessons learned from foreign militaries that allow transgender personnel to serve openly. Chapter Eight offers recommendations regarding which DoD accession, retention, separation, and deployment policies would need to be changed if a decision is made to allow transgender service members to serve openly. Chapter Nine summarizes key findings presented in the report and suggests best practices for implementing policy changes.

Appendix A presents definitions of common terms related to gender transition and transgender identity. Appendix B provides a history of the historical nomenclature associated with transgender identity. Appendix C provides details on the psychosocial, pharmacologic, surgical, and other treatments for GD. Appendix D lists the DoD accession, retention, separation, and deployment policies that we reviewed.

CHAPTER TWO

What Are the Health Care Needs of the Transgender Population?

This report begins by describing the health care needs of the U.S. transgender population overall. To discern the potential impact of changing DoD policies to allow transgender military personnel to serve openly and to ensure appropriate health care for those who seek gender transition–related treatment, it is also important to consider whether the MHS has the capacity to provide this care.

Definitions of Key Terms and Concepts

A challenge to our efforts to understand the health care needs of the transgender population in general, as well as in the military, is the varied and shifting terminology used in the clinical literature. Consequently, here, we define a range of terms that we will use throughout this review.[1] Consistent with the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the American Psychiatric Association (APA) publication that provides standard language and criteria for classifying mental health conditions, we use the term *transgender* to refer to "the broad spectrum of individuals who . . . identify with a gender different from their natal gender" (APA, 2013).[2] *Natal gender* or *birth sex*, which is the sex that an individual was assigned at birth and typically correlates with primary sex characteristics (e.g., genitalia).

We refer to the subset of the population whose gender identity does not conform with the expressions and behaviors typically associated with the sex to which they were assigned at birth as *transgender* or *gender nonconforming*. Many identities fall under these umbrella terms, including individuals who identify as androgynous, multigendered, third gender, and two-spirit people. The *gender nonconforming* category also includes individuals who *cross-dress*, which means they wear clothing that is traditionally worn by a gender different from that of their birth sex. The exact definitions of each of these identities vary under the term *gender nonconforming*, and individuals may

[1] A comprehensive list of terms and definitions is provided in Appendix A.

[2] A brief history of the DSM language and diagnostic criteria for related conditions is presented in Appendix B.

fluidly change, blend, or alter their gender identity over time. For the purposes of this analysis, we use *transgender* as an umbrella term that refers to individuals who identify with a gender different from the sex they were assigned at birth.

Importantly, under the recently established criteria and terminology outlined in DSM-5, transgender status alone does not constitute a medical condition (APA, 2013). Instead, under the revised diagnostic guidelines, only transgender individuals who experience significant related distress are considered to have a medical condition called *gender dysphoria* (GD). Some combination of psychosocial, pharmacologic (mainly but not exclusively hormonal), or surgical care may be medically necessary for these individuals. Psychotherapy to confirm a diagnosis of GD is a common first step in the process, often followed by hormone therapy and, perhaps, by gender reassignment surgery involving secondary or primary sex characteristics. Not all patients seek all forms of care. However, recognized standards of care require documentation of 12 continuous months of hormone therapy and living in the target gender role consistently and in all aspects of life. Unfortunately, the diagnosis is newly established, and data from which to estimate the size of these subgroups are lacking. In the future, however, transgender individuals seeking gender transition–related treatment are likely to require a GD diagnosis as the clinical justification.

Among transgender individuals, a subset may choose to *transition*, the term used to refer to the act of living and working in a gender different from one's sex assigned at birth. For some individuals, this may involve primarily social change but no medical treatment; this is referred to as *social transition*. For others, medical treatments, such as hormone therapy and hair removal, are important steps to align their physical body with their target gender. This is referred to as *medical transition*. A subset of those who medically transition may choose to undergo *gender reassignment surgery* to make their physical body as congruent as possible with their gender identity. This process of *surgical transition* is also often referred to as *sex* or *gender reassignment* or *gender confirmation*.

Health Care Needs of the Transgender Population

The main types of gender transition–related treatments are psychosocial, pharmacologic (primarily but not exclusively hormonal), and surgical. While one or more of these types of treatments may be necessary for some transgender individuals with GD, the course of treatments varies and must be determined on an individual basis by patients and clinicians. Since little is known about currently serving transgender service members, the following discussion draws primarily from available research on nonmilitary transgender populations.[3]

[3] The 2015 DoD Health Related Behavior Survey of active-duty service members was being fielded concurrently to this research. It marked the first time a U.S. military survey asked questions relating to gender identity.

Diagnosis and Treatments for Gender Dysphoria

Treatments deemed necessary for transgender populations have shifted over time based on research advancements and the accumulation of clinical knowledge. The World Professional Association for Transgender Health (WPATH) regularly publishes revised versions of its *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*; the most current at the time of our research was version 7. The standards are designed to guide the treatment of patients experiencing GD while recognizing that not all expressions of gender nonconformity require treatment (WPATH, 2011, p. 2). Some transgender individuals (again, the proportion is largely unknown) experience significant dysphoria (distress) with the sex and gender they were assigned at birth, and they meet formal DSM-5 diagnostic criteria for GD, as described in Appendix B of this report. For those diagnosed with GD, treatment options include psychotherapy, hormone therapy, surgery, and changes to gender expression and role (i.e., how people present themselves to the world; WPATH, 2011, pp. 9–10). We discuss these treatment options in detail in Appendix C.

Not all patients will prefer or need all or any of these options; however, when clinically indicated, appropriate care can "alleviate gender dysphoria by bringing one's physical characteristics into alignment with one's internal sense of gender" (Herman, 2013b, p. 4). There have been no randomized controlled trials of the effectiveness of various forms of treatment, and most evidence comes from retrospective studies. The widely endorsed consensus-based practice guidelines outlined in the WPATH *Standards of Care* suggest that transition-related mental health care, hormone therapy, and surgery are generally effective and constitute necessary health care for many individuals with GD.[4] The appropriate treatment plan is best determined collaboratively by patients and their health care providers. Optimally, specialized transgender health care will be provided by an interdisciplinary team (WPATH, 2011, p. 26).

Military Health System Capacity and Gender Transition–Related Treatment

To discern the potential impact of changing DoD policies to allow transgender military personnel to serve openly and to ensure appropriate health care for GD, it is also important to consider whether the MHS has the capacity to provide this care.

We anticipate that these survey results will provide additional information regarding how many transgender personnel currently serve in the U.S. military and their health behaviors.

[4] These standards are endorsed by the American Medical Association, American Psychological Association, American Academy of Family Physicians, National Association of Social Workers, World Professional Association for Transgender Health, and American College of Obstetricians and Gynecologists (see Lambda Legal, 2012). Major insurers, including Aetna and UnitedHealthcare, have incorporated many of these standards of care into their policies (see, for example UnitedHealthcare, 2015).

Psychotherapy, Hormone Therapies, and Gender Transition–Related Surgery

Both psychotherapy and hormone therapies are available and regularly provided through the military's direct care system, though providers would need some additional continuing education to develop clinical and cultural competence for the proper care of transgender patients. Surgical procedures quite similar to those used for gender transition are already performed within the MHS for other clinical indications.

Reconstructive Surgery

Reconstructive breast/chest and genital surgeries are currently performed on patients who have had cancer, been in vehicular and other accidents, or been wounded in combat. The skills and competencies required to perform these procedures on transgender patients are often identical or overlapping. For instance, mastectomies are the same for breast cancer patients and female-to-male transgender patients. Perhaps most importantly, the surgical skills and competencies for some gender transition surgeries also overlap with skills required for the repair of genital injuries sustained in combat, which have increased dramatically among troops deployed to Afghanistan. From 2009 to 2010, the percentage of wounded troops with genitourinary injuries transiting through Landstuhl Regional Medical Center in Germany nearly doubled from 4.8 percent to 9.1 percent—a dramatic increase that led some health providers to call this the "new 'signature wound'" of Operation Enduring Freedom (D. Brown, 2011).[5] There are particular similarities to the procedures recommended to treat those experiencing dismounted complex blast injuries, which typically involve multiple amputations with other injuries, often to the genitals (Wallace, 2012). Providing high-quality surgery to treat the 5 percent of combat wounds that require penile reconstruction requires extensive knowledge and practice in reconstructive techniques (Williams and Jezior, 2013). Assuming the MHS continues to directly provide health services as it has in the past, there are at least two potential implications: First, military surgeons may currently have the competencies required to surgically treat patients with GD, and, second, performing these surgeries on transgender patients may help maintain a vitally important skill required of military surgeons to effectively treat combat injuries during a period in which fewer combat injuries are sustained.

Cosmetic Surgery

Recognition of the requirement for reconstructive plastic surgery as a result of the wartime mission drives the existing DoD policy for cosmetic surgery procedures in the MHS; the services have requirements and manpower authorizations for specialists who can perform reconstructive plastic surgery (Office of the Assistant Secretary of Defense

[5] Experimental penis transplants, expected to be performed for the first time within the next year at Johns Hopkins School of Medicine, are being developed in the United States specifically for combat-wounded veterans; however, there may be benefits for transgender patients as well (Welsh, 2015).

for Health Affairs, 2005, p. 1). Cosmetic/reconstructive surgery skills need to be maintained with practice, and surgeons must also "meet board certification, recertification, and graduate medical education program requirements" (Office of the Assistant Secretary of Defense for Health Affairs, 2005, p. 1).

Current DoD policy draws a distinction between elective cosmetic plastic surgery performed "to improve the patient's appearance or self-esteem" and reconstructive plastic surgery performed on bodily structures that are abnormal due to health conditions to improve function or approximate a normal appearance (Office of the Assistant Secretary of Defense for Health Affairs, 2005, p. 3). While reconstructive surgeries constitute necessary treatment, access to elective cosmetic surgical procedures is subject to added constraints. For example, cosmetic procedures are performed on a space-available basis and restricted to those who will be TRICARE-eligible for at least six months. These procedures also require written permission from the commander of the service member's active-duty unit, and the patient must pay surgical, institutional, and anesthesia fees (Office of the Assistant Secretary of Defense for Health Affairs, 2005, p. 3).[6] DoD recognizes the need for these reconstructive surgery competencies and has crafted a policy to cover plastic surgeries to maintain providers' surgical skills and certification requirements.

Potential Consequences of Not Providing Necessary Gender Transition–Related Care

The discussion of the health care needs of transgender military personnel is incomplete without considering the potential unintended effects of constraining or limiting gender transition–related treatment. Little question remains that there are transgender personnel currently serving in the AC. Adverse consequences of not providing transition-related health care to transgender personnel could include avoidance of other necessary health care, such as important preventive services, as well as increased rates of mental and substance use disorders, suicide, and reduced productivity.

Research indicates that, "due to discrimination and problematic interactions with health care providers, transgender individuals frequently do not access health care, resulting in short and long-term adverse health outcomes" (Roller, Sedlak, and Draucker, 2015, p. 418).[7] Further, patients denied appropriate health care may turn to other solutions, such as injecting construction-grade silicone into their bodies to alter

[6] Interestingly, according to Elders et al. (2014, p. 19), there is no difference in leave policies related to recovery time between the two.

[7] For example, among NTDS respondents, 28 percent reported postponing or avoiding treatment when sick or injured, and 33 percent delayed or skipped preventive care due to discrimination or disrespect from health care providers (Grant et al., 2011, p. 76). In one study, transgender respondents had fewer self-reports of good health and were more likely to report limitations on daily activities due to health issues (Kates et al., 2015, p. 5).

their shape (State of California, 2012, p. 12). There are also potential costs related to mental health care services for individuals who do not receive such care (Herman, 2013b, p. 20). Multiple observational studies have suggested significant and sometimes dramatic reductions in suicidality, suicide attempts, and suicides among transgender patients after receiving transition-related treatment (State of California, 2012, p. 10). A study by Padula, Heru, and Campbell (2015) found that removing exclusions on transgender care "could change the trajectory of health for all transgender persons" at a minimal cost per member per month.[8]

However, we caution that it is not known how well these findings generalize to military personnel. Moreover, while the existing data offer some indication of the needs for and costs of gender transition–related health care, it is important to note that none of these studies were randomized controlled trials (the gold standard for determining treatment efficacy). In the absence of quality randomized trial evidence, it is difficult to fully assess the outcomes of treatment for GD.

[8] Specifically, they found that insurance provider coverage for transgender-related services resulted in "greater effectiveness, and was cost-effective relative to no health benefits at 5 and 10 years from a willingness-to-pay threshold of $100,000/[quality-adjusted life year]."

CHAPTER THREE

What Is the Estimated Transgender Population in the U.S. Military?

This chapter provides several estimates of the number of transgender service members in the U.S. military. To date, there have been no systematic studies of the number of transgender individuals in the U.S. general population or in the U.S. military. Current studies rely on clinical samples of health care service utilizers, nonrepresentative samples assembled in ways that are difficult to replicate, and self-reported survey data from a small number of states.

General Population Estimates of Transgender Prevalence

The transgender prevalence in the U.S. general population is thought to be significantly less than 1 percent (Gates, 2011, p. 6; APA, 2013, p. 454). However, there have been no rigorous epidemiological studies in the general U.S. population that confirm this estimate. Our subsequent estimates must be qualified, therefore, as somewhat speculative; they are based on numerous sources, including health services claims data, representative state-level health surveillance survey data, a convenience (i.e., nonrepresentative) sample recruited by an advocacy network, the experiences of foreign militaries, and selected other data sources.

The Williams Institute at the University of California, Los Angeles, School of Law, calculated that, based on estimates from Massachusetts and California, 0.3 percent of the U.S. population is transgender (Gates, 2011, p. 6). The Massachusetts data were collected between 2007 and 2009 as part of the Massachusetts Behavioral Risk Factor Surveillance System initiative. The survey suggests that 0.5 percent of the population in Massachusetts identifies as "transgender" (95-percent confidence interval: 0.3 to 0.6 percent; Conron et al., 2012). The California data combine information on the percentage of individuals who are transgender from the California Lesbian, Gay, Bisexual, and Transgender (LGBT) Tobacco Survey and the percentage of the overall population that is LGBT from the 2009 California Health Interview Survey. Gates

multiplies these values together to estimate that 0.1 percent of the population of California is transgender.[1]

To develop an estimate of transgender prevalence for the entire United States, Gates (2011) simply averages the Massachusetts and California values, yielding 0.25 percent, then rounds that up to 0.3 percent. This measure is very problematic, however. While survey-based estimates of transgender prevalence are likely to be accurate measures of true state-level transgender prevalence, it is not clear that taking an unweighted average from states with vastly different population sizes is appropriate for estimating national prevalence. For example, a weighted average calculation using the 2009 census population estimates for California and Massachusetts implies a 0.16 percent "national" prevalence estimate, as opposed to the 0.3 percent estimate calculated by Gates (2011)—a nearly 50-percent difference. We used this 0.16 percent weighted average as our combined, national estimate using the California and Massachusetts studies. This estimate was our midrange starting point, though we included both the 0.1 percent (from California) and 0.5 percent (from Massachusetts) as comparison points.

We note that there have been and continue to be other efforts to measure the prevalence of transgender identity in the general population. The two most prominent examples are the meta-analysis conducted by WPATH and a recent effort from the U.S. census. We did not use these estimates due to concerns that they systematically undercounted the prevalence of transgender identity for a variety of reasons detailed in the discussions that follow.

Separately, in 2007, the WPATH reviewed ten studies of prevalence with estimates for transgender individuals presenting for gender transition–related care, ranging from 1:11,900 to 1:45,000 for male-to-female transitions and 1:30,400 to 1:200,000 for female-to-male transitions (WPATH, 2011).[2] The studies cited were largely based on clinical usage. The WPATH authors note that these numbers should be considered "minimum estimates at best":

> The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who

[1] Although Gates (2011) states that 3.2 percent of the LGBT population is transgender, we note that an earlier document (California Department of Health Services, 2004) reporting analyses from the same survey states that 2 percent of this population is transgender. We were not able to obtain the raw data and could not verify which of the two values is correct. We used the 3.2-percent estimate to calculate the California transgender prevalence estimate.

[2] The studies were Wålinder, 1968; Wålinder, 1971; Hoenig and Kenna, 1974; Eklund, Gooren, and Bezemer, 1988; Tsoi, 1988; Bakker et al., 1993; van Kesteren, Gooren, and Megens, 1996; Weitze and Osburg, 1996; De Cuypere et al., 2007; and Zucker and Lawrence, 2009.

> present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked. (WPATH, 2011, p. 7)

Additionally, the information is based on utilization rates from the ten studies, mostly conducted in European countries, such as the United Kingdom, the Netherlands, Sweden, Germany, and Belgium. One study was conducted in Singapore. This raises concerns about the applicability of these estimates to the U.S. population due to differences in costs and social tolerance, both of which would likely make health utilization behavior in Europe significantly different from that in the United States. Moreover, the studies were conducted over a 30-year period in which utilization was dramatically increasing, suggesting that the estimates were not stable. This concern is reported in the WPATH report, with the authors noting that the trend (over time) was due to higher rates of individuals seeking care. In one example, the estimated transgender population doubled in just five years in the United Kingdom. If the numbers are increasing over time based on the use of clinics, then an estimate from ten to 15 years ago would likely be very low relative to utilization in those same places today, and again not representative of likely utilization in the United States.[3]

Harris (2015) used information on name and sex changes in Social Security Administration data files to estimate the number of transgender individuals in the U.S. population. Using information on male-to-female and female-to-male name changes, he estimates that there were 89,667 transgender individuals in the United States in 2010. Of this group, 21,833 (24 percent) also changed their sex, according to Social Security records; during some periods in U.S. history, this required documented proof of either initiation or completion of medical transition. Since name changes are not required, prevalence estimated in this manner is likely to be a lower-bound estimate of the true transgender prevalence rate in the United States. Using the 2010 population of adults age 18 and over as the denominator (234,564,071), 89,667 transgender cases implies a lower-bound transgender prevalence rate of 0.038 percent in the United States.

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[3] According to the WPATH authors,

> The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period. (WPATH, 2011, p. 7)

Prevalence-Based Approach to Estimating the Number of Transgender Service Members in the U.S. Military

Before discussing estimates of prevalence of transgender individuals in the U.S. military, it is important to note that, to our knowledge, no studies have directly measured the prevalence or incidence of transgender individuals currently serving in the active or reserve component.[4] To estimate prevalence in the military, we have constructed estimates using a combination of data sources.[5] One of those sources, the NTDS, provides detailed information on the choices and preferences of transgender individuals but it is not a randomized, representative sample of the military and thus is not generalizable.

We applied measures of population prevalence to DoD force size estimates to estimate prevalence in the U.S. military. We measured force size using information from DoD's 2014 demographics report (DoD, 2014; see Table 3.1). The demographics are separated into AC and SR. For much of the discussion of our medical care analysis, we focus on the AC. We did not include reserve-component service members, retirees, or dependents in the cost analyses because we did not have information on age and sex distribution within these beneficiary categories. Some of these beneficiary categories also have limited eligibility for health care provided through military treatment facilities (MTFs) and may receive their health care through TRICARE coverage in the purchased care setting or through other health insurance plans. For our readiness analysis, we included both the AC and SR because both components may be used for deployments. Although there are ongoing discussions regarding the feasibility of activating the Individual Ready Reserve, we excluded this population because we lacked the detailed information on gender and age needed to conduct our analysis.

Table 3.2 contains estimates of the number of transgender personnel in the AC and SR using the baseline prevalence from existing studies and shows the results of several tests that provide a range of estimates based on different assumptions in the literature. To estimate prevalence in the military, we conducted analyses using five values: (1) a lower-bound estimate of 0.1 percent based on a study in California

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[4] G. Brown (1988) found that eight out of 11 evaluated natal males with severe GD had a military background; he explains his findings by positing a "hypermasculine" phase among transgender individuals that coincides with the age of enlistment. Since the sample size in that study was extremely small, we do not consider this good evidence for this theory. Gates and Herman (2014) used estimates from the NTDS, combined with estimates of transgender prevalence (0.3 percent) from Gates (2011) and history of military service in the U.S. population from the American Community Survey, to estimate transgender prevalence in the military. Data from the National College of Health Administration showed that military experience was significantly higher among transgender individuals than among those who did not identify as transgender (9.4 percent versus 2.1 percent; Blosnich, Gordon, and Fine, 2015). However, these data were collected from only 51 institutions, and the response rate for the survey was only 20 percent, which again raises questions regarding the validity of the estimates.

[5] Our estimates were constructed using Gates (2011), which combined estimates from the Massachusetts Behavioral Risk Factor Social Surveys with the California LGBT Tobacco Survey, and Gates and Herman (2014), which used data from the NTDS, Gates (2011), and the American Community Survey.

Table 3.1
DoD Military Force Demographics

Category	Number	%
Active Component		
Sex		
Female	200,692	15
Male	1,125,581	85
Age		
<25	572,293	43
26–30	293,698	22
31–35	201,137	15
36–40	137,653	11
41+	121,492	9
Total	1,326,273	—
Selected Reserve		
Sex		
Female	149,759	18
Male	682,233	82
Age		
<25	285,494	34
26–30	156,983	19
31–35	124,179	15
36–40	86,151	10
41+	179,185	22
Total	831,992	—

SOURCE: DoD, 2014.

(Conron, 2012); (2) an upper-bound estimate of 0.5 percent based on a study in Massachusetts (Gates, 2011); (3) a population-weighted average of the California and Massachusetts studies, yielding a prevalence estimate of 0.16 percent; (4) 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 (5) a doubling of the population-weighted, gender-adjusted value, yielding a prevalence estimate of 0.37 percent.

Table 3.2
Prevalence-Based Estimates of the Number of Transgender Active-Component and Selected Reserve Service Members

Component	Total Force Size (FY 2014)	0.1%[a] (CA study)	0.16%[b] (combined, population-weighted CA + MA studies)	0.19%[c] (gender-adjusted rate)	0.37%[d] (twice gender-adjusted rate)	0.5%[e] (MA study)
Active	1,326,273	1,320	2,120	2,450	4,900	6,630
Selected Reserve	831,992	830	1,330	1,510	2,930	4,160

SOURCES: Estimates for force size are based on RAND calculations using FY 2014 data from DoD, 2014.

[a] Based on estimates of prevalence from a California study (Conron, 2012).

[b] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

[c] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

[d] Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

[e] Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

Based on the 0.1 percent lower bound, we estimate that there are approximately 1,320 transgender individuals in the AC and approximately 830 in the SR. Using the Massachusetts study (0.5 percent) as an upper bound, we estimate that there are approximately 6,630 transgender service members in the AC and 4,160 in the SR. Because these estimates are based on selected populations in the state and the variation in these populations is significant, we were concerned that they were not representative of broader national numbers, especially as they pertain to the gender mix of the military. Therefore, we adjusted the population-weighted combination of these estimates to account for the male/female distribution in the U.S. military populations. This gender adjustment is critical, as most research indicates that male-to-female transitions are two to three times more common than female-to-male transitions (APA, 2013; Horton, 2008; Gates, 2011; Grant et al., 2011). This assumption of a two to one difference in underlying prevalence across genders applied to the 0.16 percent aggregate estimate implies a natal male-specific prevalence of 0.2 percent and a natal female-specific prevalence of 0.1 percent. Assigning these values to the male/female AC distributions increases the military prevalence estimate from 0.16 percent to 0.19 percent, which implies that there are 2,450 transgender individuals in the AC and 1,510 in the SR.

The estimate of 0.37 percent doubles the gender-adjusted rate based on information provided by the NTDS that 20 percent of the transgender population in its sample reported a history of military service, which is twice the rate of the general population,

as reported in the American Community Survey (Grant et al., 2011). We note that this is likely to be an overestimate of the overall transgender population for two reasons. First, given the highly tolerant environment in Massachusetts and California, the prevalence estimates in those two states are likely to overstate the nationwide prevalence.[6] Second, the evidence that transgender individuals are twice as likely to serve in the military is based on extrapolations from a nonrepresentative sample of individuals and not on direct, rigorous study of the transgender military population.

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[6] For example, both California and Massachusetts are rated as "top places for LGBT rights" (Keen, 2015).

CHAPTER FOUR

How Many Transgender Service Members Are Likely to Seek Gender Transition–Related Medical Treatment?

We adopted two distinct but related approaches to estimate the health care utilization and impact on readiness of allowing transgender personnel to serve openly in the U.S. military. The first is what we label the *prevalence-based approach*, in which we estimated the prevalence of transgender individuals in the military and applied information on rates of gender transition and reported preferences for different medical treatments to measure utilization and the implied cost and readiness impact. This approach has the benefit of including those who may seek other forms of accommodation, even if they do not seek medical care. It also provides detailed information on the types of medical treatments likely to be sought, which can improve the accuracy of cost and readiness estimates. However, this approach suffers from a lack of rigorous evidence in terms of the rates at which transgender individuals seek treatment and instead relies on the nonscientific NTDS. It also relies on prevalence measures from only two states—Massachusetts and California—that may not be directly applicable to military populations.

We refer to our second approach as the *utilization-based approach*, which we used to estimate the rates of utilization of medical treatment. This approach has the benefit of providing real-world measures of utilization based on health insurance claims, which may be more accurate and more rigorously collected than survey information. However, this approach suffers from a lack of large-scale evidence and instead relies on several case studies that may not be directly applicable to the U.S. military. Despite these caveats, these approaches provide the best available estimate of the range in the potential number of transgender service members likely to seek medical treatment or require readiness-related accommodations.[1]

In both cases, we applied measures of population prevalence and utilization to DoD force size demographics to provide estimates of prevalence within the U.S. military. As indicated in the previous chapter, our calculations of population prevalence and health care utilization used FY 2014 data from DoD's 2014 demographics report (DoD, 2014; see Table 3.1 in Chapter Three).

[1] Again, we define *accommodations* as adjustments in military rules and policies to allow individuals to live and work in their target gender.

Prevalence-Based Approach to Estimating the Number of Gender Transition–Related Treatments in the U.S. Military

To estimate the utilization of gender transition–related health care treatments, we scaled the prevalence of transgender service members identified in Chapter Three by the rates of transition and reported take-up of medical treatments. We based our transition rates on self-reported transitions in the NTDS data. According to the NTDS, 55 percent of transgender individuals reported living and working as their target gender; we refer to this as *social transition*.[2] For others, medical treatments, such as hormone therapy and hair removal, are important steps to align their physical body with their target gender. We refer to this as *medical* or *surgical transition*.[3]

Using the prevalence estimates from Table 3.2 in Chapter Three, we used information from the NTDS on the age of transition for individuals under 25, 26–30, 31–35, 36–40, and over 40 and calibrated our estimates with the age distribution in the military. Fifty-five percent of NTDS respondents reported that they had socially transitioned over their lifetime, and the data indicate that male-to-female transition ages differ from female-to-male transition ages. Nearly 54 percent of female-to-male transitions occurred before the age of 25, compared with only 23 percent of male-to-female transitions.

We focus on social transition because we assess this as most relevant for individuals who may need accommodations as they live and work in a different gender. This was also used as the basis in some foreign militaries, as discussed in Chapter Seven. Table 4.1 presents the estimated number of individuals who may seek to transition each year under each of our prevalence assumptions. We found that a lower bound of 40 AC and 20 SR service members and an upper bound of 190 AC and 110 SR service members will seek to transition each year and may need some sort of accommodations. The population-weighted, gender-adjusted estimate implies a middle range of 65 AC and 40 SR service members who will seek to transition each year.

Next, we combine the estimates of the number of transgender service members with information on the proportion undergoing transition and the age-specific proportion undergoing gender transition–related treatment to generate the number of annual treatments. Surgical preference rates vary by transition type (male-to-female versus female-to-male transition; see Table 4.2). Surgeries are distributed evenly across

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[2] We note that an additional 27 percent of those who had not yet socially transitioned wished to transition at some point in the future. Because the timeline and desire for transition are difficult to translate to concrete numbers, we used the estimate of 55 percent of transgender individuals living and working full-time as their target gender as our planning parameter for readiness accommodations.

[3] In the NTDS sample, 65 percent of transgender individuals had medically transitioned, and 33 percent had surgically transitioned. Note that the rate of medical transitions is higher than the rate of social transitions because some individuals receive hormone treatments but do not live full-time as their target gender.

Table 4.1
Estimated Number of Transgender Service Members Who May Seek to Transition per Year

Estimate Source	Active Component (total force: 1,326,273)	Selected Reserve (total force: 831,992)
0.1% (CA study)[a]	40	20
0.16% (combined, population-weighted CA + MA studies)[b]	60	30
0.19% (gender-adjusted rate)[c]	65	40
0.37% (twice gender-adjusted rate)[d]	130	80
0.5% (MA study)[e]	190	110

SOURCES: Estimated proportions of subgroups based on Grant et al., 2011, p. 25. Estimates for the AC and SR are based on RAND calculations using FY 2014 data from DoD, 2014.

[a] Based on estimates of prevalence from a California study (Conron, 2012).

[b] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

[c] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

[d] Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

[e] Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

NOTE: The table excludes Individual and Inactive Ready Reserve members because comparable information on their demographics was not available for analysis.

four procedures for male-to-female transitions and primarily over two procedures for female-to-male transitions.

Recall, not all of the individuals seeking to transition would meet the diagnostic criteria for GD, which is a requirement for these surgeries. Moreover, even among individuals who transition in some manner, surgical treatment rates are typically only around 20 percent, with the exception of chest surgery among female-to-male transgender individuals (see Table 4.2).

Table 4.3 shows the estimated annual number of hormone therapy treatments and surgeries in the AC and SR calculated using the same prevalence assumptions described in Chapter Three (see Table 3.2). The surgeries included in the calculations are vaginoplasty, chest surgeries, orchiectomy, hysterectomy, metoidioplasty, and phalloplasty. Note that these estimates constitute the number of treatments, not necessarily the number of individuals. For hormone therapy recipients, the number of treatments and recipients is the same, and these estimates can be treated as counts of individuals. However, the number of individuals is likely smaller for surgical counts because the

Table 4.2
Lifetime Surgery Preferences Among NTDS Survey Respondents

Procedure	Have Had (%)	Want Someday (%)	Do Not Want (%)
Male-to-female			
Augmentation mammoplasty	21	53	26
Orchiectomy	25	61	14
Vaginoplasty	23	64	14
Facial surgery	17	Not reported	Not reported
Female-to-male			
Chest surgery	43	50	7
Hysterectomy	21	58	21
Metoidioplasty	4	53	44
Phalloplasty	2	27	72

SOURCE: NTDS data (Grant et al., 2011).

NOTE: These estimates are from cross-sectional data; individuals likely received each treatment only once and varied in the age at treatment initiation.

same individual may receive more than one type of surgical treatment.[4] Using the lower-bound estimate from the California study and the upper-bound estimate from the Massachusetts study (see Table 4.3), we estimated that there will be between 45 and 220 hormone treatments and between 40 and 200 transition-related surgeries annually in the AC and SR. The combined population-weighted and gender-adjusted estimate indicates a midrange of 80 hormone treatments and 70 transition-related surgical treatments annually. Although surgical procedures are most likely to be one-time events, hormone therapy treatment rates are likely to be used indefinitely, and the cost and manpower effects will apply until individuals leave the MHS. We did not have information on the length of service conditional on age and therefore could not calculate the total number of service members who would be receiving hormone therapy at any given point in time. We recommend that this line of analysis be explored in the future.

Utilization-Based Approach to Estimating the Number of Gender Transition–Related Treatments in the U.S. Military

While the prevalence-based approach provides a tractable means to estimate potential utilization of gender transition–related care, there are a number of concerns regard-

[4] For example, a female-to-male transition might include both chest surgery and phalloplasty.

Table 4.3
Estimated Annual Number of Surgeries and Hormone Therapy Users

	Active Component		Selected Reserve	
Assumption Regarding Underlying Prevalence	Annual Major Surgeries	Annual Hormone Therapy	Annual Major Surgeries	Annual Hormone Therapy
0.1% (CA study)[a]	25	30	15	15
0.16% (combined, population-weighted CA + MA studies)[b]	40	45	20	25
0.19% (gender-adjusted)[c]	45	50	25	30
0.37% (twice gender-adjusted rate)[d]	90	100	50	55
0.5% (MA study)[e]	130	140	70	80

SOURCE: RAND analysis.

