

**UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN**

CODY FLACK and
SARA ANN MAKENZIE,

Plaintiffs,

v.

WISCONSIN DEPARTMENT OF
HEALTH SERVICES and
LINDA SEEMEYER, in her official capacity
as Secretary of the Wisconsin Department
of Health Services,

Defendants.

Case No. 3:18-cv-00309-wmc
Judge William Conley

DECLARATION OF ORLY T. MAY, ESQ.

I, Orly T. May, declare as follows:

1. I am an attorney for Plaintiffs Cody Flack and Sara Ann Makenzie in the above-captioned case. I submit this declaration in connection with Plaintiffs' Motion for Preliminary Injunction.

2. Exhibit 1 to this Declaration is a true and correct copy of American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, "Gender Dysphoria" 451-459 (5th ed. 2013).

3. Exhibit 2 to this Declaration is a true and correct copy of the December 2011 Committee Opinion of the Committee on Health Care for Underserved Women of The American College of Obstetricians and Gynecologists, entitled, "Health Care for Transgender Individuals" (2011).

4. Exhibit 3 to this Declaration is a true and correct copy of the American Psychiatric Association's Position Statement on Access to Care for Transgender and Gender Variant Individuals (2012).

5. Exhibit 4 to this Declaration is a true and correct copy of the American Psychological Association's resolution, entitled, "Transgender, Gender Identity, & Gender Expression Non-Discrimination" (2008).

6. Exhibit 5 to this Declaration is a true and correct copy of the American Medical Association's policy, "Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927) (last modified in 2016).

7. Exhibit 6 to this Declaration is a true and correct copy of the American Medical Association's policy, "Removing Financial Barriers to Care for Transgender Patients H-185.950" (last modified in 2016).

8. Exhibit 7 to this Declaration is a true and correct copy of the American Medical Association's Resolution: 122 (A-08), entitled, "Removing Financial Barriers to Care for Transgender Patients."

9. Exhibit 8 to this Declaration is the American Association of Family Physician's Resolution No. 1004, entitled, "Transgender Care" (May 3, 2012).

10. Exhibit 9 to this Declaration is a true and correct copy of the Endocrine Society's Position Statement on Transgender Health (September 2017).

11. Exhibit 10 to this Declaration is a true and correct copy of State of Wisconsin, Legislative Fiscal Bureau, Joint Committee on Finance, *Medical Assistance Cost-to-Continue (Health Services -- Medicaid Services) (Paper #320) (May 25, 2017)*.

12. Exhibit 11 to this Declaration is a true and correct copy of DHS, *Current Month Health Enrollment At A Glance* (April 2018), available at <https://www.forwardhealth.wi.gov/wiportal/Tab/42/icscontent/Member/caseloads/enrollment/EnrollmentAt-A-Glance.pdf.space> (accessed and printed on May 21, 2018).

13. Exhibit 12 to this Declaration is a true and correct copy of Clearinghouse Rule 96-154 (CR 96-154), approved and adopted on December 11, 1996, by the Wisconsin Department of Health and Family Services (“DHFS”) (the predecessor to Defendant Wisconsin Department of Health Services (“DHS”)), and implemented on February 1, 1997.

14. Exhibit 13 to this Declaration is a true and correct copy of a document, “Summary of the Amendments to the Medicaid Rules that Discontinue Coverage of Medically Unnecessary Services,” dated January 6, 1995, which was prepared by the Division of Health, Wisconsin Bureau of Health Care Financing in connection with the promulgation of CR 96-154.

15. Exhibit 14 to this Declaration is a true and correct copy of a document, Fiscal Estimate: Medical Assistance: Medically Unnecessary Services, dated September 27, 1996, and an accompanying transmittal document from DHFS, Office of Legal Counsel, to the Legislative Council Rules Clearinghouse, also dated September 27, 1996. These documents were prepared in connection with the promulgation of CR 96-154.

16. Exhibit 15 to this Declaration is a true and correct copy of a webpage on the DHS website, entitled, “LGBT Health – Transgender Persons,” <https://www.dhs.wisconsin.gov/lgbthealth/transgender.htm> (accessed and printed on May 21, 2018).

17. Exhibit 16 to this Declaration are true and correct copies of the following three from DHS’s ForwardHealth Online Handbook at

<https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=85&s=8&c=608&nt=Online+Handbook>, which were accessed and printed on May 23, 2018:

- Topic #560: Breast Reconstruction
- Topic #18257: Reduction Mammoplasty
- Topic #13817: Restorative Plastic Surgery and Procedures

18. Exhibit 17 to this Declaration is a true and correct copy of Center for Excellence for Transgender Health, *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*, “Binding, packing, and tucking” 155 (Madeline B. Deutsch, MD, MPH, ed., 2d ed. 2016).

19. Exhibit 18 to this Declaration is a true and correct copy of the August 2, 2017 letter sent by DHS to Dean Health Systems Inc., denying the request for preauthorization for coverage of Plaintiff Cody Flack’s mastectomy and chest reconstruction.

20. Exhibit 19 to this Declaration is a true and correct copy of the August 2, 2017 Notice of Appeal Rights sent by DHS to Plaintiff Cody Flack.

21. Exhibit 20 to this Declaration is a true and correct copy of the November 21, 2017 Decision of Administrative Law Judge Brian C. Schneider in Plaintiff Cody Flack’s administrative appeal of Defendants’ denial of medical assistance for a mastectomy and breast reconstruction.

22. Exhibit 21 to this Declaration is a true and correct copy of the December 11, 2017 Order by Administrative Law Judge Brian C. Schneider denying Plaintiff Cody Flack’s request for rehearing in his administrative appeal of Defendants’ denial of medical assistance for a mastectomy and breast reconstruction.

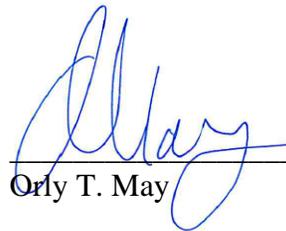
23. Exhibit 22 to this Declaration is a true and correct copy of the September 25, 2017 letter sent by Julie Sager, MD, Medical Director, Bureau of Benefits Management, Division of Medicaid Services, DHS, to the Department of Administration, Division of Hearings and Appeals, and Plaintiff Cody Flack, submitted in connection with Mr. Flack's administrative appeal of Defendants' denial of medical assistance for a mastectomy and breast reconstruction.

24. Exhibit 23 to this Declaration is a true and correct copy of S. James, *et al.*, National Center for Transgender Equality, *Executive Summary of the Report of the 2015 U.S. Transgender Survey* (2016, updated 2017).

25. Exhibit 24 to this Declaration is a true and correct copy of National Center for Transgender Equality, *2015 U.S. Transgender Survey: Wisconsin State Report* (2017).

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge and information.

Executed this 23rd day of May, 2018.


Orly T. May

EXHIBIT

1

DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS

FIFTH EDITION

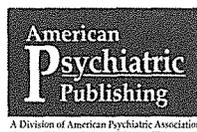
DSM-5™

AMERICAN PSYCHIATRIC ASSOCIATION

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FIFTH EDITION

DSM-5TM



Washington, DC
London, England

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Gender Dysphoria

In this chapter, there is one overarching diagnosis of gender dysphoria, with separate developmentally appropriate criteria sets for children and for adolescents and adults. The area of sex and gender is highly controversial and has led to a proliferation of terms whose meanings vary over time and within and between disciplines. An additional source of confusion is that in English “sex” connotes both male/female and sexuality. This chapter employs constructs and terms as they are widely used by clinicians from various disciplines with specialization in this area. In this chapter, *sex* and *sexual* refer to the biological indicators of male and female (understood in the context of reproductive capacity), such as in sex chromosomes, gonads, sex hormones, and nonambiguous internal and external genitalia. Disorders of sex development denote conditions of inborn somatic deviations of the reproductive tract from the norm and/or discrepancies among the biological indicators of male and female. *Cross-sex* hormone treatment denotes 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.

The need to introduce the term *gender* arose with the realization that for individuals with conflicting or ambiguous biological indicators of sex (i.e., “intersex”), the lived role in society and/or the identification as male or female could not be uniformly associated with or predicted from the biological indicators and, later, that some individuals develop an identity as female or male at variance with their uniform set of classical biological indicators. Thus, *gender* is used to denote the public (and usually legally recognized) lived role as boy or girl, man or woman, but, in contrast to certain social constructionist theories, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development. *Gender assignment* refers to the initial assignment as male or female. This occurs usually at birth and, thereby, yields the “natal gender.” *Gender-atypical* refers to somatic features or behaviors that are not typical (in a statistical sense) of individuals with the same assigned gender in a given society and historical era; for behavior, *gender-nonconforming* is an alternative descriptive term. *Gender reassignment* denotes an official (and usually legal) change of gender. *Gender identity* is a category of social identity and refers to an individual’s identification as male, female, or, occasionally, some category other than male or female. *Gender dysphoria* as a general descriptive term refers to an individual’s affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category. *Transgender* refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender. *Transsexual* denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery (*sex reassignment surgery*).

Gender dysphoria refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.

Gender Dysphoria

Diagnostic Criteria

Gender Dysphoria in Children 302.6 (F64.2)

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):
1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
 2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
 3. A strong preference for cross-gender roles in make-believe play or fantasy play.
 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
 5. A strong preference for playmates of the other gender.
 6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
 7. A strong dislike of one's sexual anatomy.
 8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

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.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

Specifiers

The posttransition specifier may be used in the context of continuing treatment procedures that serve to support the new gender assignment.

Diagnostic Features

Individuals with gender dysphoria have a marked incongruence between the gender they have been assigned to (usually at birth, referred to as *natal gender*) and their experienced/expressed gender. This discrepancy is the core component of the diagnosis. There must also be evidence of distress about this incongruence. Experienced gender may include alternative gender identities beyond binary stereotypes. Consequently, the distress is not limited to a desire to simply be of the other gender, but may include a desire to be of an alternative gender, provided that it differs from the individual's assigned gender.

Gender dysphoria manifests itself differently in different age groups. Prepubertal natal girls with gender dysphoria may express the wish to be a boy, assert they are a boy, or assert they will grow up to be a man. They prefer boys' clothing and hairstyles, are often perceived by strangers as boys, and may ask to be called by a boy's name. Usually, they display intense negative reactions to parental attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes are required. These girls may demonstrate marked cross-gender identification in role-playing, dreams, and fantasies. Contact sports, rough-and-tumble play, traditional boyhood games, and boys as playmates are most often preferred. They show little interest in stereotypically feminine toys (e.g., dolls) or activities (e.g., feminine dress-up or role-play). Occasionally, they refuse to urinate in a sitting position. Some natal girls may express a desire to have a penis or claim to have a penis or that they will grow one when older. They may also state that they do not want to develop breasts or menstruate.

Prepubertal natal boys with gender dysphoria may express the wish to be a girl or assert they are a girl or that they will grow up to be a woman. They have a preference for dressing in girls' or women's clothes or may improvise clothing from available materials (e.g., using towels, aprons, and scarves for long hair or skirts). These children may role-play female figures (e.g., playing "mother") and often are intensely interested in female fantasy figures. Traditional feminine activities, stereotypical games, and pastimes (e.g., "playing house"; drawing feminine pictures; watching television or videos of favorite female characters) are most often preferred. Stereotypical female-type dolls (e.g., Barbie) are often favorite toys, and girls are their preferred playmates. They avoid rough-and-tumble play and competitive sports and have little interest in stereotypically masculine toys (e.g., cars, trucks). Some may pretend not to have a penis and insist on sitting to urinate. More

rarely, they may state that they find their penis or testes disgusting, that they wish them removed, or that they have, or wish to have, a vagina.

In young adolescents with gender dysphoria, clinical features may resemble those of children or adults with the condition, depending on developmental level. As secondary sex characteristics of young adolescents are not yet fully developed, these individuals may not state dislike of them, but they are concerned about imminent physical changes.

In adults with gender dysphoria, the discrepancy between experienced gender and physical sex characteristics is often, but not always, accompanied by a desire to be rid of primary and/or secondary sex characteristics and/or a strong desire to acquire some primary and/or secondary sex characteristics of the other gender. To varying degrees, adults with gender dysphoria may adopt the behavior, clothing, and mannerisms of the experienced gender. They feel uncomfortable being regarded by others, or functioning in society, as members of their assigned gender. Some adults may have a strong desire to be of a different gender and treated as such, and they may have an inner certainty to feel and respond as the experienced gender without seeking medical treatment to alter body characteristics. They may find other ways to resolve the incongruence between experienced/expressed and assigned gender by partially living in the desired role or by adopting a gender role neither conventionally male nor conventionally female.

Associated Features Supporting Diagnosis

When visible signs of puberty develop, natal boys may shave their legs at the first signs of hair growth. They sometimes bind their genitals to make erections less visible. Girls may bind their breasts, walk with a stoop, or use loose sweaters to make breasts less visible. Increasingly, adolescents request, or may obtain without medical prescription and supervision, hormonal suppressors ("blockers") of gonadal steroids (e.g., gonadotropin-releasing hormone [GnRH] analog, spironolactone). Clinically referred adolescents often want hormone treatment and many also wish for gender reassignment surgery. Adolescents living in an accepting environment may openly express the desire to be and be treated as the experienced gender and dress partly or completely as the experienced gender, have a hairstyle typical of the experienced gender, preferentially seek friendships with peers of the other gender, and/or adopt a new first name consistent with the experienced gender. Older adolescents, when sexually active, usually do not show or allow partners to touch their sexual organs. For adults with an aversion toward their genitals, sexual activity is constrained by the preference that their genitals not be seen or touched by their partners. Some adults may seek hormone treatment (sometimes without medical prescription and supervision) and gender reassignment surgery. Others are satisfied with either hormone treatment or surgery alone.

Adolescents and adults with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicides. After gender reassignment, adjustment may vary, and suicide risk may persist.

Prevalence

For natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%. Since not all adults seeking hormone treatment and surgical reassignment attend specialty clinics, these rates are likely modest underestimates. Sex differences in rate of referrals to specialty clinics vary by age group. In children, sex ratios of natal boys to girls range from 2:1 to 4.5:1. In adolescents, the sex ratio is close to parity; in adults, the sex ratio favors natal males, with ratios ranging from 1:1 to 6.1:1. In two countries, the sex ratio appears to favor natal females (Japan: 2.2:1; Poland: 3.4:1).

Development and Course

Because expression of gender dysphoria varies with age, there are separate criteria sets for children versus adolescents and adults. Criteria for children are defined in a more con-

crete, behavioral manner than those for adolescents and adults. Many of the core criteria draw on well-documented behavioral gender differences between typically developing boys and girls. Young children are less likely than older children, adolescents, and adults to express extreme and persistent anatomic dysphoria. In adolescents and adults, incongruence between experienced gender and somatic sex is a central feature of the diagnosis. Factors related to distress and impairment also vary with age. A very young child may show signs of distress (e.g., intense crying) only when parents tell the child that he or she is “really” not a member of the other gender but only “desires” to be. Distress may not be manifest in social environments supportive of the child’s desire to live in the role of the other gender and may emerge only if the desire is interfered with. In adolescents and adults, distress may manifest because of strong incongruence between experienced gender and somatic sex. Such distress may, however, be mitigated by supportive environments and knowledge that biomedical treatments exist to reduce incongruence. Impairment (e.g., school refusal, development of depression, anxiety, and substance abuse) may be a consequence of gender dysphoria.

Gender dysphoria without a disorder of sex development. For clinic-referred children, onset of cross-gender behaviors is usually between ages 2 and 4 years. This corresponds to the developmental time period in which most typically developing children begin expressing gendered behaviors and interests. For some preschool-age children, both pervasive cross-gender behaviors and the expressed desire to be the other gender may be present, or, more rarely, labeling oneself as a member of the other gender may occur. In some cases, the expressed desire to be the other gender appears later, usually at entry into elementary school. A small minority of children express discomfort with their sexual anatomy or will state the desire to have a sexual anatomy corresponding to the experienced gender (“anatomic dysphoria”). Expressions of anatomic dysphoria become more common as children with gender dysphoria approach and anticipate puberty.

Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%. Persistence of gender dysphoria is modestly correlated with dimensional measures of severity ascertained at the time of a childhood baseline assessment. In one sample of natal males, lower socioeconomic background was also modestly correlated with persistence. It is unclear if particular therapeutic approaches to gender dysphoria in children are related to rates of long-term persistence. Extant follow-up samples consisted of children receiving no formal therapeutic intervention or receiving therapeutic interventions of various types, ranging from active efforts to reduce gender dysphoria to a more neutral, “watchful waiting” approach. It is unclear if children “encouraged” or supported to live socially in the desired gender will show higher rates of persistence, since such children have not yet been followed longitudinally in a systematic manner. For both natal male and female children showing persistence, almost all are sexually attracted to individuals of their natal sex. For natal male children whose gender dysphoria does not persist, the majority are *androphilic* (sexually attracted to males) and often self-identify as gay or homosexual (ranging from 63% to 100%). In natal female children whose gender dysphoria does not persist, the percentage who are *gynephilic* (sexually attracted to females) and self-identify as lesbian is lower (ranging from 32% to 50%).

In both adolescent and adult natal males, there are two broad trajectories for development of gender dysphoria: early onset and late onset. *Early-onset gender dysphoria* starts in childhood and continues into adolescence and adulthood; or, there is an intermittent period in which the gender dysphoria desists and these individuals self-identify as gay or homosexual, followed by recurrence of gender dysphoria. *Late-onset gender dysphoria* occurs around puberty or much later in life. Some of these individuals report having had a desire to be of the other gender in childhood that was not expressed verbally to others. Others do not recall any signs of childhood gender dysphoria. For adolescent males with late-onset gender dysphoria, parents often report surprise because they did not see signs of gender

dysphoria during childhood. Expressions of anatomic dysphoria are more common and salient in adolescents and adults once secondary sex characteristics have developed.

Adolescent and adult natal males with early-onset gender dysphoria are almost always sexually attracted to men (androphilic). Adolescents and adults with late-onset gender dysphoria frequently engage in transvestic behavior with sexual excitement. The majority of these individuals are gynephilic or sexually attracted to other posttransition natal males with late-onset gender dysphoria. A substantial percentage of adult males with late-onset gender dysphoria cohabit with or are married to natal females. After gender transition, many self-identify as lesbian. Among adult natal males with gender dysphoria, the early-onset group seeks out clinical care for hormone treatment and reassignment surgery at an earlier age than does the late-onset group. The late-onset group may have more fluctuations in the degree of gender dysphoria and be more ambivalent about and less likely satisfied after gender reassignment surgery.

In both adolescent and adult natal females, the most common course is the early-onset form of gender dysphoria. The late-onset form is much less common in natal females compared with natal males. As in natal males with gender dysphoria, there may have been a period in which the gender dysphoria desisted and these individuals self-identified as lesbian; however, with recurrence of gender dysphoria, clinical consultation is sought, often with the desire for hormone treatment and reassignment surgery. Parents of natal adolescent females with the late-onset form also report surprise, as no signs of childhood gender dysphoria were evident. Expressions of anatomic dysphoria are much more common and salient in adolescents and adults than in children.

Adolescent and adult natal females with early-onset gender dysphoria are almost always gynephilic. Adolescents and adults with the late-onset form of gender dysphoria are usually androphilic and after gender transition self-identify as gay men. Natal females with the late-onset form do not have co-occurring transvestic behavior with sexual excitement.

Gender dysphoria in association with a disorder of sex development. Most individuals with a disorder of sex development who develop gender dysphoria have already come to medical attention at an early age. For many, starting at birth, issues of gender assignment were raised by physicians and parents. Moreover, as infertility is quite common for this group, physicians are more willing to perform cross-sex hormone treatments and genital surgery before adulthood.

Disorders of sex development in general are frequently associated with gender-atypical behavior starting in early childhood. However, in the majority of cases, this does not lead to gender dysphoria. As individuals with a disorder of sex development become aware of their medical history and condition, many experience uncertainty about their gender, as opposed to developing a firm conviction that they are another gender. However, most do not progress to gender transition. Gender dysphoria and gender transition may vary considerably as a function of a disorder of sex development, its severity, and assigned gender.

Risk and Prognostic Factors

Temperamental. For individuals with gender dysphoria without a disorder of sex development, atypical gender behavior among individuals with early-onset gender dysphoria develops in early preschool age, and it is possible that a high degree of atypicality makes the development of gender dysphoria and its persistence into adolescence and adulthood more likely.

Environmental. Among individuals with gender dysphoria without a disorder of sex development, males with gender dysphoria (in both childhood and adolescence) more commonly have older brothers than do males without the condition. Additional predisposing

factors under consideration, especially in individuals with late-onset gender dysphoria (adulthood), include habitual fetishistic transvestism developing into autogynephilia (i.e., sexual arousal associated with the thought or image of oneself as a woman) and other forms of more general social, psychological, or developmental problems.

Genetic and physiological. For individuals with gender dysphoria without a disorder of sex development, some genetic contribution is suggested by evidence for (weak) familiarity of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygotic same-sex twins, and some degree of heritability of gender dysphoria. As to endocrine findings, no endogenous systemic abnormalities in sex-hormone levels have been found in 46,XY individuals, whereas there appear to be increased androgen levels (in the range found in hirsute women but far below normal male levels) in 46,XX individuals. Overall, current evidence is insufficient to label gender dysphoria without a disorder of sex development as a form of intersexuality limited to the central nervous system.

In gender dysphoria associated with a disorder of sex development, the likelihood of later gender dysphoria is increased if prenatal production and utilization (via receptor sensitivity) of androgens are grossly atypical relative to what is usually seen in individuals with the same assigned gender. Examples include 46,XY individuals with a history of normal male prenatal hormone milieu but inborn nonhormonal genital defects (as in cloacal bladder exstrophy or penile agenesis) and who have been assigned to the female gender. The likelihood of gender dysphoria is further enhanced by additional, prolonged, highly gender-atypical postnatal androgen exposure with somatic virilization as may occur in female-raised and noncastrated 46,XY individuals with 5-alpha reductase-2 deficiency or 17-beta-hydroxysteroid dehydrogenase-3 deficiency or in female-raised 46,XX individuals with classical congenital adrenal hyperplasia with prolonged periods of non-adherence to glucocorticoid replacement therapy. However, the prenatal androgen milieu is more closely related to gendered behavior than to gender identity. Many individuals with disorders of sex development and markedly gender-atypical behavior do not develop gender dysphoria. Thus, gender-atypical behavior by itself should not be interpreted as an indicator of current or future gender dysphoria. There appears to be a higher rate of gender dysphoria and patient-initiated gender change from assigned female to male than from assigned male to female in 46,XY individuals with a disorder of sex development.

Culture-Related Diagnostic Issues

Individuals with gender dysphoria have been reported across many countries and cultures. The equivalent of gender dysphoria has also been reported in individuals living in cultures with institutionalized gender categories other than male or female. It is unclear whether with these individuals the diagnostic criteria for gender dysphoria would be met.

Diagnostic Markers

Individuals with a somatic disorder of sex development show some correlation of final gender identity outcome with the degree of prenatal androgen production and utilization. However, the correlation is not robust enough for the biological factor, where ascertainable, to replace a detailed and comprehensive diagnostic interview evaluation for gender dysphoria.

