IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ALINA BOYDEN and
SHANNON ANDREWS,

Plaintiffs,

Case No. 17-cv-264

vs.

STATE OF WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS, et al.,

Defendants.

DECLARATION OF STEPHANIE BUDGE

I, Stephanie Budge, Ph.D., hereby declare under penalty of perjury:

1. All of the matters in this declaration are based on my personal knowledge, and I am competent to testify thereto.

2. Attached to the declaration as Exhibit 1 is a true and correct copy of my expert report prepared for the above-captioned case. Appendix A to Exhibit 1 is a true and correct copy of my curriculum vita. Appendix B to Exhibit 1 is a bibliography to the report. I am prepared to testify to the information set out in Exhibit 1, Appendix A, and Appendix B, which accurately state my expert qualifications, my opinions in this case, and the bases for those opinions.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 25th day of May 2018.

Stephanie Budge

Stephanie Budge, Ph.D.

Exhibit 1

EXPERT WITNESS REPORT OF STEPHANIE BUDGE, Ph.D.

I, Stephanie Budge, Ph.D., a licensed psychologist, have prepared this expert report pursuant to Fed. R. Civ. P. 26(a)(2) in the case of Boyden v. Wisconsin Dep't of Employee Trust Funds. I was retained as an independent consultant with expertise on issues related to gender dysphoria and the medical necessity of transition-related medical care (e.g., hormone therapy, gender confirmation surgery, facial feminization surgery) for transgender individuals. I was retained by the American Civil Liberties Union Foundation, the American Civil Liberties Union of Wisconsin Foundation, and Hawks Quindel, S.C., who represent the Plaintiffs Shannon Andrews and Alina Boyden, who are seeking insurance coverage for transition-related care and challenging the state of Wisconsin's blanket exclusion of such coverage for state employees.

Based on my training, research and clinical experiences, it is my professional opinion that if transgender individuals do not receive appropriate transition-related health care, there are often significant physical and mental health consequences, thus showing the medical necessity of such care for many transgender individuals. In alignment with my professional experiences, there is a substantial body of literature indicating that transition-related medical care is medically necessary for many transgender individuals. In addition, there is no evidence to support a policy of excluding coverage for all transition-related care for transgender individuals. As well, the evidence indicates that the cost to insurance plans of covering transition-related care for transgender individuals is minimal and may well be offset by reductions in other health care expenses that arise from failure to provide such care. It is my professional opinion that both Alina Boyden and Shannon Andrews currently meet criteria for gender dysphoria and have met criteria for gender dysphoria for many years, and that both Alina and Shannon report information

that is consistent with the medical necessity for transition-related medical care (e.g., hormones, gender confirmation surgery, including facial feminization surgery).

A. Professional Qualifications and Experience

I am a licensed psychologist who has been specializing in issues of gender identity and gender transition processes for over 10 years. I received a master's degree in educational psychology from the University of Texas at Austin in 2006 and a Ph.D. in counseling psychology in 2011 from the University of Wisconsin-Madison. My Ph.D. concentration specifically focused on transgender individuals, with a broader focus on lesbian, gay, and bisexual issues. I also received a minor in psychological assessment as part of my Ph.D. degree program. I have been a mental health professional since 2006 and I am currently licensed to practice psychology in the state of Wisconsin (license # 3244-57).

I have expertise working with individuals whose gender assigned at birth is different from their gender identity (hereafter referred to as transgender or trans individuals). I have been a mental health provider to transgender individuals since 2007. Transgender individuals have comprised the majority of my clinical caseload since 2011, and I have worked clinically with over 100 transgender clients (through individual therapy, group therapy, psychological evaluations, and providing supervision of clinical work of transgender individuals). Many of these individuals have met the Diagnostic and Statistical Manual 5 (DSM-5) criteria for gender dysphoria, a psychiatric diagnosis that signifies distress caused by incongruence between a person's assigned gender at birth and their gender identity.

I am currently an assistant professor in counseling psychology at the University of Wisconsin-Madison, where I teach courses that focus on training master's and doctoral students skills to become mental health professionals and psychological researchers. My courses

primarily focus on counseling skills, conducting psychological assessments, and research design. My faculty appointment has included clinical work at the Counseling Psychology Training Clinic (CPTC), which has included providing pro bono therapy to transgender individuals and training students in best practices in clinical work with transgender clients. As part of my faculty appointment, I direct the Trans Research Lab (TRL). As director of the lab, I design research projects that focus on transgender individuals' mental health. Of note, one of the current research projects is a clinical trial focusing on the efficacy of psychotherapy for transgender individuals. As part of this project, I trained all of the therapists in assessing gender dysphoria and writing letters for transition-related medical care for transgender clients. I also hold an appointment as a part-time (summer) clinical health psychologist at UW Health, where I conduct evaluations of transgender adolescents to determine if they require medically necessary treatments (e.g., psychological, social, and medical interventions) related to their gender identity.