[a] Based on estimates of prevalence from a California study (Conron, 2012).

[b] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

[c] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

[d] Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

[e] Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

NOTE: Hormone therapy is person-level; surgery statistics are counts of surgeries, and one person may have multiple surgeries.

ing the information on which these estimates rely. As stated previously, these concerns include both a reliance on prevalence estimates from just two states and a reliance on data from the NTDS, which were not collected from a random sample. Our utilization estimates were taken primarily from three sources:

- private health insurance utilization data on annual rates of enrollee transgender-related health care utilization in health insurance plans that cover transition-related health care, as reported by Herman (2013b)
- private health clinic data showing estimates of the rates of penectomies and bilateral mastectomies in the U.S. population in 2001, as reported by Horton (2008)[5]

[5] A penectomy is the surgical removal of the penis. A bilateral mastectomy is the surgical removal of both breasts.

- Veterans Health Administration (VHA) claims data, which were used to calculate prevalence and incidence rates of gender identity disorder (now referred to as GD in DSM-5) from 2006 to 2013, as reported by Kauth et al. (2014).

Each of these data sources provides information on a different outcome, which makes understanding the results more complicated. However, collectively, the information taken from these three studies provides a broad, useful picture regarding potential gender transition–related health care utilization in the AC population. In the following sections, we review each of these studies in detail, identify key estimates from each, and apply the estimates to the AC population identified in Table 3.2 in Chapter Three.

Private Health Insurance Utilization Estimates

Herman (2013b) reports on the experiences of 34 employers that provided gender transition–related health care benefits to their employees and dependents via their health insurance plans. This study specifically reports on the annual number of enrollees who accessed "transition-related care." This information is derived from health insurance claims data and thus is dependent on the treatments that were covered by the health insurance companies.[6] The firms surveyed typically covered major gender transition–related surgeries and hormone therapy, but they varied in their coverage of other transition-related treatments, such as vocal cord surgery.[7]

Firms reviewed by Herman (2013b) also typically did not report information on the number of dependents covered but included dependents in their utilization estimates. Data from several sources (e.g., Sonier et al., 2013; Gould, 2012) imply an approximate average one-to-one ratio of employees to dependents in privately insured firms in the United States. Thus, not accounting for the role of dependents in these utilization estimates would overstate utilization by approximately 100 percent.[8] For

[6] If firms do not cover particular treatments, it is not possible to file a claim for reimbursement. If individuals in these firms utilized services that were not covered, thus paying for treatments out of pocket or through some other form of health insurance, these utilization estimates will be biased downward.

[7] One hundred percent of firms covered major gender transition–related surgeries, including hysterectomy, oophorectomy, metoidioplasty, phalloplasty, urethroplasty, vaginectomy, orchiectomy, vaginoplasty, labiaplasty, and clitoroplasty. Ninety-two percent of firms covered bilateral mastectomy for female-to-male patients, but only 59 percent covered female-to-male chest reconstruction, and only 59 percent covered male-to-female augmentation mammoplasty (breast augmentation). All firms covered hormone therapies, specifically estrogen, progesterone, spironolactone, and testosterone.

[8] We used two different data sources to determine the typical number of dependents covered by the main policyholder in private health insurance firms in the United States. First, we used information from the Robert Wood Johnson Foundation on the number of people who are covered by employer-sponsored health insurance and are the main policyholders and on the number of people who are covered by employer-sponsored health insurance and are dependents. Using these figures, we estimated a 1-to-0.99 policyholder-to-dependent ratio in employer-sponsored private health insurance. The Economic Policy Institute also reports information on this question using data from the U.S. census Current Population Survey. Using this information, we calculated a policyholder-to-dependent ratio of 1 to 0.94.

firms that did not provide information on dependents, we imputed a one-to-one ratio of employees to dependents to identify the total number of enrolled individuals in a given health plan.

Table 4.4 presents the information from Herman (2013b) on the utilization of gender transition–related care in private health insurance firms. The first column shows available information on the identity of the firm. The second describes the number of firms in each category for which we had utilization estimates. The third contains our estimates regarding the total number of enrollees and dependents from all firms in that category. For confidentiality reasons, some surveyed data sources report only ranges for the number of employees in a firm. Therefore, we used the midpoint of the range to impute the number of employees in a particular firm, then assigned the total number of dependents based on this employee value. For example, we had utilization data from two firms in the "private 1,000–9,999 employees" category. Since we assume the midpoint value for firm size, this implies that there are 5,000 employees in each firm, or 10,000 total employees across the two firms. Assuming a one-to-one employee-to-dependent ratio implies an additional 10,000 covered individuals, resulting in a combined total of 20,000 enrollees.

The estimates presented in Table 4.4 indicate that utilization rates range from an annual low of zero individuals per 1,000 enrollees to an annual high of 0.064 individuals per 1,000 enrollees. To obtain a combined estimate of the different values, we constructed a weighted average using the existing utilization estimates, weighting by the number of covered individuals that generated each of the estimates in Table 4.4. A weighted average of all the estimates results in an overall utilization estimate of 0.0396 individuals per 1,000 enrollees.

Table 4.4
Enrollee Utilization of Gender Transition–Related Benefits in Private Health Insurance Firms

Private and Public Firms	Number of Firms	Total Contribution (enrollees + dependents)	Individual Claimants per 1,000 Enrollees
Private, fewer than 1,000 employees	1	1,000	0.0000
Private, 1,000–9,999 employees	2	20,000	0.0540
Private, 10,000–49,000 employees	5	250,000	0.0220
City and County of San Francisco	NA	80,000	0.0640
University of California	NA	100,000	0.0620
Weighted average per 1,000 enrollees			0.0396

SOURCE: Data from Herman, 2013b.

We conducted two sets of calculations using these estimates. First, we used the lowest non-zero utilization figure (0.022 claimants per 1,000 enrollees);[9] then, we used the weighted average calculation of 0.0396 per 1,000 enrollees. Applying the 0.022 claimants per 1,000 figure to the AC population of 1,326,273 implies that 29 AC service members would receive gender transition–related care annually. Applying the weighted average estimate of 0.0396 per 1,000 enrollees to the AC population implies that 53 service members would receive gender transition–related care annually.

Sensitivity Analyses

We also conducted two additional sensitivity analyses to determine the full potential scope of gender transition–related health care utilization in the AC. A key consideration when applying estimates from civilian populations to the military is that the underlying male/female distribution in the AC is different, with 85 percent of the AC population being male (versus approximately 50 percent in the civilian population). Studies suggest that the prevalence of transgender individuals is higher in the male population than in the female population (APA, 2013; Horton, 2008; Gates, 2011; Grant et al., 2011), so applying civilian estimates directly to the AC would underestimate the true utilization rates.

Accurately accounting for this issue required sex-specific utilization estimates that we could then multiply with the male/female AC distribution (85 percent male, 15 percent female). Unfortunately, we could not identify any sex-specific utilization estimates in the available private health insurance data; the aggregate cost and utilization estimates that we were able to identify already included underlying prevalence differences between the sexes. We posited that utilization would be twice as large for male-to-female transitions than for female-to-male transitions based on an assumption of linearity between transgender prevalence, for which we have sex-specific estimates, and total utilization (Horton, 2008).

Combining this assumption about differing utilization rates with the fact that the male/female labor force participation in the civilian population is close to 50 percent male and 50 percent female, we were able to solve for the sex-specific utilization estimates implied by the aggregate lower-bound (0.022) and weighted average (0.0396) values. Solving for the sex-specific utilization estimates in this manner, for the 0.022 aggregate estimate, we estimated a utilization rate of 0.0293 per 1,000 natal male enrollees and a utilization rate of 0.0146 per 1,000 natal female enrollees.[10] Similarly, for the 0.0396 weighted average figure, solving for the natal sex–specific utiliza-

[9] The unadjusted version of this figure (0.0044 percent) was also used in Belkin (2015) to estimate health care utilization in the military.

[10] The equation we solved to calculate the natal male–specific and natal female–specific utilization rates is as follows: $0.5(x) + 0.5(2x) = 0.022$. In this equation, the variable x is the natal female–specific utilization rate, and solving for x results in a value of 0.0146. Since the natal male–specific utilization rate is assumed to be twice the natal female rate, it equals 0.0293.

tion estimates, we identified a utilization rate of 0.0528 per 1,000 natal male enrollees and a utilization rate of 0.0264 per 1,000 natal female enrollees.

Applying these solved sex-specific estimates to the AC male/female distribution (1,125,581, or 85 percent male, versus 200,692, or 15 percent female) increased our initial lower-bound estimate of claimants from 29 to 36 and increased our estimate from applying the weighted average from 53 to 65.

Finally, the sociology and psychology literature speculates that there is a higher transgender prevalence in the military compared with the civilian population (G. Brown, 1988). Gates and Herman (2014) also calculated that transgender prevalence in the military is approximately twice the civilian prevalence (Gates, 2011; Gates and Herman, 2014).[11] Although we believe that the current body of empirical evidence validating this theory is weak, we take it seriously and consider the possible implications for transition-related health care utilization in the military. Assuming that transgender prevalence in the military is twice the transgender prevalence in the civilian population, and, again, assuming a direct relationship between prevalence and utilization, this would inflate our male/female distribution-adjusted estimates of individuals receiving transition-related care annually from 36 to 72, and from 65 to 129 in the AC. Table 4.5, which summarizes the results from applying the private health insurance estimates to the AC population, allows for a comparison of the different estimates.

Private Health Clinic Estimates

A second source of information regarding gender transition–related health care utilization comes from a survey of surgical clinics conducted by Horton (2008). In 2001, Horton surveyed all major clinics in the United States known to provide transition-related care to determine the number of penectomies and bilateral mastectomies performed on transgender patients. Table 4.6 reports surgery incidence estimates broken out by male-to-female transitions and female-to-male transitions. The third column shows estimates using clinic-reported data only. Horton also developed lower- and upper-bound estimates via assumptions regarding treatment counts for clinics with missing data, and these numbers are reported in the second and fourth columns of Table 4.6.[12] These data were collected in 2001 and coverage of gender transition-related benefits have increased over time, so it is also reasonable to assume that surgical tran-

[11] As stated previously, Gates and Herman (2014) used estimates from the NTDS and Gates (2011) for a transgender prevalence of 0.3 percent. That study also used data on history of military service in the U.S. population from the American Community Survey to estimate transgender prevalence in the military. Data from the National College of Health Administration show that military experience was significantly higher among transgender individuals than among those who did not identify as transgender (9.4 percent versus 2.1 percent; Blosnich, Gordon and Fine, 2015). However, data were collected from only 51 institutions, and the response rate for the survey was only 20 percent, which again raises questions regarding the validity of the estimates.

[12] Horton generated upper- and lower-bound estimates by assigning the largest and smallest surgical counts in the data to the clinics with missing values.

Table 4.5
Utilization Estimates from Applying Private Health Insurance Parameters

Annual Individual Claimants	Estimate from the Literature	Estimates Using Private Employer Data		
		Baseline	Sensitivity Analysis 1[a]	Sensitivity Analysis 2[b]
Active component, lower-bound estimate	0.022 claimants per 1,000 individuals	29	36	72
Active component, weighted average estimate	0.0396 claimants per 1,000 individuals	53	65	129

NOTES: Each cell in the "Estimates Using Private Employer Data" columns represents a unique prediction for utilization in the AC population. In the second column of the table, we describe the estimate from the literature that is applied to the AC population. See the text for details on each of the calculations.

[a] Sensitivity Analysis 1: We calculated a set of estimates that accounted for differences in the male/female distribution between the civilian and AC populations.

[b] Sensitivity Analysis 2: We calculated a set of estimates that accounted for differences in the male/female distribution between the civilian and AC populations and the possibility that transgender prevalence is twice as high in the military population as in the civilian population.

Table 4.6
Incidence of Penectomies and Bilateral Mastectomies Performed on Transgender Individuals

Transition Type	Incidence Estimates (%)		
	Low	Clinic-Reported Data	High
Male-to-female	0.00048	0.00053	0.00103
Female-to-male	0.00020	0.00030	0.00084

SOURCE: 2001 data from Horton, 2008.

NOTE: The table includes data on penectomies and bilateral mastectomies only.

sitions have also increased over time. Thus, these utilization rates of penectomies and bilateral mastectomies should be considered lower-bound estimates.

Applying these estimates to the AC male/female distribution results in low, medium, and high annual estimates of 5.8, 6.6, and 13.2 AC service members receiving these two surgeries, respectively. We reiterate here that these estimates are not directly comparable to the private health insurance estimates presented in the previous section because these estimates apply to only two specific procedures, while the private health insurance estimates include any gender transition–related procedures that private health insurance firms cover. One would expect estimates for two specific surgeries from 2001 to be lower than estimates generated from the private health insurance system in the later 2000s. Indeed, they are, but it is more difficult to make other direct

comparisons between these two estimates, given the private health insurance utilization data presented in Herman (2013b).

Veterans Health Administration Estimates

In this analysis, we used VHA data to calculate the expected annual incidence of gender identity disorder (the condition now known as GD in the DSM-5) in the AC population. As described previously, those with a gender identity disorder diagnosis are a subset of transgender individuals. Kauth et al. (2014) used VHA health claims data to identify incidence rates of new diagnoses. They also calculated prevalence rates of gender identity disorder in each year using previous yearly incidence rates. Because 2006 was the first year in their data set, the prevalence rate in the first year of their data is equivalent to the incidence rate. In the years after 2006, the prevalence rate is essentially a running total of the incidence rates in the previous years added to the most recent incidence rates.

The data in Table 4.7 imply that the incidence of gender identity disorder increased from 3.5 of 100,000 enrollees in FY 2006 to 6.7 of 100,000 enrollees in FY 2013 among veterans who use VHA health care (Kauth et al., 2014). Before applying these estimates to the AC population, we note two important points with respect to the analyses in Kauth et al. (2014). First, because the prevalence rate is simply a running total of new cases diagnosed since the first year of the study's data (2006), adding years of data prior to 2006 would mechanically increase the prevalence estimates. Thus, Kauth et al.'s prevalence calculations are a lower-bound for the total gender

Table 4.7
Prevalence and Incidence of Gender Identity Disorder Diagnoses in VHA Claims Data

Fiscal Year	New Diagnosis Rate (%)	Prevalence (%)
2006	0.0035	0.0035
2007	0.0034	0.0068
2008	0.0034	0.0098
2009	0.0038	0.0131
2010	0.0046	0.0172
2011	0.0051	0.0217
2012	0.0060	0.0270
2013	0.0067	0.0329

SOURCE: Kauth et al., 2014.

NOTE: The authors calculated new cases diagnosed and total existing cases in a given year based on the entirety of the data since 2006.

identity disorder prevalence rate in this population. Second, estimates based on claims data will likely be lower-bound estimates of incidence and prevalence, since individuals are identified only if they interact with the health care system for reasons related to gender identity disorder. These two caveats should be kept in mind when interpreting the extrapolations here.

Applying estimates from the 2013 data in Table 4.7 to the AC population, one would expect approximately 90 new cases of gender identity disorder each year and that approximately 440 AC service members would be diagnosed with this condition. Although the male/female distribution in the VHA system mirrors that of the AC, veterans who use VHA health care services may have lower socioeconomic and health status than veterans who do not use VHA health care, other military retirees, and AC service members. The VHA population also differs by age and, potentially, by other unmeasured characteristics related to underlying health status. For these varied reasons, these estimates may not be generalizable to the military population overall.

Summarizing the Estimates

Table 4.8 summarizes the key results after applying the estimates from the various data sets to the AC and SR populations. The largest estimate—270 treatments (surgeries and hormone therapies)—was calculated by combining the upper-bound population-level transgender prevalence estimate from Massachusetts with information from the NTDS data on the age of those receiving common transition-related treatments. When applied to the AC population, estimates from VHA and the private health insurance literature imply that only 30–90 AC service members will receive some type of gender transition–related treatment annually.

To understand the full implications of our estimates regarding the expected annual number of AC service members likely to obtain gender transition–related care, in Figure 4.1 we compare the above utilization estimates with the number of AC service members who self-reported visiting a mental health care provider in a given year (21 percent) and the number of AC service members who visited a mental health care specialist in a given year (7 percent; Hoge et al., 2006; McKibben et al., 2013). We chose this outcome because mental health care among military populations is an important, well-studied topic, and data were readily accessible for us to conduct the comparison. The mental health care utilization estimates represent unique service members accessing health care; thus, they compare most directly to the estimates using the private health insurance data and the NTDS hormone therapy estimates. For clarity's sake, we do not present all of the private health insurance and NTDS hormone therapy estimates in Figure 4.1. We do include the smallest, middle, and largest estimates using the private health insurance data and the largest hormone therapy estimate drawn from the NTDS data.

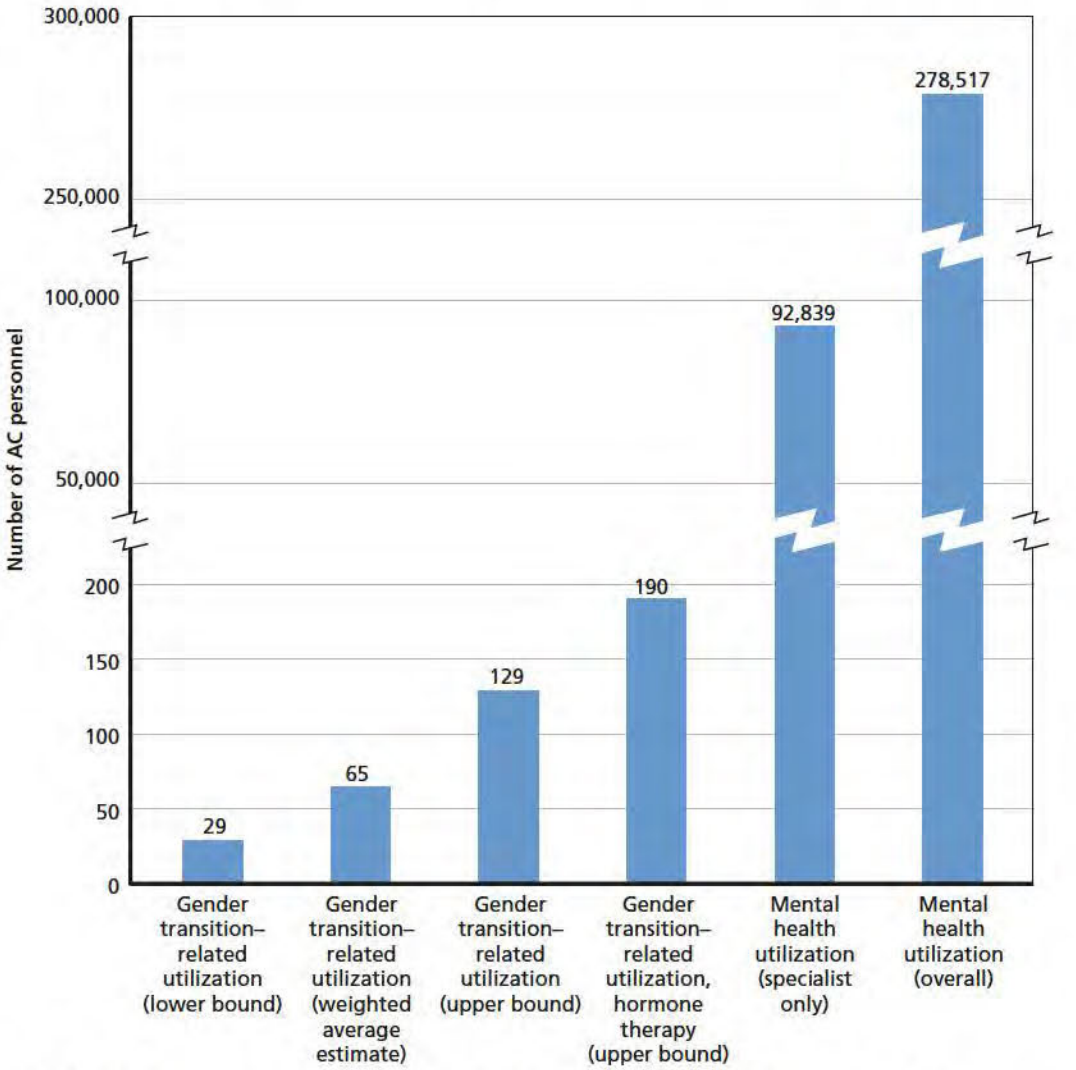
Table 4.8
Annual Gender Transition–Related Treatment Estimates from All Data Sources

	Active Component			Selected Reserve		
Estimate Type	Hormone Treatment	Surgical Treatments	All Treatments	Hormone Treatment	Surgical Treatments	All Treatments
Prevalence-based estimates (using NTDS data)						
Annual treatments based on CA study estimate (0.1%)	30	25	55	15	15	30
Annual treatments based on combined, population-weighted, gender-adjusted rate (0.19%)	50	45	95	25	30	55
Annual treatments based on MA study estimate (0.5%)	140	130	270	70	80	150
Utilization-based estimates						
Private health insurance annual individual claimants (0.022 per 1,000)	NA	NA	29	NA	NA	20
Private health insurance annual individual claimants (0.0396 per 1,000)	NA	NA	53	NA	NA	30
VHA-based annual new diagnoses (0.0067%)	90	NA	NA	60	NA	NA
Clinical utilization of penectomies and bilateral chest surgeries (0.0005%)	NA	10	NA	NA	5	NA

SOURCE: RAND analysis.

As Figure 4.1 shows, our estimates of the number of AC personnel who will use the gender transition–related health care benefits are overwhelmingly small compared with the number of AC personnel who access mental health treatment. Overall, based on our calculations, we expect annual gender transition–related health care to be an extremely small part of overall health care provided to the AC population.

Figure 4.1
Comparison of Annual Estimated Gender Transition–Related Health Care Utilization and Mental Health Care Utilization, Active Component



SOURCE: RAND analysis. Utilization rates in the figure are derived from both the prevalence-based and utilization-based approaches presented in Table 4.8.

NOTES: The non–hormone therapy transgender utilization estimates are from the application of estimates from the private health insurance data. The hormone therapy upper-bound transgender utilization estimate is from calculations using the NTDS data.

RAND *RR1350-4.1*

CHAPTER FIVE

What Are the Costs Associated with Extending Health Care Coverage for Gender Transition–Related Treatments?

In this chapter, we provide estimates for the costs associated with extending health care coverage for gender transition–related treatments. We focused on transgender service members in the AC because they have uniform MHS access. We did not include reserve-component service members in our analyses, but their MHS utilization and the associated cost will be negligible, given their highly limited military health care eligibility. Likewise, we did not include retirees or dependents in the cost analyses because we did not have information on age and sex distribution within these beneficiary categories. Some of these beneficiary categories also have limited eligibility for health care provided through MTFs and may receive their health care through TRICARE coverage in the purchased care setting or through other health insurance plans. Given these unknowns, it was only feasible to estimate the costs of gender transition–related care for AC service members; however, we recommend expanding these analyses in the future to include reserve-component members, as well as all individuals eligible for treatment under TRICARE. For the following analyses, we used demographic characteristics of the 2014 AC population to estimate the cost of providing such services.

Private Health Insurance Cost Estimates

To determine the potential costs of covering gender transition–related health care for transgender service members, we collected information on private health insurers' experiences with covering this care from two sources (Herman, 2013b; State of California, 2012). These actuarial estimates represent the expected increase in health care costs from covering a new set of treatments or a new group of beneficiaries. If employers decide to provide coverage for a particular treatment, these actuarial estimates are translated into premium increases for covered employees. These estimates should be thought of as the expected costs of extending coverage for gender transition–related care to transgender AC service members. Moreover, we note that the military may already be incurring the cost of some transgender treatments, as some patients and their providers use "omissions and ambiguities" to acquire needed care (Roller, Sedlak, and Draucker, 2015, p. 420). For example, a currently serving female-to-male patient

who had undergone a hysterectomy reported taking only the testosterone and not the estrogen prescribed as part of hormone therapy with his endocrinologist's knowledge and tacit support, while another was trying to get breast reduction surgery due to back pain rather than GD (Parco, Levy, and Spears, 2015, pp. 235–236).

Table 5.1 presents available data from public employers and private firms on the actuarial costs of covering gender transition–related care. It identifies the particular institution, the number of employees and dependents covered, and the identified premium increases due to expanding benefits.

Data from Table 5.1 show, generally, that the actuarial estimates of providing benefits for gender transition–related care increased total premiums (employee + employer share) by only a small fraction of a percent—and, in the most extreme cases, by only approximately 1 percent. Taking a weighted average of most of the information,[1] we estimated that extending insurance coverage to transgender individuals would increase health care spending by 0.038 percent. Applying this figure to total AC health care spending of $6.27 billion,[2] we find that covering gender transition–related care will increase AC health care spending by approximately $2.4 million (see Table 5.2).

The data in Table 5.1 suggest that the University of California, with 100,000 enrollees in its health plan, is one of the key drivers of the 0.038-percent weighted

Table 5.1
Actuarial Estimated Costs of Gender Transition–Related Health Care Coverage from the Literature

Public Employer Data	Actuarially Calculated Premium Increase	Total Contribution (employees + dependents)
City of Seattle	0.19% increase in health care budget	23,090
City of Portland	0.08% increase in health care budget	18,000
City of San Francisco	0% increase in health care budget	100,000
University of California	0% increase in health care budget	100,000
Private Employer Data	**Estimate**	**Total Contribution (employees + dependents)**
22 firms	Many employers reported no actuarial costs to adding benefit; estimates range from 0 to 0.2%	Mix of firm sizes
2 firms	Approximately 1% increase in premiums	5,800
1 firm	Much less than 1% increase in premium	77,000

SOURCE: Estimates are from Herman, 2013b, and State of California, 2012.

[1] We did not use information about the firm with 77,000 enrollees because it is not clear what "much less than 1 percent" implies with respect to the premium increase.

[2] Pharmaceutical and direct and purchased care inpatient and outpatient data calculated from TRICARE costs in Defense Health Agency, 2015.

average result. In addition to the actuarial increases, the University of California also reported a realized increase in health care spending of 0.05 percent, so we recalculated the weighted average figure by replacing the 0-percent estimate with the 0.05 percent estimate. This new calculation raised the overall cost estimate from 0.038 percent to 0.054 percent, or from $2.4 million to $3.4 million when applied to the AC. To summarize, our baseline estimates regarding expected gender transition–related health care costs in the AC are between $2.4 million and $3.4 million.

Sensitivity Analyses

To understand the potential full range of cost effects in the AC population, we conducted two additional sensitivity analyses similar to those described for our utilization ranges in Chapter Four. We used these sensitivity analyses to account for the skewed male/female distribution in the military population and for the possibility that transgender prevalence is higher in the military population. As in the utilization case, we were not able to identify any sex-specific effects on the premium increases. Thus, as in our utilization analysis, we assume that cost estimates are linearly related to prevalence,[3] and cost estimates for male-to-female transitions are twice the cost estimates for female-to-male transitions. Using this relationship, we again calculated natal male– and natal female–specific estimates from the aggregate estimates.

Given the assumption about differing cost effects, we calculated a natal male–specific cost estimate of 0.05 percent and a natal female–specific cost estimate of 0.025 percent for the aggregate premium estimate of 0.038 percent. Applying these sex-specific estimates to the AC male/female distribution increased our initial premium estimate from 0.038 percent to 0.047 percent. A similar calculation can be performed for our realized cost estimate of 0.054 percent. Assuming that gender transition–related health care costs are twice as large for male-to-female transitions as for female-to-male transitions, we calculated a natal male–specific cost effect of 0.072 percent and a natal female–specific cost effect of 0.036 percent. Applying these sex-specific estimates to the AC male/female distribution increased our initial premium estimate from 0.054 percent to 0.067 percent. Applying these newly calculated health care costs to the 2014 AC health care expenditures ($6.27 billion) increased our estimate of costs from the initial range of $2.4–3.4 million to a range of $2.9–4.2 million.

Finally, as noted previously, Gates (2011) and Gates and Herman (2014) calculated that transgender prevalence in the military is approximately twice that in civilian

[3] We also note that built into this linearity assumption and how it is applied in the two sensitivity analyses is the assumption that the cost of male-to-female transitions is the same as the cost of female-to-male transitions. Since there is no sex-specific information in the private health insurance cost data, the validity of the cost per case being equivalent is unknown. Padula, Heru, and Campbell (2015) estimated that a male-to-female surgical case is 33 percent more expensive than a female-to-male surgical case, but these estimates were not based on private employer data, so we did not directly incorporate this result into our calculations.

populations. Assuming that this estimate is valid, and, again, assuming that health care costs are linearly related to underlying prevalence, this would increase the above calculated value of $2.9 million to $5.8 million and the calculated value of $4.2 million to $8.4 million. Table 5.2 summarizes the results from the calculations described in this section.

To better understand the relative importance of our estimates regarding expected AC annual gender transition–related health care spending, we compared our cost estimates to the MHS spending on mental health in 2012 and to total AC health care spending in FY 2014. As Figure 5.1 shows, gender transition–related health care spending is expected to be extremely small compared with MHS spending on mental health (Blakely and Jansen, 2013) and overall AC health care expenditures (Defense Health Agency, 2015).

Summarizing the Estimates

A direct application of estimates from the private health insurance system implies a baseline spending range between $2.4 million and $3.4 million for AC gender transition–related health care. Sensitivity analyses that attempt to account for the fact that the male/female distribution in the AC population skews more heavily male than the civilian population and that transgender prevalence might be higher in the military increase this initial range to $5.8 million to $8.4 million. The implication is that even in the most extreme scenario that we were able to identify using the private health insurance data, we expect only a 0.13-percent ($8.4 million out of $6.2 billion) increase in AC health care spending.[4]

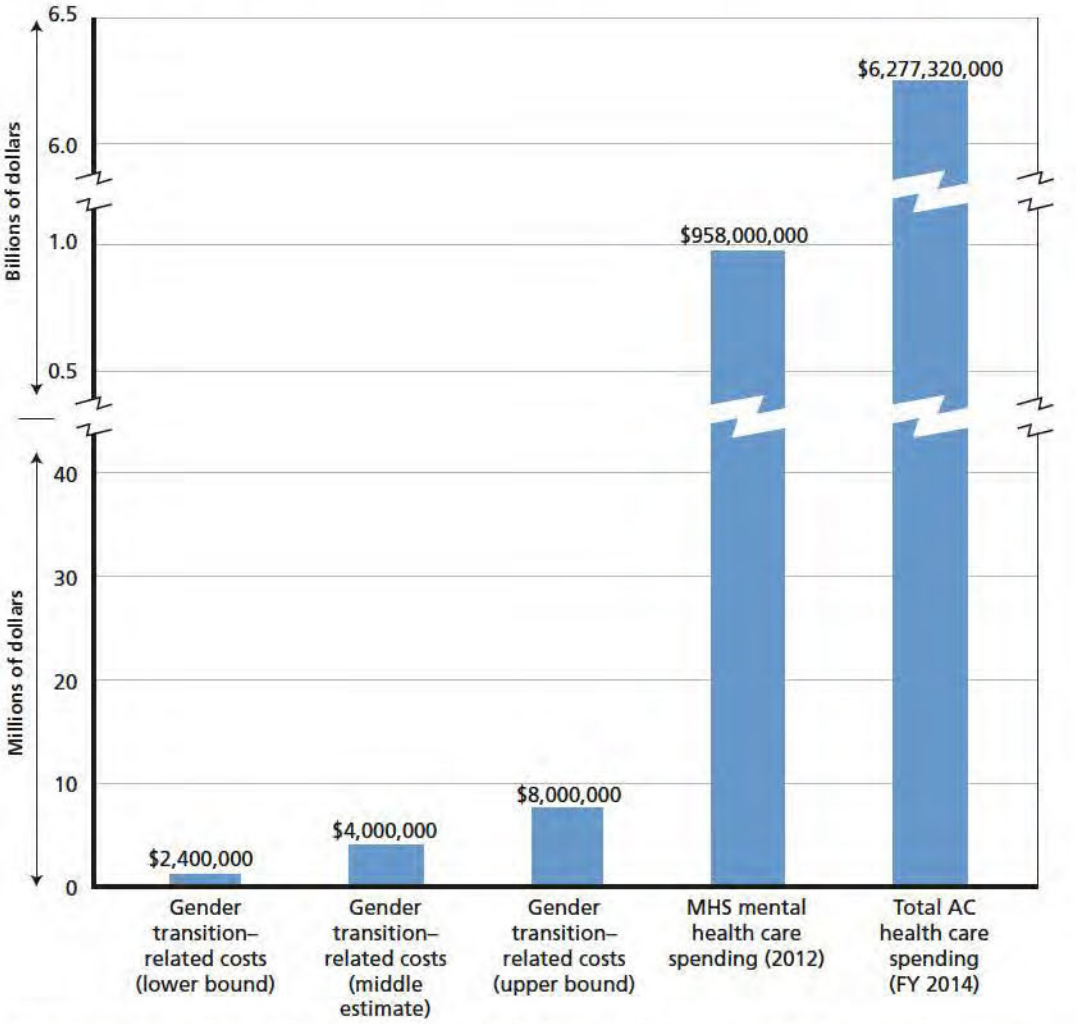
Table 5.2
Estimated Annual MHS Costs of Gender Transition–Related Health Care, Active Component

Analysis Type	Calculations Using Only Actuarial Premium Estimates 0.038% (actuarial)	Calculations Using Actuarial Premiums and Realized Values 0.054% (actuarial + realized)
Baseline	$2.4 million	$3.4 million
Sensitivity analysis 1: Adjusts for the male/female distribution in the AC population	$2.9 million	$4.2 million
Sensitivity analysis 2: Adjusts for the male/female distribution in the AC population and the assumption that transgender prevalence is twice as high in the military compared to the civilian population	$5.8 million	$8.4 million

SOURCE: RAND analysis.