Functional Consequences of Gender Dysphoria

Preoccupation with cross-gender wishes may develop at all ages after the first 2–3 years of childhood and often interfere with daily activities. In older children, failure to develop age-typical same-sex peer relationships and skills may lead to isolation from peer groups and to distress. Some children may refuse to attend school because of teasing and harass-

ment or pressure to dress in attire associated with their assigned sex. Also in adolescents and adults, preoccupation with cross-gender wishes often interferes with daily activities. Relationship difficulties, including sexual relationship problems, are common, and functioning at school or at work may be impaired. Gender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks, especially in individuals from resource-poor family backgrounds. In addition, these individuals' access to health services and mental health services may be impeded by structural barriers, such as institutional discomfort or inexperience in working with this patient population.

Differential Diagnosis

Nonconformity to gender roles. Gender dysphoria should be distinguished from simple nonconformity to stereotypical gender role behavior by the strong desire to be of another gender than the assigned one and by the extent and pervasiveness of gender-variant activities and interests. The diagnosis is not meant to merely describe nonconformity to stereotypical gender role behavior (e.g., "tomboyism" in girls, "girly-boy" behavior in boys, occasional cross-dressing in adult men). Given the increased openness of atypical gender expressions by individuals across the entire range of the transgender spectrum, it is important that the clinical diagnosis be limited to those individuals whose distress and impairment meet the specified criteria.

Transvestic disorder. Transvestic disorder occurs in heterosexual (or bisexual) adolescent and adult males (rarely in females) for whom cross-dressing behavior generates sexual excitement and causes distress and/or impairment without drawing their primary gender into question. It is occasionally accompanied by gender dysphoria. An individual with transvestic disorder who also has clinically significant gender dysphoria can be given both diagnoses. In many cases of late-onset gender dysphoria in gynephilic natal males, transvestic behavior with sexual excitement is a precursor.

Body dysmorphic disorder. An individual with body dysmorphic disorder focuses on the alteration or removal of a specific body part because it is perceived as abnormally formed, not because it represents a repudiated assigned gender. When an individual's presentation meets criteria for both gender dysphoria and body dysmorphic disorder, both diagnoses can be given. Individuals wishing to have a healthy limb amputated (termed by some *body integrity identity disorder*) because it makes them feel more "complete" usually do not wish to change gender, but rather desire to live as an amputee or a disabled person.

Schizophrenia and other psychotic disorders. In schizophrenia, there may rarely be delusions of belonging to some other gender. In the absence of psychotic symptoms, insistence by an individual with gender dysphoria that he or she is of some other gender is not considered a delusion. Schizophrenia (or other psychotic disorders) and gender dysphoria may co-occur.

Other clinical presentations. Some individuals with an emasculation desire who develop an alternative, nonmale/nonfemale gender identity do have a presentation that meets criteria for gender dysphoria. However, some males seek castration and/or penectomy for aesthetic reasons or to remove psychological effects of androgens without changing male identity; in these cases, the criteria for gender dysphoria are not met.

Comorbidity

Clinically referred children with gender dysphoria show elevated levels of emotional and behavioral problems—most commonly, anxiety, disruptive and impulse-control, and de-

pressive disorders. In prepubertal children, increasing age is associated with having more behavioral or emotional problems; this is related to the increasing non-acceptance of gender-variant behavior by others. In older children, gender-variant behavior often leads to peer ostracism, which may lead to more behavioral problems. The prevalence of mental health problems differs among cultures; these differences may also be related to differences in attitudes toward gender variance in children. However, also in some non-Western cultures, anxiety has been found to be relatively common in individuals with gender dysphoria, even in cultures with accepting attitudes toward gender-variant behavior. Autism spectrum disorder is more prevalent in clinically referred children with gender dysphoria than in the general population. Clinically referred adolescents with gender dysphoria appear to have comorbid mental disorders, with anxiety and depressive disorders being the most common. As in children, autism spectrum disorder is more prevalent in clinically referred adolescents with gender dysphoria than in the general population. Clinically referred adults with gender dysphoria may have coexisting mental health problems, most commonly anxiety and depressive disorders.

Other Specified Gender Dysphoria

302.6 (F64.8)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The other specified gender dysphoria category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for gender dysphoria. This is done by recording "other specified gender dysphoria" followed by the specific reason (e.g., "brief gender dysphoria").

An example of a presentation that can be specified using the "other specified" designation is the following:

The current disturbance meets symptom criteria for gender dysphoria, but the duration is less than 6 months.

Unspecified Gender Dysphoria

302.6 (F64.9)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The unspecified gender dysphoria category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for gender dysphoria, and includes presentations in which there is insufficient information to make a more specific diagnosis.

EXHIBIT

2



The American College of Obstetricians and Gynecologists

Women's Health Care Physicians

COMMITTEE OPINION

Number 512 • December 2011

Committee on Health Care for Underserved Women

This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Health Care for Transgender Individuals

ABSTRACT: Transgender individuals face harassment, discrimination, and rejection within our society. Lack of awareness, knowledge, and sensitivity in health care communities eventually leads to inadequate access to, underutilization of, and disparities within the health care system for this population. Although the care for these patients is often managed by a specialty team, obstetrician–gynecologists should be prepared to assist or refer transgender individuals with routine treatment and screening as well as hormonal and surgical therapies. The American College of Obstetricians and Gynecologists opposes discrimination on the basis of gender identity and urges public and private health insurance plans to cover the treatment of gender identity disorder.

The Spectrum of Transgender Identity

Transgender is a broad term used for people whose gender identity or gender expression differs from their assigned sex at birth (Box 1) (1). However, there is no universally accepted definition of the word “transgender” because of the lack of agreement regarding what groups of people are considered “transgender.” In addition, definitions often vary by geographic region and by individual (2). The American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision, considers transgender individuals to be individuals with a disturbance in sexual or gender identity. Any combination of sexual and gender identity is possible for transgender individuals (Box 2). The diagnosis of gender identity disorder is only established for individuals with clinically significant distress and functional impairment caused by the persistent discomfort with one’s assigned sex and primary and secondary sex characteristics. If untreated, gender identity disorder can result in psychologic dysfunction, depression, suicidal ideation, and even death (3).

Prevalence rates of transgender populations are not clearly established; however, studies suggest that transgender individuals constitute a small but substantial population (4). Additional research is needed among this population as outlined by the Institute of Medicine Report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2).

The social and economic marginalization of transgender individuals is widespread. Harassment, discrim-

ination, and rejection occur frequently within an individual’s own family and affect educational, employment, and housing opportunities.

Transgender individuals, particularly young transgender individuals, are disproportionately represented in the homeless population (5). Once homeless, individuals may be denied access to shelters because of their gender or are placed in inappropriate housing. Subsequently, many homeless transgender individuals turn to survival sex (the exchange of sex for food, clothing, shelter, or other basic needs), which increases the risk of exposure to sexually transmitted infections and becoming victims of violence (6). In one small study, 35% of male-to-female transgender individuals tested positive for human immunodeficiency virus (HIV), 20% were homeless, and 37% reported physical abuse (7).

Barriers to Health Care

Within the medical community, transgender individuals face significant barriers to health care. This includes the failure of most health insurance plans to cover the cost of mental health services, cross-sex hormone therapy, or gender affirmation surgery. This barrier exists despite evidence that such treatments are safe and effective and that cross-gender behavior and gender identity issues are not an issue of choice for the individual and cannot be reversed with psychiatric treatment (8). With medical and psychiatric care that affirms transgender identity, the transgender individual can lead an enhanced, functional life (9).

Box 1. Transgender Definitions

Transsexual—an individual who strongly identifies with the other sex and seeks hormones or gender-affirmation surgery or both to feminize or masculinize the body; may live full-time in the crossgender role.*

Crossdresser—an individual who dresses in the clothing of the opposite sex for reasons that include a need to express femininity or masculinity, artistic expression, performance, or erotic pleasure, but do not identify as that gender. The term “transvestite” was previously used to describe a crossdresser, but it is now considered pejorative and should not be used.†

Bigendered—individuals who identify as both or alternatively male and female, as no gender, or as a gender outside the male or female binary.†

Intersex—individuals with a set of congenital variations of the reproductive system that are not considered typical for either male or female. This includes newborns with ambiguous genitalia, a condition that affects 1 in 2,000 newborns in the United States each year.‡

Female-to-male—refers to someone who was identified as female at birth but who identifies and portrays his gender as male. This term is often used after the individual has taken some steps to express his gender as male, or after medically transitioning through hormones or surgery. Also known as FTM or transman.†

Male-to-female—refers to someone who was identified as male at birth but who identifies and portrays her gender as female. This term is often used after the individual has taken some steps to express her gender as female, or after medically transitioning through hormones or surgery. Also known as MTF or transwoman.†

*The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding. Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, Board on the Health of Select Populations, Institute of Medicine of the National Academies. Washington, DC: National Academies Press; 2011. Available at: http://www.nap.edu/openbook.php?record_id=13128&page=R1. Retrieved August 8, 2011.

† Fenway Health. Glossary of gender and transgender terms. Boston (MA): Fenway Health; 2010. Available at: http://www.fenwayhealth.org/site/DocServer/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms__fi.pdf. Retrieved July 22, 2011.

‡ Dreger AD. “Ambiguous sex”--or ambivalent medicine? Ethical issues in the treatment of intersexuality. *Hastings Cent Rep* 1998; 28:24–35.

Box 2. Sexual Identity and Gender Identity Definitions

Sex—designation of a person at birth as male or female based on anatomy and biology.*

Gender identity—a person’s innate identification as a man, woman, or something else that may or may not correspond to the person’s external body or assigned sex at birth.*

Gender expression—how individuals present themselves socially, including clothing, hairstyle, jewelry, and physical characteristics, including speech and mannerisms. This may not be the same gender in all settings.*

Sexual orientation—a person’s physical, romantic, emotional, and/or spiritual attraction to individuals of the same (lesbian or gay), different (heterosexual), or both (bisexual) biologic sexes. Sexual orientation does not define the real-life sexual practices and behaviors of an individual.*

Sexual behavior—the sexual encounters and behaviors of the individual. This is likely to be the most important factor in assessing the risk of sexually transmitted infections. Sexual behavior differs from sexual orientation; for example, not all individuals who engage in same-sex behaviors view themselves as gay, lesbian, or bisexual.

Legal sex—sex as stated on legal identifications, forms, and documents. Transgender individuals may adopt a second name other than their legal name with which they may prefer to be addressed. Transgender persons should be asked for their preferred name, even if it differs from their legal name and sex. State regulations vary and it may be difficult or impossible for a transgender individual to meet that state’s requirements to change their legal sex.†

*Fenway Health. Glossary of gender and transgender terms. Boston (MA): Fenway Health; 2010. Available at: http://www.fenwayhealth.org/site/DocServer/Handout_7-C_Glossary_of_Gender_and_Transgender_Terms__fi.pdf. Retrieved July 22, 2011.

† This is a significant issue for transgender individuals. Some states have adopted progressive laws that do not require gender-affirmation surgery or an original birth certificate; instead, these laws allow individuals to change their legal sex with a letter from their health care providers stating that the individuals live their lives as this gender. See the National Center for Transgender Equality (www.transequality.org) and the Transgender Law and Policy Institute (www.transgenderlaw.org) for more information, including descriptions of state laws.

The consequences of inadequate treatment are staggering. Fifty-four percent of transgender youth have attempted suicide and 21% resort to self-mutilation. More than 50% of persons identified as transgender have used injected hormones that were obtained illegally or used outside of conventional medical settings. Additionally, such individuals frequently resort to the illegal and dangerous use of self-administered silicone injections to

spur masculine or feminine physiologic changes (5). The American College of Obstetricians and Gynecologists, therefore, urges public and private health insurance plans to cover the treatment of gender identity disorder.

Caring for Transgender Individuals

Obstetrician–gynecologists should be prepared to assist or refer transgender individuals for routine treatment

and screening as well as hormonal and surgical therapies. Basic preventive services, like sexually transmitted infection testing and cancer screening, can be provided without specific expertise in transgender care. Hormonal and surgical therapies for transgender patients may be requested, but should be managed in consultation with health care providers with expertise in specialized care and treatment of transgender patients (see Resources). Physical and emotional issues for transgender individuals and the effects of aging, as in all other individuals, affect the health status of this population and should be addressed. Health care providers who are morally opposed to providing care to this population should refer them elsewhere for care. For more information, a resource guide on health care for transgender individuals is available at www.acog.org/departments/dept_notice.cfm?recno=18&bulletin=5825.

Creating a Welcoming Environment

Health care providers' discomfort when treating transgender individuals may alienate patients and result in lower quality or inappropriate care as well as deter them from seeking future medical care (10). Excellent resources exist to facilitate the provision of culturally competent care for transgender patients (10). Adding a "transgender" option to check boxes on patient visit records can help to better capture information about transgender patients, and could be a sign of acceptance to that person (10). Questions should be framed in ways that do not make assumptions about gender identity, sexual orientation, or behavior. It is more appropriate for clinicians to ask their patients which terms they prefer (1). Language should be inclusive, allowing the patient to decide when and what to disclose. The adoption and posting of a nondiscrimination policy can also signal health care providers and patients alike that all persons will be treated with dignity and respect. Assurance of confidentiality can allow for a more open discussion, and confidentiality must be ensured if a patient is being referred to a different health care provider. Training staff to increase their knowledge and sensitivity toward transgender patients will also help facilitate a positive experience for the patient (10). It is important to prepare now to treat a future transgender patient. Additional guidelines for creating a welcoming office environment for transgender patients have been developed by the Gay and Lesbian Medical Association and can be found at http://www.glma.org/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf.

Gender Transition: World Professional Association for Transgender Health Guidelines

The World Professional Association for Transgender Health is a multidisciplinary professional society representing the specialties of medicine, psychology, social

sciences, and law. Their published clinical guidelines about the psychiatric, psychologic, medical, and surgical management of gender identity disorders are widely used by specialists in transgender health care (11), but are not universally accepted by all members of the transgender health community because critics consider them to be overly restrictive and inflexible.

The World Professional Association for Transgender Health guidelines describe the transition from one gender to another in three stages: 1) living in the gender role consistent with gender identity; 2) the use of cross-sex hormone therapy after living in the new gender role for at least 3 months; 3) gender-affirmation surgery after living in the new gender role and using hormonal therapy for at least 12 months. Additional clinical guidelines have been published by the Endocrine Society (12).

Female-to-Male Transgender Individuals

Hormones

Methyltestosterone injections every 2 weeks are usually sufficient to suppress menses and induce masculine secondary sex characteristics (13). Before receiving androgen therapy, patients should be screened for medical contraindications and have periodic laboratory testing, including hemoglobin and hematocrit to evaluate for polycythemia, liver function tests, and serum testosterone level assessments (goal is a mid normal male range of 500 microgram/dL), while receiving the treatment.

Surgery

Hysterectomy, with or without salpingo-oophorectomy, is commonly part of the surgical process. An obstetrician-gynecologist who has no specialized expertise in transgender care may be asked to perform this surgery, and also may be consulted for routine reasons such as dysfunctional bleeding or pelvic pain. Reconstructive surgery should be performed by a urologist, gynecologist, plastic surgeon, or general surgeon who has specialized competence and training in this field.

Screening

Age-appropriate screening for breast cancer and cervical cancer should be continued unless mastectomy or removal of the cervix has occurred. For patients using androgen therapy who have not had a complete hysterectomy, there may be an increased risk of endometrial cancer and ovarian cancer (13).

Male-to-Female Transgender Individuals

Hormones

Estrogen therapy results in gynecomastia, reduced hair growth, redistribution of fat, and reduced testicular volume. All patients considering therapy should be screened for medical contraindications. After surgery, doses of estradiol, 2–4 mg/d, or conjugated equine estrogen, 2.5 mg/d, are often sufficient to keep total testosterone levels to normal female levels of less than 25 ng/dL. Nonoral therapy

also can be offered. It is recommended that male-to-female transgender patients receiving estrogen therapy have an annual prolactin level assessment and visual field examination to screen for prolactinoma (13).

Surgery

Surgery usually involves penile and testicular excision and the creation of a neovagina (14). Reported complications of surgery include vaginal and urethral stenosis, fistula formation, problems with remnants of erectile tissue, and pain. Vaginal dilation of the neovagina is required to maintain patency. Other surgical procedures that may be performed include breast implants and nongenital surgery, such as facial feminization surgery.

Screening

Age-appropriate screening for breast and prostate cancer is appropriate for male-to-female transgender patients. Opinion varies regarding the need for Pap testing in this population. In patients who have a neocervix created from the glans penis, routine cytologic examination of the neocervix may be indicated (15). The glans are more prone to cancerous changes than the skin of the penile shaft, and intraepithelial neoplasia of the glans is more likely to progress to invasive carcinoma than is intraepithelial neoplasia of other penile skin (14).

Conclusion

Obstetrician–gynecologists should be prepared to assist or refer transgender individuals. Physicians are urged to eliminate barriers to access to care for this population through their own individual efforts. An important step is to identify the sexual orientation and gender identity status of all patients as a routine part of clinical encounters and recognize that many transgender individuals may not identify themselves. The American College of Obstetricians and Gynecologists urges health care providers to foster nondiscriminatory practices and policies to increase identification and to facilitate quality health care for transgender individuals, both in assisting with the transition if desired as well as providing long-term preventive health care.

Resources

Select clinics with expertise in treating transgender individuals:

Fenway Community Health
www.fenwayhealth.org

University of Minnesota, Center for Sexual Health
www.phs.umn.edu/clinic/home.html

Callen-Lorde Community Health Center
www.callen-lorde.org

Tom Waddell Health Center
www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/
TransgenderHlthCtr.asp

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EXHIBIT

3

Position Statement on Access to Care for Transgender and Gender Variant Individuals

Approved by the Board of Trustees, July 2012

Approved by the Assembly, May 2012

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – *APA Operations Manual*.

Issue: Significant and long-standing medical and psychiatric literature exists that demonstrates clear benefits of medical and surgical interventions to assist gender variant individuals seeking transition. However, private and public insurers often do not offer, or may specifically exclude, coverage for medically necessary treatments for gender transition. Access to medical care (both medical and surgical) positively impacts the mental health of transgender and gender variant individuals.

The APA's vision statement includes the phrase: "Its vision is a society that has available, accessible quality psychiatric diagnosis and treatment," yet currently, transgender and gender variant individuals frequently lack available and accessible treatment. In addition, APA's values include the following points:

- best standards of clinical practice
- patient-focused treatment decisions
- scientifically established principles of treatment
- advocacy for patients

Transgender and gender variant individuals currently lack access to the best standards of clinical practice, frequently do not have the opportunity to pursue patient-focused treatment decisions, do not receive scientifically established treatment and could benefit significantly from APA's advocacy.

APA Position:

Therefore, the American Psychiatric Association:

1. **Recognizes that appropriately evaluated transgender and gender variant individuals can benefit greatly from medical and surgical gender transition treatments.**
2. **Advocates for removal of barriers to care and supports both public and private health insurance coverage for gender transition treatment.**
3. **Opposes categorical exclusions of coverage for such medically necessary treatment when prescribed by a physician.**

Authors: Jack Drescher, M.D., Ellen Haller, M.D., APA Caucus of Lesbian, Gay and Bisexual Psychiatrists.

Background to the Position Statement

Transgender and gender variant people are frequently denied medical, surgical and psychiatric care related to gender transition despite significant evidence that appropriately evaluated individuals benefit from such care. It is often asserted that the DSM (and ICD) diagnoses provide the only pathways to insurance reimbursement for transgender individuals seeking medical assistance. However, to date, the APA has issued no treatment guidelines for gender identity disorder (GID) in either children or adults. This omission is in contrast to an increasing proliferation of APA practice guidelines for other DSM diagnoses (1).

The absence of a formal APA opinion about treatment of a diagnosis of its own creation has contributed to an ongoing problem of many health care insurers and other third party payers claiming that hormonal treatment and sex reassignment surgery (SRS) are “experimental treatments,” “elective treatments,” or “not medically necessary,” and, therefore, not reimbursable or covered under most insurance plans. The lack of consistency in how a transgender condition is defined by some institutions further marginalizes these individuals based on their subjective, surgical and hormonal status (2). In addition, treatment is not always accessible to wards of governmental agencies, such as transgender and gender variant individuals in foster care and prison systems. In other words, the presence of the GID diagnosis in the DSM has not served its intended purpose of creating greater access to care--one of the major arguments for diagnostic retention (1).

Lack of access to care adversely impacts the mental health of transgender and gender variant people, and both hormonal and surgical treatment have been shown to be efficacious in these individuals (3-7). Practice guidelines have been developed based on peer-reviewed scientific studies and are published and available for clinicians to access (3, 8, 9). The American Medical Association and the American Psychological Association both have position statements stating the critical importance of access to care for transgender and gender variant individuals (10, 11).

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EXHIBIT

4



Transgender, Gender Identity, & Gender Expression Non-Discrimination

Adopted by the American Psychological Association Council of Representatives August, 2008.