[4] AC beneficiaries make up less than 15 percent of total TRICARE beneficiaries (Defense Health Agency, 2015).

Figure 5.1
Gender Transition–Related Health Care Cost Estimates Compared with Total Health Spending, Active Component



SOURCES: RAND analysis; Blakely and Jansen, 2013; Defense Health Agency, 2015. Estimates of premium increased and realized costs are reported in Table 5.1.

NOTES: The lower-bound estimate refers to premium increases only. The middle estimate includes premium increases and realized costs after adjusting for male/female distribution in the military. The upper-bound estimate includes premium increases and realized costs after adjusting for male/female distribution in the military and assuming the prevalence rate of transgender individuals in the military is twice that of civilian populations.

RAND *RR1350-5.1*

CHAPTER SIX

What Are the Potential Readiness Implications of Allowing Transgender Service Members to Serve Openly?

As DoD considers whether to allow transgender personnel to serve openly and to receive transition-related treatment during the course of their military service, it must consider the implications of such a policy change on the service members' ability to deploy and potential reductions in unit cohesion. In prior legal challenges to the transgender military discharge policy, DoD has expressed concern that the medical needs of these service members would affect military readiness and deployability. To address these concerns, this chapter provides estimates of the potential effects on force readiness from a policy change allowing these service members to serve openly.

A critical limitation of such an assessment is that much of the current research on transgender prevalence and medical treatment rates relies on self-reported, nonrepresentative samples. Thus, the information cited here must be interpreted with caution because it may have varying degrees of reliability. In addition, to estimate effects on readiness, we focused on transgender personnel in the AC and SR only. We did not include the Individual Ready Reserve because of the lack of publicly available, detailed demographic information. We used the same approach that applied to our analysis of health care utilization, applying both the prevalence-based and utilization-based approaches to force size. We note that the prevalence-based approach was the only approach that allowed us to estimate the number of transgender service members who may seek to live and work as their target gender. Transition does not necessarily imply the use of medical treatments, and we emphasize that some of these service members may still require accommodations in terms of housing and administrative functions (e.g., military identification cards, restrooms).

Impact on Ability to Deploy

The most salient and complex issue in allowing transgender personnel to serve openly is how DoD should regulate and manage operational deployment requirements for these personnel in the context of their transition to their target gender.

Pre-Transition

If transgender personnel are allowed to serve openly prior to transition, DoD will need to establish policies on when individuals may use the uniforms, physical standards, and facilities (e.g., barracks, restrooms) of their target gender. Additionally, DoD will need to clarify policies related to qualifications for deployment. Current deployment rules suggest that to qualify for deployment, individuals with diagnosed mental health disorders must show a "pattern of stability without significant symptoms or impairment for at least three months prior to deployment."[1] Ensuring appropriate screening will be critical to minimizing any mental health–related readiness issues. Secondary prevention measures prior to deployment, such as screening for GD, may be needed to ensure a pattern of stability and readiness for deployment.

During Transition

DoD would also need to determine when transitioning service members would be able to change uniforms and adhere to the physical standards of their target gender, as well as which facilities and identification cards they will use. Other countries have found that, in some cases, it may be necessary to restrict deployment of transitioning individuals to austere environments where their health care needs cannot be met. Deployment restrictions may also be required for individuals seeking medical treatment, including those seeking hormone therapy and surgical treatments.

We detail the constraints associated with transition-related medical treatments in Table 6.1. These constraints typically include a postoperative recovery period that would prevent any work and a period of restricted physical activity that would prevent deployment. The rightmost column of Table 6.1 presents the estimated number of nondeployable days we used to estimate the readiness impact. We note that these estimates do not account for any additional time required to determine medical fitness to deploy. Army guidelines, for example, do not permit deployment within six weeks of surgery. Nevertheless, there may be a significant difference between the estimated availability to deploy and the actual impact on deployability, as it is possible that transgender service members would time their medical treatments to minimize the effect on their eligibility to deploy.[2]

In addition to an expected, short-term inability to deploy during standard postoperative recovery time, some individuals experience postoperative complications that would render them unfit for duty. For instance, among those receiving vagino-

[1] Detailed guidance is provided in a memorandum from the Office of the Assistant Secretary of Defense for Health Affairs, 2013, p. 2.

[2] See for example, Personnel Policy Guidance Tab A (known as PPG-TAB A) that accompanies the medical guidelines document MOD TWELVE, Section 15.C, which articulates the minimal standards of fitness for deployment to the U.S. Central Command area of responsibility (U.S. Central Command, 2013).

plasty surgery, 6–20 percent have complications.[3] This implies that between three and 11 service members per year would experience a long-term disability from gender reassignment surgery. Among those receiving phalloplasty surgery, as many as 25 percent experience some medical complications (Elders et al., 2014).

Table 6.1
Gender Transition–Related Readiness Constraints

Transition Type and Treatment	Recovery Time	Leave and Deployment Implications	Estimated Nondeployable Days
Male-to-Female			
Hormone therapy only	Long-term, no recovery required	None (pending accommodations)	N/A
Augmentation mammoplasty	1 week no work, 4–6 weeks restricted physical activity	Up to 14 days medical leave, up to 60 days medical disability	75
Genital surgery (orchiectomy, vaginoplasty)	4–6 weeks no work, 8+ weeks restricted physical activity	Up to 45 days medical leave, up to 90 days medical disability	135
Female-to-Male			
Hormone therapy only	Long-term, no recovery required	None (pending accommodations)	N/A
Chest surgery	1 week no work, 4–6 weeks restricted physical activity	Up to 14 days medical leave, up to 60 days medical disability	75
Hysterectomy	2 weeks no work, 4–8 weeks restricted physical activity	Up to 21 days medical leave, up to 90 days medical disability	111
Genital surgery (metoidioplasty, phalloplasty)	2–4 weeks no work, 4–6 weeks restricted physical activity	Up to 21 days medical leave, up to 60 days medical disability	81

SOURCES: Treatment times based on RAND research compiled for this study. Estimates of numbers of treatments based on rates in Gates, 2011. Estimated nondeployable days based on RAND calculations using FY 2014 data from DoD, 2014.

NOTES: The total population in the table includes AC and SR personnel. Estimates of treatments are non-unique per person. Individuals may (and likely will) seek multiple treatments simultaneously. As such, deployment days are measured per treatment, not per individual. Estimates of nondeployable days do not include estimated delays generated by Medical Evaluation Board/Physical Evaluation Board review, which may be required depending on service rules.

[3] According to Elders et al. (2014, p. 15), summarizing findings from 15 studies, "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," and approximately 2.3 percent of patients experienced complications after vaginoplasty.

Taking the estimates for treatment and recovery time, we then applied the standards for leave and restricted physical activity.[4] We applied the recovery times and translated those into nondeployable days separated into medical leave, in which the service member is off the job, and medical disability, in which the service member can be at work but is subject to restricted physical requirements (e.g., no physical training, no heavy lifting). This provided us with the total number of nondeployable days per treatment type. We scaled this estimate by the number of days an individual can be deployed per year. For the AC, we assumed this to be 330 days per year (allowing 30 days of leave plus five days of processing time).[5] For the SR, we assumed 270 days per year (which allows nine months of deployment time). We counted each treatment separately and applied the number of treatments by treatment type shown in Table 6.1.

Note that because individuals may seek multiple treatments, sometimes at the same time, this number is not the same as the total number of individuals who will be nondeployable. Therefore, the estimates presented in Table 6.2 should be considered an upper bound in each category. Moreover, the prevalence-based estimates are significantly larger than the utilization-based estimates as shown in Table 4.8. Using the prevalence-based approach, we found that between eight and 43 of the available 1.2 million labor-years in the AC may be unavailable for deployment.[6] The combined, population-weighted, and gender-adjusted estimate implies that about 16 labor-years from the AC and about 11 labor-years from the SR may be nondeployable. This represents 0.0015 percent of available deployable labor-years across the AC and SR.

These estimates are based on surgical take-up rates ranging from 25 to 130 per year in the AC, with 55–270 total treatments, including hormone treatments. Similarly, the prevalence-based estimates imply 15–80 surgical treatments per year in the SR, with between 30 and 150 total treatments, including hormone therapy.

The utilization-based approach implies many fewer treatments. Although we could not estimate the impact on labor-years because we did not have information on specific treatments, based on usage rates in California, the utilization-based approach implies 30–50 total treatments, including surgeries and hormone therapy. Evidence from the VHA suggests that 90 service members in the AC and 50 in SR are diagnosed with GD in any given year. Such a diagnosis would be a prerequisite for any surgical treatments, suggesting that true utilization rates in the military may be significantly lower than suggested by the prevalence-based approach.

We caution that our labor-year estimates also likely overcount actual nondeployable time because our estimate captures "availability to deploy," rather than the deploy-

[4] For reference, we used the Army Regulation 40-501 (revised 2011), which governs leave and disability, and the Navy Medical Policy 07-009 (2007), which provides guidance on pre-clearance, accommodations for deployment readiness, and additional requirements in the U.S. Central Command area of operations.

[5] We based this estimate on Army Regulation 600-8-101 (2015).

[6] We define a labor-year as the amount of work done by an individual in a year.

Table 6.2
Estimated Number of Nondeployable Man-Years Due to Gender Transition–Related Treatments

Component	Total Labor-Years Available (FY 2014)	Estimated Number of Nondeployable Labor-Years				
		0.1%[a] (CA study)	0.16%[b] (combined, population-weighted CA + MA studies)	0.19%[c] (gender-adjusted rate)	0.37%[d] (twice gender-adjusted rate)	0.5%[e] (MA study)
Active	1,199,096	8.2	13.7	16.2	32.3	42.8
Selected Reserve	615,446	5.9	9.9	10.7	21.3	29.9

SOURCES: Estimates for nondeployable labor-years are based on RAND calculations using FY 2014 data from DoD, 2014.

[a] Based on estimates of prevalence from a California study (Conron, 2012).

[b] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

[c] Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

[d] Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

[e] Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

ment impact itself. This difference comes from three key assumptions that we make to calculate these estimates: (1) service members who are seeking treatment will also be deployed; (2) service members who are seeking treatment cannot time those treatments to avoid affecting their deployment eligibility; and (3) service members seek only one treatment at a time rather than having multiple treatments at the same time, which would allow concurrent (rather than sequential) recovery times. Thus, it is likely that a service member's care would have a substantial overall impact on readiness only if that service member worked in an especially unique military occupation, if that occupation was in demand at the time of transition, and if the service member needed to be available for frequent, unpredicted mobilizations.

Post-Transition

Having completed medical transition, a service member could resume activity in an operational unit if otherwise qualified. As in other cases in which a service member receives a significant medical treatment, DoD should review and ensure that any longer-term medical care or other accommodations relevant to the transgender service member's specific medical needs are addressed.

Impact on Unit Cohesion

A key concern in allowing transgender personnel to serve openly is how this may affect unit cohesion—a critical input for unit readiness. The underlying assumption is that if service members discover that a member of their unit is transgender, this could inhibit bonding within the unit, which, in turn, would reduce operational readiness. Similar concerns were raised in debates over whether to allow gay and lesbian personnel to serve openly (Rostker et al., 1993; RAND National Defense Research Institute, 2010), as well as whether to allow women to serve in ground combat positions (Schaefer et al., 2015; Szayna et al., 2015). Evidence from foreign militaries and surveys of the attitudes of service members have indicated that this was not the case for women or for lesbian and gay personnel (Schaefer et al., 2015; Harrell et al., 2007; RAND National Defense Research Institute, 2010). In examining the experiences of foreign militaries, the limited publicly available data we found indicated that there has been no significant effect of openly serving transgender service members on cohesion, operational effectiveness, or readiness. (For a more in-depth discussion of this topic, see Chapter Seven.) However, we do not have direct survey evidence or other data to directly assess the impact on the U.S. military.

Evidence from the General U.S. Population

According to recent research on the U.S. general population, attitudes toward transgender individuals are significantly more negative than attitudes toward other sexual minorities (Norton and Herek, 2013). However, heterosexual adults' positive attitudes toward and acceptance of transgender individuals are strongly correlated with their attitudes and acceptance of gay, lesbian, and bisexual individuals (Flores, 2015). As such, similar to changes seen in public attitudes toward homosexuality, tolerance and acceptance toward the transgender population could change over time. Additionally, evidence does indicate that direct interactions with transgender individuals significantly reduce negative perceptions and increase acceptance (Flores, 2015), which would suggest that those who have previously interacted with transgender individuals would be more likely to be tolerant and accepting of them in the future. Similar findings have arisen from surveys and focus groups with service members regarding attitudes toward the integration of women into direct combat positions (Szayna et al., 2015) and attitudes toward allowing gay and lesbian service members to serve openly in the U.S. military (RAND National Defense Research Institute, 2010).[7]

[7] A recent article examined the attitudes of military academy, Reserve Officers' Training Corps, and civilian undergraduates in the United States toward transgender people in general, in the workplace, and in the military (see Ender, Rohall, and Matthews, 2016).

Evidence from Foreign Militaries

While there are limited data on the effects of transgender personnel serving openly in foreign militaries, the available research revealed no significant effect on cohesion, operational effectiveness, or readiness. In the case of Australia, there is no evidence and there have been no reports of any effect on cohesion, operational effectiveness, or readiness (Frank, 2010). In the case of Israel, there has also been no reported effect on cohesion or readiness (Speckhard and Paz, 2014). Transgender personnel in these militaries have reported feeling supported and accommodated throughout their gender transition, and there is no evidence of any impact on operational effectiveness (Speckhard and Paz, 2014). In fact, commanders have reported that transgender personnel perform their military duties and contribute effectively to their units (Speckhard and Paz, 2014). Interviews with commanders in the United Kingdom also found no effect on operational effectiveness or readiness (Frank, 2010). Some commanders reported that increases in diversity had led to increases in readiness and performance. Interviews with these same commanders also found no effect on cohesion, though there were some reports of resistance to the policy change within the general military population, which led to a less-than-welcoming environment for transgender personnel. However, this resistance was apparently short-lived (Frank, 2010).

The most extensive research on the potential effects of openly serving transgender personnel on readiness and cohesion has been conducted in Canada. This research involved an extensive review of internal defense reports and memos, an analysis of existing literature, and interviews with military commanders. It found no evidence of any effect on operational effectiveness or readiness. In fact, the researchers heard from commanders that the increased diversity improved readiness by giving units the tools to address a wider variety of situations and challenges (Okros and Scott, 2015). They also found no evidence of any effect on unit or overall cohesion. However, there have been reports of bullying and hostility toward transgender personnel, and some sources have described the environment as somewhat hostile for transgender personnel (Okros and Scott, 2015).

To summarize, our review of the limited available research found no evidence from Australia, Canada, Israel, or the United Kingdom that allowing transgender personnel to serve openly has had any negative effect on operational effectiveness, cohesion, or readiness. However, it is worth noting that the four militaries considered here have had fairly low numbers of openly serving transgender personnel, and this may be a factor in the limited effect on operational readiness and cohesion.

Costs of Separation Requirements Related to Transgender Service Members

We considered the costs and benefits of providing appropriate care to transgender service members, the requirements for those who would serve openly if the current policy changed, and the costs of continuing the current administrative separation process. We analyzed the costs of separation under several assumptions: (1) some transgender personnel are currently serving but are not able to reveal their transgender status, (2) some individuals who would be desirable recruits could be excluded for reasons only related to their gender identity, and (3) some individuals who are transgender are or have been separated for reasons only related to their gender identity, which imposes separation costs.

Separation and a continued ban on open service (i.e., manpower losses) are the alternatives to meeting the medical needs of transgender individuals. As detailed in Chapter Two, the continued ban on open service may result in worsening mental health status, declining productivity, and other negative outcomes due to lack of treatment for gender identity–related issues. In addition, if DoD actively pursues separation, the process can be tedious, especially now that it requires the approval of the Under Secretary of Defense for Personnel and Readiness. Under current DoD regulations, transgender personnel can be declared administratively unfit for service if their gender identity affects their ability to meet operational or duty requirements. A June 2015 revision to DoD policy requires that a discharge justification be based on inability to meet duty requirements. However, any "administratively unfit" finding prohibits the individual from being medically evaluated for continued service.[8] Absent this process, transgender service members do not have recourse to allow mental health experts or medical professionals to review their case concurrently. This can result in unnecessary and inconsistent approaches to discharging transgender service members. As was the case in enforcing the policy on homosexual conduct, this can involve costly administrative processes and result in the discharge of personnel with valuable skills who are otherwise qualified (U.S. Government Accountability Office, 2011).

Moreover, the total cost in lost days available for deployment is negligible and significantly smaller than the lack of availability due to medical conditions. For example, in 2015 in the Army alone, there were 102,500 nondeployable soldiers, 50,000 of whom were in the AC (Tan, 2015). This accounted for about 14 percent of the AC—personnel who were ineligible to deploy for legal, medical, or administrative reasons.

[8] These boards provide an established process and mechanism for evaluating whether a service member with an ailment or diagnosis, such as a mental health diagnosis, could continue military service. The services use the Medical Evaluation Board and Physical Evaluation Board systems to determine whether personnel "with an ailment or diagnosis, such as a mental health diagnosis, can continue . . . military service," based on a thorough review of fitness to serve (DoDI 1332.38, 1996).

Of those, 37,000 could not deploy due to medical conditions.[9] Excluding those who were severely injured and required longer-term care, there were 28,490 service members who had either category 1 (up to 30 days) or category 2 (more than 30 days) restrictions. Assuming those in category 1 cannot deploy for 30 days and those in category 2 cannot deploy for 90 days, we estimate there are currently 5,300 nondeployable labor-years in the Army alone. Thus, we anticipate a minimal impact on readiness from allowing transgender personnel to serve openly.

[9] Rates of injury and nondeployability time as reported in Cox (2015).

CHAPTER SEVEN

What Lessons Can Be Learned from Foreign Militaries That Permit Transgender Personnel to Serve Openly?

As the U.S. military considers changes to its transgender personnel policy, revisions to several other policies may be necessary. Policies in need of change would cover a range of personnel, medical, and operational issues affecting individuals and units, including some policies that currently vary by gender. Examples of the latter would include housing assignments, restrooms, uniforms, and physical standards. While these are new questions for the U.S. military, there are other countries that already allow transgender personnel to serve openly in their militaries and have already addressed these policy issues.

We reviewed policies in foreign militaries that allow transgender service members to serve openly. Our primary source for the observations presented in this report was an extensive document review that included primarily publicly available policy documents, research articles, and news sources that discussed policies on transgender personnel in these countries. The information about the policies of foreign militaries came directly from the policies of these countries as well as from research articles describing the policies and their implementation. Our findings on the effects of policy changes on readiness draw largely from research articles that have specifically examined this question using interviews and analyses of studies completed by the militaries themselves. Finally, our insights on best practices and lessons learned emerged both directly from research articles describing the evolution of policy and the experiences of foreign militaries and indirectly from commonalities in the policies and experiences across our four case studies. Recommendations provided in this report are based on these best practices and lessons learned, as well as a consideration of unique characteristics of the U.S. military.

This review and analysis of the policies in foreign militaries can serve as a reference for U.S. decisionmakers as they consider possible policy revisions to support the integration of openly transgender personnel into the U.S. military. We include information on how, when, and why each country changed its policy. We also detail the policies of each country, covering such issues as the medical and administrative

requirements before gender transition can begin, housing assignments, uniform wear, and physical fitness standards.

Policies on Transgender Personnel in Foreign Militaries

According to a report by the Hague Center for Security Studies, there are 18 countries that allow transgender personnel to serve openly in their militaries: Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom (Polchar et al., 2014). This chapter describes the policies of the four countries—Australia, Canada, Israel, and the United Kingdom—with the most well-developed and publicly available policies on transgender military personnel. It focuses explicitly on policies that describe how these foreign militaries treat transgender personnel and how they address this population's gender transition needs. While the focus of the chapter is on the specific policies integrating openly transgender military personnel in these four foreign militaries, we also provide some information about what happened after the policy change, including bullying and harassment, and summarize best practices and challenges that emerged from our four case studies.[1]

The formal policies on transgender personnel in the four countries address a number of aspects of the gender transition process.[2] Generally, these policies do not explicitly address such issues as the recruitment or retention of transgender personnel, though we provide information on the qualification of transgender personnel to serve when it is available. They do generally address such issues as the requirements for transitioning, housing assignments, restroom use, uniforms, identity cards, and physical standards. They also address whether the transitioning personnel remain with their old units or shift to new ones and how other members of a unit should be informed. Finally, the policies address access to medical care and what is or is not covered by the military health care system.

In addition to addressing these crucial issues, foreign military policies on transgender personnel typically lay out a gender transition plan, which describes the timeline or steps in the transition process. However, it is worth noting that each individual's

[1] We looked for information on the policies of the other 14 countries but were unable to find any publicly available documents in English.

[2] We note a few interesting points about other countries that we investigated but for which we were unable to find sufficient publicly available information to construct a complete case. The Netherlands was the first country to allow transgender personnel to serve openly in its military, opening its ranks in 1974. New Zealand opened its military to transgender personnel in 1993; although we could not find a written policy, a 2014 report by Hague Center for Strategic Studies referred to New Zealand's as the most friendly military to transgender personnel. The New Zealand Defence Force also has an advocacy group, OverWatch, that provides support to lesbian, gay, bisexual, and transgender personnel (see Polchar et al., 2014).

gender transition is unique. While some choose to undergo hormone therapy or gender reassignment surgery, this is not required for gender transition. As a result, the timelines outlined in the policies are intended to be examples only.

Australia

In 2010, the Australian Defence Force revoked the defense instruction that prohibited transgender individuals from serving openly, stating that excluding transgender personnel from service was discrimination that could no longer be tolerated (Ross, 2014). The Australian Department of Defence, with the advocacy group Defence Lesbian, Gay, Bisexual, Transgender, and Intersex Information Service, has produced guides to support commanders, transitioning service members, and the units in which transitioning members are serving (Royal Australian Air Force, 2015). The guide outlines five stages in the gender transition process: diagnosis, commencement of treatment, disclosure to commanders and colleagues, the post-transition experience, and, if applicable, gender reassignment surgery (Royal Australian Air Force, 2015). There is no public information on the number of transgender personnel in the Australian military or the costs associated with covering gender transition–related medical care.

A service member's gender transition begins after receiving a medical diagnosis of gender incongruence from a doctor approved by the Australian Defence Force. According to Australian Defence Force policy, once service members receive this diagnosis and present a medical certification form to their commanders, they can begin the "social transition," which policy defines as the time when an individual begins living publicly as the target gender. Under the current policy, after this point, the service member's administrative record is updated to indicate the target gender for the purposes of uniforms, housing, name, identification cards, showers, and restrooms (Royal Australian Air Force, 2015). This means that, after this point, the service member is assigned to housing of the target gender, may use the restrooms of the target gender, has an identification card with the target gender and new name, and can wear the uniform of the target gender.

During the social transition, the service member may undergo hormone therapy. However, neither hormone therapy nor gender reassignment surgery is required for the administrative changes to occur. Importantly, this shift in gender for military administrative purposes may not always match the legal transition (with respect to the Australian government) to the target gender (Royal Australian Air Force, 2015). Finally, when transgender service members choose to transition, they may choose whether to stay with their current unit or transfer to a different one. They may also choose how colleagues are informed of the gender transition—that is, whether they wish to tell colleagues themselves or have a senior leader do so.

Australia's policy also addresses matters related to physical standards and medical readiness. During the transition period, a service member may be downgraded in terms of physical readiness or declared unable to deploy for some time. However, this

determination is decided on a person-by-person basis and is only temporary. According to the guide provided to service members and commanders, most individuals are placed on "MEC [Medical Employment Classification] 3—Rehabilitation" status during their medical transition or if they require four consecutive weeks of sick leave. Others may be able to remain "MEC 2—Employable and Deployable with Restrictions" for the majority of the gender transition period. In most cases, this determination is made by a certification board, though commanders are also given discretion to downgrade transitioning service members or declare them unfit to deploy, contingent on a stated inability to accommodate the service member's needs or a determination that the transitioning service member's presence would undermine the unit's performance. However, there is no public information available on the types of justifications a commander might give in making such a determination.

The deployment status of each individual will vary during the gender transition based on the transition path chosen (for example, whether hormone therapy or surgery is undertaken). Some of these treatments are covered by military health care. In Australia, medical treatments associated with gender transition, including both hormone therapy and gender reassignment surgery, are covered, but treatments considered "cosmetic" might not be (Royal Australian Air Force, 2015). However, it is not clear what is classified as cosmetic or what might be considered medically necessary. Importantly, gender transition–related medical procedures are provided only at certain facilities, so service members who wish to receive these treatments may need to make special requests for specific assignments where their needs can be met. In general, personnel are permitted to take sick leave to facilitate their medical transition (Royal Australian Air Force, 2015).

Transitioning service members' deployment status will also depend on their ability to meet physical fitness standards. During the transition period, a service member may be considered medically exempt from meeting physical fitness standards, with a coinciding readiness classification of nondeployable. Once deemed medically able to complete the test by a medical professional, the service member may be asked to meet the standards of the target gender. However, which gender standards the individual is required to meet and when is determined by the medical officer overseeing the gender transition (Royal Australian Air Force, 2015). Thus, the point at which each transitioning service member is required to meet the target-gender standards varies.

Canada

In Canada, a 1992 lawsuit from a member of the armed forces resulted in the repeal of a regulation banning gay, lesbian, and transgender individuals from serving openly in the military (Okros and Scott, 2015). In 1998, the Canadian military explicitly recognized gender identity disorder and agreed to cover gender reassignment surgery. In 2010, Canadian military policy was revised to clarify transgender personnel issues, such as name changes, uniforms, fitness standards, identity cards, and records (Okros

and Scott, 2015). An updated policy, Military Personnel Instruction 01/11, "Management of Transsexual Members," was released in 2012 (Canadian Armed Forces, 2012). It stated, "The CF [Canadian Forces] shall accommodate the needs of CF transsexual members except where the accommodation would: constitute undue hardship; or cause the CF member to not meet, or to not be capable of meeting. . . . Minimum Operational Standards Relating to Universality of Service" (Canadian Armed Forces, 2012, p. 5). Other considerations that can be used to determine whether an accommodation is reasonable include cost and the safety of other service members and the public (Canadian Armed Forces, 2012, p. 5). Data suggest that there are approximately 265 transgender personnel serving openly and that the Canadian military pays for about one gender reassignment surgery per year (Okros and Scott, 2015).

Canada's policy on transgender personnel covers such issues as housing, identification cards, restrooms, physical standards, deployment, medical treatment, and uniforms. The process is similar in most ways to that in Australia, described earlier. In Canada, one of the first steps in the gender transition process is a medical assessment in which the individual is given a diagnosis of gender incongruence and assigned a temporary medical category that defines both employment limitations and accommodations that will be needed to support the service member during gender transition. After receiving this diagnosis, service members are responsible for informing their commanders and are asked to give commanders as much notice as possible before beginning their gender transition. After that, the service member, the service member's manager, and the unit's commanding officer are expected to meet to discuss the service member's gender transition plan and to addresses any necessary accommodations. The policy recommends frequent meetings between the service member and relevant leaders and medical professionals to ensure that the transitioning service member's needs are met. The policy also identifies subject-matter experts, such as chaplains and mental health professionals, who might be available to provide advice (Canadian Armed Forces, 2012).

The policy states that the gender transition plan should address housing, uniforms, deployments, and other administrative considerations. While the timeline will vary for each individual, in most cases, after receiving the diagnosis and informing the commander, the service member is able to begin living openly as the target gender. At this point, the service member is assigned to housing of the target gender, given ID cards with the target gender and new name, given uniforms of the target gender, and permitted to use restrooms of the target gender. However, while the individual is considered a member of the target gender for all administrative purposes within the military at this point, an official name and gender change in the military personnel system requires both medical certificates and legal documentation (Canadian Armed Forces,

2012).[3] Finally, medals and awards earned by the service member prior to transitioning cannot be transferred to the new name when the service member transitions to the target gender (Okros and Scott, 2015).

While the policy expects accommodations to be made to meet the needs of transgender personnel, it also notes that commanders must strike a balance between meeting the needs and legal rights of transgender personnel and the privacy needs of other service members in restrooms, showers, and housing. It does not, however, provide guidance on how this should be accomplished (Canadian Armed Forces, 2012). The policy also makes clear that incidents of harassment must be dealt with according to the Canadian military's discrimination and harassment policy. Finally, if the transgender service member is assigned to a new unit permanently or temporarily, any required accommodations are to be communicated to the new commanding officer prior to the service member's arrival (Canadian Armed Forces, 2012).

The medical assessment and gender transition plan developed at the start of transition are also used to determine a service member's readiness status and deployability. The policy states that service members can be downgraded temporarily in terms of their readiness, ability to deploy, and eligibility for remote assignments until gender transition is complete (Canadian Armed Forces, 2012). This determination is made primarily by the medical professionals overseeing the service member's gender transition. After the gender transition is complete, the continued need for a reduced medical standard is decided on a case-by-case basis based on the service member's overall health, chronic conditions, and need for access to medical care. After beginning the gender transition, and based on the medical assessment, the service member is considered medically exempt from physical fitness testing and requirements until legally assuming the acquired or target gender (which, as noted earlier, requires provincial recognition). At that point, the fitness standards for the acquired or target gender apply. More specifically, once personnel are removed from the medical exemption list, they have 90 days to meet the new standards (Canadian Armed Forces, 2012).

A reduced medical readiness determination during gender transition is intended primarily to ensure that the service member has uninterrupted access to medical care. Once gender transition is complete, transgender service members and their commanders are responsible for identifying the service member's specific needs and how they will be addressed (Canadian Armed Forces, 2012). Gender reassignment surgery will not, however, automatically result in permanent deployment restrictions. As in Australia, gender reassignment surgery and hormone therapy are covered by military health care. The Canadian military paid for one gender reassignment surgery in 1998 and has paid for one or two surgeries per year since then (Canadian Armed Forces, 2012).

[3] Also note that the requirements for the legal change vary by province but typically involve only a statement that the individual has assumed the target gender and a medical certification from a doctor of a diagnosis of gender incongruence.

Israel

The Israel Defense Forces (IDF) have allowed transgender personnel to serve openly since 1998 (Speckhard and Paz, 2014).[4] The IDF experience with transgender personnel is somewhat unique because Israel's military is composed largely of conscripts who serve two or three years and then serve in the reserves with extended periods of active service. As a result, a very high percentage of the population spends extended periods of time mixing military and civilian life. From the perspective of this report, this blending of civilian and military life creates unique challenges for transgender personnel, as they cannot be one person in their civilian life and then a different person in their military life. Some transgender individuals receive a discharge or exemption from their military service based on their gender incongruence, but this decision is currently at the discretion of the commander. There is no official IDF policy on transgender personnel, but according to one report, senior members of the IDF are working to draft one (Speckhard and Paz, 2014). In 2014, the IDF announced that it would support transgender individuals throughout the transition process. Under this new policy, transgender teens who have not yet begun to transition to another gender will be enlisted according to their birth sex, but after enlistment, they will be given support and assistance with the gender transition process (Zitun, 2014). As a result, Speckhard and Paz (2014) noted, experiences vary for transgender personnel in the IDF. Some individuals report that once they ask to transition, they are allowed to dress and serve as their target gender. However, it is unclear how generalizable this is.

Typically, IDF administrative records use the gender at that time of enlistment. Since conscription occurs at age 18, and because hormone treatment for gender incongruence cannot legally begin until age 18, the administrative records of most personnel show their birth gender. Under a newly announced policy, personnel enlisted using their birth gender who identify as transgender can immediately receive support and treatment to begin the gender transition (Zitun, 2014). Importantly, however, as of 2014, the military identification card carries the birth gender until a service member undergoes gender reassignment surgery, even if the service member is living publically as the target gender (Speckhard and Paz, 2014). It should be noted that, in Israel, only one hospital can perform gender reassignment surgery, and this surgery cannot be performed until age 21, though some people go abroad for it (Speckhard and Paz, 2014). This creates some complications for housing and other matters, discussed in more detail later. The new policy will also allow transgender recruits to receive support for gender transition after enlistment.

Available evidence suggests that, in the IDF, assignment of housing, restrooms, and showers is typically linked to the birth gender, which does not change in the military system until after gender reassignment surgery. Service members who are undergo-

[4] We do not know the exact date for this change because there was never a formal policy allowing or prohibiting transgender personnel from serving. It was in 1998 that the first openly transgender individual served in the IDF.

ing gender transition are accommodated, however, through the use of ad hoc solutions, including giving transitioning personnel their own showers, housing, or restrooms (Speckhard and Paz, 2014). Once transitioning personnel have completed gender reassignment surgery, they can be assigned to the housing, restrooms, and showers of their acquired gender. It is also worth noting that the majority of noncombat personnel are able to live at home, off base. As a result, the housing issue does not affect a large number of transitioning personnel (Speckhard and Paz, 2014). The issue of uniforms is usually easier to address, and service members are able to wear the uniform of the target gender once they begin their gender transition.

In addition to addressing housing and other administrative matters for conscripts and career soldiers, the IDF must address transitioning reservists. The limited information available suggests that the approach to addressing the needs of this group also varies from person to person. Usually, if reserve members are in the process of transitioning or have transitioned when called to active duty, they are permitted to return to service as their target or acquired gender (following the same administrative policies described earlier). For example, a service member who served in an all-male combat unit and is transitioning to female may be moved to another position. Again, many reservists serve their duty while living at home, so housing is not usually an issue. Restroom and shower assignments are addressed on an ad hoc basis (Speckhard and Paz, 2014). Finally, some personnel who have transitioned or are in the process of transitioning are exempted from their reserve duty. However, this is becoming less common as the IDF strives to accommodate the needs of these personnel rather than exempting them from service (Speckhard and Paz, 2014).

The IDF does not have a formal policy on physical standards for transgender individuals serving their conscription duty, reserve duty, or as professional soldiers. Available information suggests only that transgender personnel can serve in any unit or occupation for which they meet the requirements, with the exception of a few male-only combat units and certain security-related positions (Speckhard and Paz, 2014). Personnel transitioning from female to male are able to serve in male-only combat units only if they can meet the requirements set for other men. Personnel transitioning from male to female cannot serve in male-only combat units once they begin hormone treatment (Speckhard and Paz, 2014).

There do appear to be some limitations on the assignment of transgender personnel, particularly in combat units. Because of austere living conditions in these types of units, necessary accommodations may not be available for service members in the midst of a gender transition. As a result, transitioning individuals are typically not assigned to combat units (Speckhard and Paz, 2014). Transgender personnel are also limited from assignment to certain security-related positions due to concerns about blackmail, based on the assumption that these service members might be open about their gender identity in the military but might not have told others, including family members. Keeping

these types of secrets might make an individual susceptible to blackmail or extortion (Speckhard and Paz, 2014).

In the IDF, medical issues and matters related to the readiness of transgender personnel are addressed on a case-by-case basis, though a more formal policy is being developed. For conscripts, the only treatment that can be provided by the military is hormone therapy because gender reassignment surgery is possible in Israel only after age 21, by which point the conscription duty is usually completed (Speckhard and Paz, 2014). Those who choose to stay in the military full-time after the age of 21, as well as those in the reserve called to back to active service, may receive both hormone therapy and gender reassignment surgery. Those who choose to undergo surgery are permitted to take a period of sick leave for the surgery and recovery, as they can for any other medical treatment or surgery (Speckhard and Paz, 2014). Israel has nationalized health care that typically covers all treatments associated with gender transition, ranging from psychiatric care to pre- and postoperative care, hormone treatment, breast augmentation, and facial feminization. Apart from the approaches used to address physical standards for transitioning individuals (discussed earlier), there are no specific policies governing the readiness classification of transitioning IDF personnel, though some are in development (Zitun, 2014).

United Kingdom

The United Kingdom lifted the ban on transgender personnel in 2000 following a European Court of Human Rights ruling that the country's policy violated the right to privacy under the European Convention on Human Rights (Frank, 2010). The policy change was implemented with guidance to commanders, as well as a code of social conduct that allowed commanders to address inappropriate behavior toward transgender personnel by appealing to broader principles of tolerance and diversity and to guard operational effectiveness (Yerke and Mitchell, 2013). In 2009, the British Armed Forces released the "Policy for Recruitment and Management of Transsexual Personnel in the Armed Forces" to offer clearer guidance to commanders on how gender transition–related issues should be addressed (Yerke and Mitchell, 2013). While transgender personnel are able to serve openly, under the current policy, they can be excluded from sports that organize around gender to ensure the safety of the individual or other participants. The British Army also provides its official policy on transgender personnel on its website:

> The Army welcomes transgender personnel and ensures that all who apply to join are considered for service subject to meeting the same mental and physical entry standard as any other candidate. If you have completed transition you will be treated as an individual of your acquired gender. Transgender soldiers serve throughout the Army playing their part in the country's security. There is a formal network that operates in the Army to ensure that transgender soldiers can find advice and support with issues that affect their daily lives. (British Army, undated)

However, the military encourages those who have not yet started their gender transition to complete their transition before joining (UK Ministry of Defence, 2009).

The 2009 UK policy is similar to those in Canada and Australia in terms of the areas covered and approaches to addressing key issues, though the UK policy provides some additional room for individual differences. The policy also includes an extensive discussion of the legal and privacy protections afforded to transgender personnel. These protections are important because they also apply to administrative and medical records in the military system.

The UK policy defines five stages of gender transition: diagnosis, social transition (the individual begins living openly as the target gender), medical treatment/hormone therapy, surgical reassignment, and postoperative transition. However, it also recognizes that the process of gender transition may be different for each person. The policy suggests that each individual work with commanders and service authorities to develop a plan that includes a timeline for transition. The gender transition plan agreed to by the service member and commanders should specify the timing of changes, such as to housing assignments and uniforms. The specific point at which a service member transitions for the purposes of name, uniform, housing, restrooms, and ID cards may vary from person to person. Typically, when service members begin living publicly as the target gender (the social transition) they are reassigned to housing of the target gender, use the restrooms and uniforms of the target gender, and are given an ID card indicating that they are a member of the target gender. Importantly, this shift in gender for administrative purposes does not have to correspond to the point at which an individual transitions gender within the UK legal system, a process that involves a diagnosis of gender incongruence and two years of living as the acquired gender (UK Ministry of Defence, 2009). The policy also notes that it is unlawful to force transgender personnel to use separate toilet or shower facilities or occupy separate housing accommodations from the rest of the force.

The gender transition plan addresses other logistics of the transition. For example, it should specify scheduled time off required for medical procedures, including gender reassignment surgery. In general, medical treatment associated with gender transition is treated like any other medical issue experienced by a service member. However, while hormone replacement therapy is covered by military health care, gender reassignment surgery is not (UK Ministry of Defence, 2009). The policy notes that the timeline and timing of the transition must take into consideration the needs of the service. As a result, at least four weeks notice is typically needed prior to the start of a service member's gender transition. The gender transition plan should also specify whether service members wish to transition in their current post or transfer to a new position and whether they want to tell their colleagues about the gender transition themselves or would like someone else to do this. This decision may depend on the size of the unit. In a small unit, it may be easy to inform fellow service members personally. In a larger organization, it may not be necessary to tell every individual. Commanders of units

with transgender personnel are encouraged to consult members of the Service Equality and Diversity staff about how to approach education and management in matters associated with transgender service members.

The UK policy also addresses medical readiness and physical standards. Transgender personnel are evaluated for medical readiness and deployability on a case-by-case basis following a medical evaluation. During the transition period, specifically during hormone treatment and immediately before and after surgery, service members may receive a reduced Medical Employment Standard, which restricts deployability and sea service (UK Ministry of Defence, 2009). Transitioning service members who continue to meet physical standards throughout this period and are able to perform their jobs may retain normal readiness standards. Usually, those who do not undergo hormone therapy or gender reassignment surgery are able to maintain a fully deployable status throughout their gender transition (UK Ministry of Defence, 2009). Service members who are undergoing hormone therapy are able to deploy, as long as the hormone dose is steady and there are no major side effects. However, deployment to all areas may not be possible, depending on the needs associated with any medication (e.g., refrigeration). Some service members may also be required to have a psychiatric evaluation, but only if they show signs of mental health distress (UK Ministry of Defence, 2009). Individuals who have finished their gender transition and can meet the requirements of their legal gender are considered fully deployable. However, those who remain in a state of reduced readiness for an extended period may have to be discharged (UK Ministry of Defence, 2009). Importantly, the British military encourages individuals who are in the midst of their gender transition and are considering joining the military to wait until the gender transition is complete before joining, as the military may not always be able to provide the support the individual needs during gender transition.

The specific physical standards a transitioning individual must meet during and after the gender transition period are determined on a case-by-case basis. The policy allows that there may be a period of time—especially for individuals transitioning from female to male—during which a service member is not yet able to meet the standards of the target gender. In these cases, medical staff and commanders may assess the individual and determine the appropriate interim standards (UK Ministry of Defence, 2009). Once the gender transition is considered "complete," personnel are required to meet the standards of the target gender (UK Ministry of Defence, 2009). However, the policy recognizes that the point at which the gender transition is complete may vary: It may be complete after hormone therapy or after surgery, or simply after the individual begins living as the target gender. Therefore, the policy continues to allow for some flexibility in physical standards, even for members at the end of their gender transition process (UK Ministry of Defence, 2009). Modified standards may be set by medical staff and commanders, if necessary. Continued failure to meet whatever physical stan-

dards are determined to be appropriate (modified or otherwise) can lead to administrative discharge (UK Ministry of Defence, 2009).

The policy also addresses positions that are "gender-restricted" or have unique standards. The United Kingdom still has a number of combat occupations closed to women. Personnel who are transitioning from male to female may not serve in male-only occupations as long as this policy remains in place. Those transitioning from female to male may hold these jobs, assuming that they are able to meet the physical standards (UK Ministry of Defence, 2009). Transgender personnel may hold positions that have unique standards related to the occupation, as long as they can meet the physical and other requirements for the specific position. Finally, according to the policy, service members may request that their medals be transferred to a new name by submitting the request in writing. They are allowed to continue wearing qualifications earned while serving as their birth gender. However, this may indicate their transgender status to others (UK Ministry of Defence, 2009).

Effects on Cohesion and Readiness

As indicated in Chapter Six, while there is limited research on the effects of transgender personnel serving openly in foreign militaries, the available evidence indicated no significant effect on cohesion, operational effectiveness, or readiness. In the Australian case, there is no evidence and there have been no reports of any effect on cohesion, operational effectiveness, or readiness (Frank, 2010). In the Israeli case, there has also been no reported effect on cohesion or readiness (Speckhard and Paz, 2014). Transgender personnel in these militaries report feeling supported and accommodated throughout their gender transition, and there has been no evidence of any effect on operational effectiveness (Speckhard and Paz, 2014). As noted earlier, commanders report that transgender personnel perform their military duties and contribute to their units effectively (Speckhard and Paz, 2014). Interviews with commanders in the United Kingdom also found no effect on operational effectiveness or readiness (Frank, 2010). Some commanders reported that increases in diversity had led to increases in readiness and performance. Interviews with these same commanders also found no effect on cohesion, though there were some reports of resistance to the policy change within the general military population, which led to a less-than-welcoming environment for transgender personnel. However, this resistance was apparently short-lived (Frank, 2010).

The most extensive research on the potential effects of openly serving transgender personnel on readiness and cohesion has been conducted in Canada. This research involved an extensive review of internal defense reports and memos, an analysis of existing literature, and interviews with military commanders. It found no evidence of any effect on operational effectiveness or readiness. In fact, the researchers

heard from commanders that the increased diversity improved readiness by giving units the tools to address a wider variety of situations and challenges (Okros and Scott, 2015). They also found no evidence of any effect on unit or overall cohesion. However, there have been reports of bullying and hostility toward transgender personnel, and some sources have described the environment as somewhat hostile for transgender personnel (Okros and Scott, 2015).

To summarize, our review of the limited available research found no evidence from Australia, Canada, Israel, or the United Kingdom that allowing transgender personnel to serve openly has had any negative effect on operational effectiveness, cohesion, or readiness. However, it is worth noting that the four militaries considered here have had fairly low numbers of openly serving transgender personnel, and this may be a factor in the limited effect on operational readiness and cohesion.

Best Practices from Foreign Militaries

Several best practices and lessons learned emerged both directly from research articles describing the evolution of policy and the experiences of foreign militaries and indirectly from commonalities in the policies and experiences across our four case studies. The best practices that extended across all cases include the following:

The Importance of Leadership

Sources from each of our case-study countries stressed that leadership support was important to executing the policy change. Leaders provided the impetus to draft and implement new policies and were integral to communicating a message of inclusion to the entire force. Supportive leaders were also important in holding accountable those personnel who participated in discrimination (Okros and Scott, 2015; Speckhard and Paz, 2014). Each of the cases underscores the importance of having strong leadership support to back and enforce the policy change, along with clearly written policies that are linked to national policy wherever possible (Frank, 2010). The militaries found that presenting a "business case" for diversity and emphasizing the advantages of an inclusive military, including better retention and recruiting, can help reduce resistance to a policy change (Frank, 2010).

Awareness Through Broad Diversity Training

The most effective way to educate the force on matters related to transgender personnel is to integrate training on these matters into the diversity and harassment training already given to the entire force. This training addresses all forms of harassment and bullying, including that based on religion, race, and ethnicity (Frank, 2010; Okros and Scott, 2015; Belkin and McNichol, 2000–2001).

In the four cases we reviewed in-depth, we found that targeting only commanders with training and information on what it means to be transgender is not as effective in fostering an inclusive and supportive environment as training that targets the entire force and is integrated into broader forcewide diversity training. The foreign militaries that we examined train not only units with transitioning individuals but also the entire force by including gender identity alongside sexual orientation, religion, ethnicity, and other markers of difference in diversity training and education. However, efforts must be made simultaneously to protect the privacy of transitioning service members. In some cases, telling a unit that a transgender member is arriving before that individual arrives can be counterproductive (Frank, 2010).

The Importance of an Inclusive Environment

An all-inclusive military environment—not just as it pertains to transgender personnel, sexual orientation, or gender identity, but a culture that embraces diversity—can support the integration of openly serving transgender personnel. In this context, gender identity is just one marker of diversity.[5]

Ensuring Availability of Subject-Matter Experts to Advise Commanders

Most of the four countries we examined in-depth also make subject-matter experts (e.g., chaplains, psychiatrists) and gender advisers (individuals who have special training in gender awareness and gender mainstreaming in the military context) available to commanders tasked with the integration of transgender personnel. Gender advisers were originally intended to deal primarily with issues associated with integrating women into male-dominated military environments, but they could also help with other gender-related matters, including transgender personnel policy. They serve directly within military units and are a readily available resource to commanders. Adopting a similar practice of integrating advisers with expertise in the area of transgender personnel policy and gender transition-related matters might also support the integration of transgender service members in the U.S. military.

Lessons Learned and Issues to Consider for U.S. Military Policy

Based on these best practices and the broader experiences of four foreign militaries, there are some key lessons to be learned and possible issues to consider when crafting U.S. military transgender personnel policy. First, in each of the four foreign militaries, there were some reports of resistance, bullying, and harassment of transgender personnel who made their gender transition public. This harassment ranged from exclusion to more aggressive behavior. In most cases, this behavior was relatively limited; however,

[5] Remarks by a Canadian subject-matter expert in a phone discussion with RAND researchers, November 2015.

in some cases, it did contribute to a hostile work environment for transgender personnel and had the effect of discouraging these personnel from being open about their gender transition or gender identity (Okros and Scott, 2015; Frank, 2010). Although the foreign militaries we examined tended to adopt a policy of no tolerance for this type of harassment, some bullying behavior may have gone unreported (Okros and Scott, 2015; Frank, 2010). In the case of Canada, the issue of restrooms for transgender personnel is an ongoing topic of discussion, and restrooms have been a common site of harassment and discrimination (Okros and Scott, 2015).

A second lesson learned is related to problems caused by the lack of an explicit, clearly written policy. For instance, in the IDF, without a clear policy, some transitioning individuals are placed in difficult and uncomfortable situations. For example, in some cases, personnel who have been permitted to begin hormone therapy cannot be housed with members of their target gender or grow their hair and fingernails (in the case of individuals transitioning from male to female). Others have been isolated, assigned to separate housing, or asked to use separate restrooms (Speckhard and Paz, 2014). Recognizing these challenges, IDF leadership is working to design a clear and explicit policy. In the Israeli case, transgender individuals were allowed to serve openly before a formal policy was written. Only when it was faced with questions about the integration of transgender personnel did the IDF begin to create a formal policy.[6] In Canada, a similar policy gap arose when transgender personnel were allowed to serve openly following a national policy revision that ended discrimination based on sexual orientation or gender. However, the focus at that point was on gay and lesbian service members, and no formal policy was created to address transgender personnel explicitly. When matters related to the medical care of transgender personnel arose, Canadian defense leaders developed a policy that just addressed this narrow, pressing issue, and did not develop policies to address the other matters (e.g., housing, restrooms, name changes). Commanders complained that the original policy was too vague and lacked sufficient details. A new, revised policy was written in 2012, and commanders have responded with positive feedback.[7] The lack of a clear, written policy has also been an issue in Australia.

A third and final issue that has come up in at least two of the countries we surveyed is that of awards and medals. In the UK case, medals and awards received prior to gender transition can be transferred to the service member's post-transition name (UK Ministry of Defence, 2009). In the Canadian case, this is not possible, and the awards remain associated only with the original name. This is a cause for concern among transgender personnel in the Canadian military, but Canadian officials have responded that they cannot rewrite history (Okros and Scott, 2015). This is a policy area that the United States should consider alongside other administrative policies.

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6 Remarks by a Canadian subject-matter expert in a phone discussion with RAND researchers, November 2015.

7 Remarks by a Canadian subject-matter expert in a phone discussion with RAND researchers, November 2015.

CHAPTER EIGHT

Which DoD Policies Would Need to Be Changed if Transgender Service Members Are Allowed to Serve Openly?

This chapter reviews DoD accession, retention, separation, and deployment policies and provides an assessment of the impact of changes required to allow transgender personnel to serve openly. For our analysis of DoD policies, we reviewed 20 current accession, retention, separation, and deployment regulations across the services and the Office of the Secretary of Defense. We also reviewed 16 other regulations that have been replaced by more recent regulations or did not mention transgender policies.[1] DoDI 6130.03 establishes medical standards for entry into military service, including a list of disqualifying physical and mental conditions, some of which are transgender-related.[2] Current DoD policy also authorizes, but no longer requires, the discharge of transgender personnel for reasons related to both medical conditions that generate disabilities, as well as mental health concerns.[3] However, a July 2015 directive from the Office of the Secretary of Defense elevated decisions to administratively separate transgender service members to the Office of the Under Secretary of Defense for Personnel and Readiness (DoD, 2015b).

Note that our review focused on transgender-specific DoD instructions that may contain unnecessarily restrictive conditions and reflect outdated terminology and assessment processes. However, in simply removing these restrictions, DoD could inadvertently affect overall standards. While we focus on reforms to specific instruc-

[1] These additional policies are listed in Appendix D.

[2] The instruction specifies conditions that disqualify accessions, including "current or history of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias"; "history of major abnormalities or defects of the genitalia including but not limited to change of sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis"; and "history of major abnormalities or defects of the genitalia such as change of sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis" (DoDI 6130.03, 2011, enclosure 4).

[3] "Sexual gender and identity disorders" are specified as medical conditions that may generate disabilities under DoDI 1332.38, enclosure 5 (2006). Mental health conditions are specified in DoDI 1332.14 (2014) and DoDI 1332.30 (2013) for enlisted and officers, respectively. DoDI 1332.18, issued on August 5, 2014, updated these guidelines and established general criteria for referral for disability evaluation and defers to service-specific standards for retention. However, a recent review of this revision suggests that service-specific regulations may still disqualify transgender personnel, and the new guidance may not overrule those service policies (Pollock and Minter, 2014).

tions and directives, we note that DoD may wish to conduct a more expansive review of personnel policies to ensure that individuals who join and remain in service can perform at the desired level, regardless of gender identity.

Accession Policy

The language pertaining to transgender individuals in accession instructions does not match that used in DSM-5.[4] This results in restrictions in DoD policy that do not match current medical understanding of gender identity issues and thus may be misapplied or difficult to interpret in the context of current medical treatments and diagnoses. Under current guidelines, otherwise qualified individuals could be excluded for conditions that are unlikely to affect their military service, and individuals with true restrictions may be more difficult to screen for and identify. Modernizing the terminology to match current psychological and medical understanding of gender identity would help ensure that existing procedures do not inadvertently exclude otherwise qualified individuals who might want to join the military. We recommend that DoD review and revise the language to match the DSM-5 for conditions related to mental fitness so that mental health screening language matches current disorders and facilitates appropriate screening and review processes for disorders that may affect fitness for duty. Similarly, physical fitness standards should specify physical requirements, rather than physical conditions. Finally, the physical fitness language should clarify when in the transition process the service member's target gender requirements will begin to apply.

Retention Policy

We recommend that DoD expand and enhance its guidance and directives to clarify and adjust, where necessary, standards for retention of service members during and after gender transition. Evidence from Canada and Australia suggests that transgender personnel may need to be held medically exempt from physical fitness testing and requirements during transition (Canadian Armed Forces, 2012; Royal Australian Air Force, 2015). However, after completing transition, the service member could be required to meet the standards of the acquired gender. The determination of when the service member is "medically ready" to complete the physical fitness test occurs on a case-by-case basis and is typically made by the unit commander.

[4] Two key changes are that the term *transsexualism* has been replaced, and *gender dysphoria* is no longer in the chapter "Sexual Desire Disorders, Sexual Dysfunctions, and Paraphilias" but, rather, has its own chapter (Milhiser, 2014).

Separation Policy

DoD may wish to revise the current separation process based on lessons learned from the repeal of Don't Ask, Don't Tell. The current process relies on administrative decisions outside the purview of the standard medical and physical review process. This limits the available documentation and opportunities for review, and it could prove burdensome if transgender-related discharges become subject to re-review. When medically appropriate, DoD may wish to establish guidance on when and how such discharge reviews should be handled. We also recommend that DoD develop and disseminate clear criteria for assessing whether transgender-related conditions may interfere with duty performance.

Deployment Policy

Deployment conditions vary significantly based on the unique environment of each deployment, with some deployed environments able to accommodate transgender individuals, even those who are undergoing medical treatments. Moreover, recent medical advancements can minimize the invasiveness of treatments and allow for telemedicine or other forms of remote medical care. Given medical and technological advances, DoD may wish to adjust some of its processes and deployment restrictions to minimize the impact on readiness. For example, current regulations specify that conditions requiring regular laboratory visits make service members ineligible for deployment, including all service members who are receiving hormone treatments,[5] since such treatments require laboratory monitoring every three months for the first year as hormone levels stabilize (Hembree et al., 2009; Elders et al., 2014). Such a change would require DoD to either permit more flexible monitoring strategies[6] or provide training to deployed medical personnel.[7] Similarly, the use of refrigerated medications is a disqualifying condition for deployment,[8] even though nearly all hormone therapies are available in other formats that do not require refrigeration.

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[5] Current regulations state that "medications that require laboratory monitoring or special assessment of a type or frequency that is not available or feasible in a deployed environment" disqualify an individual from deployment (Office of the Assistant Secretary of Defense for Health Affairs, 2013, p. 3).

[6] Some experts suggest that alternatives, such as telehealth reviews, would address this issue for rural populations with limited access to medical care (see, for example, WPATH, 2011).

[7] "Independent duty corpsmen, physician assistants, and nurses can supervise hormone treatment initiated by a physician" (Elders et al., 2014).

[8] The memo issued by the Office of the Assistant Secretary of Defense for Health Affairs states, "Medications that disqualify an individual for deployment include . . . [m]edications that have special storage considerations, such as refrigeration (does not include those medications maintained at medical facilities for inpatient or emergency use)" (Office of the Assistant Secretary of Defense for Health Affairs 2013, p. 3).

CHAPTER NINE

Conclusion

By many measures, there are currently serving U.S. military personnel who are transgender. Overall, our study found that the number of U.S. transgender service members who are likely to seek transition-related care is so small that a change in policy will likely have a marginal impact on health care costs and the readiness of the force. We estimate, based on state-level surveys of transgender prevalence, that between 1,320 and 6,630 transgender personnel may be serving in the AC, and 830–4,160 may be serving in the SR. Estimates based on studies from multiple states, weighted for population and the gender distribution in the military, imply that there are around 2,450 transgender service members in the AC and 1,510 in the SR.[1]

However, only a small proportion of these service members will seek gender transition–related treatment each year. Employing utilization and cost data from the private health insurance system, we estimated the potential impact of providing this care to openly serving transgender personnel on AC health care utilization and costs. Directly applying private health insurance utilization rates to the AC military population indicated that a very small number of service members will access gender transition–related care annually. Our estimates based on private health insurance data ranged from a lower-bound estimate of 29 AC service members to an upper-bound estimate of 129 annually using care, including those seeking both surgical and other medical treatments.

Using estimates from two states and adjusting for the male/female AC distribution, we also estimate a total of 45 gender transition–related surgeries, with 50 service members initiating transition-related hormone therapy annually in the AC.[2] We estimate 30 gender transition-related surgeries and 25 service members initiating hormone therapy treatments in the SR. These are likely to be upper-bound estimates, given the nonrepresentative sample selection procedures used in the NTDS. Furthermore, the best prevalence estimates that we were able to identify were from two of the more transgender-tolerant states in the country, and the empirical evidence that trans-

[1] Estimates are based on FY 2014 AC and SR personnel numbers.

[2] For hormone therapy recipients, the number of treatments and recipients is the same, and these estimates can be treated as counts of individuals.

gender prevalence is higher in the military than in the general population is weak. As a point of comparison, we also compared these estimated values to mental health utilization in the AC population overall. Using data from McKibben et al. (2013), we calculated that approximately 278,517 AC service members accessed mental health care treatment in 2014, the implication being that health care for the transgender population will be a very small part of the total health care provided to AC service members across the MHS.

With respect to health care costs, actuarial estimates from the private health insurance sector indicate that covering gender transition–related care for transgender employees increased premiums by less than 1 percent. Taking a weighted average of the identified firm-level data, we estimate that covering transgender-related care for service members will increase the U.S. military's AC health care spending by only 0.038–0.054 percent. Using these baseline estimates, we estimate that MHS health care costs will increase by between $2.4 million and $8.4 million. These numbers represent only a small proportion of FY 2014 AC health care expenditures ($6.27 billion) and the FY 2014 Unified Medical Program budget ($49.3 billion). This is consistent with our estimate of relatively low AC rates of gender transition–related health care utilization in the MHS.

Similarly, when considering the impact on readiness, we found that using either the prevalence-based approach or the utilization-based approach yielded an estimate of less than 0.0015 percent of total labor-years likely to be affected by a change in policy. This is much smaller than the current lost labor-years due to medical care in the Army alone.

Even if transgender personnel serve in the military at twice the rate of their prevalence in the general population and we use the upper-bound rates of health care utilization, the total proportion of the force that is transgender and would seek treatment would be less than 0.1 percent, with fewer than 130 AC surgical cases per year even at the highest utilization rates. Given this, true usage rates from civilian case studies imply only 30 treatments in the AC, suggesting that the total number of individuals seeking treatment may be substantially smaller than 0.1 percent of the total force. Thus, we estimate the impact on readiness to be negligible.

We conclude with some general recommendations and insights based on the experiences of foreign militaries that permit transgender individuals to serve openly—specifically, Australia, Canada, Israel, and the United Kingdom. Our case studies provide some guidance that policymakers should consider as they develop policies to govern the employment of transgender personnel in the U.S. military. These cases also suggested a number of key implementation practices if a decision is made to allow transgender service members to serve openly:

- Ensure strong leadership support.
- Develop an explicit written policy on all aspects of the gender transition process.

- Provide education and training to the rest of the force on transgender personnel policy, but integrate this training with other diversity-related training and education.
- Develop and enforce a clear anti-harassment policy that addresses harassment aimed at transgender personnel alongside other forces of harassment.
- Make subject-matter experts and gender advisers serving within military units available to commanders seeking guidance or advice on gender transition-related issues.
- Identify and communicate the benefits of an inclusive and diverse workforce.

APPENDIX A

Terminology

Augmentation mammoplasty: breast augmentation involving implants or lipofilling

Buccal administration: placement of medication between the gums and cheek

Chest surgery: surgery to create a contoured, male-looking chest

Clitoroplasty: surgical creation/restoration of a clitoris

Cross-dresser: someone who dresses in the clothes of the other gender, not always on a full-time basis

Female-to-male: those assigned female sex at birth who identify as male; transgender men; transmen

Gender: an individual's gender identity, which is influenced by societal norms and expectations; public, lived role as male or female

Gender assignment: initial assignment at birth as male or female; yields "natal gender" (APA, 2013, p. 451)

Gender atypical: behaviors not typical for one's gender "in a given society and historical era" (APA, 2013, p. 451)

Gender identity: "one's inner sense of one's own gender, which may or may not match the sex assigned at birth" (Office of Personnel Management, 2015, p. 2)

Gender dysphoria: "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)" (WPATH, 2011, p. 2).