Whereas transgender and gender variant people frequently experience prejudice and discrimination and psychologists can, through their professional actions, address these problems at both an individual and a societal level;

Whereas the American Psychological Association opposes prejudice and discrimination based on demographic characteristics including gender identity, as reflected in policies including the Hate Crimes Resolution (Paige, 2005), the Resolution on Prejudice Stereotypes and Discrimination (Paige, 2007), APA Bylaws (Article III, Section 2), the Ethical Principles of Psychologists and Code of Conduct (APA 2002, 3.01 and Principle E);

Whereas transgender and other gender variant people benefit from treatment with therapists with specialized knowledge of their issues (Lurie, 2005; Rachlin, 2002), and that the Ethical Principles of Psychologists and Code of Conduct state that when scientific or professional knowledge ...is essential for the effective implementation of their services or research, psychologists have or obtain the training....necessary to ensure the competence of their services..." (APA 2002, 2.01b);

Whereas discrimination and prejudice against people based on their actual or perceived gender identity or expression detrimentally affects psychological, physical, social, and economic well-being (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Resolution on Prejudice Stereotypes and Discrimination, Paige, 2007; Riser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

Whereas transgender people may be denied basic non-gender transition related health care (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; GLBT Health Access Project, 2000; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Riser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

Whereas gender variant and transgender people may be denied appropriate gender transition related medical and mental health care despite evidence that appropriately evaluated individuals benefit from gender transition treatments (De Cuypere et al., 2005; Kuiper & Cohen-Kettenis, 1988; Lundstrom, et al., 1984; Newfield, et al., 2006; Pfafflin & Junge, 1998; Rehman et al., 1999; Ross & Need, 1989; Smith et al., 2005);

Whereas gender variant and transgender people may be denied basic civil rights and protections (Minter, 2003; Spade, 2003) including: the right to civil marriage which confers a social status and important legal benefits, rights, and privileges (Paige, 2005); the right to obtain appropriate identity documents that are consistent with a post-transition identity; and the right to fair and safe and harassment-free institutional environments such as care facilities, treatment centers, shelters, housing, schools, prisons and juvenile justice programs;

Whereas transgender and gender variant people experience a disproportionate rate of homelessness (Kammerer et al., 2001), unemployment (APA, 2007) and job discrimination (Herbst et al., 2007), disproportionately report income below the poverty line (APA, 2007) and experience other financial disadvantages (Lev, 2004);

Whereas transgender and gender variant people may be at increased risk in institutional environments and facilities for harassment, physical and sexual assault (Edney, 2004; Minter, 2003; Peterson et al., 1996; Witten & Eyler, 2007) and inadequate medical care including denial of gender transition treatments such as hormone therapy (Edney, 2004; Peterson et al., 1996; Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Newfield et al., 2006; Riser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

Whereas many gender variant and transgender children and youth face harassment and violence in school environments, foster care, residential treatment centers, homeless centers and juvenile justice programs (D'Augelli, Grossman, & Starks, 2006; Gay Lesbian and Straight Education Network, 2003; Grossman, D'Augelli, & Slater, 2006);

Whereas psychologists are in a position to influence policies and practices in institutional settings, particularly regarding the implementation of the Standards of Care published by the World Professional Association of Transgender Health (WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association) which recommend the continuation of gender transition treatments and especially hormone therapy during incarceration (Meyer et al., 2001);

Whereas psychological research has the potential to inform treatment, service provision, civil rights and approaches to promoting the well-being of transgender and gender variant people;

Whereas APA has a history of successful collaboration with other organizations to meet the needs of particular populations, and organizations outside of APA have useful resources for addressing the needs of transgender and gender variant people;

Therefore be it resolved that APA opposes all public and private discrimination on the basis of actual or perceived gender identity and expression and urges the repeal of discriminatory laws and policies;

Therefore be it further resolved that APA supports the passage of laws and policies protecting the rights, legal benefits, and privileges of people of all gender identities and expressions;

Therefore be it further resolved that APA supports full access to employment, housing, and education regardless of gender identity and expression;

Therefore be it further resolved that APA calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment to transgender and gender variant individuals and encourages psychologists to take a leadership role in working against discrimination towards transgender and gender variant individuals;

Therefore be it further resolved that APA encourages legal and social recognition of transgender individuals consistent with their gender identity and expression, including access to identity documents consistent with their gender identity and expression which do not involuntarily disclose their status as transgender for transgender people who permanently socially transition to another gender role;

Therefore be it further resolved that APA supports access to civil marriage and all its attendant benefits, rights, privileges and responsibilities, regardless of gender identity or expression;

Therefore be it further resolved that APA supports efforts to provide fair and safe environments for gender variant and transgender people in institutional settings such as supportive living environments, long-term care facilities, nursing homes, treatment facilities, and shelters, as well as custodial settings such as prisons and jails;

Therefore be it further resolved that APA supports efforts to provide safe and secure educational environments, at all levels of education, as well as foster care environments and juvenile justice programs, that promote an understanding and acceptance of self and in which all youths, including youth of all gender identities and expressions, may be free from discrimination, harassment, violence, and abuse;

Therefore be it further resolved that APA supports the provision of adequate and necessary mental and medical health care treatment for transgender and gender variant individuals;

Therefore be it further resolved that APA recognizes the efficacy, benefit and medical necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments;

Therefore be it further resolved that APA supports access to appropriate treatment in institutional settings for people of all gender identities and expressions; including access to appropriate health care services including gender transition therapies;

Therefore be it further resolved that APA supports the creation of educational resources for all psychologists in working with individuals who are gender variant and transgender;

Therefore be it further resolved that APA supports the funding of basic and applied research concerning gender expression and gender identity;

Therefore be it further resolved that APA supports the creation of scientific and educational resources that inform public discussion about gender identity and gender expression to promote public policy development, and societal and familial attitudes and behaviors that affirm the dignity and rights of all individuals regardless of gender identity or gender expression;

Therefore be it further resolved that APA supports cooperation with other organizations in efforts to accomplish these ends.

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Find this article at:

<http://www.apa.org/about/policy/transgender.aspx>

EXHIBIT

5

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

Topic: Health Insurance	Policy Subtopic: Benefits and Coverage
Meeting Type: Annual	Year Last Modified: 2016
Action: NA	Type: Health Policies
Council & Committees: NA	undefined

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.

Policy Timeline

Res. 05, A-16

EXHIBIT

6

Removing Financial Barriers to Care for Transgender Patients H-185.950

Topic: Health Insurance	Policy Subtopic: Benefits and Coverage
Meeting Type: Annual	Year Last Modified: 2016
Action: Modified	Type: Health Policies
Council & Committees: NA	undefined

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Policy Timeline

Res. 122

A-08

Modified: Res. 05, A-16

EXHIBIT

7

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(A-08)

Introduced by: Resident and Fellow Section, Massachusetts Medical Society, California
Medical Association, Medical Society of the State of New York

Subject: Removing Financial Barriers to Care for Transgender Patients

Referred to: Reference Committee A

1 Whereas, The American Medical Association opposes discrimination on the basis of
2 gender identity¹ and
3

4 Whereas, Gender Identity Disorder (GID) is a serious medical condition recognized as
5 such in both the Diagnostic and Statistical Manual of Mental Disorders (4th Ed., Text
6 Revision) (DSM-IV-TR) and the International Classification of Diseases (10th Revision),²
7 and is characterized in the DSM-IV-TR as a persistent discomfort with one's assigned
8 sex and with one's primary and secondary sex characteristics, which causes intense
9 emotional pain and suffering;³ and
10

11 Whereas, GID, if left untreated, can result in clinically significant psychological distress,
12 dysfunction, debilitating depression and, for some people without access to appropriate
13 medical care and treatment, suicidality and death;⁴ and
14

15 Whereas, The World Professional Association For Transgender Health, Inc. ("WPATH")
16 is the leading international, interdisciplinary professional organization devoted to the
17 understanding and treatment of gender identity disorders,⁵ and has established
18 internationally accepted Standards of Care⁶ for providing medical treatment for people
19 with GID, including mental health care, hormone therapy and sex reassignment surgery,
20 which are designed to promote the health and welfare of persons with GID and are
21 recognized within the medical community to be the standard of care for treating people
22 with GID; and
23

24 Whereas, An established body of medical research demonstrates the effectiveness and
25 medical necessity of mental health care, hormone therapy and sex reassignment
26 surgery as forms of therapeutic treatment for many people diagnosed with GID;⁷ and
27

28 Whereas, Health experts in GID, including WPATH, have rejected the myth that such
29 treatments are "cosmetic" or "experimental" and have recognized that these treatments
30 can provide safe and effective treatment for a serious health condition;⁷ and
31

32 Whereas, Physicians treating persons with GID must be able to provide the correct
33 treatment necessary for a patient in order to achieve genuine and lasting comfort with
34 his or her gender, based on the person's individual needs and medical history;⁸ and
35

36 Whereas, The AMA opposes limitations placed on patient care by third-party payers
37 when such care is based upon sound scientific evidence and sound medical opinion;^{9, 10}
38 and

1 Whereas, Many health insurance plans categorically exclude coverage of mental health,
2 medical, and surgical treatments for GID, even though many of these same treatments,
3 such as psychotherapy, hormone therapy, breast augmentation and removal,
4 hysterectomy, oophorectomy, orchiectomy, and salpingectomy, are often covered for
5 other medical conditions; and
6

7 Whereas, The denial of these otherwise covered benefits for patients suffering from GID
8 represents discrimination based solely on a patient's gender identity; and
9

10 Whereas, Delaying treatment for GID can cause and/or aggravate additional serious and
11 expensive health problems, such as stress-related physical illnesses, depression, and
12 substance abuse problems, which further endanger patients' health and strain the health
13 care system; therefore be it
14

15 RESOLVED, That the AMA support public and private health insurance coverage for
16 treatment of gender identity disorder (Directive to Take Action); and be it further
17

18 RESOLVED, That the AMA oppose categorical exclusions of coverage for treatment of
19 gender identity disorder when prescribed by a physician (Directive to Take Action).

Fiscal Note: No significant fiscal impact.

References

1. AMA Policy H-65.983, H-65.992, and H-180.980
2. Diagnostic and Statistical Manual of Mental Disorders (4th ed.. Text revision) (2000) ("DSM-IV-TR"), 576-82, American Psychiatric Association; International Classification of Diseases (10th Revision) ("ICD-10"), F64, World Health Organization. The ICD further defines transsexualism as "[a] desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex." ICD-10, F64.0.
3. DSM-IV-TR, 575-79
4. Id. at 578-79.
5. World Professional Association for Transgender Health: <http://www.wpath.org>. Formerly known as The Harry Benjamin International Gender Dysphoria Association.
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8. The Harry Benjamin International Gender Dysphoria Association’s Standards of Care for Gender Identity Disorders, at 18.
9. Id.
10. AMA Policy H-120.988

Relevant AMA policy

H-65.983 Nondiscrimination Policy

The AMA opposes the use of the practice of medicine to suppress political dissent wherever it may occur. (Res. 127, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CEJA Rep. 2, A-05)

H-65.992 Continued Support of Human Rights and Freedom

Our AMA continues (1) to support the dignity of the individual, human rights and the sanctity of human life, and (2) to oppose any discrimination based on an individual's sex, sexual orientation, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies. (Sub. Res. 107, A-85; Modified by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmation A-05)

H-180.980 Sexual Orientation as Health Insurance Criteria

The AMA opposes the denial of health insurance on the basis of sexual orientation. (Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97)

H-120.988 Patient Access to Treatments Prescribed by Their Physicians

The AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an unlabeled indication when such use is based upon

sound scientific evidence and sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate "off-label" uses of drugs on their formulary. (Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04)

EXHIBIT

8



Resolution No. 1004

2012 National Conference of Special Constituencies—Sheraton Kansas City Hotel at Crown Center

1 Transgender Care

2

3 Submitted by: Laura Ellis, MD, FAAFP, GLBT

4 Werner Brammer, MD, FAAFP, GLBT

5 Bruce Echols, MD, FAAFP, GLBT

6 Andrew Goodman, MD, GLBT

7

8 WHEREAS, Gender Identity Disorder is a medically recognized condition, and

9

10 WHEREAS, persons with Gender Identity Disorder who are not provided care can suffer serious
11 psychological and physical issues including suicide, and

12

13 WHEREAS, care for Gender Identity Disorder is lifelong and multifaceted including surgical,
14 hormonal, and psychological support and

15

16 WHEREAS, this care is expensive and out of reach of many people, and

17

18 WHEREAS, many insurers specifically exclude transgender care, and

19

20 WHEREAS, the American Academy of Family Physicians (AAFP) has already resolved that
21 employers and health plans should not discriminate by actual or perceived gender in the
22 provision of prescription drugs and devices, elective sterilization procedures, and diagnostic
23 testing (2011 COD), now, therefore, be it

24

25 RESOLVED, That the American Academy of Family Physicians (AAFP) support efforts to
26 require insurers to provide coverage for comprehensive care of transgendered individuals
27 including medical care, screening tests based on medical need rather than gender, mental
28 health care, and, when medically necessary, gender reassignment surgery.

EXHIBIT

9

TRANSGENDER HEALTH

INTRODUCTION

Over the last few decades, there has been a rapid expansion in the understanding of gender identity along with the implications for the care of transgender and gender incongruent individuals. In parallel with the greater societal awareness of transgender individuals, evidence-based and data-driven protocols have increased. While there continue to be gaps in knowledge about the optimal care for transgender individuals, the framework for providing care is increasingly well-established as is the recognition of needed policy changes.

BACKGROUND

The medical consensus in the late 20th century was that transgender and gender incongruent individuals suffered a mental health disorder termed “gender identity disorder.” Gender identity was considered malleable and subject to external influences. Today, however, this attitude is no longer considered valid. Considerable scientific evidence has emerged demonstrating a durable biological element underlying gender identity.^{1,2} Individuals may make choices due to other factors in their lives, but there do not seem to be external forces that genuinely cause individuals to change gender identity.

Although the specific mechanisms guiding the biological underpinnings of gender identity are not entirely understood, there is evolving consensus that being transgender is not a mental health disorder. Such evidence stems from scientific studies suggesting that: 1) attempts to change gender identity in intersex patients to match external genitalia or chromosomes are typically unsuccessful^{3,4}; 2) identical twins (who share the exact same genetic background) are more likely to both experience transgender identity as compared to fraternal (non-identical) twins⁵; 3) among individuals with female chromosomes (XX), rates of male gender identity are higher for those exposed to higher levels of androgens *in utero* relative to those without such

exposure, and male (XY)-chromosome individuals with complete androgen insensitivity syndrome typically have female gender identity⁶; and 4) there are associations of certain brain scan or staining patterns with gender identity rather than external genitalia or chromosomes^{7,8}.

CONSIDERATIONS

Transgender individuals are often denied insurance coverage for appropriate medical and psychological treatment. Over the last decade, there has been considerable research on and development of evidence-based standards of care that have proven to be both safe and efficacious for the treatment of gender dysphoria/gender incongruence. There is also a growing understanding of the impact that increased access to such treatments can have on the mental health of these individuals.

The Endocrine Society’s Clinical Practice Guideline on gender dysphoria/gender incongruence⁹ provides the standard of care for treating transgender individuals. The guideline establishes a framework for the appropriate treatment of these individuals and standardizes terminology to be used by healthcare professionals. These recommendations include evidence that treatment of gender dysphoria/incongruence is medically necessary and should be covered by insurance.

Despite increased awareness, many barriers to improving the health and well-being of transgender patients remain. Oftentimes, treatment for gender dysphoria/gender incongruence is considered elective by insurance companies, which fail to provide coverage for physician-prescribed treatment. Access to appropriately trained healthcare professionals can also be challenging as there is a lack of formal education on gender dysphoria/gender incongruence among clinicians trained in the United States. A 2016 survey of endocrinologists, the physicians most likely to care for these patients, found that over 80% have never received training on care of transgender patients¹⁰.

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¹Saraswat A, et al. Evidence Supporting the Biologic Nature of Gender Identity. *Endocr Pract.* 2015 Feb;21(2): 199-204.

²Rosenthal SM. Approach to the Patient: Transgender Youth: Endocrine Considerations. *J Clin Endocrinol Metab.* 2014 Dec;99(12):4379-89.

³Saraswat A, et al. Evidence Supporting the Biologic Nature of Gender Identity. *Endocr Pract.* 2015 Feb;21(2): 199-204

⁴Rosenthal SM. Approach to the Patient: Transgender Youth: Endocrine Considerations. *J Clin Endocrinol Metab.* 2014 Dec;99(12):4379-89.

⁵Heylens G, et al. Gender Identity Disorder in Twins: A Review of the Case Report Literature. *J Sex Med.* 2012 Mar;9(3):751-7.

⁶Dessens AB, et al. Gender Dysphoria and Gender Change in Chromosomal Females with Congenital Adrenal Hyperplasia. *Arch Sex Behav.* 2005 Aug;34(4):389-97.

⁷Saraswat A, et al. Evidence Supporting the Biologic Nature of Gender Identity. *Endocr Pract.* 2015 Feb;21(2): 199-204

⁸Rosenthal SM. Approach to the Patient: Transgender Youth: Endocrine Considerations. *J Clin Endocrinol Metab.* 2014 Dec;99(12):4379-89.

⁹Endocrine Society Draft Clinical Practice Guideline on Gender Dysphoria/ Gender Incongruence (publication expected September 13, 2017).

¹⁰Davidge-Pitts, C., et al. Transgender Health in Endocrinology: Current Status of Endocrinology Fellowship Program and Practicing Clinicians. *J Clin Endocrinol Metab.* (2017) 102(4):1286-1290.



POSITION STATEMENT

This can have an adverse impact on patient outcomes, particularly in rural and underserved areas. In fact, studies have indicated that 70% of transgender individuals have experienced maltreatment by medical providers, including harassment and violence.¹¹ Transgender individuals who have been denied care show an increased likelihood of committing suicide and self-harm.¹² It is critical that transgender individuals have access to the appropriate treatment and care to ensure their health and well-being.

FUTURE CONSIDERATIONS

While the data are strong for both a biological underpinning to gender identity and the relative safety of hormone treatment (when appropriately monitored medically), the gaps in knowledge to optimize care over a lifetime are profound. Comparative effectiveness research in hormone regimens is needed to determine: the best endocrine and surgical protocols, as it is not yet known if certain regimens are safer or more effective than others; the degree of improvement as a result of the intervention (e.g. decrease in mental health diagnoses); the need for training of health care providers and the most effective training methods; and whether there are cardiovascular, malignancy, or other long-term risks from hormone interventions, particularly as the transgender individual ages. Further, studies are needed to elucidate the biological processes underlying gender identity as well as to determine strategies for fertility preservation and for the optimal approaches to gender non-conforming children. To successfully establish and enact these protocols requires long-term, large-scale studies across countries that employ the same care protocols.

POSITIONS

- There is a durable biological underpinning to gender identity that should be considered in policy determinations.
- Medical intervention for transgender individuals (including both hormone therapy and medically indicated surgery) is effective, relatively safe (when appropriately monitored), and has been established as the standard of care.¹³ Federal and private insurers should cover such interventions as prescribed by a physician as well as the appropriate medical screenings that are recommended for all body tissues that a person may have.
- Increased funding for national research programs is needed to close the gaps in knowledge regarding transgender medical care and should be made a priority.

¹¹ *ibid.*

¹² *ibid.*

¹³Endocrine Society Draft Clinical Practice Guideline on Gender Dysphoria/ Gender Incongruence (publication expected September 13, 2017).

EXHIBIT

10



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May 25, 2017

Joint Committee on Finance

Paper #320

Medical Assistance Cost-to-Continue (Health Services -- Medicaid Services)

[LFB 2017-19 Budget Summary: Page 204, #2]

CURRENT LAW

The medical assistance (MA) program, also known as "Medicaid," provides health care coverage to adults and children in families with household income below certain levels, and to elderly, blind or disabled individuals who have limited resources. Certified healthcare providers provide a wide range of services to program recipients. The Department of Health Services (DHS) administers the program under a framework of state and federal law through a plan approved by the federal Centers for Medicare and Medicaid Services (CMS).

The program has two primary components -- elderly, blind and disabled (EBD) Medicaid and BadgerCare Plus. EBD Medicaid provides coverage to individuals who are elderly, blind, or disabled who meet the program's income and asset standards. Individuals may receive services provided under the state's long-term care waiver programs, such as Family Care and IRIS (Include, Respect, I Self-Direct), as well as acute care services, including physician services, prescription drugs, and inpatient and outpatient hospital services. Many individuals enrolled in EBD Medicaid also qualify for Medicare benefits. For these "dual eligible" individuals, the state's MA program pays for services not otherwise covered under Medicare, as well as Medicare's cost-sharing requirements.

BadgerCare Plus provides coverage to individuals and families that meet the program's income standards. In general, children and pregnant women in households with income up to 300% of the federal poverty level (FPL), and non-pregnant, non-disabled adults in households with income up to 100% of the FPL, qualify for Badger Care Plus. Enrollees primarily receive acute care services, such as hospital and physician services, prescription drugs, and maternity and prenatal care coverage.

As of March 2017, approximately 1.1 million individuals were enrolled in MA or MA-

related programs (excluding SeniorCare). Of that total, approximately 800,000 were enrolled in BadgerCare Plus and 225,000 were enrolled in EBD Medicaid. The 80,000 remaining enrollees participated in other MA-supported programs, including limited benefit programs such as Medicare cost-sharing assistance to individuals who do not qualify for full MA coverage and the state's family planning only services program.

MA benefits are funded from the following sources: (a) state general purpose revenue (GPR); (b) federal matching funds (FED); (c) program revenues (PR), primarily rebate revenue provided by drug manufacturers; and (d) segregated revenues (SEG), primarily from the MA trust fund.

GOVERNOR

Provide \$213,493,300 (\$48,108,600 GPR, \$52,127,800 FED, \$139,335,500 PR, and -\$26,078,600 SEG) in 2017-18 and \$787,820,700 (\$231,282,300 GPR, \$381,580,900 FED, \$202,736,900 PR, and -\$27,779,400 SEG) in 2018-19 to fund projected costs of MA program benefits during the 2017-19 biennium under a cost-to-continue scenario. The funding increase is based on the administration's projections of program caseload growth, changes in the use and cost of providing medical and long-term care services, changes to the state's federal medical assistance percentage (FMAP), and other funding changes over the remainder of 2016-17 and the 2017-19 biennium.

In addition, the bill would reduce funding for MA benefits by \$320,300 GPR annually to reflect a transfer from the MA benefits appropriation to the state's mental health institutes to correct an error made with a gubernatorial veto included in 2015 Act 55.

The following table shows the total funding for MA benefits under the administration's cost-to-continue estimate, but also incorporating the proposed transfer to the mental health institutes budget. For the purposes of this table, the SEG funding has been adjusted to eliminate double-counted funds.

<u>Fund Source</u>	<u>2016-17 Base</u>	<u>2017-18</u>	<u>2018-19</u>
GPR	\$2,910,973,500	\$2,958,761,800	\$3,141,935,500
FED	5,161,878,800	5,214,006,600	5,543,459,700
PR	770,931,100	910,266,600	973,668,000
SEG	<u>616,740,000</u>	<u>589,037,800</u>	<u>586,145,800</u>
Total	\$9,460,523,400	\$9,672,072,800	\$10,245,209,000

DISCUSSION POINTS

1. The bill includes funding to reflect the administration's estimate of the cost of providing MA benefits during the 2017-19 biennium under a scenario in which no changes are made to the program. [Other decision items, addressed in other LFB issue papers, adjust the MA

budget to reflect program changes, such as increases to provider reimbursement rates.] This "cost-to-continue" estimate is based on assumptions for dozens of parameters, but these assumptions generally fall into a few key categories: (a) average monthly enrollment for each of the MA eligibility groups; (b) utilization and cost of services provided on a fee for service basis; (c) managed care capitation rates; and (d) federal policy and formula changes, including changes to the federal matching percentage and Medicare premiums for dually-eligible MA members.

2. Although MA benefits are funded with four funding sources (GPR, FED, PR, and SEG), and all four are adjusted as a result of the cost-to-continue estimate, the primary focus of this paper is the estimated change to GPR-funded costs. Under the administration's cost-to-continue estimate, GPR funding would increase above the 2016-17 appropriation base by \$48.1 million in 2017-18 and \$231.3 million in 2018-19 for a total of \$279.4 million over the biennium.

3. In a separate decision item, the bill would reduce MA benefits funding by \$320,300 GPR annually to fund a transfer to the GPR appropriation for the mental health institutes. For the purposes of the calculating the change to the cost-to-continue estimate, this paper treats this reduction as part of the administration's MA budget estimate, since the reduction is not associated with any MA program changes that would reduce program costs. With the inclusion of this change, the administration's adjusted cost-to-continue estimate results in a biennial GPR change of \$278.8 million. The Committee addressed the funding increase to the mental health institutes in its earlier action on LFB Issue Paper #360.

4. This paper provides a description of the principal assumptions underlying the administration's MA cost-to-continue estimate, and provides a reestimate of providing MA benefits under the cost-to-continue scenario. In some cases, changes to the administration's assumptions are warranted, based on an analysis of recent program trends. In other cases, the estimate can be updated with more recent enrollment and cost data. Under the reestimate presented in this paper, the total GPR cost over the biennium would be lower than the administration's estimate by \$95.6 million over the biennium, reducing the above-base increase for MA to \$183.2 million.

MA Program Enrollment

5. Table 1 below shows the actual 2015-16 monthly average enrollment by MA eligibility group, as well as the administration's enrollment projections for 2016-17 through 2018-19.

TABLE 1**Actual and Projected Monthly Average Enrollment by Group**

	Actual	Administration Estimates		
	<u>2015-16</u>	<u>2016-17</u>	<u>2017-18</u>	<u>2018-19</u>
Elderly, Blind, Disabled MA				
Elderly	63,003	64,767	66,518	68,513
Disabled, Non-Elderly Adults	136,377	136,534	139,530	143,421
Disabled Children	<u>31,833</u>	<u>31,087</u>	<u>31,552</u>	<u>32,172</u>
EBD Total	231,213	232,388	237,600	244,106
BadgerCare Plus				
Parents and Caretakers	175,941	170,802	171,273	173,934
Children	469,599	467,242	468,805	472,851
Pregnant Women	21,075	20,432	20,419	20,624
Childless Adults	<u>149,129</u>	<u>145,393</u>	<u>145,663</u>	<u>146,790</u>
BadgerCare Plus Total	815,744	803,869	806,160	814,199
Other Full Benefit MA				
Foster Care/Subsidized Adoption	18,671	19,404	19,973	20,581
Well Woman	655	597	598	604
Limited Benefit Groups				
Family Planning Only	39,389	38,058	38,446	38,832
Medicare Cost Sharing Assistance	21,916	21,970	22,231	22,454
Total Enrollment	1,127,588	1,116,286	1,125,008	1,140,776
Change from Previous Year		-11,302	8,722	15,768

6. To estimate the caseload in each category, the administration used annualized growth rates for each six-month period between in January, 2017 and the end of the biennium. [Estimated growth rates for the six-month period between January, 2017 and June, 2017 do not directly affect the MA estimate for the 2017-19 biennium, but do have an indirect effect, since they set the starting point for the 2017-19 projections.] The administration's percentage growth rates are "conservative" in the sense that they are higher than recent growth trends. To illustrate, Table 2 shows, by enrollment category, the annualized percentage growth percentages for each six-month period that the administration used to develop the MA cost-to-continue estimate, compared to the actual annualized growth rate from April, 2016 to March, 2017. [The actual growth rates shown in the table are based on a best-fit slope of the monthly data in order to smooth out month-to-month variations and seasonal effects.]

TABLE 2

**Annualized Enrollment Growth Rates--
Actual Change Compared to Administration's Budget Assumptions**

	Actual Change-- April, 2016 to March, 2017	Administration's Enrollment Growth Assumptions				
		2016-17 2 nd Half	2017-18		2018-19	
			1 st Half	2 nd Half	1 st Half	2 nd Half
Elderly, Blind, Disabled*	0.1%	2.0%	2.0%	2.7%	2.7%	2.7%
BadgerCare Plus						
Children	-0.1%	0.5%	0.5%	0.8%	1.0%	1.0%
Parents	-0.3	0.5	1.0	1.0	2.0	2.0
Pregnant Women	-0.2	1.0	1.0	1.0	1.0	1.0
Childless Adults	0.0	0.5	0.5	0.5	1.0	1.0
Other Full Benefit MA						
Foster Care	0.1%	3.0%	3.0%	3.0%	3.0%	3.0%
Well Woman	-0.7	0.0	1.0	1.0	1.0	1.0
Partial Benefit MA						
Family Planning Only	-0.1%	1.0%	1.0%	1.0%	1.0%	1.0%
Medicare Cost Sharing	0.3	1.0	1.0	1.0	1.0	1.0

* EBD subgroups are combined to avoid a mismatch between the recent enrollment data used for the trend analysis and the administration's projections, which are based on slightly different groupings.

7. As shown in the first column of the table above, enrollment has been relatively flat or declined slightly over the past 12 months in most enrollment categories. If these patterns continue through the 2017-19 biennium, the administration's cost-to-continue estimate would overstate the cost of MA benefits, all else being equal.

8. Recent enrollment trends suggest that the cost-to-continue estimate should be adjusted using lower growth rate assumptions. However, recent trends are not always a good indicator of future caseload changes. If, for instance, the state or national economy falls into recession during the next two years, MA enrollment would increase at a faster rate. Consequently, although a downward adjustment to the administration's growth rate assumptions may be warranted, it would be prudent to assume a rate of growth somewhat above recent trends to allow for a contingency margin. Table 3 shows the revised growth rates for each category, along with the actual annual percentage change from April, 2016, through March, 2017.

TABLE 3**Annualized Enrollment Growth Rates--
Actual Change Compared to Revised Assumptions**

	Actual Change-- April, 2016 to March, 2017	Revised Enrollment Growth Assumptions				
		2016-17	2017-18		2018-19	
		2 nd Half	1 st Half	2 nd Half	1 st Half	2 nd Half
Elderly, Blind, Disabled	0.1%	1.7%	2.0%	2.0%	2.0%	2.0%
BadgerCare Plus						
Children	-0.1%	-1.0%	0.5%	0.5%	0.5%	0.5%
Parents	-0.3	-3.0	0.5	0.5	0.5	0.5
Pregnant Women	-0.2	0.5	0.5	0.5	0.5	0.5
Childless Adults	0.0	0.5	0.5	0.5	0.5	0.5
Other Full Benefit MA						
Foster Care	0.1%	3.0%	3.0%	3.0%	3.0%	3.0%
Well Woman	-0.7	0.0	1.0	1.0	1.0	1.0
Partial Benefit MA						
Family Planning Only	-0.1%	0.0%	1.0%	1.0%	1.0%	1.0%
Medicare Cost Sharing	0.3	0.0	1.0	1.0	1.0	1.0

9. The revised growth estimates shown in the table above are higher than recent trends, but generally below the administration's estimates. Generally, EBD groups are assumed to grow at an annualized growth rate of 2.0%, while BadgerCare Plus groups are assumed to grow at a rate of 0.5% on an annualized basis. Other than changes to the second half of 2016-17 to reflect the most recent enrollment data, the revised estimate maintains the administration's growth rate assumptions for the smaller enrollment groups ("Other Full Benefit MA" and "Partial Benefit MA"). Although these growth rates would be larger than recent experience, the estimates for these groups have only a minor impact on the overall cost-to-continue estimate. Overall, the revised caseload assumptions reduce GPR costs by approximately \$16 million over the biennium, relative to the administration's estimate.

10. The cost-to-continue reestimate presented in this paper makes no explicit assumptions with respect to any enrollment impact of proposed changes to childless adult eligibility that are included in the Department's federal childless adult waiver request, which was released to the public in draft form on April 19. The draft waiver request would impose eligibility conditions for childless adults enrolled in MA, including the payment of premiums for certain beneficiaries, drug screening, testing, and mandatory participation in treatment, and an employment and training requirement. These proposals have the potential to reduce childless adult enrollment, either due to the failure of current enrollees or new applicants to satisfy the new eligibility criteria, or due to a reduction in new applications. However, because of uncertainties regarding the impact of these provisions (either individually or in combination) and the timing of implementation, no enrollment is built into the reestimate. For a more detailed discussion of the waiver provisions, see LFB Issue Paper #324.

Utilization and Cost of Services

11. In developing the cost-to-continue estimate, the administration makes assumptions on changes in service "intensity," which is the growth in the utilization and cost of services delivered on a fee-for-service (FFS) basis. For most FFS services, the cost-to-continue estimate is based on a continuation of the same reimbursement rates as are used in the base year (since reimbursement rate increases are considered as separate decision items). For others, however, cost rate increases are built into the cost-to-continue estimate. As an example, since prescription drug reimbursement is based on pharmacies' actual acquisition costs, the intensity estimate for drugs reflects adjustments for both usage and cost. Likewise, the inpatient and outpatient hospital reimbursement rate methodology is built, in part, on changes to hospitals' costs, and so the hospital intensity estimate reflects those rate changes.

12. In general, the administration's intensity estimates were based on a trend analysis. Since the introduction of the budget, the Department has collected additional data on FFS costs, affecting the 2016-17 starting point for the 2017-19 biennial projections. These changes have been incorporated into the reestimate.

13. In addition to various adjustments to the 2016-17 starting point, DHS has made recommendations for other cost adjustments to reflect program changes that were not incorporated into the administration's original estimate. For instance, the Department recommends increases totaling \$18.7 million GPR over the biennium (\$45.4 million all funds) to make payments to health maintenance organizations (HMOs) for meeting new care coordination requirements that the Department has included in the HMO contract for beneficiaries whose MA eligibility stems from eligibility for supplemental security income (SSI). The Department also recommends an adjustment to estimated drug manufacturer rebate collections. Based on recent trends in collections, the Department estimates that rebates will equal 61% of gross drug costs, up from 59% used in the administration's estimate, resulting in a reduction in GPR costs of \$28 million over the biennium. These changes and other similar adjustments are included in the reestimate.

14. One of the Department's recommendations deserves separate consideration. The Department recommends that additional funding be provided to cover the anticipated cost of the prescription drug nusinersen (sold under the brand name Spinraza), which was recently approved for the treatment of children diagnosed with spinal muscular atrophy (SMA). SMA is a rare genetic condition affecting muscle control that, in its most severe forms, leads to substantial physical disability and often leads to early death. SMA is diagnosed in approximately 1 out of every 10,000 births, although the disease has several classes that vary in the severity of symptoms. Although Spinraza has been shown to be effective in stopping or partially reversing the course of the disease in some SMA cases, the cost of the treatments is high. During the first year of treatment of a child with SMA, the total cost of six Spinraza injections is \$750,000 (before drug rebates). Thereafter, in cases where the drug has shown effectiveness, children require three injections per year at a cost of \$325,000. Based on an estimate of the number of children with SMA in Wisconsin, the Department has recommended an increase to the GPR budget for MA of \$37 million over the biennium (\$90 million all funds). However, there are reasons to believe that this estimate is high. Investment analysts generally have projected that Biogen, the holder of the Spinraza license, will earn around

\$1 billion from worldwide sales of Spinraza in 2018, increasing up to \$2 billion by 2020 (the drug has been approved in the United States and Europe thus far). If these sales projections are correct, the Department's cost estimates for Wisconsin's MA program would account for approximately 4.5% of worldwide sales, an unrealistically high proportion given the population of the state and the share of children with MA coverage. The reestimate presented in this paper uses a smaller estimate, increasing MA funding by \$14.3 million over the biennium to reflect anticipated Spinraza costs.

Managed Care Capitation Rates

15. Most of MA benefits are delivered through managed care organizations (MCOs), including FamilyCare MCOs and BadgerCare Plus and SSI HMOs. Under the managed care system, the MCO arranges the care for each enrolled member and pays medical claims. MA pays the MCO a monthly capitation rate for each enrolled member, plus administrative fees and supplemental payments to cover specific costs outside the capitation rate calculation. Capitation payments are established each year using service utilization data from previous years. The administration's cost-to-continue estimate generally assumes that monthly capitation rates will increase by 2.5% to 3.0% in each year. Although this rate of increase would be somewhat higher than capitation rate increases seen in recent years, the administration's assumptions are consistent with a cautious budgeting approach, allowing for the reasonable possibility of rate growth in excess of recent trends.

Federal Formula Factors

16. In addition to caseload and intensity, MA benefit costs are affected by factors related to federal formulas. These include the federal medical assistance percentage (FMAP), the state's "clawback" payment, made by states to the federal government to partially fund Medicare Part D prescription drug benefits, and Medicare premiums and cost sharing assistance for dually-eligible MA beneficiaries.

Standard Federal Matching Percentage

17. The federal medical assistance matching percentage is based on the relationship between the state's per capita income and the national average per capita income. Under the formula, a state with a per capita income equal to the national average has an FMAP of 55%, while states with a per capita income lower or higher than the average will have an FMAP that is higher or lower than 55%, respectively.

18. The administration's MA cost-to-continue estimates were based on projections of the state's FMAP for the 2017-19 biennium available at the time of the introduction of the bill. The estimate assumed a federal fiscal year 2017-18 FMAP of 58.77% and a federal fiscal year 2018-19 FMAP of 58.95%. Since the time of these estimates, the federal Bureau of Economic Analysis has published data on state and national 2016 per capita income. Incorporating this data into the FMAP calculation results in a slight increase to the federal fiscal year 2018-19 FMAP, from 58.95% to 59.02%. This change has the effect of reducing the GPR costs of MA program benefits by approximately \$7.9 million and increasing FED costs by a corresponding amount.

Children's Health Insurance Program Enhanced Matching Percentage

19. The federal government provides a higher FMAP for certain services and populations. One such program deserves special mention because of its significant effect on the cost-to-continue estimate. The Children's Health Insurance Program (CHIP) provides an enhanced federal match for pregnant women and certain children, generally those in households with income above 150% of the federal poverty level (the CHIP threshold varies by the age of the child). The enhanced FMAP is calculated to reduce the state's standard share by 30%. In addition, the federal Patient Protection and Affordable Care Act (ACA) provided for an additional 23 percentage point increase to the enhanced CHIP FMAP, beginning in 2015-16 and ending in 2018-19. With that increase, the state's FMAP for services provided to CHIP-eligible enrollees is approximately 94%.

20. Unlike most Medicaid expenditures, the amount of federal funds available to each state for CHIP-funded services is capped by annual federal allotments. Since CHIP was created in 1997, Congress has periodically reauthorized the program, providing a multi-year extension to the CHIP allotments. The last such act, passed in 2015, extended allotments through federal fiscal year 2017. If Congress does not act to provide allotments in federal fiscal year 2018 and beyond, states will eventually exhaust remaining 2017 allotments. If that happens, any program expenditures for CHIP-eligible enrollees would then be subject to federal matching at the standard FMAP, rather than the enhanced FMAP.

21. The federal Medicaid and CHIP Payment and Access Commission (MACPAC), which advises Congress on Medicaid issues, estimates that without Congressional action some states will begin to exhaust their allotments by the end of calendar year 2017. MACPAC projects that Wisconsin will exhaust its CHIP allotments in April, 2018.

22. The administration's cost-to-continue estimate is based on the assumption that Wisconsin will continue to have sufficient CHIP allotments to take advantage of the enhanced CHIP FMAP through the end of the 2017-19 biennium. Based on the MACPAC projections, this would require Congress to provide additional allotments beginning in federal fiscal year 2018. The reestimate presented in this paper retains this assumption, while noting that this is a decision to be made by policymakers, and so is not subject to fiscal analysis.

23. If Congress does not authorize additional CHIP allotments, the impact on the GPR costs of providing MA benefits to CHIP enrollees would be substantial. If, for instance, MA benefits for these enrollees were subject to the standard FMAP, rather than the enhanced FMAP in state fiscal year 2018-19, GPR costs would increase by an estimated \$113 million in that year.

24. Another possibility is that CHIP allotments are reauthorized, but that the 23 percentage point increase to the enhanced CHIP FMAP is repealed for federal fiscal year 2018-19. In this event, MA expenditures for children eligible under CHIP would be matched at a rate of approximately 71% instead of 94% for the final nine months of the 2017-19 biennium, increasing estimated GPR expenditures by approximately \$55 million in 2018-19.

Clawback Payments

25. Since 2006, state Medicaid programs have been required to make a payment each year to fund a portion of the costs of the federal Medicare Part D program, in recognition that Part D results in state Medicaid program savings on drugs for dually-eligible enrollees. The amount of this "clawback" payment is based on a formula that is intended to equal 75% of each state's estimated savings. Year-to-year payments change based on the number of dually-eligible MA beneficiaries, the change in per capita drug spending under Part D, and the state's FMAP.

26. The administration's estimate of clawback payments was based on the assumption that per capita drug spending would increase by 12% annually in calendar years 2018 and 2019. However, the federal Medicare and Medicaid Services (CMS) has recently projected that Part D per capita drug expenditures will increase by just 1.2% in 2018. Because the Part D per capita increase is an element of the clawback formula, the cost-to-continue estimate presented in this paper revises the estimate of 2018 clawback payments to reflect the CMS projections. For 2019, the reestimate assumes an 8% growth in per capita drug costs, which is the approximate increase assumed for that year by the Medicare Trustees for the purposes of Medicare Part D budget projections. These revisions result in a reduction of clawback payments of \$36 million GPR over the biennium.

Medicare Premiums and Cost Sharing for Dually-Eligible Enrollees

27. MA pays the Medicare Part A and Part B premiums and, in some cases, deductibles and coinsurance for enrollees who are dually-eligible for Medicaid and Medicare. The administration's cost-to-continue estimate assumes growth in these costs based on recent trends. The largest component of the administration's estimated increase is due to a projected 13% annual increase to the Medicare Part B premium in calendar years 2018 and 2019. However, the 2016 Medicare Trustee's report projects that Part B premiums will be significantly lower in those years than the administration's estimates. Revising the Part B premiums to be more in line with the Medicare Trustee's projections reduces the GPR-funded portion of the cost-to-continue estimate by \$22 million over the biennium.

Summary and Discussion of Revised Cost-to-Continue Estimate

28. The revisions to the cost-to-continue estimate assumptions discussed in this paper, as well as various technical corrections, result in, relative to the bill, a reduction of \$95.6 million to the GPR funding for MA benefits over the biennium and a total reduction of \$132.6 million in the MA benefits budget from all sources. Relative to the MA base, GPR funding for MA would increase by \$183.1 million GPR over the biennium and by \$866.4 million from all fund sources.

29. Table 4 shows the MA benefits funding by fund source under the reestimate, as well as the change to the funding provided by the bill. The SEG funding has been adjusted to eliminate double-counted funds to give a more accurate representation of total MA benefits funding under the cost-to-continue scenario. These changes reflect the difference between the revised cost-to-continue estimate and the administration's cost-to-continue estimate as modified by a separate decision item that would reduce MA benefits by \$320,300 GPR annually in order to offset an increase to the GPR appropriation for the mental health institutes.

TABLE 4

Reestimated MA Cost-to-Continue Funding

	Reestimate Funding		Change to Bill		
	<u>2017-18</u>	<u>2018-19</u>	<u>2017-18</u>	<u>2018-19</u>	<u>Biennium</u>
GPR	\$2,932,345,300	\$3,072,781,400	-\$26,416,500	-\$69,154,100	-\$95,570,600
FED	5,176,912,800	5,476,025,700	-37,093,800	-67,434,000	-104,527,800
PR	940,257,200	1,013,131,900	29,990,600	39,463,900	69,454,500
SEG*	<u>588,126,400</u>	<u>585,118,500</u>	<u>-911,400</u>	<u>-1,027,300</u>	<u>-1,938,700</u>
Total	\$9,637,641,700	\$10,147,057,500	-\$34,431,100	-\$98,151,500	-\$132,582,600

* SEG amounts are adjusted to remove double-counted funds. For technical reasons related to this adjustment, the amounts shown in the "Change to Bill" columns differ from the change to unadjusted an appropriation that is reflected in the final estimate (fiscal estimate box).

30. With limited exceptions, the medical assistance program is required by state and federal law to pay for the cost of all medically necessary services for program enrollees. If the amount of funding provided in the biennial budget is insufficient to fund these costs, the Department's options to administratively reduce costs are somewhat limited. In the event of a budget shortfall in MA, the Committee or the full Legislature may be required to act, either by increasing the MA appropriations or making statutory program changes to reduce costs. For this reason, there are risks associated with underestimating the MA budget. In order to provide some context for understanding these risks, the following points discuss some of the uncertainties involved in developing the budget estimates.

31. Some of risks to the revised cost-to-continue estimate have already been discussed above. Chief among these is the potential that a change to the state or national economy would result in job losses and a reduction in household income. Depending upon the timing of an economic downturn, the resulting increase in MA enrollment could cause benefit expenditures to exceed the reestimated budget.

32. Another significant risk is potential changes in federal policy as it relates to Medicaid or broader healthcare policy. A potential decision to not renew CHIP allocations was already mentioned, but other changes to federal policy could also affect the state's MA spending. Discussions in Congress on the potential repeal of the Affordable Care Act are ongoing. The elimination of or reduction to income-based premium tax credits for the purchase of health insurance could reduce opportunities to obtain coverage for households near the poverty line, which may push some, who would otherwise purchase commercial insurance with these subsidies, to seek or retain MA coverage.

33. As noted with the discussion of the prescription drug Spinraza, the cost of new drugs or new medical technology can increase the cost of health coverage in ways that are not anticipated. The cost-to-continue estimate includes an "intensity" adjustment to account for increasing usage or costs, but these adjustments are generally based on past trends, which may not fully account for

future costs.

34. While conditions may change in ways that increase MA costs above budget estimates, changing conditions can also lower costs below those estimates, as illustrated by the 2015-17 biennium MA budget. According to the Department's most recent estimates, GPR costs for MA benefits during the 2015-17 biennium will be lower than the amount budgeted by \$330 million. There are multiple factors behind this reduction, which amounts to 5.8% of the biennial GPR budget for the program. Nursing home and home health utilization, for instance, have been lower than expected. In addition, prescription drug spending has been lower than expected, but despite a lower gross cost, drug manufacturer rebates have exceeded budget estimates. Finally, while the 2015-17 budget estimates were based on increasing enrollment in BadgerCare Plus (consistent with the trends at the time), the caseload has remain unchanged or declined for many of the enrollment categories.

35. While there are risks associated with underestimating MA benefit costs, an overestimate represents a lost opportunity to allocate state funds to other purposes. The administration's cost-to-continue estimate for the 2017-19 biennium can be characterized as a conservative estimate that, in many respects, builds in a budget margin in the event of an economic recession or other major contingencies. The cost-to-continue estimate presented in this paper uses updated data and revised assumptions, resulting in a lower MA budget (Alternative 1). Consistent with the 2017-19 biennium general fund revenue estimates produced by this office, the reestimate does not account for a possible economic recession, but still retains an overall cautious approach that allows for the possibility that MA costs will increase above recent trends.

36. The Committee could decide to mitigate the risks associated with an economic recession or other factors that increase GPR-funded MA costs by transferring an amount from the general fund to the medical assistance trust fund (MATF), to create a reserve. In the event that GPR funding is not sufficient to pay all MA benefits costs in the biennium, the Department could submit a request under s. 13.10 of the statutes to increase the MATF SEG appropriation, allowing the Department to spend the reserve for MA benefit costs. Any amounts of this reserve not used in the 2017-19 biennium would remain in the MATF and be available for future MA costs. Although the Committee could provide any amount for this purpose, one option would be to transfer \$55,000,000, which is the estimated amount of the additional cost that the state would incur if the 23 percentage point increase to the CHIP FMAP were eliminated in federal fiscal year 2018-19 (Alternative 2). Alternatively, the Committee could transfer one-half of this amount (\$27,500,000), to provide a smaller contingency reserve under the assumption that the underlying estimate provides a sufficient margin to allow the MA benefits budget to absorb some of the additional GPR cost that would be associated with a decision to eliminate the 23 percentage point increase to the CHIP FMAP (Alternative 3).