Gender nonconformity: "the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex" (WPATH, 2011, p. 5, citing Institute of Medicine definition)

Gender transition–related surgery/gender-confirming surgery/sex reassignment surgery: surgery to mitigate distress associated with gender dysphoria by aligning sex characteristics with gender identity

Genderqueer: those who "define their gender outside the construct of male or female, such as having no gender, being androgynous, or having elements of multiple genders" (Roller, Sedlak, and Draucker, 2015, p. 417)

Gluteal augmentation: buttocks augmentation involving implants or lipofilling

Hormone therapy: "the administration of exogenous endocrine agents to induce feminizing or masculinizing changes" (WPATH, 2011, p. 33)

Hysterectomy: surgery to remove the uterus

Intersex: "a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male" (Intersex Society of North America, undated)

Labiaplasty: plastic surgery for altering or creating the labia

Lipofilling: injection of fat rather than artificial implants

Male-to-female: those assigned male sex at birth who identify as female; transgender females; transwomen

Mastectomy: surgical removal of one or both breasts

Metoidioplasty: surgically relocating a clitoris that has been enlarged by hormone therapy to a more forward position that more closely resembles that of a penis; average length is 1.5–2 inches

Oophorectomy: surgical removal of one or both ovaries

Orchiectomy: surgical removal of one or both testicles

Ovariectomy: surgical removal of one or both ovaries

Parenteral administration: intravenous injection (into a vein) or intramuscular infusion (into muscle) of medication

Penectomy: surgical removal of the penis

Phalloplasty: surgical creation/reconstruction of a penis using one of a variety of techniques including free or pedicled (attached) flap (see Rashid and Tamimy, 2013)

Primary sex characteristics: physical characteristics/sex organs directly involved in reproduction

Salpingo-oophorectomy: removal of the ovaries and fallopian tubes

Scrotoplasty: surgical creation/reconstruction of testicles; in transmen, native labia tissue is used; testicular implants can be used

Secondary sex characteristics: physical characteristics that appear at puberty and vary by sex but are not directly involved in reproduction (e.g., breasts)

Sex: a person's biological status as male or female based on chromosomes, gonads, hormones, and genitals (intersex is a rare exception)

Sexual orientation: sexual identity in relation to the gender to which someone is attracted: heterosexual, homosexual, or bisexual

Thyroid chondroplasty: removal or reduction of the Adam's apple

Transdermal administration: delivery of medication across the skin with patches

Transgender: "an umbrella term used for individuals who have sexual identity or gender expression that differs from their assigned sex at birth" (Roller, Sedlak, and Draucker, 2015, p. 417)

Transsexual: someone whose gender identity is inconsistent with their assigned sex and who desires to permanently transition their physical characteristics to match their inner sense of their own gender

Urethroplasty: surgical reconstruction or fabrication of the urethra.

Vaginectomy (colpectomy): surgical removal of all or part of the vagina

Vaginoplasty: surgical creation/reconstruction of a vagina

Vulvoplasty: surgical creation/reconstruction of the vulva

APPENDIX B

History of DSM Terminology and Diagnoses

A brief historical understanding of the evolving diagnostic nomenclature pertaining to transgender status is important to discussions of related health care. DSM-III (APA, 1980) first contained the diagnosis of transsexualism. DSM-III-R (APA, 1987) introduced gender identity disorder, non-transsexual type. In DSM-IV (APA, 1994), these two diagnoses were merged and called *gender identity disorder*. Gender identity disorder, together with the paraphilias (disorders of extreme, dangerous, or abnormal sexual desire, including transvestic fetishism, sometimes referred to as cross-dressing), constituted the DSM-IV section "Sexual and Gender Identity Disorders."

With DSM-5 (APA, 2013) came the migration from *gender identity disorder* to *gender dysphoria*. The clinical significance of the shift in DSM-5 was great: For the first time, without accompanying symptoms of distress, transgender individuals were no longer considered to have a diagnosable mental disorder. The historical parallel with homosexuality is hard to miss: In 1980, DSM-III similarly normalized the DSM-II diagnosis of homosexuality, moving instead to ego-dystonic homosexuality, a diagnosis reserved only for gay persons who felt related distress. In the next DSM iteration, DSM-III-R, all reference to homosexuality as a diagnostic term was removed. In the aftermath of depathologizing gender nonconformity, a similar move relating to transgender status appears to be underway.

As noted in this report, there is a consensus among clinicians and their professional organizations that transition-related treatment with hormones or surgery constitutes necessary health care, though there is a divide over whether it serves as "a strategy to diminish the serious suffering" of the patient or "a method to assist people in finding self-actualization" (Gijs and Brewaeys, 2007, p. 184). The conclusion that transition-related surgery "is an effective treatment for gender identity disorder in adults" is based primarily on retrospective studies of satisfaction rather than randomized controlled trials or prospective studies (Gijs and Brewaeys, 2007, p. 199). The prevalence of post-operative regret is very low, though "little empirical research has been done" on related risk and protective factors (Gijs and Brewaeys, 2007, pp. 201, 204). Overall, surgery is considered "the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals," but rigorous controlled-outcome studies evaluating its

effectiveness should be conducted despite feasibility and ethical challenges (Gijs and Brewaeys, 2007, pp. 215–216; Buchholz, 2015, p. 1786).

DSM-5 Diagnostic Criteria: Gender Dysphoria in Adolescents and Adults 302.85 (F64.1)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
   1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
   2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
   3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
   4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
   5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
   6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

APPENDIX C

Treatments for Gender Dysphoria

In this appendix, we provide additional details about psychosocial, pharmacologic, surgical, and other treatments for gender dysphoria (GD).

Psychotherapy

The emphasis of psychotherapy for this population today is on "affirming a unique transgender identity," rather than focusing on gender transition (Institute of Medicine, 2011, p. 52). Mental health professionals can also help patients presenting with GD navigate the process of coming out to family, friends, and peers; treat comorbid mental health conditions;[1] weigh options related to gender identity, gender expression, and transition-related treatment interventions; and conduct assessments, make referrals, and guide preparation for and provide support through the transition-related treatment process (WPATH, 2011, pp. 22–26). Referral from a mental health professional is necessary under the standards of care for those seeking breast/chest or genital surgeries, and the latter also requires confirmation from an independent mental health provider (WPATH, 2011, p. 27). Mental health providers may also serve an important role on behalf of their patients by providing education and advocacy within the community and supporting changes to identity documents (WPATH, 2011, p. 31).

Of note, treatment aimed at changing one's gender identity to align with the sex assigned at birth has proven unsuccessful and is no longer considered ethical care; mental health providers who are unwilling or unable to provide appropriate care should refer patients to a provider who is (WPATH, 2011, p. 32).

Hormone Therapy

Hormone therapy is necessary for many individuals with GD (WPATH, 2011, p. 33). It has two major goals: (1) reduce naturally occurring hormones to minimize secondary sex characteristics and (2) maximize desired feminization/masculinization using the principles and medications used for hormone replacement in non-transgender patients who do not produce enough hormones, such as women who have had hyster-

[1] Co-occurring mental health conditions could range from anxiety and depression, which are common among the transgender population, to more severe and rare illnesses, such as schizophrenia or bipolar disorder.

ectomies or men with low testosterone (WPATH, 2011, p. 33; Hembree et al., 2009). As with most medications, there are risks, which may increase in the presence of some health conditions or behaviors (such as smoking); these should be evaluated and managed (Hembree et al., 2009).

For those transitioning from female to male, hormone therapy should lead to "deepened voice, clitoral enlargement (variable, 3–8 cm), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and increased percentage of body fat." For those transitioning from male to female, hormone therapy should lead to "breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fat" (WPATH, 2011, p. 36). The timeline for these and other physical changes varies by individual; expected onset is within months, and maximum expected effect (such as body fat and muscle mass changes) is generally achieved in three or more years. Feminizing hormone therapy typically involves both estrogen and antiandrogens.[2] Masculinizing hormone therapy consists primarily of testosterone, which is available in oral, transdermal, parenteral (intravenous/intramuscular), buccal (cheek), and implantable administrations; brief use of progestin can help stop menstrual periods early in treatment (WPATH, 2011, p. 49). Detailed clinical practice guidelines are available from the Endocrine Society (Hembree et al., 2009).

Gender Transition–Related Surgery

As noted, gender transition–related surgery (also called sex reassignment surgery or gender-confirming surgery) is necessary for some transgender patients. Under the standards of care, mental health professionals must refer patients for surgery; in addition, criteria for both breast/chest and genital surgery include persistent and well-documented GD, the capacity to make informed decisions and to consent, and for other mental or general health concerns to be reasonably well controlled if present (WPATH, 2011, p. 59). Hormone therapy is not a prerequisite for breast/chest (also called "top") surgery, though it is recommended for 12–24 months for male-to-female patients to achieve optimal results (Hembree et al., 2009).

For genital (also called "bottom") surgery, 12 continuous months of hormone therapy are required prior to oophorectomy or orchiectomy (surgical removal of ovaries or testicles), unless contraindicated; health record documentation of "12 continuous months of living in a gender role that is congruent with their gender identity . . . consistently, on a day-to-day basis and across all settings of life" is also required for metoidioplasty (surgical relocation of an enlarged clitoris), phalloplasty (surgical creation of a penis), or vaginoplasty (surgical creation of a vagina; WPATH, 2011,

[2] Transdermal rather than oral estrogen is recommended. Common antiandrogens include spironolactone (an antihypertensive agent that requires electrolyte monitoring); cyproterone acetate (not approved in the United States); GnRH agonists, such as gosrelin, buserelin, or triptorelin (available as injectables or implants); and 5-alpha reductase inhibitors, such as finasteride and dutasteride (WPATH, 2011, p. 48).

pp. 60–61). Mastectomy is often the only surgery undertaken by the female-to-male population; for those who do undergo genital surgery, phalloplasty is relatively uncommon, as it often requires multiple procedures and has frequent complications (WPATH, 2011, pp. 63–64). Surgeons should work closely with patients and other care providers, if needed, to ensure that the advantages, disadvantages, and risks of various treatments and procedures are well understood.

Other Treatments

Aside from breast/chest and genital surgery, other surgical interventions may include liposuction, lipofilling, and various aesthetic procedures. For male-to-female patients, these may include "facial feminization surgery, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), [and] hair reconstruction"; female-to-male patients may seek pectoral implants (WPATH, 2011, pp. 57–58). There is ongoing debate regarding whether these and other transition-related treatments are "medically necessary" (and therefore covered by insurance). For example, in some circumstances, facial hair removal for male-to-female patients may constitute necessary transition-related treatment: One study found that those who have undergone the procedure were "less likely to experience harassment in public spaces," and harassment can "have a negative impact on the success of a person's treatment for gender dysphoria" (Herman, 2013b, p. 19). In addition, voice and communication therapy to develop vocal characteristics and nonverbal communication patterns congruent with gender identity may prevent "vocal misuse and long-term vocal damage" (WPATH, 2011, pp. 52–54).

APPENDIX D

Review of Accession, Retention, and Separation Regulations

Directive	Date	Department
Air Force Instruction 36-2002, *Regular Air Force and Special Category Accessions*	4/7/1999, revised 6/2/2014	Air Force
Air Force Instruction Guidance Memorandum AFI48-123_AFGM2015-01, "Guidance Memorandum: AFI 48-123, *Medical Examinations and Standards*"	8/27/2015	Air Force
Air Force Instruction Guidance Memorandum 48-123_AFGM4, "Air Force Guidance Memorandum to AFI 48-123, *Medical Examinations and Standards*"	1/29/2013	Air Force
Air Force Recruiting Service Instruction 36-2001, *Recruiting Procedures for the Air Force*	8/1/2012	Air Force
Air Force Instruction 41-210, *TRICARE Operations and Patient Administration Functions*	6/6/2012	Air Force
U.S. Army Recruiting Command, *Pocket Recruiter Guide*	7/1/2013	Army
Army Regulation 635-40, *Physical Evaluation for Retention, Retirement, or Separation*	3/20/2012	Army
Army Regulation 601-280, *Army Retention Program*	9/15/2011	Army
Army Regulation 40-501, *Standards of Medical Fitness*	8/4/2011	Army
Army Regulation 40-66, *Medical Record Administration and Healthcare Documentation*	1/4/2010	Army
Army Regulation 635-200, *Active Duty Enlisted Administrative Separations*	9/6/2011	Army
Army Regulation 601-210, *Active and Reserve Components Enlistment Program*	3/12/2013	Army
DoDI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*	4/28/2010, revised 9/13/11	DoD
DoDI 1332.18, *Disability Evaluation System (DES)*	8/5/2014	DoD
Office of the Under Secretary of Defense for Personnel and Readiness, *Disability Evaluation System (DES) Pilot Operations Manual*	12/2008	DoD

Directive	Date	Department
Marine Corps Order 1040.31, *Enlisted Retention and Career Development Program*	9/8/2010	Marine Corps
Marine Corps Order 6110.3, *Marine Corps Body Composition and Military Appearance Program*	8/8/2008	Marine Corps
Marine Administrative Message 064/11, "Amplification to Testing Accession Standards for the Purpose of Application to Marine Office Commissioning Programs"	1/26/2011	Marine Corps
Navy Military Personnel Manual 1306-964, "Recruiting Duty"	5/9/2014	Navy
Navy Medicine Manual P-117, *Manual of the Medical Department*, Chapter 15, Article 15-31, "Waivers of Physical Standards"	5/3/2012	Navy and Marine Corps

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APA—*See* American Psychiatric Association.

Army Regulation 40-501, *Standards of Medical Fitness*, December 14, 2007, revised August 4, 2011.

Army Regulation 600-8-101, *Personnel Processing (In-, Out-, Soldier Readiness, and Deployment Cycle)*, February 19, 2015.

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Current U.S. Department of Defense (DoD) policy bans transgender personnel from serving openly in the military. DoD has begun considering changes to this policy, but the prospect raises questions regarding access to gender transition–related health care, the range of transition-related treatments that DoD will need to provide, the potential costs associated with these treatments, and the impact of these health care needs on force readiness and the deployability of transgender service members. A RAND study identified the health care needs of the transgender population and transgender service members in particular. It also examined the costs of covering transition-related treatments, assessed the potential readiness implications of a policy change, and reviewed the experiences of foreign militaries that permit transgender service members to serve openly.

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IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., *Plaintiffs,* v. DONALD J. TRUMP, et al., *Defendants.*	Case No. 17-cv-02459 (MJG)

EXPERT DECLARATION OF THE HONORABLE BRAD R. CARSON IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Brad Rogers Carson, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this declaration.

Professional Background and Experience

1. I served as the Acting Under Secretary of Defense for Personnel and Readiness ("USD P&R") from April 2, 2015 to April 8, 2016. In that capacity, and at the direction of the Secretary of Defense, I led a group of senior personnel drawn from all of the armed services to develop, over many months of information collection and analysis, a Department-wide policy regarding service by transgender people, all as more fully described below.

2. I attended Baylor University and obtained an undergraduate degree in history in 1989. After college, I attended Trinity College in Oxford, England on a Rhodes Scholarship and earned a Master's degree in Politics, Philosophy, and Economics. When I returned to the United States, I attended the University of Oklahoma College of Law, graduating with a law degree in 1994.

3. After I graduated law school, I practiced as an attorney at the law firm Crowe & Dunlevy. From 1997 to 1998 I served as a White House Fellow, where I worked as a Special Assistant to the Secretary of Defense. From 2001 to 2005, I served in Congress as the Representative for the State of Oklahoma's 2nd District.

4. In addition to my civilian career, I am also a commissioned officer in the United States Navy Reserve. I currently serve in the Individual Ready Reserve. I deployed to Iraq in 2008 as Officer-in-Charge of intelligence teams embedded with the U.S. Army's 84th Explosive Ordnance Disposal Battalion. In Iraq, our teams were responsible for investigation of activities relating to improvised explosive devices and the smuggling of weapons and explosives. For my service in Iraq, I was awarded the Bronze Star Medal and other awards.

5. I have held several leadership positions within the Department of Defense ("DoD"). In 2011, I was nominated by the President to serve as General Counsel to the United States Army and unanimously confirmed by the U.S. Senate. As General Counsel, my duties included providing legal advice to the Secretary, Under Secretary, and Assistant Secretaries of the Army regarding the regulation and operation of the U.S. Army. I also assisted in the supervision of the Office of the Judge Advocate General. I served as General Counsel to the United States Army until March 2014.

6. In late 2013, while serving in that position, I was nominated by the President to serve as Under Secretary of the Army. I was unanimously confirmed by the U.S. Senate in February 2014 and sworn in on March 27, 2014. As Under Secretary of the Army, I was the second ranking civilian official in the Department of the Army. My responsibilities included the welfare of roughly 1.4 million active and reserve soldiers and other Army personnel, as well as a variety of matters relating to Army readiness, including oversight of installation management

and weapons and equipment procurement. With the assistance of two Deputy Under Secretaries, I directly supervised the Assistant Secretaries of the Army for Manpower and Reserve Affairs; Acquisition, Logistics and Technology; Financial Management and Comptroller; Installations, Energy and Environment; and Civil Works. My responsibilities involved the management and allocation of an annual budget amounting to almost $150 billion.

7. I was appointed by the President to serve as acting USD P&R in April 2015. In that capacity, I functioned as the principal staff assistant and advisor to the Secretary and Deputy Secretary of Defense for Total Force Management with respect to readiness; National Guard and Reserve component affairs; health affairs; training; and personnel requirements and management, including equal opportunity, morale, welfare, recreation, and quality of life matters. My responsibilities over these matters extended to more than 2.5 million military personnel.

DEVELOPMENT OF POLICY REGARDING TRANSGENDER SERVICE MEMBERS

8. On July 28, 2015, then-Secretary of Defense Ashton B. Carter ordered me, in my capacity as USD P&R, to convene a working group to formulate policy options for DoD regarding transgender service members (the "Working Group"). Secretary Carter ordered the Working Group to present its recommendations within 180 days. In the interim, transgender service members were not to be discharged or denied reenlistment or continuation of service on the basis of gender identity without my personal approval.

9. The Working Group included roughly twenty-five members. Each branch of military service was represented by a senior uniformed officer (generally a three-star admiral or general), a senior civilian official, and various staff members. The Surgeons General and senior

representatives of the Chaplains for each branch of service also attended the Working Group meetings.

10. The Working Group formulated its recommendations by collecting and considering evidence from a variety of sources, including a careful review of all available scholarly evidence and consultations with medical experts, personnel experts, readiness experts, health insurance companies, civilian employers, and commanders whose units included transgender service members.

THE FINDINGS OF THE RAND REPORT

11. On behalf of the Working Group, I requested that RAND, a nonprofit research institution that provides research and analysis to the Armed Services, complete a comprehensive study of the health care needs of transgender people, including potential health care utilization and costs, and to assess whether allowing transgender service members to serve openly would affect readiness.

12. In 2016, RAND presented the results of its exhaustive study in a report entitled Assessing the Implications of Allowing Transgender Personnel to Serve Openly ("RAND Report").

13. The RAND Report explained that according to the American Psychiatric Association, the term transgender refers to "the broad spectrum of individuals who identify with a gender different from their natal sex." The RAND Report also explained that "transgender status alone does not constitute a medical condition," and that "only transgender individuals who experience significant related distress are considered to have a medical condition called gender dysphoria (GD)." For those individuals, the recognized standard of care includes some combination of psychosocial, pharmacological, and/or surgical care. "Not all patients seek all

forms of care." "While one or more of these types of treatments may be medically necessary for some transgender individuals with GD, the course of treatment varies and must be determined on an individual basis by patients and clinicians."

14. The RAND Report evaluated the capacity of the military health system (MHS) to provide necessary care for transgender service members. The RAND Report determined that necessary psychotherapeutic and pharmacological care are available and regularly provided through the MHS, and that surgical procedures "quite similar to those used for gender transition are already performed within the MHS for other clinical indications." In particular, the MHS already performs reconstructive surgeries on patients who have been injured or wounded in combat. "The skills and competencies required to perform these procedures on transgender patients are often identical or overlapping." In addition, the RAND Report noted that "performing these surgeries on transgender patients may help maintain a vitally important skill required of military surgeons to effectively treat combat injuries."

15. The RAND Report also examined all available actuarial data to determine how many transgender service members are likely to seek gender transition-related medical treatment. The RAND Report concluded that "we expect annual gender transition-related health care to be an extremely small part of overall health care provided to the AC [Active Component] population."

16. The RAND Report similarly concluded that the cost of extending health care coverage for gender transition-related treatments is expected to be "an exceedingly small proportion of DoD's overall health care expenditure."

17. The RAND Report found no evidence that allowing transgender people to serve openly would negatively impact unit cohesion, operational effectiveness, or readiness.

18. The RAND Report found that the estimated loss of days available for deployment due to transition-related treatments "is negligible." Based on estimates assuming the highest utilization rates, it concluded that the number of nondeployable man-years due to gender transition-related treatments would constitute 0.0015 percent of all available deployable labor years across both the Active Component and Select Reserves.

19. The RAND Report also found no evidence that permitting openly transgender people to serve in the military would disrupt unit cohesion. The RAND Report noted that while similar concerns were raised preceding policy changes permitting open service by gay and lesbian personnel and allowing women to serve in ground combat positions, those concerns proved to be unfounded. The RAND Report found no evidence to expect a different outcome for open service by transgender persons.

20. The RAND Report examined the experience of eighteen other countries that permit open service by transgender personnel—including Israel, Australia, the United Kingdom, and Canada. The Report found that all of the available research revealed no negative effect on cohesion, operational effectiveness, or readiness. Some commanders reported that "increases in diversity led to increases in readiness and performance."

21. The Rand Report also identified significant costs associated with separation and a ban on open service, including "the discharge of personnel with valuable skills who are otherwise qualified."

ISSUES CONSIDERED BY THE WORKING GROUP

22. The Working Group sought to identify and address all relevant issues relating to service by openly transgender persons, including deployability. In addition to taking into consideration the conclusions of the RAND Report, the Working Group discussed that while

some transgender service members might not be deployable for short periods of time due to their treatment, this is not unusual, as it is common for service members to be non-deployable for periods of time due to medical conditions such as pregnancy, orthopedic injuries, obstructive sleep apnea, appendicitis, gall bladder disease, infectious disease, and myriad other conditions. For example, the RAND Report estimated that at the time of the report, 14 percent of the active Army personnel—or 50,000 active duty soldiers—were ineligible to deploy for legal, medical, or administrative reasons.

23. The Working Group also addressed the psychological health and stability of transgender people. In addition to taking into account the conclusions of the RAND Report, the Working Group concluded, based on discussions with medical experts and others, that being transgender is not a psychological disorder. While some transgender people experience gender dysphoria, that condition is resolved with appropriate medical care. In addition, the Working Group noted the positive track record of transgender people in civilian employment, as well as the positive experiences of commanders with transgender service members in their units.

24. The Working Group also concluded that transgender service members would have ready access to any relevant necessary medication while deployed in combat settings. It determined that military policy and practice allows service members to use a range of medications, including hormones, while in such settings. The MHS has an effective system for distributing prescribed medications to deployed service members across the globe, including those in combat settings.

25. The Working Group also concluded that banning service by openly transgender persons would require the discharge of highly trained and experienced service members, leaving

unexpected vacancies in operational units and requiring the expensive and time-consuming recruitment and training of replacement personnel.

26. The Working Group also concluded that banning service by openly transgender persons would harm the military by excluding qualified individuals based on a characteristic with no relevance to a person's fitness to serve.

27. I concluded my service as USD P&R on April 8, 2016. By that time, the Working Group was unanimously resolved that transgender personnel should be permitted to serve openly in the military.

RECENT REVERSAL OF POLICY

28. On July 26, 2017, President Donald Trump issued a statement that transgender individuals will not be permitted to serve in any capacity in the Armed Forces. On August 25, 2017, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security to reverse the policy adopted in June 2016 that permitted military service by openly transgender persons. That memorandum stated: "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."

29. President Trump's stated rationale for a ban on military service by openly transgender service members is unfounded and refuted by the comprehensive investigation and review performed by the Working Group.

30. In addition to contravening the Working Group's conclusions and the exhaustive supporting evidence that was collected, I believe that prohibiting transgender individuals from serving openly in the military is harmful to the public interest for several reasons. My belief is based on my experience as USD P&R and in other leadership positions within DoD, and upon my active duty experience in Iraq.

31. First, a prohibition on service by openly transgender individuals would degrade military readiness and capabilities. Many military units include transgender service members who are highly trained and skilled and who perform outstanding work. Separating these service members will deprive our military and our country of their skills and talents.

32. Second, banning military service by openly transgender persons would impose significant costs that far outweigh the minimal cost of permitting them to serve. A study authored in August 2017 by the Palm Center and professors associated with the Naval Postgraduate School estimated that separating transgender service members currently serving in the military would cost $960 million, based on the costs of recruiting and training replacements.

33. Third, the sudden and arbitrary reversal of the DoD policy allowing openly transgender personnel to serve will cause significant disruption and thereby undermine military readiness and lethality. This policy bait-and-switch, after many service members disclosed their transgender status in reliance on statements from the highest levels of the chain of command, conveys to service members that the military cannot be relied upon to follow its own rules or maintain consistent standards.

34. Fourth, in addition to the breach of transgender service members' trust resulting in the deprivation of their careers and livelihood, the President's policy reversal will cause other historically disadvantaged groups in the military, including women and gay and lesbian service

members, to question whether their careers and ability to serve as equal members of the military may also be sacrificed.

35. Fifth, those serving in our Armed Forces are expected to perform difficult and dangerous work. The President's reversal of policy puts tremendous additional and unnecessary stress on transgender service members, their command leaders, and those with whom they serve.

36. In short, the President's reversal of the policy permitting military service by openly transgender individuals has had, and will continue to have, a deleterious effect on readiness, force morale, and trust in the chain of command in the Armed Services.

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

Dated: September 11, 2017

Brad Rogers Carson

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., *Plaintiffs,* v. DONALD J. TRUMP, et al., *Defendants.*	Case No. 17-cv-02459 (MJG)

EXPERT DECLARATION OF MAJOR GENERAL MARGARET C. WILMOTH, U.S. ARMY (RET.) IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Margaret Chamberlain Wilmoth, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this declaration.

Professional 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 six or seven 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 35 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, 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 60 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 the 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 though 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.

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 penalty of perjury that the foregoing is true and correct.

Dated: September 10th, 2017

Margaret C. Wilmoth

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., *Plaintiffs*, v. DONALD J. TRUMP, et al., *Defendants*.	Case No. 1:17-cv-02459 Date: October 27, 2017

BRIEF OF RETIRED MILITARY OFFICERS AND FORMER NATIONAL SECURITY OFFICIALS AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION AND OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

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INTEREST OF *AMICI CURIAE*

Amici are retired military officers and former national security officials, who have collectively devoted countless decades to strengthening U.S. security interests. They have been responsible for the readiness of the service members under their command in times of hostilities and peace, and supervised and participated in policy processes involving military readiness and personnel at the senior-most levels of the U.S. government, across the administrations of both major political parties. They greatly appreciate and value military expertise and the need for the judiciary to defer to it when the circumstances demand. They file this submission to offer their perspective that this is not a case where deference is warranted, in light of the absence of any considered military policymaking process, and the sharp departure from decades of precedent on the approach of the U.S. military to major personnel policy changes. Furthermore, amici contend that the categorical exclusion of transgender individuals on the basis of group characteristics rather than individual fitness to serve is inimical to the national security interests of the United States.

ARGUMENT

On the morning of July 26, 2017, President Donald Trump issued three tweets that suddenly announced a ban on transgender service members serving in the military. The tweets did not emerge from a policy review of any kind. In advance of his decision, he did not consult his military officials; his Joint Chiefs of Staff were unaware that he planned to make this decision at all. Less than a month later, President Trump issued a Presidential Memorandum that formalized the tweets, but that document again did not identify any policymaking process or consultations with senior military officials leading to the decision. The Presidential Memorandum also did not point to a single piece of evidence demonstrating that the ban was necessary for reasons of military necessary, national security, or any other legitimate national interest.[1]

He now seeks to shield that decision from judicial review, claiming throughout his papers that he is owed "the utmost deference" in cases "involving the judgment of military authorities."[2] These assertions neglect the very simple fact that the President's tweets and Memorandum did not involve the judgment of any military authorities at all. In fact, the President's actions at issue here are about as far removed as one could imagine from those cases where courts have deferred to the genuine "considered" or "professional judgment" of the executive branch on military matters. *Winter v. Nat. Res. Def. Council*, 555 U.S. 7, 24 (2008) (quotations and citations omitted); *Goldman v. Weinberger*, 475 U.S. 503, 508-09 (1986).

[1] Presidential Memorandum from the President of the United States to Secretaries of Defense and Homeland Security, 82 Fed. Reg. 41,319 (Aug. 25, 2017) [hereinafter "Presidential Memorandum"].
[2] Mem. in Supp. of Def. Mot. to Dismiss, *Stone v. Trump*, 17-cv-02459, Oct. 12, 2017, at 3, 22 [hereinafter "Def. Mem."]; *see also id.* at 23-25.

Defendants are unable to point to a single case where a court afforded deference to a President's military judgment when that President undertook no considered review, consulted no military officials, and cited no evidence in support of his decision. Indeed, the President's actions here represent a remarkable departure from decades of practice across multiple administrations regarding the proper approach to making major policy changes on personnel issues within the U.S. military. And perhaps it should not come as a surprise that such an arbitrary process resulted in a policy that the evidence overwhelmingly shows will impair our military's readiness, harm unit cohesion, deplete urgently needed military resources, and undermine the foreign policy of the United States.

Although this case *affects* national security, it involves no identifiable national security *judgment* of the sort that deserves—much less compels—judicial deference. Amici know quite well the critical importance of military expertise to the security of our nation, and the need for the judiciary to defer to that expertise when the circumstances demand. However, the President should not be allowed to hide behind a cloak of deference a capricious and discriminatory act that involved no considered consultation, no professional military decision-makers and no evidentiary basis or review, and will do grievous harm not only to the service members immediately affected, but to the national security and foreign policy interests of the United States.

I. The President's actions departed sharply from decades of practice involving similar military policy changes.

Throughout its history, the U.S. military has exercised great care in the selection, training, and retention of qualified personnel as an integral aspect of military readiness. Significant changes to its personnel policies—particularly those involving the categorical exclusion of entire groups from military service—have been subjected time and again to a

process that includes: 1) a searching policy review, 2) involving senior military officials, 3) that thoroughly examines the best available evidence on the impact and consequences of the change. This practice is a reflection of the gravity of such decisions and a realization that even incremental changes in military policy can dramatically affect our Armed Forces' overall readiness to protect our country.