ALTERNATIVES

1. Reduce funding for MA benefits by \$35,436,400 (-\$26,416,500 GPR, -\$37,093,800 FED, \$29,990,600 PR, and -\$1,916,700 SEG) in 2017-18 and \$98,794,800 (-\$69,154,100 GPR, -\$67,434,000 FED, \$39,463,900 PR, and -\$1,670,600 SEG) in 2018-19 to reflect a

reestimate of MA benefits costs under a cost-to-continue scenario. [Adoption of this reestimate would have the effect of deleting the bill's proposed \$320,300 annual GPR reduction to the MA benefits appropriation associated with the mental health institutes funding provision.]

ALT 1	Change to	
	Base	Bill
GPR	\$183,179,700	- \$95,570,600
FED	329,180,900	- 104,527,800
PR	411,526,900	69,454,500
SEG	<u>- 57,445,300</u>	<u>- 3,587,300</u>
Total	\$866,442,200	- \$134,231,200

2. Adopt the appropriation changes in Alternative 1. In addition, transfer \$55,000,000 from the general fund to the medical assistance trust fund to provide a reserve for addressing any potential shortfalls in GPR funding for MA benefits.

ALT 2	Change to	
	Base	Bill
GPR	\$183,179,700	- \$95,570,600
FED	329,180,900	- 104,527,800
PR	411,526,900	69,454,500
SEG	<u>- 57,445,300</u>	<u>- 3,587,300</u>
Total	\$866,442,200	- \$134,231,200
GPR-Transfer	\$55,000,000	\$55,000,000
SEG-Revenue	\$55,000,000	\$55,000,000

3. Adopt the appropriation changes in Alternative 1. In addition, transfer \$27,500,000 from the general fund to the medical assistance trust fund to provide one-half of the reserve amount as Alternative 2.

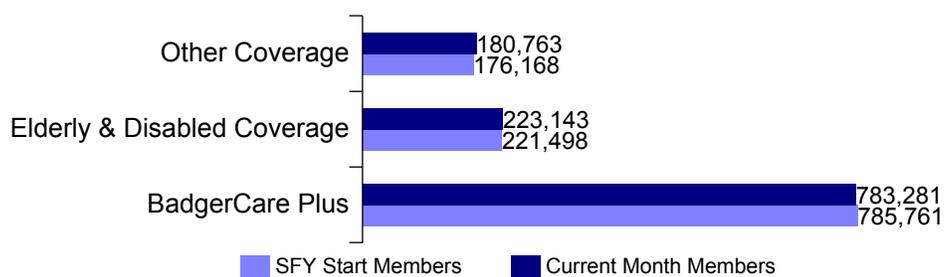
ALT 3	Change to	
	Base	Bill
GPR	\$183,179,700	- \$95,570,600
FED	329,180,900	- 104,527,800
PR	411,526,900	69,454,500
SEG	<u>- 57,445,300</u>	<u>- 3,587,300</u>
Total	\$866,442,200	- \$134,231,200
GPR-Transfer	\$27,500,000	\$27,500,000
SEG-Revenue	\$27,500,000	\$27,500,000

Prepared by: Jon Dyck

EXHIBIT

11

Current Month Health Care Enrollment At A Glance



Category	Apr-2018		
	Current Month Members	% Change since Start of SFY	% Change from Last Month
Children	421,028	2.6 %	-0.1 %
Parents/Caretakers	140,083	-2.8 %	-0.5 %
Pregnant Women	18,793	-0.2 %	-0.7 %
Youths Exiting	924	8.8 %	-1.0 %
Income Extensions	53,612	-19.8 %	-3.4 %
Express Enroll-PW	143	-14.9 %	5.1 %
Express Enroll-Children	102	-8.9 %	5.2 %
Childless Adults	148,596	3.0 %	-0.8 %
BadgerCare Plus	783,281	-0.3 %	-0.6 %
SSI	114,319	-0.9 %	-0.1 %
SSI-Related	19,727	1.6 %	0.0 %
Institutionalized	14,586	-4.6 %	-0.6 %
Waiver	43,305	4.1 %	0.7 %
MAPP	31,206	4.6 %	0.4 %
Elderly & Disabled Coverage	223,143	0.7 %	0.1 %
SeniorCare	92,864	1.1 %	0.2 %
TB-Related	124	-18.4 %	-1.6 %
Medicare Beneficiaries	21,141	6.0 %	-0.4 %
Well Woman MA	559	-2.8 %	-1.1 %
Foster Care	9,786	-0.3 %	0.0 %
Subsidized Adoption	14,759	2.1 %	0.8 %
Miscellaneous	1,808	10.2 %	1.3 %
Family Planning Only Services	39,722	5.3 %	1.0 %
Other Coverage	180,763	2.6 %	0.4 %
** Grand Total	1,187,187	0.3 %	-0.3 %

Note: HCTC program ended 12/31/2013. BadgerCare Plus Basic ended 03/31/2014.

EXHIBIT

12

Clearinghouse Rule 96-154

CERTIFICATE

STATE OF WISCONSIN)
) SS
 DEPARTMENT OF HEALTH AND FAMILY SERVICES)

I, Joseph Leean, Secretary of the Department of Health and Family Services and custodian of the official records of the Department, do hereby certify that the annexed rules relating to elimination of coverage under the Medical Assistance program for services that are medically unnecessary were duly approved and adopted by this Department on December 11, 1996.

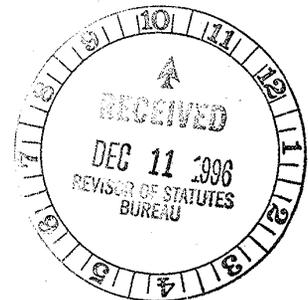
I further certify that this copy has been compared by me with the original on file in the Department and that this copy is a true copy of the original, and of the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department at the State Office Building, 1 W. Wilson Street, in the city of Madison, this 11th day of December, 1996.

SEAL:



 Joseph Leean, Secretary
 Department of Health and Family Services



96-154
 2-1-97

ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
REPEALING, RENUMBERING, RENUMBERING AND AMENDING, AMENDING,
REPEALING AND RECREATING AND CREATING RULES

To repeal HSS 105.36(2)(e) and (7)(b)6., 107.06(2)(zb), (zc), (zl), (zn), (zp) and (zq) and (Note) and (zs) and 107.21(1)(d)4.; to renumber HSS 105.36(2)(f) and (g) and (7)(b)7., 107.06(2)(zd) to (zk), (zo), (zr) and (zt), and 107.21(1)(d)5. to 8.; to renumber and amend HSS 107.06(2)(zm); to amend HSS 105.36(7)(b)5., 107.02(2)(a), 107.03(17) and (18) and 107.06(2)(zc), as renumbered, and (5)(w) and (x), 107.10(2)(d) and (e) and 107.24(5)(j) and (k); to repeal and recreate HSS 107.06(2)(h), 107.06(5)(a), 107.10(2)(c) and 107.21(1)(c)3. and (3); to create HSS 107.03(19) to (26), 107.06(2)(zb)4., (zn) and (zo) and (4)(h) and (i), 107.10(2)(f) and (g), (3)(l) and (4)(n) to (t) and 107.24(5)(l) to (p), relating to elimination of coverage under the medical assistance (MA) program for services that are medically unnecessary, including services and items that enhance fertility in males or females, and limitation of coverage of certain other services to medically necessary situations.

Analysis Prepared by the Department of Health and Family Services

These amendments to the Department's rules for the medical assistance (MA) program eliminate coverage of some services that the Department has determined are not medically necessary and limit the coverage of certain other services to medically necessary situations. They also remove the requirement of prior authorization for sterilizations.

MA coverage will be discontinued for services and items that are provided for the purpose of enhancing fertility in males or females, including but not limited to artificial insemination, infertility counseling, impotence and infertility testing, impotence devices, reversal of female sterilizations, reversal of vasectomies, office visits and other medical encounters to enhance fertility, and other fertility-enhancing services and items. Drugs that are used to treat infertility and drugs that are used to treat impotence will not be covered when used for those purposes but will be covered when used for other medical purposes.

MA coverage will be prohibited for other services determined to be medically unnecessary, including services related to surrogate parenting, ear lobe repair, tattoo removal and drugs, including hormone therapy, associated with transsexual surgery. Under current rules the MA program requires prior authorization for most of these services and pays infrequently for them.

The order also eliminates MA coverage for non-medical food and for non-emergency intestinal bypass or gastric stapling. Services, including drugs, related to non-surgical abortions must comply with current state abortion statutes (s. 20.927, Stats.), must only be prescribed by a physician, and must comply with MA provider handbooks and bulletins. This order strengthens the Department's ability to assure compliance with current abortion statutes.

The Department's authority to repeal, renumber, renumber and amend, amend, repeal and recreate and create these rules is found in s. 49.45(10), Stats. The rules interpret s. 49.46(2) Stats.

SECTION 1. HSS 105.36(2)(e) is repealed.

SECTION 2. HSS 105.36(2)(f) and (g) are renumbered 105.36(2)(e) and (f).

SECTION 3. HSS 105.36(7)(b)5. is amended to read:

HSS 105.36(7)(b)5. Instructions on the use of the chosen method, provision of supplies and schedule for revisits; and

SECTION 4. HSS 105.36(7)(b)6. is repealed.

SECTION 5. HSS 105.36(7)(b)7. is renumbered 105.36(7)(b)6.

SECTION 6. HSS 107.02(2)(a) is amended to read:

HSS 107.02(2)(a) Services which fail to comply with program policies or state and federal statues, rules and regulations, for instance, sterilizations performed ~~without prior authorization and~~ without following proper informed consent procedures, or controlled substances prescribed or dispensed illegally;

SECTION 7. HSS 107.03(17) and (18) are amended to read:

HSS 107.03(17) Separate charges for the time involved in completing necessary forms, claims or reports; and

(18) Services provided by a hospital or professional services provided to a hospital inpatient are not covered services unless billed separately as hospital services under s. HSS 107.08 or 107.13 (1) or as professional services under the appropriate provider type. No recipient may be billed for these services as non-covered.;

SECTION 8. HSS 107.03(19) to (26) are created to read:

HSS 107.03(19) Services, drugs and items that are provided for the purpose of enhancing the prospects of fertility in males or females, including but not limited to the following:

- (a) Artificial insemination, including but not limited to intra-cervical and intra-uterine insemination;
 - (b) Infertility counseling;
 - (c) Infertility testing, including but not limited to tubal patency, semen analysis or sperm evaluation;
 - (d) Reversal of female sterilization, including but not limited to tubouterine implantation, tubotubal anastomoses or fimbrioplasty;
 - (e) Fertility-enhancing drugs used for the treatment of infertility;
 - (f) Reversal of vasectomies;
 - (g) Office visits, consultations and other encounters to enhance the prospects of fertility;
- and
- (h) Other fertility-enhancing services and items;
- (20) Surrogate parenting and related services, including but not limited to artificial insemination and subsequent obstetrical care;
- (21) Ear lobe repair;

(22) Tattoo removal;

(23) Drugs, including hormone therapy, associated with transsexual surgery or medically unnecessary alteration of sexual anatomy or characteristics;

(24) Transsexual surgery;

(25) Impotence devices and services, including but not limited to penile prostheses and external devices and to insertion surgery and other related services; and

(26) Testicular prosthesis.

SECTION 9. HSS 107.06(2)(h) is repealed and recreated to read:

HSS 107.06(2)(h) Female circumcision;

SECTION 10. HSS 107.06(2)(zb) and (zc) are repealed.

SECTION 11. HSS 107.06(2)(zd) is renumbered 107.06(2)(zb).

SECTION 12. HSS 107.06(2)(zb)4. is created to read:

HSS 107.06(2)(zb)4. Breast reconstruction and reduction;

SECTION 13. HSS 107.06(2)(ze) to (zk) are renumbered 107.06(2)(zc) to (zi) and HSS 107.06(2)(zc), as renumbered, is amended to read:

HSS 107.06(2)(zc) 1. Rhinoplasty, primary;

2. Rhinoplasty, complete;

3. Rhinoplasty, including major septal repair;

SECTION 14. HSS 107.06(2)(zl) is repealed.

SECTION 15. HSS 107.06(2)(zm) is renumbered 107.06(2)(zj) and amended to read:

HSS 107.06(2)(zj) Constructing an artificial vagina;

SECTION 16. HSS 107.06(2)(zn) is repealed.

SECTION 17. HSS 107.06(2)(zo) is renumbered 107.06(2)(zk).

SECTION 18. HSS 107.06(2)(zp) and (zq) and Note are repealed.

SECTION 19. HSS 107.06(2)(zr) is renumbered 107.06(2)(zl).

SECTION 20. HSS 107.06(2)(zs) is repealed.

SECTION 21. HSS 107.06(2)(zt) is renumbered 107.06(2)(zm).

SECTION 22. HSS 107.06(2)(zn) and (zo) are created to read:

HSS 107.06(2)(zn) Drugs identified by the department that are sometimes used to enhance the prospects of fertility in males or females, when proposed to be used for treatment of a non-fertility related condition;

(zo) Drugs identified by the department that are sometimes used to treat impotence, when proposed to be used for treatment of a non-impotence related condition;

SECTION 23. HSS 107.06(4)(h) and (i) are created to read:

HSS 107.06(4)(h) Obesity-related procedures. Gastric bypass or gastric stapling for obesity is limited to medical emergencies, as determined by the department.

(i) Abortions. 1. Abortions, both surgically-induced and drug-induced, are limited to those that comply with s. 20.927, Stats.

2. Services, including drugs, directly related to non-surgical abortions shall comply with s. 20.927, Stats., may only be prescribed by a physician, and shall comply with MA policy and procedures as described in MA provider handbooks and bulletins.

SECTION 24. HSS 107.06(5)(a) is repealed and recreated to read:

HSS 107.06(5)(a) Services and items that are provided for the purpose of enhancing the prospects of fertility in males or females, within the meaning of s. HSS 107.03(19).

SECTION 25. HSS 107.06(5)(w) and (x) are amended to read:

HSS 107.06(5)(w) ~~Intestinal~~ Non-emergency gastric bypass or gastric stapling for obesity; and

(x) Separate charges for pump technician services; ~~and.~~

SECTION 26. HSS 107.10(2)(c) is repealed and recreated to read:

HSS 107.10(2)(c) Medically necessary, specially formulated nutritional supplements and replacement products, including enteral and parenteral products used for the treatment of severe health conditions such as pathologies of the gastrointestinal tract or metabolic disorders, as described in the MA provider handbooks and bulletins.

SECTION 27. HSS 107.10(2)(d) and (e) are amended to read:

HSS 107.10(2) (d) Drugs which have been demonstrated to entail substantial cost or utilization problems for the MA program, including antibiotics which cost \$100 or more a day. These drugs shall be noted in the Wisconsin medicaid drug index; and

(e) Any drug produced by a manufacturer who has not entered into a rebate agreement with the federal secretary of health and human services, as required by 42 USC 1396r-8, if the prescribing provider under sub. (1) demonstrates to the department's satisfaction that no other drug sold by a manufacturer who complies with 42 USC 1396r-8 is medically appropriate and cost-effective in treating the recipient's condition;:

SECTION 28. HSS 107.10(2)(f) and (g), (3)(l) and (4)(n) to (t) are created to read:

HSS 107.10(2)(f) Drugs identified by the department that are sometimes used to enhance the prospects of fertility in males or females, when proposed to be used for treatment of a condition not related to fertility; and

(g) Drugs identified by the department that are sometimes used to treat impotence, when proposed to be used for the treatment of a condition not related to impotence.

(3)(l) Services, including drugs, directly related to non-surgical abortions shall comply with s. 20.927, Stats., may only be prescribed by a physician, and shall comply with MA policy and procedures as described in MA provider handbooks and bulletins.

(4)(n) Drugs provided for the treatment of males or females for infertility or to enhance the prospects of fertility;

(o) Drugs provided for the treatment of impotence;

(p) Drugs, including hormone therapy, associated with transsexual surgery or medically unnecessary alteration of sexual anatomy or characteristics;

(q) Drugs or combinations of drugs that are administered to induce abortions, when the abortions do not comply with s. 20.927, Stats., and s. HSS 107.10(3)(l);

(r) Food;

(s) Infant formula, except when the product and recipient's health condition meet the criteria established by the department under sub. (2)(c) to verify medical need; and

(t) Enteral nutritional products that do not meet the criteria established by the department under sub. (2)(c) to verify medical need, when an alternative nutrition source is available, or that are solely for the convenience of the caregiver or the recipient.

SECTION 29. HSS 107.21(1)(c)3. is repealed and recreated to read:

HSS 107.21(1)(c)3. Diagnostic and other procedures not for the purpose of enhancing the prospects of fertility in males or females:

- a. Endometrial biopsy when performed after a hormone blood test;
- b. Laparoscopy;
- c. Cervical mucus exam;
- d. Vasectomies;
- e. Culdoscopy; and
- f. Colposcopy;

SECTION 30. HSS 107.21(1)(d)4. is repealed.

SECTION 31. HSS 107.21(1)(d)5. to 8. are renumbered 107.21(1)(d)4. to 7.

SECTION 32. HSS 107.21(3) is repealed and recreated to read:

HSS 107.21(3) NON-COVERED SERVICES. The following services are not covered services:

(a) The sterilization of a recipient under the age of 21 or of a recipient declared legally incapable of consenting to such a procedure;

(b) Services and items that are provided for the purpose of enhancing the prospects of fertility in males or females, including but not limited to:

1. Artificial insemination, including but not limited to intra-cervical or intra-uterine insemination;

2. Infertility counseling;

3. Infertility testing, including but not limited to tubal patency, semen analysis or sperm evaluation;

4. Reversal of female sterilizations, including but not limited to tubouterine implantation, tubotubal anastomoses or fimbrioplasty;

5. Fertility-enhancing drugs provided for the treatment of infertility;

6. Reversal of vasectomies;

7. Office visits, consultations and other encounters to enhance fertility; and

8. Other fertility-enhancing services and items;

(c) Impotence devices and services, including but not limited to penile prostheses and external devices and to insertion surgery and other related services;

(d) Testicular prosthesis; and

(e) Services that are not covered under ss. HSS 107.03 and 107.06(5).

SECTION 33. HSS 107.24(5)(j) to (k) are amended to read:

HSS 107.24(5)(j) All repairs of a hearing aid or other assistive listening device performed by a dealer within 12 months after the purchase of the hearing aid or other assistive listening device. These are included in the purchase payment and not as separate services; and

(k) Hearing aid or other assistive listening device batteries which are provided in excess of the guidelines enumerated in the MA speech and hearing provider handbook;

SECTION 34. HSS 107.24(5)(l) to (p) are created to read:

HSS 107.24(5)(l) Items that are provided for the purpose of enhancing the prospects of fertility in males or females;

(m) Impotence devices, including but not limited to penile prostheses;

(n) Testicular prosthesis;

(o) Food; and

(p) Infant formula and enteral nutritional products except as allowed under

s. HSS 107.10(2)(c).

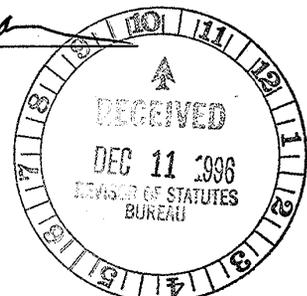
The repeals and rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register as provided in s. 227.22(2), Stats.

Wisconsin Department of Health and
Family Services

Dated: December 11, 1996

By: _____


Joe Lisan
Secretary



SEAL:

PA08103.AD\CODE

EXHIBIT

13

Summary of the Amendments to the Medicaid Rules that Discontinue Coverage of Medically Unnecessary Services

This paper summarizes the proposed changes to the Medicaid administrative rules to limit or discontinue coverage of medically unnecessary services, to strengthen some definitions of covered services, to enable the Department to determine cost effective dispensing quantities, to bring uniformity in coverage of oral surgery in the dental and physician benefit, and to make some technical changes.

Medicaid Services to be Discontinued

Services and products that are provided for the purpose of increasing fertility will no longer be covered by the Wisconsin Medicaid program. These services include, but are not limited to:

- ✓ artificial insemination (not covered now)
- ✓ infertility counseling
- ✓ impotence and infertility testing
- ✓ impotence devices
- ✓ reversal of female sterilizations and vasectomies
- ✓ drugs used for the treatment of impotence and infertility
- ✓ office visits and other medical encounters to enhance fertility
- ✓ other fertility enhancing services and products
- ✓ services related to surrogate parenting

Other services and products determined not to be medically necessary will not be covered, including:

- ✓ ear lobe repair
- ✓ nipple reconstruction and repair
- ✓ tattoo removal
- ✓ drugs or hormone therapy to alter physical sexual characteristics
- ✓ transsexual surgery
- ✓ food products

Medicaid Services that Require Prior Authorization

Some services, such as breast reconstruction, that have always required prior authorization, are now specifically listed in the rules.

Emergency Services

- ✓ Emergency Definition - The definition of emergency is clarified to parallel current language in the HMO contract.
- ✓ Intestinal Bypass/Gastric Stapling Surgery - Rule language is updated to reflect

current statutes, stating that intestinal bypass or gastric stapling surgery for obesity will not be covered, except in a medical emergency.

Changes in the Drug Rules

- ✓ Strengthening the Abortion Rules Language - The Program's position on abortion is reiterated through language that excludes coverage of drugs that are administered for abortions, when the abortions do not comply with s.20.927 Stats.
- ✓ 100 Day Dispensing - To promote most cost-efficient drug dispensing, the Department will create a list of maintenance drugs that must be dispensed as prescribed by the prescriber, up to 100 days.

Durable Medical Equipment

- ✓ Definition of Custom - The term "custom" is defined so that only equipment that is uniquely designed and constructed can be called "custom." This will limit the equipment that can receive the higher level of reimbursement for customization.
- ✓ Wheelchairs in Nursing Homes - Revised language clarifies when wheelchairs are covered outside the nursing home rates.

Physician/Dental Conformity and Technical Changes

Pursuant to federal requirements, both the dental and the physician rules are modified to achieve uniformity in coverage and in prior authorization requirements for oral surgeries.

Several technical changes are made to the non-covered services and prior authorization sections of the physician rules and the non-covered services section of the dental rules. For example, the dental services that were added to the benefit several years ago were removed from the non-covered services list. This language change brings some sections of these rules up-to-date with current coverage as mandated by state legislation.

Improved Definition of Nutritional Product Coverage

Nutritional product coverage is limited to specially formulated enteral products that are used for the treatment of health disorders and that meet criteria established by the Department.