The paradigmatic case of a major personnel change in the U.S. military is President Truman's decision seven decades ago to integrate African Americans into the Armed Forces. Although African Americans had served in the United States military since the Revolutionary War,[3] many had served in segregated units due to perceived concerns about unit cohesion and morale.[4] Prompted by growing concern about racial inequality and unrest in the United States, on December 5, 1946 President Truman issued an Executive Order appointing the President's Committee on Civil Rights, a presidential commission comprised of senior defense officials, religious leaders, and civil rights activists to study, *inter alia*, the desegregation of the military.[5] Over nearly a year, the Committee deliberated across ten meetings, undertook multiple studies, heard from numerous witnesses in public and private hearings, received hundreds of communications from private organizations and individuals, and was assisted in its work by twenty-five agencies across the federal government.[6]

In December 1947, the Committee issued its final report. The report found that the practices of the military services in excluding African-Americans was "indefensible", concluding

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[3] Michael Lee Lanning, *African Americans in the Revolutionary War* 73 (2000).
[4] Martin Binkin & Mark J. Eitelberg, *Blacks and the Military* 25-26 (1982).
[5] Harry S. Truman Library and Museum, *Records of the President's Committee on Civil Rights* (2000), available at http://www.trumanlibrary.org/hstpaper/pccr.htm.
[6] President's Committee on Civil Rights, *To Secure These Rights: The Report of the President's Committee on Civil Rights* XI (1947), http://www.trumanlibrary.org/civilrights/srights1.htm; *Records of the President's Committee on Civil Rights*, *supra* note 5.

that that practice had "cost[] lives and money in the inefficient use of human resources," "weaken[ed] our defense" by "preventing entire groups from making their maximum contribution to the national defense," and "impose[d] heavier burdens on the remainder of the population."[7] As a result, the Committee called for an immediate end to discrimination and segregation based on "race, color, creed, or national origin, in the organization and activities of all branches of the Armed Services."[8] Several months later, President Truman issued an executive order declaring that it would be the policy of the United States to require equality of treatment and opportunity for all persons in the U.S. Armed Services without regard to race, and convening a Committee on Equality of Treatment and Opportunity in the Armed Services to "recommend revisions in military regulations in order to implement the government's policy of desegregation of the armed services."[9]

The Obama Administration's repeal of the Don't Ask, Don't Tell directive, which allowed gay, lesbian or bisexual people to serve openly in the military, followed a similarly searching process. The repeal came on the heels of a comprehensive Pentagon review—in March 2010, Secretary of Defense Gates convened a working group co-chaired by the General Counsel of the Department of Defense and the General of the U.S. Army and comprised of senior civilian and military leaders from across the Armed Services to undertake a comprehensive review of the impacts of a repeal of the law.[10] The working group conducted 95

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[7] *To Secure These Rights: The Report of the President's Committee on Civil Rights* XI, *supra* note 5, at 46-47, 162-63.
[8] *Id.* at 163.
[9] Harry S. Truman Library and Museum, *Records of the President's Committee on Equality of Treatment and Opportunity in the Armed Services*, available at http://www.trumanlibrary.org/hstpaper/fahy.htm; Exec. Order No. 9981, 13 Fed. Reg. 4313 (July 28, 1948).
[10] U.S. Dep't of Defense, *Report of the Comprehensive Review of the Issues Associated with a Repeal of "Don't Ask, Don't Tell,"* Nov. 30, 2010,

"information exchange forums" at 51 bases and installations around the world, conducted 140 focus groups, solicited input from nearly 400,000 active duty and reserve service members, engaged the RAND Corporation to update its earlier 1993 study, *Sexual Orientation and U.S. Military Personnel Policy*, studied foreign militaries' integration of gays and lesbians, and conducted a thorough legal review.[11]

On November 30, 2010, the working group issued a 256-page report rejecting the contention that allowing gays to serve openly in the military would result in long-lasting and detrimental effects on unit cohesion or the ability of units to conduct military missions.[12] It also offered a series of recommendations for implementing a repeal of the law in the areas of leadership, training, education and the management of moral and religious objections.[13] Shortly thereafter, Secretary Gates and Chairman of the Joint Chiefs Admiral Mullen called on Congress to immediately repeal the Don't Ask, Don't Tell law. Congress passed just such a bill, which President Obama signed into law. Seven months later, President Obama, newly confirmed Secretary of Defense Panetta, and Admiral Mullen formally certified under the new statute that the American military was ready to repeal the old policy.[14]

The decision to include female service members in combat roles likewise emerged from a careful evidence-based process—this time, a congressionally mandated policy and legal review undertaken by the Secretary of Defense, in consultation with the Military Department Secretaries, of the policies and regulations that had officially barred women from serving in combat positions. After an "extensive review" of the policies and laws governing the assignment

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http://archive.defense.gov/home/features/2010/0610_dadt/DADTReport_FINAL_20101130(secure-hires).pdf.

[11] *Id.* at 33-39.

[12] *Id.* at 119.

[13] *Id.* at 3.

[14] Jody Feder, *"Don't Ask, Don't Tell": A Legal Analysis,* CRS Rep. R40795, Aug. 6, 2013.

of women in the Armed Forces and the feasibility of opening to women military occupational specialties that were then closed to them, the Department of Defense found in a February 2012 report that, given the "dynamics of the modern-day battlefield . . . there is no compelling reason for continuing the portion of the policy that precludes female service members from being assigned to . . . direct ground combat units", and declared its intent to rescind the "co-location rule" that prevented female Service members from being assigned to units that were doctrinally required to physically co-locate with direct ground combat units.[15]

Secretary Panetta also issued a directive at that time to conduct an in-depth review of the remaining barriers to service for women. After several months of additional study, on January 24, 2013, Secretary Panetta announced that the Department would rescind the Direct Combat Exclusion Rule on women serving in previously restricted occupations.[16] He also called on each of the services to undertake their own separate "women in the service" reviews of how to move forward with the integration of women into previously closed positions, and identify any recommended exemptions for particular positions.[17] This process led to more than thirty additional studies over the next three years to inform the contours of the policy change.[18] After the Secretaries of each of the services completed their reviews and submitted their final

[15] U.S. Dep't of Defense, *Report to Congress on the Review of Laws, Policies, and Regulations Restricting the Service of Female Members in the U.S. Armed Forces*, Feb. 2012; Fact Sheet: Women in Service Review (WISR) Implementation, https://www.defense.gov/Portals/1/Documents/pubs/Fact_Sheet_WISR_FINAL.pdf.
[16] Kristy N. Kamarck, *Women in Combat: Issues for Congress*, Cong. Res. Serv. R42075, Dec. 13, 2016.
[17] U.S. Dep't of Defense, *Statement from Pentagon Press Secretary Peter Cook on Secretary Carter's Approval of Women in Service Review Implementation Plans*, March 10, 2016.
[18] Fact Sheet, *supra* note 15.

recommendations, Secretary of Defense Ashton Carter on December 3, 2015 ordered the military to open all combat jobs to women who meet the validated occupational standards.[19]

Finally, the very opening of military service to transgender personnel that President Trump now seeks summarily to reverse emerged from its own rigorous policymaking process. In July 2015, Secretary Carter issued a directive creating a formal working group to study the "policy and readiness implications of welcoming transgender persons to serve openly" in the military.[20] Over the course of the following year, the working group engaged in what one senior member described as a "detailed, deliberative, [and] carefully run process."[21] Each military service was represented in the working group by a senior uniformed officer, a senior civilian official, and various staff members.[22] The working group created sub-groups to investigate specific issues, consulted with medical, personnel, and readiness experts, and spoke with health insurance companies and commanders of transgender service members.[23] At the end of this comprehensive process, the working group unanimously concluded that transgender individuals should be permitted to serve openly in the Armed Forces.[24]

Meanwhile, the Department also had commissioned a separate, independent study from the RAND Corporation. The study focused on seven broad research questions, among them the cost of providing medical coverage to transgender individuals, the readiness implications of the

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[19] U.S. Sec'y of Defense, *Remarks on the Women-in-Service Review*, Dec. 3, 2015, https://www.defense.gov/News/Speeches/Speech-View/Article/632495/remarks-on-the-women-in-service-review/; Kamarck, *supra* note 16.
[20] U.S. Dep't of Defense, *Statement by Secretary of Defense Ash Carter on DOD Transgender Policy*, Release No: NR-272-15, July 13, 2015.
[21] Decl. of Raymond Edwin Mabus, Jr. In Support of Plaintiffs' Motion for Preliminary Injunction at 3, *Karnoski v. Trump*, No. 2:17-cv-1297 (W.D. Wash. 28 Aug. 2017).
[22] Decl. of Brad R. Carson in Support of Plaintiffs' Motion for Preliminary Injunction at 3, *Karnoski v. Trump*, No. 2:17-cv-1297 (W.D. Wash. 28 Aug. 2017).
[23] *Id*. at 3.
[24] *Id*. at 7.

proposed policy, and any applicable lessons from the eighteen foreign militaries that already allowed open transgender service.[25] RAND laid out its findings in a 71-page report, concluding that allowing transgender people to serve openly would place an "exceedingly small" burden on health care expenditures and have a "minimal impact" on readiness.[26] Based on the thorough review carried out by these two groups, Secretary Carter announced the policy change in June 2016. For more than a year after that change, transgender individuals currently in the military were able to serve openly alongside their fellow service members. The Department released a 71-page handbook specifying implementation strategies,[27] and issued guidelines for both in-service medical transition procedures and treatment of gender dysphoria.[28] But for President Trump's abrupt about-face, this studied, measured, and incremental process would have concluded on January 1, 2018 with the accession of openly transgender individuals into the U.S. military.

Each of the above personnel decisions was the product of a rigorous policy review involving senior military officials and an evidence-based examination of the likely impact of the proposed change. In sharp contrast, on the morning of July 26, 2017, President Trump suddenly announced a ban on transgender persons serving in the military. In a series of three tweets, the President (speaking as @realDonaldTrump) declared,

> "The United States Government will not accept or allow . . . [t]ransgender individuals to serve in any capacity in the U.S. Military. Our military must be focused on decisive and

[25] RAND Corp., *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* ix (2016).
[26] *Id*. at xi and 47.
[27] U.S. Dep't of Defense, *Transgender Service in the U.S. Military: An Implementation Handbook* (2016).
[28] U.S. Dep't of Defense, *Instr. 1300.28, In-Service Transition for Transgender Service Members* (Oct. 1, 2016); Memorandum, Assistant Secretary of Defense for Health Affairs, to Assistant Secretary of the Army et al., *Guidance for Treatment of Gender Dysphoria for Active and Reserve Component Service Members*, July 29, 2016.

> overwhelming . . . victory and cannot be burdened with the tremendous medical costs and disruption that transgender [sic] in the military would entail. Thank you[.]"

No effort was made—nor evidence presented—to show that this pronouncement resulted from any analysis of the cost or disruption allegedly caused by allowing transgender individuals to serve openly in the military. The Joint Chiefs of Staff were not consulted at all on the decision before the President issued the tweet. Secretary of Defense James N. Mattis, who was on vacation at the time, was given only a single day's notice that the decision was coming.[29] The decision was announced so abruptly that White House and Pentagon officials were unable to explain the most basic of details about how it would be carried out.[30]

About four weeks later, President Trump followed up the tweets with a Memorandum entitled "Military Service by Transgender Individuals," directed to the Secretary of Defense and the Secretary of Homeland Security.[31] This Memorandum instructs the Department of Defense to return to the earlier policy of discrimination against transgender service members, including by involuntary or dishonorable discharge, and maintains and extends in time the current bar on accession of transgender individuals into the military.[32] Again, the Memorandum does not point to any policy process that led to the decision, does not cite consultations with any military officers, and does not identify a single piece of evidence to support the decision. The

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[29] Barbara Starr et al., *US Joint Chiefs blindsided by Trump's transgender ban*, CNN (July 27, 2017), http://www.cnn.com/2017/07/27/politics/trump-military-transgender-ban-joint-chiefs/index.html; Julie Hirschfeld Davis & Helene Cooper, *Trump Says Transgender People Will Not Be Allowed in the Military*, N.Y.Times (July 26, 2017), https://www.nytimes.com/2017/07/26/us/politics/trump-transgender-military.html?_r=0.

[30] Davis & Cooper, *supra* note 29.

[31] Presidential Memorandum, *supra* note 1.

[32] The Proclamation states that the new policies will go into effect by March 23, 2018, and the Department of Defense has already started to develop plans to carry out the directive. Presidential Memorandum, *supra* note 1; Statement by Secretary of Defense Jim Mattis on Military Service by Transgender Individuals, Aug. 29, 2017.

Memorandum suggests in passing that the Departments would "continue to study the issue," even as it declares a sweeping change affecting thousands of transgender service-members.

The President now seeks to shield this decision from judicial scrutiny by invoking "the highly deferential review" that the Constitution has historically afforded national security and military judgments.[33] He claims that such deference is appropriate here because the lawsuit is challenging "military decision-making," and "professional military judgments."[34] However, there is no sign of respect for military decision-making or professional military judgments to be found anywhere in the President's actions. He not only failed to involve senior military officials in his decision at all, but he is seeking to displace the considered judgment of military officials regarding the treatment of transgender individuals in the military from just a year earlier. The Supreme Court in fact has given "great deference to the *professional judgment of military authorities* concerning the relative importance of a particular military interest," *Winter v. Nat. Res. Def. Council*, 555 U.S. 7, 24 (2008) (emphasis added) (quotations and citations omitted), and the "*considered professional judgment*" of "appropriate military officials," *Goldman v. Weinberger*, 475 U.S. 503, 508-09 (1986) (emphasis added). But the record in this case hints at nothing remotely resembling a considered or professional judgment of this sort.

Earlier cases show how the courts have looked for considered judgment before affording constitutional deference to the coordinate branches in areas of policy making involving military personnel. For example, in *Rostker v. Goldman*, 453 U.S. 57 (1981), the Supreme Court upheld the constitutionality of provisions that authorized the President to require men, but not women, to register for the draft. The Court deferred to "Congress' evaluation of th[e] evidence," noting that "[t]his case is quite different from several of the gender-based discrimination cases we have

[33] Def. Mem. at 3.
[34] Def. Mem. at 3, 24.

considered in that . . . Congress did not act 'unthinkingly' or 'reflexively and not for any considered reason.'" *Id.* at 72, 83 (quoting Br. for Appellees) (emphasis omitted). The Court pointed to the fact that the issue was "extensively considered by Congress in hearings, floor debate, and in committee." *Id.* at 72; *see also, e.g.*, *id.* at 63, 79.

On the other hand, the U.S. District Court for the District of Columbia found unconstitutional a statutory provision barring the assignment of female personnel to duty on navy vessels other than hospital ships and transports. *Owens v. Brown*, 455 F. Supp. 291 (D.D.C. 1978). The court acknowledged that "a high degree of deference is owed to the political branches of government in the area of military affairs," in part because "oversight of military operations typically involves complex, subtle, and professional judgments that are best left to those steeped in the pertinent learning." *Id.* at 299 (quotations and citations omitted). But the court noted that the provision in that case "was added casually, over the military's objections and without significant deliberation," and the Court found compelling "the results of the experiment conducted by the Navy on the USS Sanctuary . . . that assigning women to noncombat duty on vessels will pose no insurmountable obstacles." *Id.* at 305, 309.

The Fourth Circuit also has chosen or declined to afford deference to the national security prerogatives of the executive based on whether the decision reflected a considered policymaking process. In *Thomasson v. Perry*, the court premised its decision upholding the constitutionality of the Don't Ask, Don't Tell policy on a lengthy discussion of the policy deliberations that took place before the enactment of the directive, including studies and reviews undertaken by the Department of Defense, the RAND Corporation, and congressional committees, and consultations with the Joint Chiefs of Staff and leaders of each service. 80 F.3d 915, 921-23 (4th Cir. 1996). Emphasizing that the directive emerged from an "exhaustive review" and "extensive

deliberation" by the executive branch and Congress, the court only then went on to defer to what it described as the "considered judgment" of those coordinate branches of government. *Id.* at 922-27.

But when the record shows no such considered judgment or process, the Fourth Circuit has chosen not to defer to the President. Recently, in *Int'l Refugee Assistance Project ("IRAP") v. Trump*, the Fourth Circuit ruled that the plaintiffs challenging President Trump's second Executive Order[35] restricting the entry of individuals from several Muslim-majority countries would likely succeed on the merits of their Establishment Clause claim, over the President's attempt to invoke deference on national security grounds. 857 F.3d 554 (4th Cir. 2017), *vacated as moot sub nom.*, *Trump v. Int'l Refugee Assistance Project*, __ S.Ct. __, 2017 WL 4518553.[36] In reaching that conclusion, the Court gave significant weight to "the exclusion of national security agencies from the decision-making process," and the fact that "President Trump issued the First Executive Order without consulting the relevant national security agencies," to conclude that the Order's "stated national security interest was provided in bad faith, as a pretext for its religious purpose." *Id.* at 592, 596.

President Trump's actions in this case show no signs of the policy judgment that traditionally has given rise to judicial deference on military issues. This is not a case involving the "professional judgment" of "appropriate military officials," as no military officials were involved in the decision at all. *Goldman*, 475 U.S. at 508-09. Nor is this a case where the decision resulted from an "exhaustive review", as in fact there was no review to speak of.

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[35] Exec. Order No. 13,780, 82 Fed. Reg. 13,209 (Mar. 6, 2017).

[36] Although the decision was vacated as moot, such decisions are relied on by courts for their persuasive value, including those in the Fourth Circuit. *See, e.g.*, *United States v. Kanasco, Ltd.*, 123 F.3d 209, 211 (4th Cir. 1997); *Nuclear Regulatory Comm'n v. Fed. Labor Relations Auth.*, 859 F.2d 302, 309 (4th Cir. 1988); *Maryland State Conference of NAACP Branches v. Maryland Dep't of State Police*, 72 F. Supp. 2d 560, 567 (D. Md. 1999) (same).

Thomasson, 80 F.3d at 927. The President's tweets and Memorandum far more closely resembles those where the decision was made "casually," *Owens,* 455 F. Supp. at 305, or "reflexively and not for any considered reason," *Rostker*, 453 U.S. at 72, or "without consulting the relevant national security agencies" in the process, *IRAP*, 857 F.3d at 596.

Indeed, the process that led to the decision in this case is not only wanting, but is a departure from the steps that were followed in considering similar personnel changes in cases throughout history. The Supreme Court has emphasized that "[d]epartures from the normal procedural sequence . . . might afford evidence that improper purposes are playing a role" in government action. *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 267 (1977). The President's failure to consult any military experts, his failure to ground his decision in any evidence or facts, indeed his failure to undertake any considered review at all, is so dramatic a break from precedent for such a major personnel change that it only provides further reason to question his insistence now to this Court that national security concerns, and not discriminatory animus, motivated the decision.

II. The President's actions will harm the national security and foreign policy interests of the United States.

The Presidential Memorandum asserts that a ban on transgender service members is necessary to avoid "hinder[ing] military effectiveness and lethality, disrupt[ing] unit cohesion, or tax[ing] military resources."[37] However, the Memorandum offers not a single piece of evidence to support these assertions. In fact, the evidence is overwhelmingly to the contrary—the categorical exclusion of transgender individuals on the basis of group characteristics rather than individual fitness will gravely harm the effectiveness of our military and the national security and foreign policy interests of the United States.

First, the President's actions will negatively impact military readiness. Imposing a ban on transgender service will significantly disrupt and distract from the core mission of the military services, by pulling people out of mission-ready, mission-critical units. President Trump proposes to expand the number of active duty Army and Marine Corps service members by 70,000 personnel—but to accomplish such an ambitious goal without degrading the effectiveness of our troops, the U.S. military will need to recruit all qualified individuals, not to exclude entire groups from military service based on rank prejudice and sweeping generalizations and without regard for individuals' capacity to serve.[38] Significantly, the RAND Corporation found that transition-related health care would have a negligible impact on the ability of any affected soldiers to deploy.[39]

Second, these actions pose a serious threat to unit cohesion. They order transgender troops to live a lie, authorize discriminatory behavior among fellow service members, and place troops in the unconscionable position of having "to choose between reporting their comrades or

[37] Presidential Memorandum, *supra* note 1.
[38] K.K. Rebecca Lai et al., *Is America's Military Big Enough?*, N.Y. Times, Mar. 22, 2017.
[39] RAND Corp., supra note 25.

disobeying policy."[40] Transgender service members have long been allowed to serve openly in the militaries of such close United States allies as Israel and the United Kingdom without any evidence of harm to unit cohesion, and these transgender service members have already served alongside U.S. troops in NATO units without any demonstrated adverse effect. In fact, the RAND study looked at the experiences of the 18 foreign countries that permit open transgender military service and found not only that such a policy did not negatively affect cohesion, but "direct interactions with transgender individuals significantly reduce negative perceptions and increase acceptance, which would suggest that those who have previously interacted with transgender individuals would be more likely to be accepting of them in the future."[41]

Third, the President's decision will deplete the military of valuable funds at a moment of budget austerity. According to one estimate, the financial cost to recruit, replace, and retrain the estimated 12,800 service members who would be ejected from the military under the new policy would be $960 million.[42] On the other side of the ledger, the RAND report found that even in "the most extreme scenario that we were able to identify using the private health insurance data, we expect only a 0.13-percent ($8.4 million out of $6.2 billion) increase in active component health care spending" as a result of incorporating openly transgender troops into the military.[43] And so, the President's decision will cost the U.S. military more money than it saves by a ratio of nearly 115 to 1.

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[40] Palm Center, Fifty-Six Retired Generals and Admirals Warn That President Trump's Anti-Transgender Tweets, If Implemented, Would Degrade Military Readiness 1 (Aug. 1, 2017), http://www.palmcenter.org/wp-content/uploads/2017/08/56-GOFO-statement-2.pdf.
[41] RAND Corp., *supra* note 25, at 44 (internal citations omitted).
[42] Palm Center, Discharging Transgender Troops Would Cost $960 Million (Aug. 2017), http://www.palmcenter.org/wp-content/uploads/2017/08/cost-of-firing-trans-troops-3.pdf.
[43] RAND Corp., *supra* note 25, at xi-xii.

Finally, judicial deference to the President's actions would send a troubling signal to those abroad, showing both allies and adversaries that the United States military is willing to distort its justly admired personnel polices to serve prejudice and political expediency. The President's tweets and Memorandum convey to the world that able and patriotic American citizens, eager and qualified to serve their country's military, can nevertheless be denied equal rights and opportunity based on illusory arguments. That message undermines the efforts of the U.S. government to advance principles of non-discrimination and equality throughout the world as a longstanding central tenet of its foreign policy, and erodes the credibility of the United States as a leader in seeking to hold governments accountable to their human rights obligations, not least of all as a critical avenue for promoting peace and security and avoiding humanitarian crises around the globe.

Against all of the above evidence of harm, the President's tweets and Memorandum did not cite a single piece of information to the contrary. In their papers to this Court, Defendants mostly gesture towards language from the RAND study that they claim could have served as the basis for this decision, while even they are forced to acknowledge the study's own conclusions (still undisputed in this record) that there will be a "negligible" impact on readiness, a "minimal" impact on unit cohesion and "relatively low" costs.[44] For the most part though, Defendants seek to defend the President's actions not on the evidence or the facts, but by falling back on their core argument: "it is not this Court's role to resolve a battle of the experts in reviewing a military policy."[45] But there is no battle, because they cite no experts as the basis for this decision to overturn abruptly a considered policy, only tweets and a memorandum benefiting from no

[44] Def. Mem. at 27-28; RAND Corp. *supra* note 5, at 47, 70.
[45] Def. Mem. at 28.

process, citing no evidence, and soliciting none of the vast professional expertise that comprises the ranks of our Nation's military leaders.

Such a shallow, transparently discriminatory façade is unworthy of the deference that the Constitution has historically afforded to genuine national security and military judgment.

CONCLUSION

For all of the foregoing reasons, the plaintiffs' requests for relief should be granted.

Respectfully submitted,

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APPENDIX

LIST OF AMICI

1. Brigadier General (Ret.) Clara L. Adams-Ender, USA

2. Brigadier General Ricardo Aponte, USAF (Ret.)

3. Vice Admiral Donald Arthur, USN (Ret.)

4. Major General (Ret.) Donna Barbisch, USA

5. Michael R. Carpenter served as Deputy Assistant Secretary of Defense for Russia, Ukraine, Eurasia from 2015 to 2017.

6. Brigadier General Stephen A. Cheney, USMC (Ret.)

7. Brigadier General (Ret.) Julia Cleckley, USA

8. Derek Chollet served as Assistant Secretary of Defense for International Security Affairs from 2012 to 2015.

9. Rear Admiral Christopher Cole, USN (Ret.)

10. Major General J. Gary Cooper, USMC (Ret.)

11. Rudy DeLeon served as Deputy Secretary of Defense from 2000 to 2001. Previously, he served as Under Secretary of Defense for Personnel and Readiness from 1997 to 2000.

12. Rear Admiral Jay A. DeLoach, USN (Ret.)

13. Brigadier General John W. Douglass, USAF (Ret.) served as Assistant Secretary of the Navy for Research, Development and Acquisition from 1995 to 1998.

14. Major General (Ret.) Paul D. Eaton, USA

15. Major General (Ret.) Mari K. Eder, USA

16. Andrew Exum served as Deputy Assistant Secretary of Defense for Middle East Policy from 2015 to 2017.

17. Brigadier General (Ret.) Evelyn "Pat" Foote, USA

18. Lieutenant General Walter E. Gaskin, USMC (Ret.)

19. Vice Admiral Kevin P. Green, USN (Ret.)

20. General Michael Hayden, USAF (Ret.), served as Director of the Central Intelligence Agency from 2006 to 2009, and Director of the National Security Agency from 1995 to 2005.

21. Chuck Hagel served as Secretary of Defense from 2013 to 2015. From 1997 to 2009, he served as U.S. Senator for Nebraska.

22. Kathleen Hicks served as Principal Deputy Under Secretary of Policy from 2012 to 2013.

23. Brigadier General (Ret.) David R. Irvine, USA

24. Lieutenant General Arlen D. Jameson (USAF) (Ret.), served as the Deputy Commander of U.S. Strategic Command.

25. Brigadier General (Ret.) John H. Johns, USA

26. Colin H. Kahl served as Deputy Assistant to the President and National Security Advisor to the Vice President. Previously, he served as Deputy Assistant Secretary of Defense for the Middle East from 2009 to 2011.

27. Rear Admiral Gene Kendall, USN (Ret.)

28. Lieutenant General (Ret.) Claudia Kennedy, USA

29. Major General (Ret.) Dennis Laich, USA

30. Major General (Ret.) Randy Manner, USA

31. Brigadier General (Ret.) Carlos E. Martinez, USAF (Ret.)

32. General (Ret.) Stanley A. McChrystal, USA, served as Commander of Joint Special Operations Command from 2003 to 2008, and Commander of the International Security Assistance Force and Commander, U.S. Forces Afghanistan from 2009 to 2010.

33. Kelly E. Magsamen served as Principal Deputy Assistant Secretary of Defense for Asian and Pacific Security Affairs from 2014 to 2017.

34. Leon E. Panetta served as Secretary of Defense from 2011 to 2013. From 2009 to 2011, he served as Director of the Central Intelligence Agency.

35. Major General (Ret.) Gale S. Pollock, CRNA, FACHE, FAAN.

36. Rear Admiral Harold Robinson, USN (Ret.)

37. Brigadier General (Ret.) John M. Schuster, USA

38. David Shear served as the Assistant Secretary of Defense for Asian and Pacific Security Affairs from July 2014 to June 2016.

39. Rear Admiral Michael E. Smith, USN (Ret.)

40. Brigadier General (Ret.) Paul Gregory Smith, USA

41. Julianne Smith served as Deputy National Security Advisor to the Vice President of the United States from 2012 to 2013. Previously, she served as the Principal Director for European and NATO Policy in the Office of the Secretary of Defense in the Pentagon.

42. Admiral James Stavridis, USN (Ret.), served as the 16th Supreme Allied Commander at NATO.

43. Brigadier General (Ret.) Marianne Watson, USA

44. William Wechsler served as Deputy Assistant Secretary for Special Operations and Combating Terrorism at the U.S. Department of Defense from 2012 to 2015.

45. Christine E. Wormuth served as Under Secretary of Defense for Policy from 2014 to 2016.

46. Rear Admiral Dick Young, USN (Ret.)

CERTIFICATE OF SERVICE

I, Phillip Spector, hereby certify that on October 27, 2017, the foregoing document was filed and served through the CM/ECF system.

Respectfully Submitted,

/s/

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., *Plaintiffs*, v. DONALD J. TRUMP, et al., *Defendants*.	)	Civil Action No. 17-cv-2459 (MJG)

DECLARATION OF ERIC K. FANNING
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Eric K. Fanning, declare as follows:

1. I served as Secretary of the Army from May 18, 2016 to January 20, 2017.

2. I received a Bachelor's Degree in History from Dartmouth College in 1990. From 1991 until 1996, I worked in various government positions in Washington, D.C., as a research assistant with the House Armed Services Committee, a special assistant in the Office of the Secretary of Defense, and Associate Director of Political Affairs at the White House. From 1997 to 1998, I worked on the national and foreign assignment desks at CBS News in New York. Subsequently, I worked at Robinson, Lerer & Montgomery, a strategic communications firm. From 2001 to 2006, I was Senior Vice President for Strategic Development at Business Executives for National Security, a Washington, D.C.-based think tank, where I was in charge of international programs and all regional office operations in six cities across the country. I next served as managing director at CMG, another strategic communications firm. From 2008 to 2009, I was Deputy Director of the Commission on the Prevention of Weapons of Mass Destruction Proliferation and Terrorism, which issued its report in December of 2008.

3. From 2009 to 2013, I served as the Deputy Under Secretary of the Navy and Deputy Chief Management Officer. In this role, I led the department's business transformation and governance processes and coordinated efforts to identify enterprise-wide efficiencies. From April 18, 2013 to February 17, 2015, I served as Under Secretary of the Air Force after being nominated by the President to that position and confirmed by the Senate. From June 21, 2013 through December 20, 2013, I served as Acting Secretary of the Air Force.

4. In March 2015, I was assigned as the Special Assistant to the Secretary and Deputy Secretary of Defense (Chief of Staff). In this role, I helped manage Secretary of Defense Ashton Carter's transition into office, built his leadership team, and oversaw the day-to-day staff activities of the Office of the Secretary of Defense.

5. On June 30, 2015, President Barack Obama directed me to serve as Acting Under Secretary of the Army and Chief Management Officer. In that position, I served as the Secretary of the Army's senior civilian assistant and principal adviser on matters related to the management and operation of the Army, including development and integration of the Army Program and Budget. From November 3, 2015 to January 11, 2016, I served as Acting Secretary of the Army. On November 3, 2015, President Obama nominated me to serve as Secretary of the Army, and the Senate confirmed my nomination on May 17, 2016.

6. As Secretary of the Army, I was head of the Department of the Army and had statutory responsibility for all matters relating to the United States Army: manpower, personnel, reserve affairs, installations, environmental issues, weapons systems and equipment acquisition, communications, and financial management. Subject to the authority, direction, and control of the Secretary of Defense, the Secretary of the Army is responsible for all affairs of the Department of the Army, including the morale and welfare of personnel. My personnel-related

oversight responsibilities included the development and implementation of recruitment, training, retention, and medical policies for active duty and reserve Army personnel. For duties other than those as a member of the Joint Chiefs of Staff, the Chief of Staff of the Army, the most senior uniformed Army officer, operated under my authority, direction, and control.

7. I oversaw the Department of the Army's participation in the Working Group that comprehensively reviewed military policy with regard to transgender persons serving openly in each of the service branches and which attempted to identify any practical, objective impediments to such service. It was based upon that review and the recommendations of that group that the Department of Defense announced on June 30, 2016, that transgender service members could openly serve in the U.S. military.

8. I am aware of the announcements of a new policy on transgender service, both through Twitter in late July 2017, and then in a Presidential Memorandum ("the Memorandum") issued by the White House on August 25, 2017. Although providing the Secretaries of Defense and Homeland Security the opportunity to review the current policies, the Memorandum sets March 23, 2018 as the date by which the June 2016 policy "shall" be reversed (section 3) and transgender individuals will be subject to discharge as a result of disclosure of their transgender status.

9. Based on my knowledge and experience in military personnel and readiness challenges, as a result of service as a senior executive in each of the three military departments as well as Chief of Staff to the Secretary of Defense, the recently announced policy change is causing significant harm to current service members who have already disclosed their status as an individual who is also transgender to their commanders.

10. The Memorandum asserts that the "previous Administration" had an "[in]sufficient basis" for allowing open service, and therefore, this Administration is directing the reversal of policy changes that had enabled open service based on its "meaningful concerns" about the impact of open service on "under military effectiveness and lethality, disrupt unit cohesion, or tax military resources."

11. In my experience, this communicates that the Commander in Chief of the U.S. military believes that transgender service members are unfit for military duty solely because of their transgender status. It degrades the value of transgender individuals not only to those service members themselves, but gives license to their leaders and fellow service members to do the same, in an environment where the ability to unqualifiedly and mutually rely on each other is an indispensable element of service. The Memorandum on its face marks these service members as deserving of impending involuntary discharge.

12. The Memorandum alone, and certainly when animated by the President's tweets, causes harm by preventing transgender service members from serving on equal terms with other service members based on their merit; serves to substantially limiting their advancement and promotion opportunities in the military; and undermines their standing with superiors and peers, as described above. Opportunity to succeed and advance in the military should not depend on gender identity, nor any other factor other than ability to meet the required standards.

13. The harm extends beyond the individuals involved to the whole ethos of the military as a meritocracy where all Americans who want to serve and can meet its standards should be afforded the opportunity to do so. Unjustified, categorical bans on Americans qualified and ready to serve diminishes that organizing principle.