EXHIBIT

14

1995 Session

FISCAL ESTIMATE
DOA-2048 N(R10/94)

- ORIGINAL
- UPDATED
- CORRECTED
- SUPPLEMENTAL

LRB or Bill No./Adm. Rule No.
HSS 105 and 107

Amendment No. if Applicable

Subject
MEDICAL ASSISTANCE: MEDICALLY UNNECESSARY SERVICES

Fiscal Effect

State: No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

Increase Costs - May be possible to Absorb Within Agency's Budget Yes No

- Increase Existing Appropriation
- Decrease Existing Appropriation
- Create New Appropriation
- Increase Existing Revenues
- Decrease Existing Revenues

Decrease Costs

Local: No local government costs

1. Increase Costs
- Permissive
 - Mandatory
2. Decrease Costs
- Permissive
 - Mandatory

3. Increase Revenues
- Permissive
 - Mandatory
4. Decrease Revenues
- Permissive
 - Mandatory

5. Types of Local Governmental Units Affected:
- Towns
 - Villages
 - Cities
 - Counties
 - Others _____
 - School Districts
 - WTCS Districts

Fund Sources Affected

- GPR
- FED
- PRO
- PRS
- SEG
- SEG-S

Affected Ch. 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

These amendments to the Medical Assistance rules clarify existing policy and clearly eliminate coverage of some services that the Department has determined are not medically necessary, including services and drugs to treat infertility; limit the coverage of certain other services and drugs to medically necessary situations, eliminate coverage for non-medical food, non-emergency intestinal bypass or gastric stapling and drugs that are administered to induce abortions; and make technical corrections or improvements in related rule language.

The rule changes will not affect the expenditures or revenues of local governments. Local governments are not involved in the financing or administration of Medical Assistance.

The rule changes are expected to result in nominal savings for state government.

Long-Range Fiscal Implications

Agency/Prepared by: (Name & Phone No.)

Date

9/27/96

DEPARTMENT OF HEALTH & FAMILY SERVICES
Office of Legal Counsel
OFB-140 (9/89)

STATE OF WISCONSIN

TRANSMITTAL TO LEGISLATIVE COUNCIL RULES CLEARINGHOUSE

PROPOSED RULES OF THE DEPARTMENT OF HEALTH AND FAMILY SERVICE

HSS 105 & 107 Wis. Adm. Code

MEDICAL ASSISTANCE: MEDICALLY UNNECESSARY SERVICES

Statutory Authority:

Section s. 49.45(10), Stats.

Analysis: Reason for Rules, Intended Effects, Requirements

These amendments to the Department's rules for the Medical Assistance program eliminate coverage of some services that the Department has determined are not medically necessary and limit the coverage of certain other services to medically necessary purposes.

The rule changes make clear that the MA program will not pay for the specified services or will not pay for them when they are provided for certain purposes. Actually the program has hardly ever paid for any of those services or for those purposes, but questions about coverage continue to come up.

Forms (Copies attached when available):

N/A

Agency Procedure for Promulgation:

Public hearing under ss. 227.16, 227.17 and 227.18, Stats.; approval of rules in final draft form by the Secretary; and legislative standing committee review under s. 227.19, Stats.

Names and Phone Numbers of Agency Contacts:

Marjorie Hannon Pifer, Division of Health, 266-1940

Date Sent to LC Clearinghouse:

September 27, 1996



cc Rev of Stats, DOA

EXHIBIT

15



LGBT Health - Transgender Persons



"Transgender" is a term that describes gender identity, gender expression, and behavior that does not conform with socially ascribed gender norms for one's biological sex at birth. Some people might alter their bodies with hormones or surgery so that their gender identity and biological sex at birth match more closely. Others may express gender in less permanent ways, including through clothing, hair, makeup, pronoun usage, and other gender expression behaviors. Still others choose not to alter their external appearance. Regardless, transgender people are unified by the desire to be seen and treated in a way consistent with how they self-identify.

Transgender people have many of the same health concerns as non-transgender people. There is a relative lack of data on transgender people but existing research suggests that transgender people have higher rates of adverse outcomes in substance abuse, HIV, depression, anxiety, self-harm, and violence.



Sexual orientation refers to the sex of people someone is attracted to and has sexual interest in, while gender identity refers to a person's internal understanding of his or her own gender. Someone who is transgender may identify as heterosexual, bisexual, or gay or lesbian.

The following selection of resources is intended to increase awareness of health issues and disparities affecting transgender people.

Hyperlinks marked  in the content below are Wisconsin resources.

For people who need medical interventions such as hormones or surgery, these might be covered under private insurance plans. Currently, Wisconsin BadgerCare, BadgerCare Plus, Medicaid, and State of Wisconsin employee health insurance (ETF) do not cover gender reassignment surgery or drugs related to gender reassignment or hormone replacement. Please contact your health insurance company to learn more details about what services are covered by your insurance.

General Resources

[Center of Excellence for Transgender Health](#)

Description: Based at the University of California, San Francisco, this academic center focuses on increasing access to comprehensive, effective, and affirming healthcare services for trans and gender-variant communities.

Resource availability: Internet

[Health information for transgender people](#)

Description: General health information for transgender people, published by the CDC

Resource availability: Internet

[Pediatric and Adolescent Transgender Health \(PATH\) Clinic](#)

Description: The Pediatric and Adolescent Transgender Health (PATH) Clinic, located at UW Health / American Family Children's Hospital in Madison, provides clinical services and education about medical care options for gender-variant children and adolescents.

Resource availability: Internet

[Transgender Aging Network](#)

Description: Online support group and email news list hosted by FORGE

Resource availability: Milwaukee

[See all General Resources](#)[Alcohol And Drugs](#)[Alcohol addiction](#)

Description: Symptoms of alcohol addiction and statistics about alcohol use among LGBT people published by the Pride Institute

Resource availability: Minneapolis, Minnesota; Fort Lauderdale, Florida; Internet

[Drug abuse](#)

Description: Symptoms of drug abuse and statistics about drug use among LGBT people published by the Pride Institute

Resource availability: Minneapolis, Minnesota and Fort Lauderdale, Florida

[Pride Institute](#)

Description: LGBT drug and alcohol addiction treatment center

Resource availability: Minneapolis, Minnesota and Fort Lauderdale, Florida

[Cancer](#)[National LGBT Cancer Network](#)

Description: Information on population specific cancer risks, optional electronic screening reminder **Resource availability:** Internet

[National LGBT Cancer Project](#)

Description: National nonprofit LGBT organization providing cancer survivor support and advocacy services.

Resource availability: Internet

[HIV/AIDS](#)[AIDS Resource Center of Wisconsin](#) 

Description: Medical center, social services, and prevention programs

Resource availability: Wisconsin

[Centers for Disease Control and Prevention](#)

Description: Fact sheet and additional information regarding HIV infection in transgender communities.

Resource availability: Internet

[Wisconsin HIV/STD/Hepatitis C Information and Referral Center](#) 

Description: Fact sheets, testing referrals, and external links

Resource availability: Internet

[Mental Health](#)[Anxiety disorders in LGBT populations](#)

Description: Information on anxiety disorders in LGBT populations published by the Pride Institute

Resource availability: Minneapolis, Minnesota; Fort Lauderdale, Florida; Internet

[Depression in LGBT populations](#)

Description: Information on depression in LGBT populations published by the Pride Institute

Resource availability: Minneapolis, Minnesota; Fort Lauderdale, Florida; and Internet

[National Suicide Prevention Lifeline](#)

Description: A 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress.

Resource availability: Internet and toll-free hotline: 1-800-273-TALK [8255]

Sexual Health

[General STD information](#)
Description: The CDC's webpage about STDs, including a testing site locator, statistics, and treatment guidelines
Resource availability: Internet

[Wisconsin HIV/STD/Hepatitis C Information and Referral Center](#)
Description: Information and service finder for STD diagnosis and treatment
Resource availability: Wisconsin

Tobacco

[Centers for Disease Control and Prevention -- Tips from Former Smokers](#)
Description: Real stories of Lesbian, Gay, Bisexual, and Transgender (LGBT) people who are suffering from smoking-related diseases and disabilities.
Resource availability: Internet

[National LGBT Tobacco Control Network](#)
Description: Quit strategies and resources, outreach information, statistics, and scientific literature
Resource availability: Internet

Violence/Safety

[Anti-Violence Project](#)
Description: Victim advocacy, community outreach, and service provider education program at the Milwaukee LGBT Community Center
Resource availability: Milwaukee

[Northwest Network](#)
Description: LGBT information and support regarding abuse and violence (based in Seattle, WA)
Resource availability: Internet

[Transgender Sexual Violence Project Description](#)
Description: Resources, including information, support groups, and a listserv, for transgender individuals and others who are not served by other sexual violence response systems; hosted by FORGE
Resource availability: Milwaukee, Internet

[StopBullying.gov](#)
Description: Information from various government agencies on how kids, teens, young adults, parents, educators and others in the community can prevent or stop bullying.
Resource availability: Internet

(Photograph on this page courtesy of Diverse and Resilient.)

Last Revised: December 13, 2017

EXHIBIT

16

[Search](#)

Welcome » May 23, 2018 12:22 PM

Program Name: BadgerCare Plus and Medicaid

Handbook Area: Physician

05/23/2018

[Covered and Noncovered Services : Surgery Services](#)

Topic #560

Breast Reconstruction

Breast reconstruction requires [PA \(prior authorization\)](#); however, PA is **waived** for breast reconstruction when performed following a mastectomy for breast cancer and when the claim includes one of the following [ICD \(International Classification of Diseases\)](#) diagnosis codes for breast cancer or a personal history of breast cancer. (Breast reconstruction is identified by [CPT \(Current Procedural Terminology\)](#) codes 19316–19325, 19340–19350, 19357–19369, 19380–19396.)

ICD Diagnosis Code	Description
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.311	Malignant neoplasm of lower-inner quadrant of right female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
C50.411	Malignant neoplasm of upper-outer quadrant of right female breast
C50.412	Malignant neoplasm of upper-outer quadrant of left female breast
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.611	Malignant neoplasm of axillary tail of right female breast
C50.612	Malignant neoplasm of axillary tail of left female breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
Z85.3	Personal history of malignant neoplasm of breast

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Wisconsin Department of Health Services

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Browser Tab ID: 6 -9

[Search](#)

Welcome » May 23, 2018 12:25 PM

Program Name: BadgerCare Plus and Medicaid

Handbook Area: Physician

05/23/2018

[Covered and Noncovered Services : Surgery Services](#)

Topic #18257

Reduction Mammoplasty

[Reduction mammoplasty](#) for female members with breast hypertrophy (enlarged breasts) is covered by ForwardHealth with [PA](#) (prior authorization).

Reduction mammoplasty is clinically indicated for women 18 years of age or older with breast hypertrophy if all of the following are true:

- There is significant physical functional impairment.
- The procedure can be reasonably expected to improve the physical functional impairment.
- Signs and/or symptoms resulting from the breast hypertrophy have not responded adequately to any non-surgical interventions.

Surgery is considered cosmetic unless breast hypertrophy is causing significant pain, paresthesias, or ulceration. Reduction mammoplasty for asymptomatic members is considered cosmetic and noncovered.

Providers are required to use [CPT \(Current Procedural Terminology\)](#) procedure code 19318 (Reduction mammoplasty) when submitting claims for reduction mammoplasty. The diagnosis code for breast hypertrophy must be indicated.

All reduction mammoplasties require PA. ForwardHealth has established clinical criteria for approval of a PA request for reduction mammoplasty. Reduction mammoplasties that do not meet the PA approval criteria are considered noncovered. Any charges related to a noncovered reduction mammoplasty will not be reimbursed.

Note: For male members with excess breast tissue, ForwardHealth covers mastectomy for gynecomastia when medically necessary per Wis. Admin. Code § [DHS 101.03\(96m\)](#); however, [PA](#) is required.

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Wisconsin Department of Health Services

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Browser Tab ID: 7 -11

[Search](#)

Welcome » May 23, 2018 12:27 PM

Program Name: BadgerCare Plus and Medicaid

Handbook Area: Physician

05/23/2018

[Covered and Noncovered Services : Codes](#)

Topic #13817

Restorative Plastic Surgery and Procedures

ForwardHealth covers restorative plastic surgeries and procedures when medically necessary per Wis. Admin. Code § [DHS 101.03\(96m\)](#); however, [PA \(prior authorization\)](#) is required for coverage of certain surgeries and procedures.

Note: PA is not required for [reconstruction after surgery for breast cancer](#).

The following table lists allowable [CPT \(Current Procedural Terminology\)](#) procedure codes for restorative plastic surgery and procedures that require PA.

Surgery	
CPT Procedure Code(s)	Service Description
11200-11201	Removal of skin tags
11920-11922	Tattooing
11950-11954	Subcutaneous injection of filling material (eg, collagen)
15780-15782	Dermabrasion
15786-15793	Abrasion and chemical peels
15820-15823	Blepharoplasty
15824-15829	Rhytidectomy
17360	Chemical exfoliation for acne (eg, acne paste, acid)
19316*	Mastopexy
19324-19325*	Mammoplasty, augmentation
19355	Correction of inverted nipples

19340-19369*	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
19380*	Revision of reconstructed breast
19396*	Preparation of moulage for custom breast implant
21083**	Impression and custom preparation; palatal lift prosthesis
21087**	Nasal prosthesis
21120-21123**	Genioplasty
21137	Reduction forehead; contouring only
21270**	Malar augmentation, prosthetic material
21280-21282	Medial or lateral canthopexy
30120	Excision or surgical planing of skin of nose for rhinophyma
30400-30450	Rhinoplasty
67900-67909	Repair of brow ptosis, repair of blepharoptosis
69300	Otoplasty, protruding ear, with or without size reduction

* Prior authorization is not required for these procedures if they are performed following a mastectomy for breast cancer and if the claim includes an allowable breast cancer or personal history of breast cancer diagnosis code.

** Prior authorization is required to process claims for DME (durable medical equipment) related to these procedures. The [DME Index](#) includes the PA requirements for DME.

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Wisconsin Department of Health Services

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Browser Tab ID: 15 -25

EXHIBIT

17

Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People

Center of Excellence for Transgender Health

Department of Family & Community Medicine

University of California, San Francisco

2nd Edition – Published June 17, 2016

Editor - Madeline B. Deutsch, MD, MPH



32. Binding, packing, and tucking

Primary author: Madeline B. Deutsch, MD, MPH

Tucking allows a visibly smooth crotch contour. In this practice, the testicles (if present) are moved into the inguinal canal, and moving the penis and scrotum posteriorly in the perineal region. Tight fitting underwear, or a special undergarment known as a *gaffe* is then worn to maintain this alignment. In some cases, adhesive or even duct tape may be used. In addition to local skin effects, this practice could result in urinary trauma or infections, as well as testicular complaints, which are covered elsewhere.

Packing is the placing of a penile prosthesis in one's underwear, giving both an outward appearance as well as reducing gender dysphoria.

Binding involves the use of tight fitting sports bras, shirts, ace bandages, or a specially made *binder* to provide a flat chest contour. In some people with larger breasts, multiple garments may be used, and breathing may be restricted. Prolonged binding may result in breast pain, local skin irritation, or fungal infections.

EXHIBIT

18

6082806800

5/21/2018 6:06:36 PM PAGE 2/003 Fax Server

2018-05-21 16:34

West Plastic Surgery 608 824 4941 >> 6082806800

P 2/3

Scott Walker
Governor



State of Wisconsin
Department of Health Services

Linda Seemeyer
Secretary

FORWARDHEALTH
PRIOR AUTHORIZATION
313 BLETNER BLVD
MADISON WI 53784
Telephone: 800-947-9627
Fax: 608-221-8616
TTY: 711
www.forwardhealth.wi.gov

August 02, 2017

0000045
DEAN HEALTH SYSTEMS INC
CHRISTINE NORMINGTON
1808 W BELTLINE HWY
MADISON, WI 53713 -2334

PA Number: 5171990032
PA Status: DENIED
PA Amendment Status:
Member Name: CODY J FLACK
PA Process Type: 117
Provider Sequence: 1
Letter Sequence: 133

Dear DEAN HEALTH SYSTEMS INC:

Your request for prior authorization (PA) has been finalized based on criteria established by the Department of Health Services and as stated in DHS 106.03(4), Wis. Admin. Code. Refer to the adjudication detail on the enclosed attachment for the service specific authorization.

An approved PA does not guarantee payment. Reimbursement is contingent upon enrollment of the member and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to the approval or after the authorization expiration date. Reimbursement will be in accordance with ForwardHealth payment methodology and policy. If the member is enrolled in a BadgerCare Plus managed care program at the time a prior authorized service is provided, ForwardHealth reimbursement will be allowed only if the service is not covered by the managed care program.

If the PA request was denied or modified, a Notice of Appeal Rights letter has been sent to the member. Only the member, or authorized person acting on behalf of the member, may file an appeal with the Division of Hearings and Appeals. Providers are encouraged to remain in contact with the member during the appeal process. Providers may offer the member information necessary to file an appeal and help present his or her case during a fair hearing.

If you have any questions about the decisions made on this PA, please contact Provider Services at 800-947-9627.

Sincerely,

ForwardHealth

Enclosure

F-11156 (03/14)

Wisconsin.gov

6082806800

5/21/2018 6:06:36 PM PAGE 3/003 Fax Server

2018-05-21 16:35

West Plastic Surgery 608 824 4941 >> 6082806800

P 3/3

Member Name: CODY J FLACK
 Member Identification Number: 5442392456
 Primary Diagnosis: F640
 Secondary Diagnosis:

PA Number: SF71990032
 PA Status: DENIED
 PA Amendment Status:

August 02, 2017, Page 2 of 2

Billing Practice Location Provider
 Provider Name: DEAN HEALTH SYSTEMS INC
 Provider Address: DEAN CLINIC CORPORATE
 1808 W. BELTLINE HWY
 MADISON, WI 53713 -2334
 Provider Identification Number: 1053358846
 Provider Taxonomy: 193200000X
 Provider ZIP Code:

08/02/17: Per WI administrative code DHS 107.03(24) transsexual surgery is a non-covered service. BA

Line #	Line Status	Rendering Provider	Taxonomy	Service	Modifier	POS	Unit Auth	Dollar Grant Auth Date	Expire Date	Group ID
01	DENIED	1407899545	208200000X	19303	50	24	0.000	\$0.00 08/02/2017	08/02/2017	
MAST SIMPLE COMPLETE 0126 - THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.										
02	DENIED	1407899545	208200000X	19350	50	24	0.000	\$0.00 08/02/2017	08/02/2017	
BREAST RECONSTRUCTION 0126 - THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.										

EXHIBIT

19

Scott Walker
Governor

Linda Seemeyer
Secretary



State of Wisconsin
Department of Health Services

FORWARDHEALTH

PRIOR AUTHORIZATION
313 BLETNER BLVD
MADISON WI 53784

Telephone: 800-947-9627
Fax: 608-221-8616
TTY: 711
www.forwardhealth.wi.gov

August 02, 2017

0000009
CODY J FLACK



Member Identification Number: [REDACTED]
Local County or Tribal Agency
Telephone Number: () -

BadgerCare Plus Notice of Appeal Rights

Appeal Date: 09/16/2017

In BadgerCare Plus, certain services and products must be reviewed and approved before payment can be made for them. This review process is called prior authorization (PA). The purposes of this letter are to notify you that BadgerCare Plus has either denied or modified a request for prior authorization of a service or product that was submitted on your behalf and to inform you of your right to appeal that decision.

Your provider DEAN HEALTH SYSTEMS INC requested prior authorization for the following service(s):

Service Code	Modifier	Service Description	Unit	Dollar
19303	50	MAST SIMPLE COMPLETE	1.000	\$7,113.00
19350	50	BREAST RECONSTRUCTION	1.000	\$12,118.50



August 02, 2017, Page 2 of 4

That prior authorization request, PA number 5171990032, was reviewed by BadgerCare Plus medical consultants. Based on that review, the following services have been denied or modified as follows:

Denied Services:

Service Code	Modifier	Service Description	Unit	Dollar
19303	50	MAST SIMPLE COMPLETE	1.000	\$7,113.00
19350	50	BREAST RECONSTRUCTION	1.000	\$12,118.50

Modified Services:

BadgerCare Plus's denial or modification of the services requested was made for the following reasons:

0126 - THE SERVICE REQUESTED IS NOT A COVERED BENEFIT. THE REQUEST DOES NOT MEET ONE OR MORE OF THE CRITERIA FOUND IN WISCONSIN ADMINISTRATIVE CODE.

0126 - THE SERVICE REQUESTED IS NOT A COVERED BENEFIT. THE REQUEST DOES NOT MEET ONE OR MORE OF THE CRITERIA FOUND IN WISCONSIN ADMINISTRATIVE CODE.

BadgerCare Plus bases its decisions on criteria found in the Wisconsin Administrative Code. BadgerCare Plus may modify or deny a prior authorization request if one or more of the criteria are not supported by documentation submitted by your provider. The specific regulation(s) that support the reason for the denial/modification of your provider's request for services is found in the following Wisconsin Administrative Code:

0126 - DHS 107.03 WISCONSIN ADMINISTRATIVE CODE

0126 - DHS 107.03 WISCONSIN ADMINISTRATIVE CODE

We have sent your provider the denied/modified prior authorization request. We encourage you to contact DEAN HEALTH SYSTEMS INC to review the prior authorization request and the reasons for the decision.

Your Rights and Responsibilities

You or your designated representative may appeal this decision in accordance with state and

August 02, 2017, Page 3 of 4

federal law within 45 days. To file an appeal, you may do one of the following:

- 1) Call your local county or tribal agency at the telephone number listed on the first page of this letter for an appeal form and/or assistance in completing it.
- 2) Write a letter requesting an appeal to the Division of Hearings and Appeals at the following address:

Division of Hearings and Appeals
Department of Administration
PO Box 7875
Madison, WI 53707-7875

The appeal form or letter should include all of the following:

- The name, address, phone number of the BadgerCare Plus member for whom the appeal is being made.
- The member identification number.
- The prior authorization number 5171990032 of the denied/modified request.
- The reason you think the denial or modification of the prior authorization is wrong.

REMEMBER: You must mail or deliver your appeal to your local county or tribal agency or the Division of Hearings and Appeals so it is *received* by the 45-day deadline, which is 09/16/2017 .

You will lose your right to an appeal if your request to appeal is not received by the local county or tribal agency or the Division of Hearings and Appeals by 09/16/2017 .

If you file an appeal, you may expect the following to occur:

- The State Division of Health Care Access and Accountability (DHCAA) will be required to explain, in writing, the reason(s) for the denial or modification of the services your provider requested. This explanation will be mailed to you.
- The Division of Hearings and Appeals will schedule a hearing to consider your appeal and will notify you of the time and place by mail. Hearings are generally held at your local county or tribal agency. You may want to ask your local county or tribal agency if there is free legal help available in your area.
- At that hearing, you (or you may choose a friend, relative, attorney, provider, etc, to represent you) will have an opportunity to explain your need for the service to a hearing officer. Division of Health Care Access and Accountability staff may also appear in person or participate by telephone.

August 02, 2017, Page 4 of 4

- Based on all the information available, the hearing officer will make a decision on your appeal, notify you of the decision by mail, and advise you of any additional appeal rights.

Whether or not you appeal, BadgerCare Plus will pay for any services it has approved. After the hearing officer makes a decision on your appeal, BadgerCare Plus will continue to pay for the approved services plus any additional services the hearing officer directs BadgerCare Plus to pay.

If you need information about accommodation for a disability or for language translation, please call 608-266-3096 (voice) or 608-264-9853 (TTY) immediately so arrangements can be made. The staff at these numbers will not be able to provide you with information about the reasons for BadgerCare Plus's decision to deny or modify the prior authorization request. These telephone numbers at the Division of Hearings and Appeals should only be used for questions about the hearing process.

F-11194 (10/08)

EXHIBIT

20



**STATE OF WISCONSIN
Division of Hearings and Appeals**

In the Matter of

Cody Flack
[REDACTED]

DECISION
Case #: MPA - 183168

PRELIMINARY RECITALS

Pursuant to a petition filed August 23, 2017, under Wis. Stat., §49.45(5), to review a decision by the Division of Medicaid Services (DMS) to deny Medical Assistance (MA) authorization for a mastectomy and breast reconstruction, a hearing was held on November 14, 2017, by telephone. A hearing set for October 6, 2017 was rescheduled at the petitioner's request.

The issue for determination is whether the DMS correctly denied MA coverage for the requested surgery.

PARTIES IN INTEREST:

Petitioner:

Petitioner's Representative:

Cody Flack
[REDACTED]

Michael Prochaska
[REDACTED]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703

By: Written submission of Julie Sager, MD
Division of Medicaid Services
PO Box 309
Madison, WI 53701-0309

ADMINISTRATIVE LAW JUDGE:

Brian C. Schneider
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a 29-year-old resident of Brown County who receives MA.
2. Petitioner is a transgender man. He previously had a hysterectomy that was covered by MA, and he is taking testosterone cypionate, also covered by MA.

3. On July 18, 2017, Dean Health Systems requested prior authorization for a complete mastectomy and breast reconstruction, PA no. 5171990032. By a letter dated August 2, 2017, the DMS denied the request because it is not covered benefit.
4. The requested surgery is part of petitioner's transition from female to male.

DISCUSSION

The MA program may only reimburse providers for medically necessary and appropriate health care services and equipment listed in Wis. Stat., §§49.46(2) and 49.47(6)(a), as implemented by Wis. Admin. Code, Chapter DHS 107. §DHS 107.03 lists services that are not covered by MA, and no. (24) is transsexual surgery. The subsection was implemented in 1997 as part of Clearinghouse Rule CR 96-154.

Petitioner does not dispute that the proposed surgery falls within the prohibition of §DHS 107.03(24). Petitioner and his partner make a number of arguments, in particular that the prohibition is unconstitutional, that the agency usurped the legislature in creating the prohibition, that it violates the Wis. Stat., §49.45 standard that the MA program provide appropriate health care and obtain the most benefits available under Federal Title XIX (those arguments were made in petitioner's partner's brief), and from petitioner, that despite its transsexual nature the surgery nevertheless is medically necessary because it will improve petitioner's general mental health and his gender dysphoria, and finally that the DMS is inconsistent in its approval since it approves the testosterone.

The arguments are reasoned and credible. However, the Division of Hearings and Appeals is limited in its authority. Case law in Wisconsin has recognized that the powers of administrative agencies are limited to those expressly granted by the legislature or necessarily implied by the statutes. *DOR v. Hogan*, 198 Wis. 2d 792, 816, 543 N.W.2d 825 (Ct. App. 1995), provides in pertinent part:

Few principles are as well established as the proposition that administrative agencies, as entities created by the legislature as part of the executive branch of government, have only such powers as are expressly granted to them by the legislature, or as may be necessarily implied from the applicable statutes.... In determining the nature and scope of an agency's powers, its enabling statutes are to be "strictly construed to preclude the exercise of a power not expressly granted," and "[a]ny reasonable doubt as to the existence of an implied power should be resolved against [the agency]."

Emphasis added; citations omitted. Administrative agencies do not have the power to declare statutes or rules unconstitutional. See *Society Ins. V. Labor & Industry Review Com'n*, 2010 WI 68, ¶ 76, n. 5, 326 Wis. 2d 444, 786 N.W. 2d 385; *Warshafsky v. Journal Co.*, 63 Wis. 2d 130, 147, 216 N.W.2d 197 (1974). In addition, it is the long-standing policy of the Division of Hearings and Appeals that Administrative Law Judges do not possess equitable powers. See *Wisconsin Socialist Workers 1976 Campaign Committee v. McCann*, 433 F. Supp. 540, 545 (E.D. Wis.1977). This office must limit its review to the law as set forth in statutes, federal regulations, and administrative code provisions.

While the proposed surgery presumably would favorably address petitioner's gender dysphoria, the surgery nevertheless is transsexual surgery that specifically is not covered under the code. I also cannot order the surgery because the DMS inconsistently approves testosterone, which would appear to be uncovered under Wis. Admin. Code, §DHC 107.03(23); it is unknown why the DMS covers the testosterone.

Because the Wisconsin Administrative Code specifically defines transsexual surgery as not covered by MA, I must uphold the denial.

CONCLUSIONS OF LAW

The DMS correctly denied the requested surgery because it is listed as not covered by MA in Wis. Admin. Code, §DHS 107.03(24).

THEREFORE, it is ORDERED

That the petition for review is hereby dismissed.

REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision**. Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Madison,
Wisconsin, this 21 day of November, 2017



Brian C. Schneider
Administrative Law Judge
Division of Hearings and Appeals

THIS IS A COPIED COPY OF THE
ORIGINAL AND DELETED MADE IN THIS
WATER AND THERE IS NO DIVISION OF
HEARINGS AND APPEALS IN THE CITY
OF MADISON, WISCONSIN.

EXHIBIT

21



STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

Cody Flack
[REDACTED]
[REDACTED]

REHEARING REQUEST ORDER
Case #: MPA - 183168

Your request for a rehearing received on December 8, 2017 is hereby denied.

Pursuant to Wis. Stat., §227.49, a rehearing may be granted only on the basis of a material error of law or fact or upon the discovery of new evidence sufficiently strong to reverse or modify the order and which could not have been discovered previously by due diligence. The petition must specify in detail the grounds for the relief sought and supporting authorities. Your request does not establish the grounds necessary for granting a rehearing in this matter.

Although I stand by my conclusions that the Division of Hearings and Appeals does not have authority to address the issues raised, particularly the issue of sex discrimination, your argument concerning the administrative rules depends on the huge assumption that the prohibition of MA coverage of transsexual surgery is due to belief/finding/conclusion that such surgery is not necessary. There is no evidence to support that assumption, so I would be unable to find that the code provision duplicates other codes provisions.

This is an order disposing of a petition for rehearing. Parties having standing to appeal may file a petition to Circuit Court under Wis. Stat., §227.53. A petition to Circuit Court must be served and filed no more than 30 days after the date of a denial of a timely rehearing petition. An appeal must be served on the Department of Health Services, 1 West Wilson Street, Room 651, Madison, Wisconsin, 53703 as respondent. Copies of the appeal must also be served on all other 'Parties in Interest' identified in the original administrative hearing decision in this case.

Given under my hand at the City of Madison,
Wisconsin, this 17 day of December, 2017

A handwritten signature in cursive script, appearing to read 'Brian C. Schneider'.

Brian C. Schneider
Administrative Law Judge

THIS IS A CERTIFIED COPY OF THE DECISION MADE IN THIS
MATTER AND FILED IN THE DIVISION OF HEARINGS AND
APPEALS IN THE CITY OF MADISON, WISCONSIN

c: Division of Health Care Access and Accountability - email
Michael Prochaska

EXHIBIT

22



Scott Walker
Governor

DIVISION OF MEDICAID SERVICES

1 WEST WILSON STREET
PO BOX 309
MADISON WI 53701-0309

Linda Seemeyer
Secretary

State of Wisconsin
Department of Health Services

Telephone: 608-266-8922
Fax: 608-266-1096
TTY: 711

September 25, 2017

Department of Administration
Division of Hearings and Appeals
5005 University Avenue, Suite 201
P.O. Box 7875
Madison, WI 53707-7875

And

MPA-05/183168

Cody Flack

Dear Hearing Examiner and Mr. Flack:

The Division of Hearings and Appeals (DHA) has requested that the Department of Medicaid Services (DMS), submit a summarized statement outlining the facts and basis for denial of Prior Authorization (PA) #5171990032 for bilateral complete simple mastectomy (service code 19303) and breast reconstruction (nipple graft- service code 19350).

Mr. Flack is a 29 year old transgender man who is seeking the aforementioned services as part of gender confirmation surgery. The primary diagnosis listed with the prior authorization request is transsexualism (F64.0). Mr. Flack also carries a diagnosis of gender dysphoria which is an accepted medical indication for the surgical treatment requested.

This request was denied by DMS as Wis. Admin. Code DHS 107.03(24) specifically lists 'transsexual surgery' as a non-covered service under medical assistance.

The medical necessity of the services requested was not taken into account as reimbursement by Medicaid for this type of surgery is currently excluded by DHS regulations.

Furthermore, please take notice of the attached federal court decision staying enforcement of Section 1557 of the Affordable Care Act regulations related to gender identity.

Division of Hearings and Appeals
Cody Flack, MPA-05/183168
September 25 2017
Page 2 of 2

It is anticipated that the Division of Medicaid Services will not be participating in the fair hearing.

Sincerely,

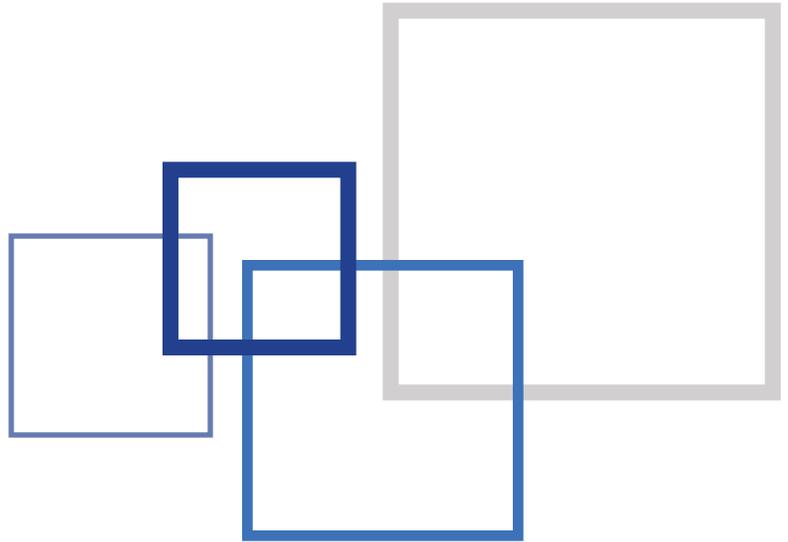
A handwritten signature in black ink, appearing to read 'Julie Sager', with a long horizontal flourish extending to the right.

Julie Sager, MD
Medical Director
Bureau of Benefits Management
Division of Medicaid services
Wisconsin Department of Health Services

Encl.

EXHIBIT

23



THE REPORT OF THE

2015

U.S.

TRANSGENDER

SURVEY

EXECUTIVE SUMMARY

December 2016

USTS Executive Summary

The 2015 U.S. Transgender Survey (USTS) is the largest survey examining the experiences of transgender people in the United States, with 27,715 respondents from all fifty states, the District of Columbia, American Samoa, Guam, Puerto Rico, and U.S. military bases overseas. Conducted in the summer of 2015 by the National Center for Transgender Equality, the USTS was an anonymous, online survey for transgender adults (18 and older) in the United States, available in English and Spanish. The USTS serves as a follow-up to the groundbreaking 2008–09 National Transgender Discrimination Survey (NTDS), which helped to shift how the public and policymakers view the lives of transgender people and the challenges they face. The report of the 2015 USTS provides a detailed look at the experiences of transgender people across a wide range of categories, such as education, employment, family life, health, housing, and interactions with the criminal justice system.

The findings reveal disturbing patterns of mistreatment and discrimination and startling disparities between transgender people in the survey and the U.S. population when it comes to the most basic elements of life, such as finding a job, having a place to live, accessing medical care, and enjoying the support of family and community. Survey respondents also experienced harassment and violence at alarmingly high rates. Several themes emerge from the thousands of data points presented in the full survey report.

Pervasive Mistreatment and Violence

Respondents reported high levels of mistreatment, harassment, and violence in every aspect of life. One in ten (10%) of those who were out to their immediate family reported that a family member was violent towards them because they were transgender, and 8% were kicked out of the house because they were transgender.

The majority of respondents who were out or perceived as transgender while in school (K–12) experienced some form of mistreatment, including being verbally harassed (54%), physically attacked (24%), and sexually assaulted (13%) because they were transgender. Further, 17% experienced such severe mistreatment that they left a school as a result.

In the year prior to completing the survey, 30% of respondents who had a job reported being fired, denied a promotion, or experiencing some other form of mistreatment in the workplace due to their gender identity or expression, such as being verbally harassed or physically or sexually assaulted at work.

In the year prior to completing the survey, 46% of respondents were verbally harassed and 9% were physically attacked because of being transgender. During that same time period, 10% of respondents were sexually assaulted, and nearly half (47%) were sexually assaulted at some point in their lifetime.

Severe Economic Hardship and Instability

The findings show large economic disparities between transgender people in the survey and the U.S. population. Nearly one-third (29%) of respondents were living in poverty, compared to 12% in the U.S. population. A major contributor to the high rate of poverty is likely respondents' 15% unemployment rate—three times higher than the unemployment rate in the U.S. population at the time of the survey (5%).

Respondents were also far less likely to own a home, with only 16% of respondents reporting homeownership, compared to 63% of the U.S. population. Even more concerning, nearly one-third (30%) of respondents have experienced homelessness at some point in their lifetime, and 12% reported experiencing homelessness in the year prior to completing the survey because they were transgender.

Harmful Effects on Physical and Mental Health

The findings paint a troubling picture of the impact of stigma and discrimination on the health of many transgender people. A staggering 39% of respondents experienced serious psychological distress in the month prior to completing the survey, compared with only 5% of the U.S. population. Among the starkest findings is that 40% of respondents have attempted suicide in their lifetime—nearly nine times the attempted suicide rate in the U.S. population (4.6%).

Respondents also encountered high levels of mistreatment when seeking health care. In the year prior to completing the survey, one-third (33%) of those who saw a health care provider had at least one negative experience related to being transgender, such as being verbally harassed or refused treatment because of their gender identity. Additionally, nearly one-quarter (23%) of respondents reported that they did not seek the health care they needed in the year prior to completing the survey due to fear of being mistreated as a transgender person, and 33% did not go to a health care provider when needed because they could not afford it.

The Compounding Impact of Other Forms of Discrimination

When respondents' experiences are examined by race and ethnicity, a clear and disturbing pattern is revealed: transgender people of color experience deeper and broader patterns of discrimination than white respondents and the U.S. population. While respondents in the USTS sample overall were more than twice as likely as the U.S. population to be living in poverty, people of color, including Latino/a (43%), American Indian (41%), multiracial (40%), and Black (38%) respondents, were more than three times as likely as the U.S. population (12%) to be living in poverty. The unemployment rate among transgender people of color (20%) was four times higher than the U.S. unemployment rate (5%). People of color also experienced greater health disparities. While 1.4% of all respondents were living with HIV—nearly five times the rate in the U.S. population (0.3%)—the rate among Black respondents (6.7%) was substantially higher, and the rate for Black transgender women was a staggering 19%.

Undocumented respondents were also more likely to face severe economic hardship and violence than other respondents. In the year prior to completing the survey, nearly one-quarter (24%) of undocumented respondents were physically attacked. Additionally, one-half (50%) of undocumented respondents have experienced homelessness in their lifetime, and 68% have faced intimate partner violence.

Respondents with disabilities also faced higher rates of economic instability and mistreatment. Nearly one-quarter (24%) were unemployed, and 45% were living in poverty. Transgender people with disabilities were more likely to be currently experiencing serious psychological distress (59%) and more likely to have attempted suicide in their lifetime (54%). They also reported higher rates of mistreatment by health care providers (42%).

Increased Visibility and Growing Acceptance

Despite the undeniable hardships faced by transgender people, respondents' experiences also show some of the positive impacts of growing visibility and acceptance of transgender people in the United States.

One such indication is that an unprecedented number of transgender people—nearly 28,000—completed the survey, more than four times the number of respondents in the 2008–09 NTDS. This number of transgender people who elevated their voices reflects the historic growth in visibility that the transgender community has seen in recent years. Additionally, this growing visibility has lifted up not only the voices of transgender men and women, but also people who are non-binary, which is a term that is often used to describe

people whose gender identity is not exclusively male or female, including those who identify as having no gender, a gender other than male or female, or more than one gender. With non-binary people making up over one-third of the sample, the need for advocacy that is inclusive of all identities in the transgender community is clearer than ever.

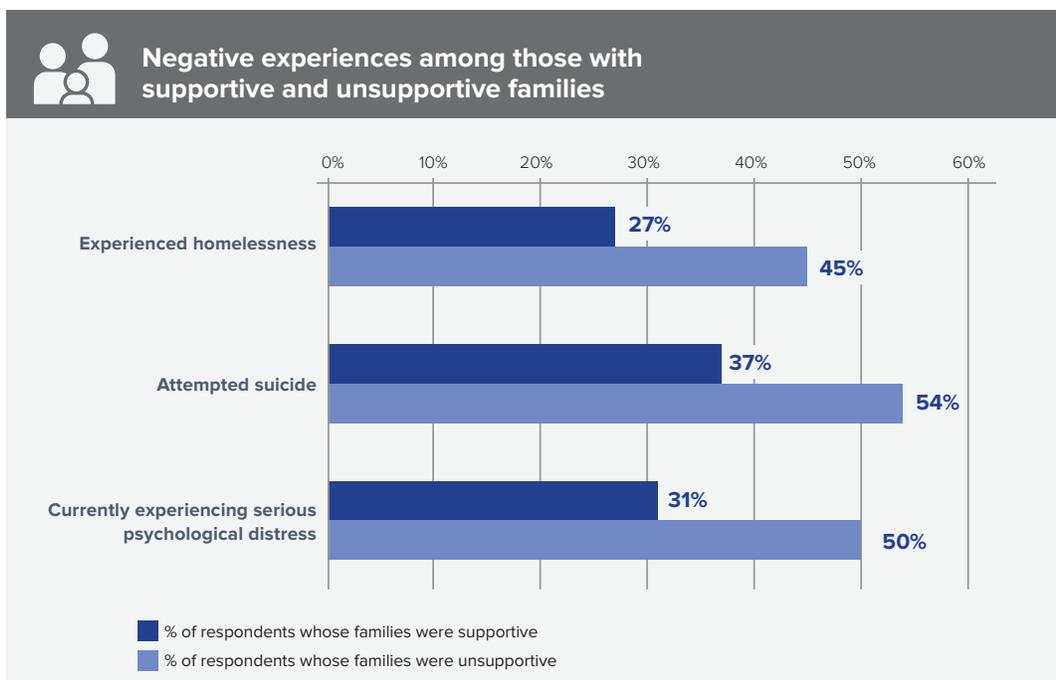
Respondents' experiences also suggest growing acceptance by family members, colleagues, classmates, and other people in their lives. More than half (60%) of respondents who were out to their immediate family reported that their family was supportive of them as a transgender person. More than two-thirds (68%) of those who were out to their coworkers reported that their coworkers were supportive. Of students who were out to their classmates, more than half (56%) reported that their classmates supported them as a transgender person.

Overall, the report provides evidence of hardships and barriers faced by transgender people on a day-to-day basis. It portrays the challenges that transgender people must overcome and the complex systems that they are often forced to navigate in multiple areas of their lives in order to survive and thrive. Given this evidence, governmental and private institutions throughout the United States should address these disparities and ensure that transgender people are able to live fulfilling lives in an inclusive society. This includes eliminating barriers to quality, affordable health care, putting an end to discrimination in schools, the workplace, and other areas of public life, and creating systems of support at the municipal, state, and federal levels that meet the needs of transgender people and reduce the hardships they face. As the national conversation about transgender people continues to evolve, public education efforts to improve understanding and acceptance of transgender people are crucial. The rates of suicide attempts, poverty, unemployment, and violence must serve as an immediate call to action, and their reduction must be a priority. Despite policy improvements over the last several years, it is clear that there is still much work ahead to ensure that transgender people can live without fear of discrimination and violence.

Overview of Key Findings

Family Life and Faith Communities

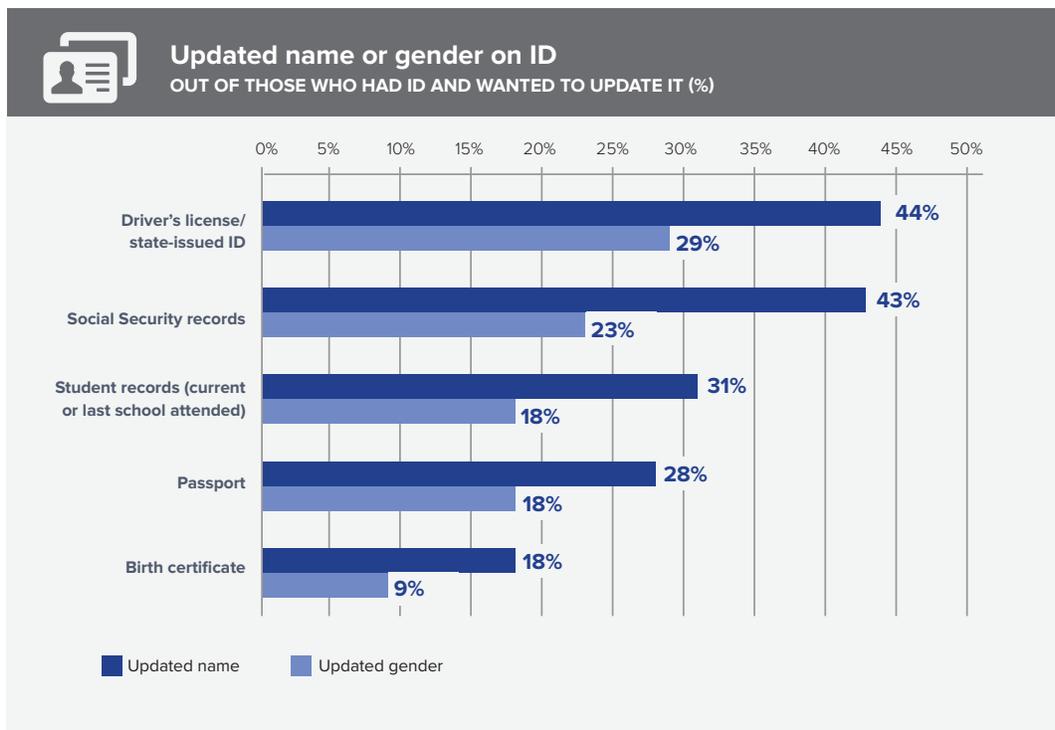
- **A majority of respondents (60%) who were out to the immediate family they grew up with said that their family was generally supportive of their transgender identity,** while 18% said that their family was unsupportive, and 22% said that their family was neither supportive nor unsupportive.
- **Those who said that their immediate families were supportive were less likely to report a variety of negative experiences related to economic stability and health,** such as experiencing homelessness, attempting suicide, or experiencing serious psychological distress.



- **One in ten (10%)** respondents who were out to their immediate family reported that a **family member was violent towards them** because they were transgender.
- **One in twelve (8%)** respondents who were out to their immediate family **were kicked out of the house**, and one in ten (10%) ran away from home.
- **Nineteen percent (19%)** of respondents who had ever been part of a **spiritual or religious community left due to rejection**. Forty-two percent (42%) of those who left later found a welcoming spiritual or religious community.