14. Furthermore, the Presidential Memorandum and Secretary of Defense Jim Mattis' August 29, 2017 announcement that he will "carry out the president's policy direction" by "develop[ing] a study and implementation plan" sends the clear message to American society that the U.S. Army is not, as General Mark Milley, the Army's Chief of Staff and highest ranked officer, declared in 2016 "open to all Americans who meet the standard, regardless of who they are."

15. That declaration is essential to ensuring the military has access to the best and brightest America has to offer and that those who seek to serve know that they will be judged by their performance alone, rather than the artificial prejudices that once hampered the advancement and acceptance of African Americans, women, religious minorities, and gays and lesbians in our nation's armed forces.

16. In addition, when the military fails to keep pace with the demographic change of our nation and departs from the core principle of opportunity for all that can meet its high standards, it results in an erosion of understanding between those who serve and those who freedom those service members defend. The President's tweets and directive undoubtedly exacerbate this divide, both by creating a single class of Americans he deems unfit to serve and dividing the nation by telling them that only these individuals are unfit.

17. Finally, during my tenure as Secretary of the Army, I am unaware of any instance prior to or after June 2016 when a transgender person seeking to enlist or accept a commission in the Army was granted a waiver from the Army's medical accession standards.

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

DATED: October 20, 2017

Eric K. Fanning

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., *Plaintiffs*, v. DONALD J. TRUMP, et al., *Defendants*.	)	Civil Action No. 17-cv-2459 (MJG)

DECLARATION OF DEBORAH LEE JAMES
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Deborah Lee James, declare as follows:

1. I served as the Secretary of the United States Air Force ("USAF") from December 20, 2013 to January 20, 2017.

2. I hold a Bachelor's Degree in Comparative Area Studies from Duke University (1979), and a Master's Degree in International Affairs from Columbia University (1981). From 1983 until 1993, I worked as a professional staff member for the Armed Services Committee of the United States House of Representatives, including as a senior advisor to the Subcommittee for Military Personnel and Compensation. From 1993 to 1998, I served as Assistant Secretary of Defense for Reserve Affairs, responsible for advising the Secretary of Defense on all matters pertaining to roughly 1.8 million National Guard and Reserve personnel. I then held a variety of senior positions at Science Applications International Corporation (SAIC), including as President of the Technical and Engineering Sector overseeing more than 8,000 employees.

3. As Secretary of the USAF, I functioned as the chief executive of the Department of the Air Force, with the authority to conduct all of its affairs, subject to the authority, direction, and control of the Secretary of Defense. As Secretary, I had comprehensive oversight

responsibility for (i) the Department of the Air Force's annual budget, (ii) overseeing the organization, training, supplying, equipping and mobilization of USAF personnel, and (iii) overseeing the construction and maintenance of military equipment, buildings, and structures. In connection with my personnel-related oversight responsibilities, I administered the development and implementation of recruitment, retention, and medical policies for active duty and reserve USAF personnel. Among the people who directly reported to me was the Chief of Staff of the USAF, the most senior uniformed USAF officer.

4. As Secretary, I was responsible for supervising the Department of the Air Force's participation in a working group convened by the Department of Defense in 2015 to identify the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the "Working Group").

5. Based on the Working Group's analysis and recommendations, the Department of Defense announced in June 2016 that it would begin to allow transgender people to serve openly in the Armed Forces.

6. On July 26, 2017, President Donald Trump issued a statement that transgender individuals will not be permitted to serve in any capacity in the Armed Forces. On August 25, 2017, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security to reverse the policy adopted in June 2016 that permitted military service by openly transgender persons. The President's memorandum stated that the military would return to the pre-June 2016 policy on March 23, 2018.

7. Based on my experience regarding military personnel, and in particular personnel and operations of the USAF, the President's announced decision to ban openly transgender

people from serving in the military effective March 23, 2018 is presently harming transgender people currently serving in the military in several significant respects.

8. Airmen are typically deployed for periods of time that exceed several months, and planning for a deployment begins several months in advance of the deployment. Commanders in charge of overseeing deployments must take into account the certainty with which Airmen will be available for the entire length of a deployment when making assignment decisions.

9. Given the President's announcement that transgender service members will be subject to separation from the military beginning March 23, 2018, commanders cannot rely on transgender Airmen being able to complete deployments that continue beyond that date. Transgender Airmen with deployment terms that extend beyond March 2018 will thus lose opportunities for assignments because command will not be able to determine with certainty that transgender Airmen will be present for the entire duration of the deployment. In addition to negatively impacting individual Airmen, this uncertainty harms USAF readiness and capabilities where commanders are not able to make assignments based solely on the capabilities and experiences of those under their command.

10. Even outside the deployment context, transgender Airmen will lose out on assignments, opportunities, and experiences they would otherwise receive but for the President's announcement that they will be subject to separation in March 2018. Commanders will be reluctant to invest time and money on training transgender Airmen for important or significant assignments or tasks where commanders believe the Airmen will be expected to leave the USAF in the near future.

11. In addition, the President's announced ban on transgender people serving in the military creates a sub-class of service members, placing transgender people on unequal footing

as compared to their non-transgender peers for reasons having nothing to do with their capabilities or past performance, and suggesting that transgender Airmen are unworthy of their comrades' trust and support. A lack of trust among service members is deeply concerning, as trust and respect throughout the chain of command is essential to promote military effectiveness. Thus, in addition to causing present harm to transgender Airmen, the President's ban will have a deleterious effect on the USAF's effectiveness and capabilities as well.

12. The President's announced ban is also anathema to the ethos of the military in general, and in particular the USAF. In the USAF, individual Airmen are given assignments and receive commendations and promotions on the basis of their individual merit and skill set. The USAF, and the military in general, are weakened when this fundamental building block of their identities is fractured through suggesting that service members should be judged based on characteristics having nothing to do with their ability to perform their job.

13. Finally, I am not aware of any instance – before or after June 2016 – where a transgender person seeking to join the military was granted a waiver to the ban on service of openly transgender individuals. Even if a transgender person were to seek a waiver at this time, doing so would be futile in light of the President's order making transgender service members subject to separation beginning in March 2018.

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

DATED: October 21, 2017

Deborah Lee James

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., *Plaintiffs*, v. DONALD J. TRUMP, et al., *Defendants*.	)	Civil Action No. 17-cv-2459 (MJG)

DECLARATION OF RAYMOND EDWIN MABUS, JR.
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Raymond Edwin Mabus, Jr., declare as follows:

1. I served as the United States Secretary of the Navy from May 19, 2009 to January 20, 2017.

2. Prior to serving as Secretary of the Navy, I earned a Bachelor's degree in English and Political Science from the University of Mississippi in 1969, a Master's Degree in political science from Johns Hopkins University in 1970, and a J.D. from Harvard Law School in 1976. Prior to attending law school, I served from 1970 until 1972 in the Navy aboard the cruiser USS Little Rock, achieving the rank of Lieutenant, junior grade. Following law school, I worked as a law clerk in the United States Court of Appeals for the Fifth Circuit. From 1977 until 1978, I worked as legal counsel for the Cotton Subcommittee of the Agriculture Committee of the United States House of Representatives. From 1979 to 1980, I was an associate at the law firm of Fried, Frank, Harris, Shriver and Kampleman in Washington, D.C. and from 1980 to 1983, I was Legal Counsel and Legislative Assistant to the Governor of Mississippi. From 1984 to 1988, I served as Mississippi State Auditor (an elected position), and from 1988 to 1992 as Governor of Mississippi. From 1994 to 1996 I served as the United States Ambassador to Saudi

Arabia. From 1998 to 2000 I served as President of Frontline Global Services, a consulting company. From 2003-2007 I served as Chairman of Foamex, Incorporated, a public manufacturing company, and from 2006 to 2007 as Foamex's Chief Executive Officer as well.

3. As Secretary of the Navy, I functioned as the chief executive of the Department of the Navy, with the authority to conduct all of its affairs. As Secretary, I had comprehensive oversight responsibility for (i) the Department of the Navy's annual budget, (ii) overseeing the recruitment, organization, training, supplying, equipping, mobilizing, and demobilizing of Navy personnel, and (iii) overseeing the construction, outfitting, and repair of naval equipment, ships, and facilities. I was also responsible for the formulation and implementation of policies and programs that are consistent with the national security policies and objectives established by the President and the Secretary of Defense.

4. In connection with my personnel-related oversight responsibilities, I oversaw the administration of recruitment, retention, and medical policies for active duty and reserve Navy personnel. As Secretary, I performed these duties before, during, and after the end of the "Don't Ask, Don't Tell" ban on gay service members serving openly in the military in 2011.

5. Also during this period, I oversaw the Navy and the Marine Corps through the end of United States military operations in Iraq and the surge of tens of thousands of United States troops in Afghanistan. I am keenly aware that the recruitment and retention of capable and qualified service members is of critical importance to the readiness of the Navy and the Marines.

6. I was part of a Working Group that comprehensively reviewed military policy with regard to transgender people serving across the service branches. It was based upon that review and the recommendations of that group that the Department of Defense announced in June 2016 that it would begin allowing transgender people to serve openly in the military.

7. I am aware that in a series of announcements made on Twitter on July 26, 2017, and then again in a formal memorandum issued by the White House on August 25, 2017, President Trump announced the reversal of military policy stating that transgender individuals would no longer be able to serve in any capacity. The memorandum set March 23, 2018 as the date when military policy would revert to the pre-June 2016 policy whereby transgender individuals are subject to discharge upon disclosure of their transgender status.

8. Based on my experience in military personnel and operations, the recently announced policy change is presently causing significant harms to current servicemembers who have disclosed that they are transgender. Those harms are not speculative or future harms. They are current harms that prevent transgender service members from serving on equal terms with non-transgender service members and that impose substantial limitations on their opportunities within the military.

9. Consideration of the ways in which deployment decisions are made highlights the current limitations and lost opportunities being experienced by transgender service members. Consistent with naval operations, ships may deploy for up to 9 months at a time. Commanders making decisions about how to staff naval operations must consider the length of time that a sailor will be available for a deployment. If a sailor may not be available for the full length of a deployment, command knows that they will have to expend significant resources to backfill staffing needs in order to address the diminishment of resources. Rather than face those challenges, command will predictably make assignments based on certainty about sailors' ability to serve the full length of deployment.

10. Because of the announcement of the ban on transgender people being able to serve after March 2018, command lacks the requisite certainty that transgender service members will be able to complete the terms of their deployments where they extend beyond that date.

11. Similarly, command must regularly make personnel decisions that relate to "permanent change of station" (PCS) moves. PCS moves are made to ensure maximum utilization of personnel and to achieve military missions. PCS moves involve transporting service members and their families to a different base and duty station, often across the country or the world. The introduction of any uncertainty with regard to a service member's future service, or status, changes command's consideration of PCS moves and military operations staffing. Based on my experience, the announced ban on transgender people serving is impacting PCS moves.

12. As a result of the announced ban, transgender service members are losing opportunities for assignments that they are capable of doing. These include lost opportunities for deployment, training, and assignments. These lost opportunities are based not on individual assessment of the service member's merit but rather based on whether the person is transgender. These lost opportunities, in addition to depriving transgender members of the military of the ability to serve on equal footing with their peers, hinder transgender service members opportunities for advancement and promotions as well.

13. The impact of this immediate harm reaches beyond the individual service member and affects the institution of the military as a whole. The military is designed to be a meritocracy where individuals receive opportunities and tackle assignments based on their ability to do the job. The institution is weakened when people are denied the ability to serve not because they are unqualified or because they cannot do the job but because of who they are.

14. The ban on transgender service members weakens the military in a second way as well. With an all-volunteer force, which is the current structure of the military, a small segment of the population is responsible for the security of the whole. In this circumstance, it becomes even more important to have a diverse military in order to maintain a strong connection between those who serve to protect society and the society that the force is protecting. Banning a segment of the community from service weakens the bond of that connection between the military and society and sends a message that certain segments of the community are not within the scope of the mission. That message interferes with and diminishes military readiness and lethality.

15. I know of no instance either prior to June 2016 or since when a transgender person seeking to enlist was granted a waiver to the ban on service. In any case, it would be futile for a transgender person to seek a waiver to join the military at this point in time since, according to the announced policy, they would be subject to administrative discharge as soon as March 2018.

16. This sudden reversal of the DoD policy permitting open service undermines the morale and readiness of other groups who must now deal with the stress and uncertainty created by this dangerous precedent, which represents a stark departure from the foundational principle that military policy will be based on military, not political, considerations. In 2011, the "Don't Ask, Don't Tell" policy prohibiting gay, lesbian, and bisexual people from openly serving in the military (Department of Defense Directive 1304.26) was repealed. More recently, DoD also removed remaining barriers for women serving in certain ground combat positions. The sudden reversal of the DoD's policy with respect to transgender service members sets a precedent suggesting that these policies may be abruptly reversed for baseless reasons as well.

17. This sudden reversal may also have a chilling effect on the confidence of other service members that they will continue to be able to serve. Religious and ethnic minorities who have seen an increase in discrimination under the current administration may fear that the military may seek to ban them next, creating a culture of fear that is anathema to the stability and certainty that makes for an effective military.

18. This sudden reversal undermines the confidence of all service members that important military policy decisions will be made under careful review and consistent with established process. Rational decision making in the adoption of and change to policy impacts the military's ability to recruit and retain competent, high-performing people. The sudden reversal of policy makes recruitment and retention more difficult, as does the damage done to the military's image and reputation as promoting fairness and equality and of being open to all qualified Americans. That image and reputation are critical to the military's ability to attract talented and idealistic young people. Actions that tarnish that reputation cause real harm.

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

DATED: October 19, 2017

Raymond E. Mabus, Jr.

Exhibit 4

Former Army Secretary Questions Trump Administration Claim that Military Is Not Ready to Accept Transgender Applicants

www.palmcenter.org/former-senior-pentagon-official-disputes-trump-administration-claim-military-not-ready-for%e2%80%8b-transgender-applicants-2/

December 7, 2017

SAN FRANCISCO, CA – Eric Fanning, former Secretary of the U.S. Army, questioned the Trump administration's claim yesterday that the military is not ready to accept transgender applicants. According to Fanning, **"the Department of Defense was on track to lift the accession ban for transgender service effective July 1, 2017. This was one year after Secretary Carter ordered the Services to ensure that all Americans who could meet the standards should be afforded the opportunity to serve. I can see no reason why the Department should not be fully prepared to execute Secretary Carter's policy change, particularly after being afforded an extra six months due to the Department's delay earlier this year."** Fanning served as U.S. Army Secretary under President Obama.

Fanning's comments follow Brad Carson's observation yesterday that the military had already prepared for the lifting of the enlistment ban before President Trump took office. Carson, who served as acting Under Secretary of Defense for Personnel and Readiness in the Obama administration, said that, **"the Pentagon had already done most of the preparation and training in anticipation of the lifting of the accession ban before the presidential transition, so to claim that the military is not ready to lift the ban now seems a stretch."** Carson was responsible for personnel policy for all service members, and deployed to Iraq as a U.S. Navy officer. Both Fanning and Carson offered their remarks to Palm Center researchers in response to a Trump administration affidavit claiming that the military is not ready to accept transgender troops. A federal court has ordered the military to lift its enlistment ban by January 1, 2018.

According to Aaron Belkin, processing transgender applicants does not require anything different from what recruiters and examiners do every day. Belkin said that, **"there is nothing special about evaluating a transgender applicant for military service, as recruiters and examiners deal with medical documents for every candidate, and handle the confirmation of identity documents, name changes and the like on a regular basis."** Belkin is director of the Palm Center.

A comprehensive 2016 RAND Corporation study found that lifting the enlistment ban would require only minor regulatory revisions, which were finalized in June 2016. Belkin added that, **"The military was ready to lift the enlistment ban one year ago and it is ready to do so today."**

Transgender troops have served openly in the U.S. military for the past 18 months, and have been widely praised by commanders. Eighteen foreign militaries allow transgender troops to serve openly, and none have reported any compromise to readiness.

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Implementation

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., *Plaintiffs,* v. DONALD TRUMP, et al., *Defendants.*	Case No. 17-cv-02459 (MJG)

EXPERT DECLARATION OF GEORGE RICHARD BROWN, MD, DFAPA IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR PARTIAL STAY OF PRELIMINARY INJUNCTION PENDING APPEAL

I, George R. Brown, declare as follows:

1. I make this declaration based on my own personal knowledge.

2. As set forth in my previous declaration, dated September 11, 2017 and submitted by me in this case in support of Plaintiffs' motion for preliminary injunctive relief, I am a Professor of Psychiatry and the Associate Chairman for Veterans Affairs in the Department of Psychiatry at the East Tennessee State University, Quillen College of Medicine. My responsibilities include advising the Chairman; contributing to administrative, teaching, and research missions of the Department of Psychiatry; consulting on clinical cases at the University and at Mountain Home Veterans Health Administration ("VHA") Medical Center, where I also hold an appointment; and acting as a liaison between the VHA Medical Center and the East Tennessee State University Department of Psychiatry. I served as a psychiatrist on active duty in the United States Air Force. The majority of my work involves research, teaching, and consulting about health care in the military and civilian transgender populations. My CV is attached to my earlier declaration.

3. I reviewed the declaration submitted in the case by Lernes Hebert, and I am responding to the statements set forth therein.

4. On June 30, 2016, the military changed its policy from one that categorically excluded transgender people from enlistment to one that authorizes the enlistment of qualified transgender individuals. The policy the military adopted and set forth in DTM 16-005 authorizes enlistment for individuals who have a diagnosis of gender dysphoria upon a demonstration that they have completed gender transition and have been stable in the newly assigned gender for 18 months. The target effective date for that policy was originally one year from the date of its announcement, or July 1, 2017. The day before July 1, 2017, that date was moved to January 1, 2018.

5. Following the adoption of DTM 16-005, the military began training throughout the branches to meet the target date of July 1, 2017 for implementation. As a contractor for the Department of Defense, I was part of that process and trained approximately 250 medical personnel working in Military Entrance Processing Stations (MEPS) throughout the military, including medical division personnel, chief and assistant chief medical officers, and fee-based medical providers on the accessions policy. That training took place in San Antonio, Texas on May 2, 2017.

6. I have in-depth familiarity both with the transgender enlistment policy and military enlistment policies as they relate to medical clearances and reviews for enlistees.

7. I do not agree that implementing the accessions policy in DTM 16-005 by January 1, 2018 will impose extraordinary burdens on the military. The implementation of accessions criteria for transgender enlistees is no more complex than other accessions criteria on which MEPS personnel are knowledgeable and regularly trained.

8. The accessions criteria for transgender people are straightforward and do not require extensive or detailed knowledge. To the contrary, it simply requires MEP personnel to identify applicants who have a diagnosis of gender dysphoria -- a diagnosis with which medical professionals should already be familiar. It also involves review of the individual's substantiating and supporting medical documentation to confirm that the period of stability (18 months) has been met. This process does not involve any unique complexities or burdens and is well within the capacity of military personnel involved in the enlistment review process.

9. Acting Deputy Assistant Secretary Hebert's statement that "personnel involved in that accession enterprise have rotated in the past several months" is not a legitimate reason to delay implementing the accessions policy for transgender people. Military personnel rotations are ordinary shifts that are expected and anticipated throughout the military. The military system anticipates routine staff turnover. Nothing about routine staff turnover should justify a delay of enlistment policy implementation.

10. Any minimal burden imposed on MEPS as a result of implementing the accessions policy for transgender people will be further reduced by the small number of transgender people who are likely to seek enlistment. Based on decades of medical experience and research, it is clear that only a very small percentage of the overall population is transgender. There is no reason to expect MEPS to receive a large number of enlistment applications from transgender enlistees on or after January 1. I personally have trained hundreds of MEPS personnel. The military system ensures backup availability to review enlistment materials should any ever be needed.

11. Based on my knowledge and experience, I do not agree that the military will be unprepared on January 1, 2018 to implement the transgender enlistment policy set forth in DTM 16-005.

DATED: December 12, 2017

George R. Brown, MD, DFAPA

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Civil Action No. 17-cv-2459 (MJG)
	)	
DONALD J. TRUMP, et al.,	)	
	)	
Defendants.	)	

DECLARATION OF DEBORAH LEE JAMES IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR CLARIFICATION AND, IF NECESSARY, A PARTIAL STAY OF PRELIMINARY INJUNCTION PENDING APPEAL

I, Deborah Lee James, declare as follows:

1. As noted in my previous declaration in this case signed and dated October 21, 2017, I served as the Secretary of the United States Air Force ("USAF") from December 20, 2013 to January 20, 2017. As Secretary, I was responsible for supervising the Department of the Air Force's participation in a working group convened by the Department of Defense in 2015 to identify the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the "Working Group"). On June 30, 2016, then Secretary of Defense Ashton Carter announced that the military would allow transgender people to openly serve. Included within that announcement and change of policy was a direction that the military would adopt changes to the accessions policy to begin allowing accession by transgender people starting on July 1, 2017.

2. Based on my personal knowledge, the USAF had nearly completed the necessary preparations for implementing the change in accessions policy when I left office in January 2017.

3. The change in accessions to authorize transgender people to serve was consistent with the approach generally for authorizing people to serve with curable or treatable medical conditions. It included notifying and training medical personnel across the services regarding information relating to the underlying medical condition associated with some transgender individuals and the period of stability after treatment necessary for enlistment.

4. The preparations for implementing the change in policy could readily have been completed by the initial target date of July 1, 2017, well within the current target date of January 1, 2018.

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

DATED: December 13th, 2017

Deborah Lee James

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., *Plaintiffs*, v. DONALD J. TRUMP, et al., *Defendants*.	)	Civil Action No. 17-cv-2459 (MJG)

DECLARATION OF RAYMOND EDWIN MABUS, JR. IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR CLARIFICATION AND, IF NECESSARY, A PARTIAL STAY OF PRELIMINARY INJUNCTION PENDING APPEAL

I, Raymond Edwin Mabus, Jr., declare as follows:

1. As set forth in my previous declaration in this case signed and dated October 19, 2017, I was part of a Working Group that comprehensively reviewed military policy with regard to transgender people serving across the service branches. It was based upon that review and the recommendations of that group that the Department of Defense announced in June 2016 that it would begin allowing transgender people to serve openly in the military and would begin on July 1, 2017 also allowing accession by transgender people.

2. Based on my experience in military personnel and operations, allowing transgender candidates to apply for military service was not a complicated process to begin with, especially in light of the highly complex strategic, technical, personnel and medical issues that the military addresses day in and day out.

3. Based on my personal knowledge, the Services had already completed almost all of the necessary preparation for lifting the accession ban when I left office almost a year ago. It is

inconsistent with my understanding of the status of those efforts and the workings of military personnel to conclude that the military would not be prepared almost a year later—and six months after the date on which the policy was originally scheduled to take effect—to permit accessions by transgender people.

4. As set forth in my previous declaration, it is not the lifting of the ban on accession by qualified transgender individuals that will compromise military readiness, good order, and discipline; it is the sudden reversal of military policy and the treatment of loyal transgender Americans as second-class citizens that are the true sources of disruption.

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

DATED: December 12, 2017

Raymond E. Mabus, Jr.

No. 17-5267

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

JANE DOE 1 et al.,
Plaintiffs-Appellees,

v.

DONALD J. TRUMP, President of the United States, et al.
Defendants-Appellants

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DECLARATION OF ERIC K. FANNING IN SUPPORT OF APPELLEES' OPPOSITION TO APPELLANTS' EMERGENCY MOTION FOR ADMINISTRATIVE STAY AND PARTIAL STAY PENDING APPEAL

I, Eric K. Fanning, declare as follows:

1. As noted in my previous declarations in this case signed and dated August 28, 2017 and October 15, 2017, I served as Secretary of Army from May 18, 2016 to January 20, 2017. As Secretary, I oversaw the Department of the Army's participation in the Working Group that comprehensively reviewed

military policy with regard to transgender persons serving openly in each of the service branches and which attempted to identify any practical, objective impediments to such service. It was based upon that review and the recommendations of that group that the Department of Defense announced on June 30, 2016, that transgender service members could openly serve in the U.S. military.

2. The Working Group's recommendations also resulted in change of military standards for accessions, also announced on June 30, 2016, to authorize transgender individuals to enlist and commission into the Armed Forces.

3. Based on my experience in military personnel and operations, implementing that change required training throughout the Services—training that required preparation, development, and effective implementation. However, much of the new process for transgender accessions mirrored an existing process. These changes to policy for transgender accession, set forth in DTM 16-005, were consistent with standards already in place authorizing individuals with a range of medical conditions to accede to military service. As a result, the training program was designed to focus on helping military professionals understand the terminology and range of possible documentation unique to transgender individuals to assist them in applying to preexisting, well-understood procedures, rather than carving out any new process specifically designed for accessions of these individuals.

4. At the time I left office, less than a year ago, the Department of Defense was on track to fully implement the change in accession policy effective July 1, 2017. Based on the training and implementation efforts that took place during my time of service, and my understanding that any such efforts were not halted before June 30, 2017, I cannot identify any reason why the military would not be prepared to permit accessions of transgender people by January 1, 2018, six months beyond the initial target date that had been set for the accessions policy change.

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

DATED: December 14, 2017

Exhibit 3

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE 1, *et al.*,
Plaintiffs
v.
DONALD J. TRUMP, *et al.*,
Defendants

Civil Action No. 17-1597 (CKK)

ORDER
(December 11, 2017)

Presently before the Court is Defendants' Motion for a Partial Stay of the Court's Preliminary Injunction Pending Appeal. ECF No. 73 ("Defs.' Mot."). Defendants request a partial stay of the Court's October 30, 2017 preliminary injunction pending the outcome of their recently filed appeal to the United States Court of Appeals for the District of Columbia Circuit ("D.C. Circuit"). Specifically, Defendants request that the Court stay the part of the injunction that prevents Defendants from enforcing the "Accession Directive" in President Donald J. Trump's August 25, 2017 Presidential Memorandum ("Presidential Memorandum"). Plaintiffs oppose Defendants' motion on various grounds.[1]

In summary form, the Accession Directive indefinitely extended a prohibition against transgender individuals entering the military (a process formally referred to as "accession"). As relevant to this motion, the effect of the Court's October 30, 2017 preliminary injunction was to revert to the *status quo* with regard to accession that existed before the issuance of the

[1] The Court's consideration has focused on the following documents: Defs.' Mot. for Partial Stay of Preliminary Injunction Pending Appeal and the attached Declaration of Lernes J. Hebert, ECF No. 73 (filed on December 6, 2017); Pls.' Opp'n to Defs.' Mot. for Partial Stay of Preliminary Injunction Pending Appeal and the attached Declarations of George Richard Brown, MD, DFAPA and Raymond Edwin Mabus, Jr., ECF No. 74 (filed on December 8, 2017).

Presidential Memorandum—that is, the accession policy established in a June 30, 2016 Directive-type Memorandum ("DTM"), as modified by Secretary of Defense James Mattis on June 30, 2017. That policy allowed for the accession of transgender individuals into the military beginning on January 1, 2018.[2]

The Court will not stay its preliminary injunction pending Defendants' appeal. "In the D.C. Circuit, a court assesses four factors when considering a motion to stay an injunction pending appeal: (1) the moving party's likelihood of success on the merits of its appeal, (2) whether the moving party will suffer irreparable injury, (3) whether issuance of the stay would substantially harm other parties in the proceeding, and (4) the public interest." *Akiachak Native Cmty. v. Jewell*, 995 F. Supp. 2d 7, 12 (D.D.C. 2014) (citing *Wash. Metro. Area Transit Comm'n v. Holiday Tours, Inc.*, 559 F.2d 841, 843 (D.C. Cir. 1977)). None of these factors justifies staying the Court's preliminary injunction.

[2] As the Court understands it, the policy that will go into effect on that date states:

> (1) A history of gender dysphoria is disqualifying, unless, as certified by a licensed medical provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months;
>
> (2) A history of medical treatment associated with gender transition is disqualifying, unless, as certified by a licensed medical provider: (a) the applicant has completed all medical treatment associated with the applicant's gender transition; and (b) the applicant has been stable in the preferred gender for 18 months; and (c) If the applicant is presently receiving cross-sex hormone therapy post-gender transition, the individual has been stable on such hormones for 18 months;
>
> (3) A history of sex reassignment or genital reconstruction surgery is disqualifying, unless, as certified by a licensed medical provider: (a) a period of 18 months has elapsed since the date of the most recent of any such surgery; and (b) no functional limitations or complications persist, nor is any additional surgery required.

Decl. of Deborah Lee James, ECF No. 13-5 ("James Decl."), Ex. B. Transgender applicants will also be subject to all of the same medical and physical requirements as all other applicants.

1. Irreparable Injury

The Court begins with the main focus of Defendants' motion: their argument that they will be "irreparably harmed" if they begin to accept transgender individuals into the military on January 1, 2018. In support of their motion, Defendants have submitted a declaration from Lernes J. Hebert, the Acting Deputy Assistant Secretary of Defense for Military Personnel Policy in the Office of the Under Secretary of Defense for Personnel and Readiness. *See* Decl. of Lernes J. Hebert, ECF No. 73-1 ("Hebert Decl."). Mr. Hebert states that "[i]mplementing the Court's orders with respect to the accessions policy . . . by January 1, 2018, will impose extraordinary burdens on the Department and the military services." *Id.* ¶ 5. This statement is apparently based on Mr. Hebert's assertions that "there are considerable requirements associated with implementing this significant and complex policy change," that "implementation of a new accession policy necessitates preparation, training, and communication to ensure those responsible for application of the accession standards are thoroughly versed in the policy and its implementation procedures," and that "the implementation of accessions criteria is . . . a complex undertaking." *Id.* ¶¶ 5-6. Mr. Hebert represents that "notwithstanding the implementation efforts made to date, the Department still would not be adequately and properly prepared to begin processing transgender applicants for military service by January 1, 2018." *Id.* ¶ 9.

The Court is not convinced by Mr. Hebert's declaration that Defendants will be irreparably harmed in the absence of a stay. Although Mr. Hebert's declaration contains a lengthy discussion of the administrative difficulties associated with implementing a new accession policy in general, it fails to acknowledge the considerable amount of time Defendants have already had to prepare for the implementation of this particular policy. The directive from the Secretary of Defense requiring the military to prepare to begin allowing accession of

transgender individuals was issued on June 30, 2016—nearly one and a half years ago. For more than a year preceding the summer of 2017, it was the policy and intention of the military that transgender individuals would soon begin to accede. Moreover, the Court issued the preliminary injunction in this case approximately six weeks ago, and since then Defendants have been on notice that they would be required to implement the previously established policy of beginning to accept transgender individuals on January 1, 2018. In other words, with only a brief hiatus, Defendants have had the opportunity to prepare for the accession of transgender individuals into the military for nearly one and a half years.

Moreover, Mr. Hebert's declaration glosses over the fact that considerable work has been done already during this lengthy period. With their opposition to Defendants' motion to stay, Plaintiffs have submitted the declaration of Dr. George Richard Brown, who has been part of the military's training program for the implementation of its transgender accession policy. Dr. Brown states that he "trained approximately 250 medical personnel working in Military Entrance Processing Stations (MEPS) throughout the military." Decl. of George Richard Brown, MD, DFAPA, ECF No. 74-1, ¶ 5. Plaintiffs have also submitted the declaration of former Secretary of the Navy Raymond Edwin Mabus, Jr., who states that nearly a year ago "the Services had already completed almost all of the necessary preparation for lifting the accession ban." *See* Decl. of Raymond Edwin Mabus, Jr., ECF No. 74-2 ("Mabus Decl."), ¶ 3.

The record that was before the Court when it considered Plaintiffs' motion for a preliminary injunction also demonstrates that considerable work has already been done to prepare for transgender accession. For example, that record shows that the Acting Under Secretary of Defense for Personnel and Readiness, Peter Levine, published an "implementation handbook" in 2016 entitled "Transgender Service in the U.S. Military." Decl. of Raymond

Edwin Mabus, Jr., ECF No. 13-9, Ex. F. That document is a lengthy, exhaustive "practical day-to-day guide" prepared to assist Service members and commanders in understanding and implementing the policy of open transgender military service. James Decl., ¶ 34. The record also indicates that each branch of the Armed Forces issued memoranda in 2016 for implementing the transgender accession policy.