Identity Documents

- Only 11% of respondents reported that *all* of their IDs had the name and gender they preferred, while more than two-thirds (68%) reported that *none* of their IDs had the name and gender they preferred.



- The cost of changing ID documents was one of the main barriers respondents faced, with 35% of those who have not changed their legal name and 32% of those who have not updated the gender on their IDs reporting that it was because they could not afford it.
- Nearly **one-third (32%)** of respondents **who have shown an ID with a name or gender that did not match their gender presentation were verbally harassed, denied benefits or service, asked to leave, or assaulted.**

Health Insurance and Health Care

- **One in four (25%) respondents experienced a problem in the past year with their insurance related to being transgender**, such as being denied coverage for care related to gender transition or being denied coverage for routine care because they were transgender.
- **More than half (55%) of those who sought coverage for transition-related surgery in the past year were denied**, and 25% of those who sought coverage for hormones in the past year were denied.
- **One-third (33%) of those who saw a health care provider in the past year reported having at least one negative experience related to being transgender**, with higher rates for people of color and people with disabilities. This included being refused treatment, verbally harassed, or physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.
- In the past year, **23% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person**, and 33% did not see a doctor when needed because they could not afford it.

Psychological Distress and Attempted Suicide

- **Thirty-nine percent (39%) of respondents experienced serious psychological distress** in the month before completing the survey (based on the Kessler 6 Psychological Distress Scale), compared with only 5% of the U.S. population.
- **Forty percent (40%) have attempted suicide in their lifetime**, nearly nine times the rate in the U.S. population (4.6%).
- **Seven percent (7%) attempted suicide in the past year**—nearly twelve times the rate in the U.S. population (0.6%).

HIV

- Respondents were **living with HIV (1.4%) at nearly five times the rate in the U.S. population (0.3%)**.
- **HIV rates were higher among transgender women (3.4%)**, especially transgender women of color. **Nearly one in five (19%) Black transgender women were living with HIV**, and American Indian (4.6%) and Latina (4.4%) women also reported higher rates.

Experiences in Schools

- **More than three-quarters (77%)** of those who were out or perceived as transgender at some point between Kindergarten and Grade 12 (K–12) **experienced some form of mistreatment**, such as being verbally harassed, prohibited from dressing according to their gender identity, disciplined more harshly, or physically or sexually assaulted because people thought they were transgender.
- **Fifty-four percent (54%)** of those who were out or perceived as transgender in K–12 **were verbally harassed, nearly one-quarter (24%) were physically attacked, and 13% were sexually assaulted in K–12 because of being transgender.**
- **Seventeen percent (17%)** faced such severe mistreatment as a transgender person that they left a K–12 school.
- **Nearly one-quarter (24%)** of people who were out or perceived as transgender in college or vocational school **were verbally, physically, or sexually harassed.**

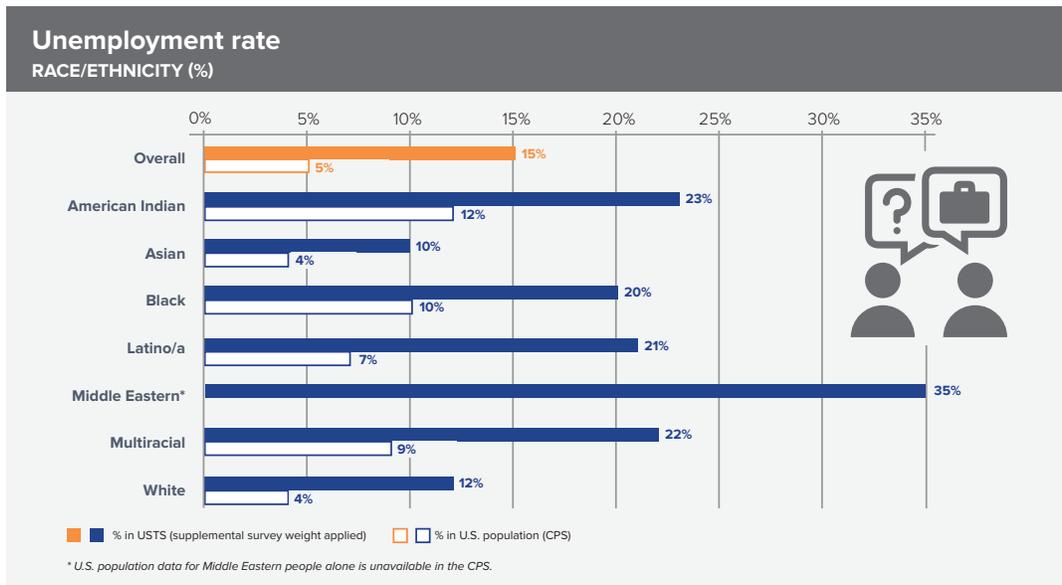


Experiences of people who were out as transgender in K–12 or believed classmates, teachers, or school staff thought they were transgender

EXPERIENCES	% OF THOSE WHO WERE OUT OR PERCEIVED AS TRANSGENDER
Verbally harassed because people thought they were transgender	54%
Not allowed to dress in a way that fit their gender identity or expression	52%
Disciplined for fighting back against bullies	36%
Physically attacked because people thought they were transgender	24%
Believe they were disciplined more harshly because teachers or staff thought they were transgender	20%
Left a school because the mistreatment was so bad	17%
Sexually assaulted because people thought they were transgender	13%
Expelled from school	6%
One or more experiences listed	77%

Income and Employment Status

- **The unemployment rate among respondents (15%) was three times higher than the unemployment rate in the U.S. population (5%),** with Middle Eastern, American Indian, multiracial, Latino/a, and Black respondents experiencing higher rates of unemployment.



- **Nearly one-third (29%) were living in poverty, more than twice the rate in the U.S. population (12%).**

Employment and the Workplace

- **One in six (16%)** respondents who have ever been employed—or 13% of all respondents in the sample—**reported losing a job because of their gender identity or expression** in their lifetime.
- **In the past year, 27%** of those who held or applied for a job during that year—19% of all respondents—**reported being fired, denied a promotion, or not being hired for a job they applied for because of their gender identity or expression.**
- **Fifteen percent (15%)** of respondents who had a job in the past year were verbally harassed, physically attacked, and/or sexually assaulted at work because of their gender identity or expression.
- **Nearly one-quarter (23%)** of those who had a job in the past year reported other forms of mistreatment based on their gender identity or expression during that year,

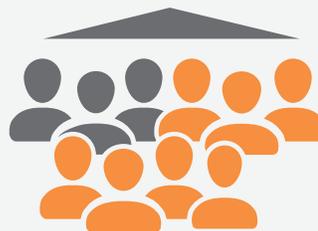
such as being forced to use a restroom that did not match their gender identity, being told to present in the wrong gender in order to keep their job, or having a boss or coworker share private information about their transgender status without their permission.

- **Overall, 30% of respondents who had a job in the past year reported being fired, denied a promotion, or experiencing some other form of mistreatment related to their gender identity or expression.**
- **More than three-quarters (77%) of respondents who had a job in the past year took steps to avoid mistreatment in the workplace,** such as hiding or delaying their gender transition or quitting their job.

Housing, Homelessness, and Shelter Access

- **Nearly one-quarter (23%) of respondents experienced some form of housing discrimination in the past year,** such as being evicted from their home or denied a home or apartment because of being transgender.
- **Nearly one-third (30%) of respondents have experienced homelessness at some point in their lives.**
- **In the past year, one in eight (12%) respondents experienced homelessness** because of being transgender.
- **More than one-quarter (26%) of those who experienced homelessness in the past year avoided staying in a shelter because they feared being mistreated as a transgender person.** Those who did stay in a shelter reported high levels of mistreatment: **seven out of ten (70%)** respondents who stayed in a shelter in the past year reported some form of mistreatment, including being harassed, sexually or physically assaulted, or kicked out because of being transgender.

Seven out of ten respondents who stayed in a shelter in the past year reported being mistreated because of being transgender.



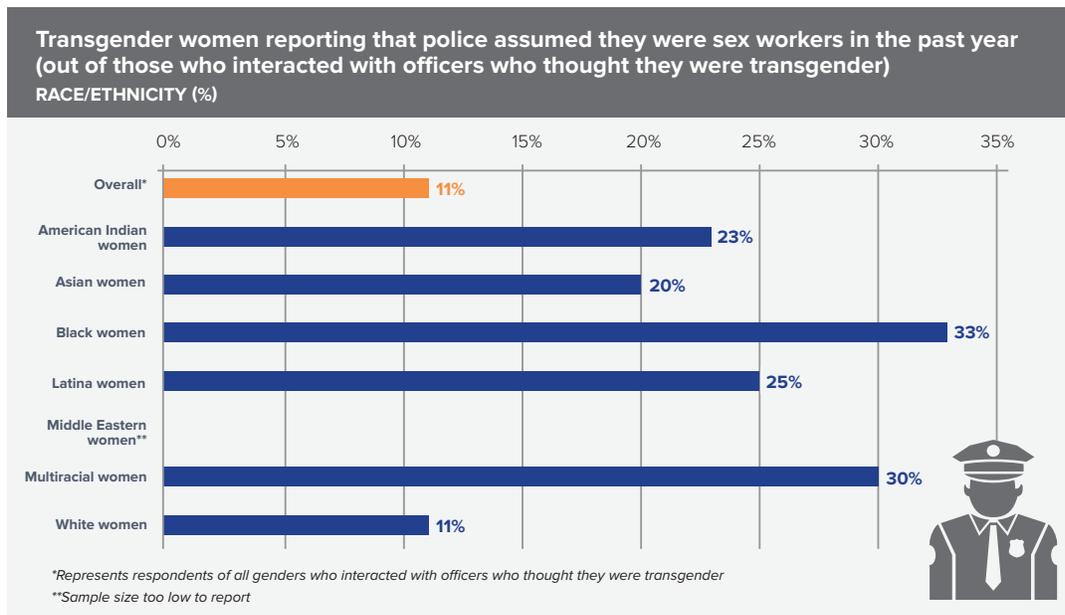
- Respondents were nearly **four times less likely to own a home (16%) compared to the U.S. population (63%).**

Sex Work and Other Underground Economy Work

- Respondents reported high rates of experience in the underground economy, including sex work, drug sales, and other work that is currently criminalized. **One in five (20%) have participated in the underground economy** for income at some point in their lives—including 12% who have done sex work in exchange for income—and 9% did so in the past year, with higher rates among women of color.
- Respondents who interacted with the police either while doing sex work or while the police mistakenly thought they were doing sex work reported high rates of police harassment, abuse, or mistreatment, with **nearly nine out of ten (86%) reporting being harassed, attacked, sexually assaulted, or mistreated in some other way by police.**
- **Those who have done income-based sex work were also more likely to have experienced violence.** More than three-quarters (77%) have experienced intimate partner violence and 72% have been sexually assaulted, a substantially higher rate than the overall sample. Out of those who were working in the underground economy at the time they took the survey, nearly half (41%) were physically attacked in the past year and over one-third (36%) were sexually assaulted during that year.

Police Interactions and Prisons

- **Respondents experienced high levels of mistreatment and harassment by police.** In the past year, of respondents who interacted with police or law enforcement officers who thought or knew they were transgender, **more than half (58%) experienced some form of mistreatment.** This included being verbally harassed, repeatedly referred to as the wrong gender, physically assaulted, or sexually assaulted, including being forced by officers to engage in sexual activity to avoid arrest.
- **Police frequently assumed that respondents—particularly transgender women of color—were sex workers.** In the past year, of those who interacted with law enforcement officers who thought or knew they were transgender, one-third (33%) of Black transgender women and 30% of multiracial women said that an officer assumed they were sex workers.
- **More than half (57%)** of respondents said they would feel **uncomfortable asking the police for help** if they needed it.
- Of those who were arrested in the past year (2%), **nearly one-quarter (22%) believed they were arrested because they were transgender.**



- Respondents who were held in jail, prison, or juvenile detention in the past year faced **high rates of physical and sexual assault by facility staff and other inmates**. In the past year, nearly one-quarter (23%) were physically assaulted by staff or other inmates, and one in five (20%) were sexually assaulted. Respondents were over **five times more likely to be sexually assaulted by facility staff** than the U.S. population in jails and prisons, and over **nine times more likely to be sexually assaulted by other inmates**.

Harassment and Violence

- **Nearly half (46%) of respondents were verbally harassed** in the past year because of being transgender.
- **Nearly one in ten (9%) respondents were physically attacked** in the past year because of being transgender.
- **Nearly half (47%) of respondents were sexually assaulted** at some point in their lifetime and **one in ten (10%) were sexually assaulted in the past year**. Respondents who have done sex work (72%), those who have experienced homelessness (65%), and people with disabilities (61%) were more likely to have been sexually assaulted in their lifetime.
- **More than half (54%) experienced some form of intimate partner violence**, including acts involving coercive control and physical harm.
- **Nearly one-quarter (24%) have experienced severe physical violence by an intimate partner, compared to 18% in the U.S. population.**

Places of Public Accommodation

- Respondents reported being denied equal treatment or service, verbally harassed, or physically attacked at many places of public accommodation—places that provide services to the public, like retail stores, hotels, and government offices. Out of respondents who visited a place of public accommodation where staff or employees thought or knew they were transgender, **nearly one-third (31%) experienced at least one type of mistreatment in the past year in a place of public accommodation.** This included 14% who were denied equal treatment or service, 24% who were verbally harassed, and 2% who were physically attacked because of being transgender.
- **One in five (20%) respondents did not use at least one type of public accommodation** in the past year because they feared they would be mistreated as a transgender person.

Denied equal treatment or service, verbally harassed, or physically attacked in public accommodations in the past year because of being transgender

LOCATION VISITED	% OF THOSE WHO SAID STAFF KNEW OR THOUGHT THEY WERE TRANSGENDER
Public transportation	34%
Retail store, restaurant, hotel, or theater	31%
Drug or alcohol treatment program	22%
Domestic violence shelter or program or rape crisis center	22%
Gym or health club	18%
Public assistance or government benefit office	17%
Department of Motor Vehicles (DMV)	14%
Nursing home or extended care facility	14%
Court or courthouse	13%
Social Security office	11%
Legal services from an attorney, clinic, or legal professional	6%



Experiences in Restrooms

The survey data was collected before transgender people’s restroom use became the subject of increasingly intense and often harmful public scrutiny in the national media and legislatures around the country in 2016. Yet respondents reported facing frequent harassment and barriers when using restrooms at school, work, or in public places.

- **Nearly one in ten (9%) respondents reported that someone denied them access to a restroom in the past year.**
- In the past year, **respondents reported being verbally harassed (12%), physically attacked (1%), or sexually assaulted (1%)** when accessing a restroom.

- **More than half (59%)** of respondents **avoided using a public restroom** in the past year because they were afraid of confrontations or other problems they might experience.
- **Nearly one-third (32%)** of respondents **limited the amount that they ate and drank** to avoid using the restroom in the past year.
- **Eight percent (8%)** reported having a **urinary tract infection, kidney infection, or another kidney-related problem** in the past year as a result of avoiding restrooms.

More than half (59%) of respondents **avoided using a public restroom** in the past year because they were afraid of confrontations or other problems they might experience.

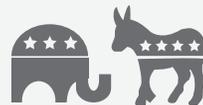


Civic Participation and Party Affiliation

- **More than three-quarters (76%)** of U.S. citizens of voting age in the sample reported that they were registered to vote in the November 2014 midterm election, compared to 65% in the U.S. population.
- **More than half (54%)** of U.S. citizens of voting age reported that they had voted in the midterm election, compared to 42% in the U.S. population.
- **Half (50%)** of respondents identified as Democrats, **48%** identified as Independents, and **2%** identified as Republicans, compared to 27%, 43%, and 27% in the U.S. population, respectively.

Political party affiliation

POLITICAL PARTY	% IN USTS	% IN U.S. POPULATION (GALLUP)
Democrat	50%	27%
Independent	48%	43%
Republican	2%	27%



About the National Center for Transgender Equality

The National Center for Transgender Equality (NCTE) is the nation's leading social justice policy advocacy organization devoted to ending discrimination and violence against transgender people. NCTE was founded in 2003 by transgender activists who recognized the urgent need for policy change to advance transgender equality. NCTE now has an extensive record winning life-saving changes for transgender people. NCTE works by educating the public and by influencing local, state, and federal policymakers to change policies and laws to improve the lives of transgender people. By empowering transgender people and our allies, NCTE creates a strong and clear voice for transgender equality in our nation's capital and around the country.

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The Report of the
2015 U.S. Transgender Survey: Executive Summary

by:

Sandy E. James, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet, and Ma'ayan Anafi
December 2016

RECOMMENDED CITATION

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *Executive Summary of the Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

The full report of the 2015 U.S. Transgender Survey is available at www.USTransSurvey.org.

Updated December 2017

THE REPORT OF THE



EXHIBIT

24



Wisconsin State Report

The 2015 U.S. Transgender Survey (USTS) is the largest survey examining the experiences of transgender people in the United States, with 27,715 respondents nationwide. The USTS was conducted by the National Center for Transgender Equality in the summer of 2015. Of respondents in the USTS, 541 were Wisconsin residents.¹ This report discusses the experiences of respondents living in Wisconsin.

Income and Employment Status

- 22% of respondents in Wisconsin were unemployed.²
- 26% were living in poverty.³

Employment and the Workplace

- 16% of respondents who have ever been employed reported losing a job in their lifetime because of their gender identity or expression.
- In the past year, 28% of those who held or applied for a job during that year reported being fired, being denied a promotion, or not being hired for a job they applied for because of their gender identity or expression.
- Respondents who had a job in the past year reported being verbally harassed (12%) and sexually assaulted (1%) at work because of their gender identity or expression.
- 18% of those who had a job in the past year reported other forms of mistreatment based on their gender identity or expression during that year, such as being forced to use a restroom that did not match their gender identity, being told to present in the wrong gender in order to keep their job, or having a boss or coworker share private information about their transgender status with others without their permission.

Education

- 77% of those who were out or perceived as transgender at some point between Kindergarten and Grade 12 (K–12) experienced some form of mistreatment, such as being verbally harassed, prohibited from dressing according to their gender identity, disciplined more harshly, or physically or sexually assaulted because people thought they were transgender.
 - 45% of those who were out or perceived as transgender in K–12 were verbally harassed, 23% were physically attacked, and 11% were sexually assaulted in K–12 because of being transgender.
 - 18% faced such severe mistreatment as a transgender person that they left a K–12 school.

- 23% of respondents who were out or perceived as transgender in college or vocational school were verbally, physically, or sexually harassed because of being transgender.

Housing, Homelessness, and Shelter Access

- 17% of respondents experienced some form of housing discrimination in the past year, such as being evicted from their home or denied a home or apartment because of being transgender.
- 26% have experienced homelessness at some point in their lives.
- 8% experienced homelessness in the past year because of being transgender.
- 39% of respondents who experienced homelessness in the past year avoided staying in a shelter because they feared being mistreated as a transgender person.

Public Accommodations

- Respondents reported being denied equal treatment or service, verbally harassed, or physically attacked at many places of public accommodation—places that provide services to the public, like retail stores, hotels, and government offices.
- Of respondents who visited a place of public accommodation where staff or employees thought or knew they were transgender, 36% experienced at least one type of mistreatment in the past year. This included 17% who were denied equal treatment or service, 26% who were verbally harassed, and 2% who were physically attacked because of being transgender.

Restrooms

- 8% of respondents reported that someone denied them access to a restroom in the past year.
- In the past year, respondents reported being verbally harassed (12%), physically attacked (2%), and sexually assaulted (1%) when accessing a restroom.
- 62% of respondents avoided using a public restroom in the past year because they were afraid of confrontations or other problems they might experience.
- 33% of respondents limited the amount that they ate or drank to avoid using the restroom in the past year.

Police Interactions

- Respondents experienced high levels of mistreatment and harassment by police. In the past year, of respondents who interacted with police or other law enforcement officers who thought or knew they were transgender, 58% experienced some form of mistreatment. This included being verbally harassed, repeatedly referred to as the wrong gender, physically assaulted, or sexually assaulted, including being forced by officers to engage in sexual activity to avoid arrest.
- 51% of respondents said they would feel uncomfortable asking the police for help if they needed it.

Health

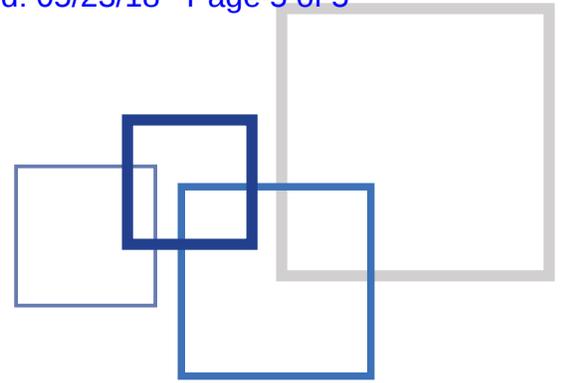
- 30% of respondents experienced a problem in the past year with their insurance related to being transgender, such as being denied coverage for care related to gender transition or being denied coverage for routine care because they were transgender.
- 33% of those who saw a health care provider in the past year reported having at least one negative experience related to being transgender. This included being refused treatment, verbally harassed, or physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care.
- In the past year, 24% of respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person, and 33% did not see a doctor when needed because they could not afford it.
- 38% of respondents experienced serious psychological distress in the month before completing the survey (based on the Kessler 6 Psychological Distress Scale).⁴
- 11% of respondents reported that a professional, such as a psychologist, counselor, or religious advisor, tried to stop them from being transgender.

Identity Documents

- Only 9% of respondents reported that *all* of their IDs had the name and gender they preferred, while 70% reported that *none* of their IDs had the name and gender they preferred.
- The cost of changing IDs was one of the main barriers respondents faced, with 38% of those who have not changed their legal name and 34% of those who have not updated the gender on their IDs reporting that it was because they could not afford it.
- 25% of respondents who have shown an ID with a name or gender that did not match their gender presentation were verbally harassed, denied benefits or service, asked to leave, or assaulted.

ENDNOTES | WISCONSIN STATE REPORT

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1. The number of respondents in Wisconsin (n=541) is an unweighted value. All reported percentages are weighted. For more information on the weighting procedures used to report 2015 U.S. Transgender Survey data, see the full survey report, available at www.USTransSurvey.org.
 2. For reference, the U.S. unemployment rate was 5% at the time of the survey, as reported by the Bureau of Labor Statistics. See the full report for more information about this calculation.
 3. For reference, the U.S. poverty rate was 12% at the time of the survey. The research team calculated the USTS poverty measure using the official poverty measure, as defined by the U.S. Census Bureau. USTS respondents were designated as living in poverty if their total family income fell under 125% of the official U.S. poverty line. See the full report for more information about this calculation.
 4. For reference, 5% of the U.S. population reported experiencing serious psychological distress during the prior month as reported in the 2015 National Survey on Drug Use and Health. See the full report for more information about this calculation.



2015 U.S. Transgender Survey

Wisconsin State Report

October 2017



The full report and Executive Summary of the 2015 U.S. Transgender Survey are available at www.USTransSurvey.org.

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