Instead of acknowledging what has already been done, Mr. Hebert's declaration uses sweeping and conclusory statements to support his assertion that there is an unmanageable amount of work left to do. He states that Defendants "would not be adequately and properly prepared" to accept transgender individuals by January 1, 2018. Hebert Decl. ¶ 9. But Mr. Hebert fails to explain what *precisely* needs to be completed by this date in order for Defendants to be prepared to begin transgender accessions.[3] Especially in light of the record evidence showing, with specifics, that considerable work has already been done, the Court is not convinced by the vague claims in Mr. Hebert's declaration that a stay is needed.

Finally, Defendants also complain that they may suffer unnecessary costs and confusion by allowing transgender individuals to accede on January 1, only to later change to some other accession policy that they have indicated they are in the process of preparing. Mr. Hebert states that "the Department will be twice burdened if it is required to implement [the June 30, 2016 DTM] by January 1, 2018, and then potentially a different policy after the Department concludes its study and finalizes a policy." Hebert Decl. ¶ 10. Although they hint in their most recent pleading that a new policy proposal is forthcoming in the next few weeks, Defendants fail to

[3] There is no evidence in the record that would suggest that the number of transgender individuals who might seek to accede on January 1, 2018 would be overwhelmingly large. To the contrary, although the Court understands that there may be some dispute as to the amount of transgender individuals in the general population and in the military, the record thus far suggests that the number is fairly small.

provide the Court with any insight at all into what the policy might be. The Court is left to speculate. On the one hand, to the extent the policy Defendants foresee adopting in the future is a *ban* on accessions—which the Court has already concluded is likely to be proven unconstitutional—this is clearly not a reason to stay the injunction in this case. On the other hand, as the Court has already explained, there is no reason to conclude on the present record that Defendants intend to implement any sort of policy *allowing* for the accession of transgender individuals. Defendants have never given the Court any reason to conclude that this would be the case.

In sum, having carefully considered all of the evidence before it, the Court is not persuaded that Defendants will be irreparably injured by allowing the accession of transgender individuals into the military beginning on January 1, 2018.

2. Likelihood of Success on the Merits

The remaining factors that the Court assesses when considering whether to stay an injunction pending an appeal also weigh against Defendants' motion. Unsurprisingly, the Court does not agree with Defendants that they are likely to prevail on the merits of their appeal. All of Defendants' arguments on this factor have already been raised and rejected by the Court. Defendants argue that the Court erred by entering a "worldwide injunction," by finding that Plaintiffs had established standing and irreparable injury, by not allowing Secretary of Defense Mattis to violate the Court's injunction by "exercising his independent authority" to preclude transgender individuals from the military, by not applying the "appropriate level of deference" to the Presidential Memorandum, and by finding that the equities favored an injunction. Defs.' Mot. at 7-8. The Court has already explained its reasons for rejecting most of these arguments in its 76-page Memorandum Opinion granting Plaintiffs' motion for a preliminary injunction. *See*

Oct. 30, 2017 Mem. Op., ECF No. 61. It will not repeat those reasons again here, but instead incorporates the analysis in its previous Opinion into this Order as though restated in full.

The record before the Court has not changed in any significant way since it issued its preliminary injunction. The Court previously held that Plaintiffs are likely to succeed on their claim that the Accession Directive violates the Fifth Amendment based on a number of factors, "including the sheer breadth of the exclusion ordered by the directive[ ], the unusual circumstances surrounding the President's announcement of [it], the fact that the reasons given for [it] do not appear to be supported by any facts, and the recent rejection of those reasons by the military itself." Oct. 30, 2017 Mem. Op. at 3. These factors support enjoining the Accession Directive today as much as they did when the Court issued its injunction on October 30, 2017.

Finally, the Court notes that there was nothing improper about the scope of the preliminary injunction. Plaintiffs presented facial constitutional challenges to several directives in the Presidential Memorandum. The Court found that Plaintiffs were likely to succeed in demonstrating that some of those directives were unconstitutional, and accordingly barred Defendants from enforcing them. There was nothing improper about this course of action. *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2307 (2016) ("[I]f the arguments and evidence show that a statutory provision is unconstitutional on its face, an injunction prohibiting its enforcement is 'proper.'"); *Harmon v. Thornburgh*, 878 F.2d 484, 495 (D.C. Cir. 1989) ("When a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed.").

3. Harm to Plaintiffs

Defendants' cursory argument that "Plaintiffs will not be harmed by a stay" is also unpersuasive. As the Court has already held, Plaintiffs were being injured every day the

Presidential Memorandum's directive preventing accession was in force. That directive "stigmatizes Plaintiffs as less capable of serving in the military, reduces their stature among their peers and officers, stunts the growth of their careers, and threatens to derail their chosen calling or access to unique educational opportunities." Oct. 30, 2017 Mem. Op. at 73. It also subjects them to a continuing alleged violation of their rights under the Fifth Amendment. *Id.* Moreover, there is evidence in the record suggesting that if the Accession Directive remains in effect, it would render Plaintiff Regan Kibby ineligible to attend the Naval Academy and prevent Plaintiff Dylan Kohere from enrolling as a cadet in his university's ROTC program. Mabus Decl. ¶ 5; Decl. of Mr. Robert O. Burns, ECF No. 45-3, ¶ 6. Put simply, the notion that Plaintiffs will suffer no harm by allowing the Accession Directive to remain in force pending Defendants' appeal is simply wrong.

4. Public Interest

Finally, Defendants' one-sentence argument about the "public interest" effectively restates their argument regarding irreparable injury. That argument has already been rejected above. The Court has previously explained why the public interest favors preliminary injunctive relief in this case. *See* Oct. 30, 2017 Mem. Op., at 74-75. To the extent Defendants argue that accepting transgender individuals on January 1, 2018 would harm military readiness, the Court directs Defendants to the Court's finding in its October 30, 2017 Memorandum Opinion that, on the record before the Court, there is absolutely no support for the claim that service of transgender individuals would have any negative effect on the military at all. *Id.* at 75. The factual record has not changed in any material way since the Court issued its prior Opinion.

5. Conclusion

For all of the above reasons, Defendants' motion for a partial stay of its preliminary injunction pending appeal is **DENIED**. As a final point, the Court notes that Defendants' portrayal of their situation as an emergency is belied by their litigation tactics. The Court issued its preliminary injunction requiring Defendants to comply with the January 1, 2018 deadline on October 30, 2017. Defendants did not file an appeal of that decision until November 21, 2017, and did not file the current motion for a stay of that deadline until December 6, 2017, requesting a decision by noon today, December 11, 2017. There is also no indication that Defendants have sought any sort of expedited review of their appeal, the first deadlines in which are not until January, 2018. If complying with the military's previously established January 1, 2018 deadline to begin accession was as unmanageable as Defendants now suggest, one would have expected Defendants to act with more alacrity.

SO ORDERED.

/s/
COLLEEN KOLLAR-KOTELLY
United States District Judge

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

Training Recruiters and Examiners to Evaluate Transgender Applicants Is Not Complicated or Time-Consuming

Vice Admiral Donald C. Arthur, USN (Ret.)
Former Surgeon General of the U.S. Navy

Major General Gale Pollock, USA (Ret.)
Former Acting Surgeon General of the U.S. Army

Rear Admiral Alan M. Steinman, USCG (Ret.)
Former Director of Health and Safety (Surgeon General equivalent) of the U.S. Coast Guard

December 2017

EXECUTIVE SUMMARY

1) Trump administration officials claim that to begin processing transgender applicants for military service, the Defense Department must train approximately 23,000 personnel. As a result, they argue, a federal court's order to allow accession of transgender individuals on January 1, 2018 "will impose extraordinary burdens on the Department and the military services."

2) Administration officials argue that "[n]o other accession standard has been implemented that presents such a multifaceted review of an applicant's medical history;" and the military will have to "ensure that the 'tens of thousands' of service members 'dispersed across the United States' responsible for implementing accession policies 'have a working knowledge or in-depth medical understanding of the standards.'"

3) Former military leaders have cast doubt on the administration's claims by confirming that most training required to begin processing transgender applicants was completed by the time of the presidential transition in January 2017.

4) Beyond former leaders' confirmation that DOD completed most preparatory work by the time of the transition, the administration's claims are suspicious because training recruiters and medical evaluators to process applications from transgender candidates is neither complicated nor time-consuming.

5) Recruiters do not need additional training to process applications from transgender candidates because their only relevant responsibility is to help applicants prepare a package of medical information, a simple and straightforward task. According to one of the nation's top experts in accession policies and practices, sending a one-page instruction to all recruiting stations would suffice if it has not already been done.

6) Medical evaluators do not require in-depth training because they are already well versed in DOD's method for deriving objective and relatively simple assessments of medical fitness, and because potential comorbidities of gender dysphoria and its treatment are not unique to transgender people and are routinely assessed in non-transgender people during the accession process. Medical evaluators are not asked to make judgments that are different from the ones they already make.

7) Teaching medical evaluators to process applications from transgender candidates requires less than one day of training.

8) Even if DOD had not completed most preparation for the lifting of the accession ban almost one year ago, training personnel to process transgender applicants would not be difficult or time-consuming.

Trump administration officials have claimed that in order to begin processing transgender applicants for military service, the Defense Department (DOD) must train approximately 23,000 personnel, including 20,367 recruiters, 2,785 employees of Military Entrance Processing Stations (MEPS), 32 Service Medical Waiver Authorities, and personnel at military entrance training locations and the medical facilities that support them.[1] According to the administration, training will be difficult and complex, because "[n]o other accession standard has been implemented that presents such a multifaceted review of an applicant's medical history" and because the military will have to "ensure that the 'tens of thousands' of service members 'dispersed across the United States' responsible for implementing accession policies 'have a working knowledge or in-depth medical understanding of the standards.'"[2] As a result, the administration argues, a federal court's order requiring DOD to allow accession of transgender individuals into military service on January 1, 2018 "will impose extraordinary burdens on the Department and the military services."[3]

Former military leaders have cast doubt on the administration's claims by confirming that most of the training required to begin processing transgender applicants was completed by the time of the presidential transition in January 2017. According to former Navy Secretary Ray Mabus, "The Services had already completed almost all of the necessary preparation for the lifting of the enlistment ban when we left office almost a year ago."[4] Former Air Force Secretary Deborah Lee James confirmed that, "It took less than a year for the Services to successfully prepare for DADT repeal, and they have now had 18 months to get ready for transgender enlistment. When I left office in January, we had already done most of the work to prepare for this policy change."[5]

Beyond former leaders' confirmation that DOD had already completed most training and other preparatory work in anticipation of the lifting of the accession ban by the time that President Trump took office, the administration's claims are suspicious because training recruiters and medical evaluators to process applications from transgender candidates is neither complicated nor time-consuming. "Tens of thousands" of recruiters and examiners do not require "a working knowledge or in-depth medical understanding of the standards." The accession standard for gender dysphoria is no different from the standard that evaluators use to assess all other medical conditions. And medical evaluators are not being asked to make judgments that are different from the ones they are already making. No one, in other words, requires in-depth training, and even if DOD had not completed most preparation for the lifting of the accession ban almost one year ago, training personnel to process transgender applicants would not be difficult or time-consuming.

1) Recruiters require no additional training to process applications from transgender candidates

Of the 23,000 personnel who DOD claims must be trained to process transgender applicants, 20,367 (89 percent) are recruiters. Recruiters, however, do not need additional training to process applications from transgender candidates. All service members who are now recruiters have received training along with the rest of the force, beginning in

June 2016, in inclusive retention policy for transgender personnel, so they understand the basic outlines of policy and the basic facts of gender identity.

The Trump administration claims that military recruiters are responsible for 1) "resolving any gender identity conflict between an applicant's government identification documents and the gender in which they present themselves"; and 2) "assisting the applicant complete the Accession Medical Prescreen Report (DD Form 2807-2), including providing substantiating and supporting medical documents." The first claim is incorrect, as established by the military's own procedures and forms that are part of the recruiting process. The second claim about recruiter responsibility is correct, but the task requires no additional training because transgender applicants would be handled in exactly the same manner as other applicants, a task which recruiters are already competent to perform.

First, there is no gender identity conflict for recruiters to resolve. Transgender applicants will be processed and enlisted in the gender established by the government identification they are required to provide to confirm identity. There is no other option, and nothing to resolve. It is irrelevant what gender they "present" in, as it is not the recruiter's job to decide whether the applicant acts or looks sufficiently like a man or a woman, and it is not the recruiter's job to verify that the applicant has an appropriate gender presentation. These judgments are irrelevant to the accession process.

Recruiters record the applicant's legal gender by checking a box on DD Form 1966, *Record of Military Processing*, "the principle document to report military processing and enlistment data elements."[6] They verify the applicant's gender in the same way they verify all identifying information, such as age and citizenship status, for all applicants: by reference to government identification such as a birth certificate or passport.[7] Government documents determine the gender of enlistment, not the judgment of the recruiter as to "the gender in which they present themselves." This is consistent with military policy on transgender service that has been in effect since June 2016. Under that policy, the military recognizes a service member's gender by the member's gender marker in the Defense Enrollment Eligibility Reporting System (DEERS), which cannot be changed without a corresponding change in the member's government identification.[8] Verification of gender is far less complicated than verification of citizenship status and requires no new skills or procedures.

Second, recruiters do not need to understand transgender medicine or transgender accession standards any more than they need to understand cardiology or cardiology accession standards. Recruiters help candidates fill out medical disclosure forms and determine whether medical records are needed and what documentation may be necessary. But they do not diagnose gender dysphoria.

Recruiters' only relevant responsibility is to help applicants prepare a required package of medical information, a simple and straightforward task. DD Form 2807-2, *Accessions Medical Prescreen Report* (7 pages) contains clear, simple instructions to the recruiter and the applicant about what is required for the medical packet that goes to MEPS. "This

form must be completed by the applicant with the assistance of the recruiter, parent(s), or guardian, as needed… If an applicant has been seen by any Health Care Provider (HCP) and/or has been hospitalized for any reason, medical records/documentation must be obtained and submitted along with a medical release to USMEPCOM." The requirement to prepare a medical package does not change based on the nature of an applicant's medical history. If the applicant has a medical history of any kind, the applicant must provide relevant medical records. The process will not change for transgender applicants.

According to one U.S. Army Recruiter, "Last year, recruiters were briefed on transgender persons serving in the military, and my entire recruiting battalion received training. As recruiters, we only process and help build the packets for those meeting basic qualifications, so processing applications from transgender candidates is actually quite simple for us. At this point, DoD just has to make changes to some forms. Everything with processing applicants is self-explanatory."[9]

Recruiters require no training to process transgender applicants, because the only points recruiters need to understand are that qualified transgender people are permitted to serve, and that recruiters should process their paperwork the same way they process paperwork for everyone else. According to one of the nation's top experts in accession policies and practices, sending a one-page instruction to all recruiting stations would suffice if it has not already been done.[10]

2) Medical evaluators do not require in-depth training to process applications from transgender candidates

Medical evaluators do not require in-depth training because (a) they are already well versed in DOD's method for deriving objective and relatively simple assessments of medical fitness; (b) potential comorbidities of gender dysphoria and its treatment are not unique to transgender people and are routinely assessed in non-transgender people during the accession process; and (c) learning to process applications from transgender candidates requires less than one day of training.

Dr. George R. Brown, a VA psychiatrist and former Air Force officer who has studied transgender health in military populations for more than 30 years, personally trained several hundred MEPS employees in anticipation of the lifting of the accession ban on transgender applicants. According to Dr. Brown, in-depth training is not necessary.

> The accessions criteria for transgender people are straightforward and do not require extensive or detailed knowledge. To the contrary, it simply requires MEP personnel to identify applicants who have a diagnosis of gender dysphoria, a diagnosis with which medical professionals should already be familiar. It also involves review of the individual's substantiating and supporting medical documentation to confirm that the period of stability (18 months) has been met. This process does not involve any unique complexities or burdens and is well within the capacity of military personnel involved in the enlistment review process.[11]

The transgender accession standard, discussed below, was constructed to track the way that all other medical histories are evaluated, so medical evaluators are not asked to make judgments that are different from the ones they already make. According to former Army Secretary Eric Fanning,

> … [M]uch of the new process for transgender accessions mirrored an existing process. These changes to policy for transgender accession…were consistent with standards already in place authorizing individuals with a range of medical conditions to accede to military service. As a result, the training program was designed to focus on helping military professionals understand the terminology and range of possible documentation unique to transgender individuals to assist them in applying to preexisting, well-understood procedures, rather than carving out any new process specifically designed for accessions of these individuals.[12]

Gender dysphoria itself is not new to the military (putting aside the outdated terminology in the current accession regulation), as DOD has been identifying and excluding people at accession based on gender dysphoria and transgender identity for decades. Gender dysphoria and its treatment are not new to medicine and research, as shown by the fact that the WPATH Standards of Care[13] for transgender medicine was first published in 1979 and is now in its seventh edition. Even those MEPS employees who are unfamiliar with medical treatment for gender dysphoria, however, do not require in-depth training.

a) Medical evaluators are already well versed in the DOD accession regulation's method for deriving objective and relatively simple assessments of medical fitness

The DOD accession regulation—DODI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*—frequently uses conditional factors to guide medical evaluators in qualifying candidates with a particular medical condition, and to channel MEPS evaluations toward objective and relatively simple assessments that are within the competence of examiners. These conditional factors are phrased in terms of words like UNLESS, IF, WHEN, or DOES (sometimes capitalized, sometimes not). All fit the same purpose of determining when a particular condition is minor, stable, and/or corrected, and therefore unlikely to interfere with successful military service or cause undue burden. For example, a history of Attention Deficit Hyperactivity Disorder is disqualifying UNLESS a candidate can demonstrate, among other things, that "During periods off of medication after the age of 14, the applicant has been able to maintain at least a 2.0 grade point average without accommodations."[14]

DODI 6130.03 provides a variety of tools to examiners in service of medical evaluation:[*]

[*] Paragraph numbers in citations refer to the accession medical standards in Enclosure 4 of DODI 6130.03. "SMPG" (if noted) indicates that USMEPCOM has issued Supplemental Guidance to DODI 6130.03 as an aid in interpreting the regulation.

• MEPS can require records of civilian medical care and disqualify applicants if they do not produce them (¶¶ 4c3b SMPG (LASIK), 14a (abnormal menstruation), 14n SMPG (PAP smear)).

• MEPS can in some cases rely on the medical judgment of the applicant's primary care or specialist providers, and can require applicants to submit outside evaluation and testing (¶¶ 4c3e SMPG (LASIK), 12p SMPG (tachycardia), 21b SMPG (hypertension), 25b4 SMPG (renal glycosuria), 25f SMPG (thyroid disorders)).

• Accession standards often cite and summarize research or practice standards from civilian medicine as an aid to examiners in understanding a particular medical condition (¶¶ 11h SMPG (chest wall malformation), 12a1 (heart murmur), 14a SMPG (abnormal menstruation), 14h SMPG (PCOS), 25b SMPG (diabetes)).

• Accession standards sometimes rely on simple passage of time (e.g., 6 months after breast/chest surgery, ¶ 11p) or ability to perform simple functional tasks (e.g., ability to drink from a straw after surgical repair of cleft lip or palate defects, ¶ 8a) as indicators of fitness and absence of persistent complications.

• MEPS can refer unusual or outlier cases for review by outside specialists (¶¶ 4c3e SMPG (LASIK), 4h4 SMPG (ocular hypertension), 12a1 SMPG (heart murmur)).

Armed with these tools, MEPS examiners determine candidates' fitness for duty, regardless of the complexity of any particular applicant's medical history.

b) Potential comorbidities of gender dysphoria are not new to medical evaluators

The new accession standard for transgender applicants, established in June 2016 but not yet placed in service, designates a history of gender dysphoria, or a history of medical treatment associated with gender transition, as disqualifying UNLESS the candidate can document 18 months of medical, social, occupational and/or psychological stability.[15] MEPS examiners can easily determine transgender candidates' fitness for duty, because comorbidities of gender dysphoria and its treatment are not unique to transgender people and are routinely assessed in non-transgender people during the accession process.

Assuming the most challenging scenario that would apply in a small minority of cases, gender dysphoria and its treatment present three potential areas that are familiar to medical evaluators: mental health, endocrine/hormones, and surgical recovery.

I. Mental health: DODI 6130.03 already directs examiners to use conditional UNLESS factors in evaluating the severity and stability of certain mental health histories. Every

diagnosis in DSM-5 involves a finding of "clinically significant distress or impairment in social, occupational, or other important areas of functioning," and so the task for accession examiners in these cases is to apply UNLESS factors to identify applicants whose mental health history is unlikely to interfere with successful military service. In general, the UNLESS factors explore whether impairment still exists or will be recurrent, probing circumstances such as success in school or work, prior need for hospitalization, encounters with law enforcement, and need for psychiatric medication (¶¶ 29a (ADHD), 29b (learning disorder), 29g (depression), 29h (adjustment disorder), 29i (behavior disorder); 29p (anxiety disorder)).

Examiners have the authority to require applicants to submit Individualized Education Plans, other school records, counseling records, and medication records for the purpose of evaluating UNLESS factors (¶¶ 29a SMPG (ADHD), 29b SMPG (learning disorder)).

The UNLESS factors used in ¶ 29 to evaluate impairment are no more difficult to apply for transgender applicants than they are for non-transgender applicants. The factors rely in large part on success in life activities that are common to all applicants regardless of gender identity.

II. Endocrine/Hormones: In several instances in DODI 6130.03, standards for women appear to assume (without specifying) that applicants are being medically treated with hormones, because the standards apply to conditions that are typically treated with hormones. Use of hormones for these conditions is not disqualifying and is not directly evaluated during the accession process. The task for the MEPS examiner is only to confirm that the condition is responsive to treatment and unlikely to interfere with routine activities (¶¶ 14a (abnormal menstruation), 14d (dysmenorrhea), 14e (endometriosis), 14h (PCOS)). In addition, amenorrhea secondary to hormonal contraceptives like Depo-Provera is expressly not disqualifying (¶ 14c SMPG).

DODI 6130.03 requires examiners to assess several other maintenance medications and determine whether the course of treatment is stable (e.g., no side effects for 6 months from cholesterol drugs, ¶ 25i; asymptomatic while taking GERD medication, ¶ 13a SMPG). With a small amount of training on medical standards of care for transgender individuals, combined with references to clinical research that are commonly included in DODI 6130.03, examiners are competent to determine whether hormone treatment is stable and effective. Examiners also have the authority to require applicants to submit pertinent records, testing, evaluation, and opinion from civilian providers if needed.

III. Surgical recovery: Many surgical procedures are not permanent disqualifications under DODI 6130.03. When UNLESS factors are used, they typically rely on one or both of two indicators that rule out functional limitations or persistent complications. One possible factor is the passage of time (e.g., 6 months after abdominal surgery, open or laparoscopic, ¶ 13f); the other enumerates the limitations or complications that the examiner should look for in assessing fitness.

Some surgeries are common to transgender and non-transgender applicants. For example, chest wall surgery (including breast) is not disqualifying if more than six months have passed and no functional limitations persist (¶ 11p). The reason for surgery would differ between transgender and non-transgender applicants, but the surgery itself would be evaluated in the same way under existing standards. No new medical knowledge or standard would be required for assessment of chest or breast surgery in transgender applicants.

Genital surgeries may in some cases raise issues that are not common to transgender and non-transgender applicants, but only a small percentage of transgender persons will have genital surgery at any time in their lives (approximately 25% for MTF, and less than 5% for more complicated FTM surgeries).[16] The expected number who would present at accession having had genital surgery would be even lower, given the typical age range for enlistment.

While the surgical procedures differ, the limitations or complications that can result from surgical procedures are similar for transgender and non-transgender persons. DODI 6130.03 relies on UNLESS factors to evaluate fitness in comparable post-surgical circumstances. For example, penile hypospadias reconstruction is not disqualifying unless accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction (¶ 15e). The point is not that hypospadias reconstruction is comparable to genital surgery for purposes of gender transition, but that existing UNLESS standards require examiners to evaluate similar consequences or complications of surgery. Complications related to infection, urethral stricture, or voiding dysfunction are not unique to men or to women, and they are not unique to transgender or to non-transgender people. Similarly, DODI 6130.03 requires examiners to assess whether applicants have "current or recurrent urethral or ureteral stricture or fistula involving the urinary tract" (¶ 16g). If these conditions can be evaluated in some applicants, they can be evaluated in other applicants.

Finally, earlier versions of DODI 6130.03 suggested that genital surgery for the purpose of "change of sex" was disqualifying only if complications persisted. Of course, whether surgical complications persisted was not relevant under policy that otherwise automatically excluded all applicants with a gender identity different from gender assigned at birth. However, the inclusion of a conditional UNLESS-style factor suggests that accession examiners were once considered competent to assess complications resulting from such genital surgeries. The following is a quote from the 2004 version of DODI 6130.03 (then DODI 6130.4), ¶¶ E1.12.13, E1.13.10:

> Major Abnormalities and Defects of the Genitalia, Such as a Change of Sex. A history thereof, or dysfunctional residuals from surgical correction of these conditions.

The prior Army medical enlistment standard that applied to all enlistees prior to the establishment of a common DOD standard in 1986 (AR 40-501, ¶ 2-14s, first issued in 1961) was even more detailed in the description of potential complications:

> *Major abnormalities and defects of the genitalia* such as a change of sex, a history thereof, or complications (adhesions, disfiguring scars, etc.) residual to surgical correction of these conditions.

Lifting the accession ban requires medical evaluators to apply existing standards and tools to people who were previously disqualified automatically. This is not a matter of new medical knowledge or new practices, but rather the same medical knowledge applied to more people. Exclusionary policy artificially prevented medical examiners from seeing the commonalities in medical issues between transgender and non-transgender applicants.

c) Training medical examiners to evaluate transgender candidates requires less than one day

Very little training is needed to teach medical examiners how to evaluate transgender applicants because the accession standard was constructed to track the way that all other medical histories are evaluated; examiners are already well versed in DOD's method for deriving objective and relatively simple assessments of medical fitness; and potential comorbidities of gender dysphoria are not new to medical examiners or unique to transgender applicants. For all of these reasons, the training that MEPS medical personnel undergo to learn how to evaluate transgender candidates is only four hours long.[17] The training includes a slide show; discussions of accession regulations, definition and diagnosis of gender dysphoria, and effects of medical treatments; and a period for questions and answers. Even if DOD had not completed most preparation for the lifting of the accession ban almost one year ago, training personnel to process transgender applicants would not be difficult or time-consuming.

[1] Declaration of Lernes J. Hebert, Acting Deputy Assistant Secretary of Defense, Military Personnel Policy, Office of the Under Secretary of Defense for Personnel and Readiness, filed in Doe v. Trump, U.S. District Court, District of Columbia, Dec. 6, 2017, 4-5.
[2] Department of Justice, Appellants' Emergency Motion for Administrative Stay and Partial Stay Pending Appeal, filed in the District of Columbia Circuit Court of Appeals, Dec. 11, 2017, 14 (quoting Hebert Declaration).
[3] Hebert Declaration, 3-4.
[4] Alan Bishop et al., DoD Is Ready to Accept Transgender Applicants (Palm Center, December 2017), 2-3, http://www.palmcenter.org/wp-content/uploads/2017/12/DOD-Is-Ready-to-Accept-Transgender-Applicants-2.pdf.
[5] *Id*.
[6] DOD Instruction 1304.02, Accession Processing Data Collection Forms (Sept. 9, 2011), 16.
[7] See, for example, Army Regulation 601-210, Regular Army and Reserve Components Enlistment Program (Aug. 31, 2016), 5-8.
[8] DOD Instruction 1300.28, In-Service Transition for Transgender Service Members (Oct. 1, 2016), 3, 10-11.
[9] U.S. Army Recruiter, personal communication with the authors.
[10] Professor Mark Eitelberg (Emeritus), Naval Postgraduate School, personal communication with the authors.
[11] Declaration of George Richard Brown, MD, DFAPA, filed in Doe v. Trump, U.S. District Court, District of Columbia, Dec. 8, 2017, 3.
[12] Declaration of Eric K. Fanning, Former Secretary of the Army, filed in Doe v. Trump, District of Columbia Circuit Court of Appeals, Dec. 15, 2017, 2.
[13] Eli Coleman et al. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, *International Journal of Transgenderism*, 13: 165-232.
[14] DOD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services (Apr. 28, 2010, incorporating Change 1, Sept. 13, 2011), 46-47.
[15] Secretary of Defense, DTM 16-005, Military Service of Transgender Service Members (June 30, 2016), 1-2.
[16] Jaime M. Grant, Lisa A. Mottet and Justin Tanis (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, 79.
[17] Dr. George R. Brown, personal communication with the authors.

UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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ORDER

November 21, 2017

Before

WILLIAM J. BAUER, *Circuit Judge*
DANIEL A. MANION, *Circuit Judge*
ILANA DIAMOND ROVNER, *Circuit Judge*

No. 17-2991	CITY OF CHICAGO, Plaintiff - Appellee v. JEFFERSON B. SESSIONS III, Attorney General of the United States, Defendant - Appellant
Originating Case Information:	
District Court No: 1:17-cv-05720 Northern District of Illinois, Eastern Division District Judge Harry D. Leinenweber	

The following are before the court:

1. **DEFENDANT-APPELLANT'S MOTION FOR PARTIAL STAY OF PRELIMINARY INJUNCTION PENDING APPEAL**, filed on October 13, 2017, by counsel for the appellant.

2. **OPPOSITION TO DEFENDANT'S MOTION TO STAY NATIONWIDE APPLICATION OF PRELIMINARY INJUNCTION**, filed on October 18, 2017, by counsel for the appellee.

3. **DEFENDANT-APPELLANT'S STATUS REPORT**, filed on November 17, 2017, by counsel for the appellant.

4. **REPLY IN SUPPORT OF DEFENDANT-APPELLANT'S MOTION FOR PARTIAL STAY OF PRELIMINARY INJUNCTION PENDING APPEAL**, filed on November 17, 2017, by counsel for the appellant.

5. **PLAINTIFF-APPELLEE'S STATUS REPORT**, filed on November 20, 2017, by counsel for the appellee.

6. **BRIEF OF STATES OF CALIFORNIA AND ILLINOIS AS AMICI CURIAE IN SUPPORT OF CITY OF CHICAGO'S RESPONSE TO DEFENDANT-APPELLANT'S MOTION FOR PARTIAL STAY OF PRELIMINARY INJUNCTION PENDING APPEAL AND AGAINST THE STAY**, filed on November 21, 2017, by counsel.

IT IS ORDERED that the motion for partial stay of the preliminary injunction is **DENIED**.

IT IS FURTHER ORDERED that briefing in this appeal shall proceed as follows:

1. The brief and required short appendix of the appellant are due by November 28, 2017.

2. The brief of the appellee is due by December 28, 2017.

3. The reply brief of the appellant, if any, is due by January 11, 2018.

Important Scheduling Notice !

Notices of hearing for particular appeals are mailed shortly before the date of oral argument. Criminal appeals are scheduled shortly after the filing of the appellant's main brief; civil appeals after the filing of the appellee's brief. If you foresee that you will be unavailable during a period in which your particular appeal might be scheduled, please write the clerk advising him of the time period and the reason for such unavailability. Session data is located at http://www.ca7.uscourts.gov/cal/calendar.pdf. Once an appeal is formally scheduled for a certain date, it is very difficult to have the setting changed. See Circuit Rule 34(e).

form name: **c7_Order_3J**(form ID: **177**)

CERTIFICATE OF SERVICE

I hereby certify that on December 18, 2017, I caused the foregoing Supplemental Addendum to be filed with the Clerk of the U.S. Court of Appeals for the Fourth Circuit using the appellate CM/ECF system and will be served upon all parties via the CM/ECF system.

/s/ David M. Zionts
David M. Zionts
Counsel for Plaintiffs-Appellees

December 18, 2017