I have published 62 invited and peer-reviewed journal articles and book chapters, with the majority of these focusing on transgender individuals. Notably, several of these publications are focused on evaluating transgender individuals to assess their eligibility for transition-related care, including hormone treatment and surgery; how to engage in clinical decision-making related to mental health care for transgender individuals; and effective psychotherapeutic treatment for transgender individuals. I have been involved in more than 100 academic presentations (internationally, nationally, and locally). The majority of these presentations have been focused on transgender individuals. I am an associate editor for the journal *Psychotherapy*. I am also on the editorial board for two peer-reviewed academic journals: *Psychology of Sexual Orientation and Gender Diversity* and the *International Journal of Transgenderism*. Researchers

in the United States and internationally have sought my assistance as an expert reviewer for research focused on transgender individuals.

I have received several awards for my work in the science and clinical practice of working with transgender individuals. Most recently, (along with colleagues) I received the 2017 paper award for *The Counseling Psychologist* related to a major contribution on *Research on Transgender People and Issues*. I received the 2015 American Psychological Association Early Career Award for work with LGBT populations from the Society for Counseling Psychology and I was the first recipient of the APA Transgender Research Award in 2010. Locally, I am also a member of the Wisconsin Trans Health Coalition, which is an organization focused on improving health care for transgender individuals throughout Wisconsin. My primary role on the coalition is to consult on research projects and collect data about transgender individuals in Wisconsin to tailor health care interventions for local community members.

I am also a member of the Society for Lesbian, Gay, Bisexual, and Transgender Issues within the American Psychological Association (APA) (of which I am also a member). I am co-chair of the Science Committee for the Society. The Science Committee is charged with ensuring that the most relevant and up-to-date research regarding LGBT individuals is disseminated through the Society and to full membership of the APA. We provide programming at the annual APA convention to disseminate cutting edge research on the best psychological practices and evidence-based treatments with LGBT individuals. At the 2018 APA annual convention, I will be disseminating up-to-date information about evidence-based treatments for transgender individuals. I am also member of the World Professional Association of Transgender Health (WPATH). WPATH (formerly known as the Harry Benjamin International Gender Dysphoria Association) is an interdisciplinary professional and educational organization of individuals

worldwide specializing in research and practice in transgender health. As a WPATH member, I attend conferences that focus on transgender individuals and present my own research to provide trainings to other professionals.

I am attaching a copy of my current C.V., which lists my qualifications, experience, and publications, as Appendix A to this report.

Prior Expert Witness Experience

I have previous experience as an expert psychologist in an immigration case that was focused on a transgender woman seeking asylum in the United States. Her case was heard by the United States Department of Justice Executive Office for Immigration Review. I prepared an expert report for that case in May 2015. I was also hired as an expert witness in the case *Whitaker v. Kenosha Unified School District.* As part of my role in the case, I prepared and wrote a declaration and expert report describing my psychological assessments of a transgender youth who had reported experiencing discrimination at his high school. I was not deposed and I did not testify in this case.

Compensation

I am being compensated at an hourly rate of $200/hour for actual time devoted for my expert services and testimony in this case, as well as expenses and costs. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

BASIS FOR OPINIONS

In this report, I use my clinical and academic expertise to provide an overview and discussion of gender identity, the psychological processes surrounding gender identity development for transgender individuals, and the appropriate clinical standards for gender transition and treatment of gender dysphoria in transgender adults. I then discuss the medical

necessity of gender transition-related medical and psychological care for transgender individuals, as informed by authoritative research, prevailing medical and psychological standards, and ethical standards for psychological practice with transgender clients. I also provide reasons why blanket exclusions for transition-related care are not supported by research or policy and why transition-related care is cost-effective treatment. I then provide separate clinical assessments of Alina Boyden and Shannon Andrews, the plaintiffs in the lawsuit, and provide my professional opinion related to their diagnoses of gender dysphoria and whether or not transition-related care would be considered a medical necessity for both plaintiffs, respectively.

In preparing this report, I reviewed the formative and influential psychological and public health research on transgender individuals published over the past decade, including in-press research and recently published studies. I have included a bibliography in Appendix B to this report. The majority of these publications come from highly-respected, peer-reviewed journals on LGBT and/or psychological issues. I also reviewed: the Plaintiffs' Amended Complaint; State Defendants' Responses to Plaintiffs' Requests to Admit, Interrogatories and for Production of Documents; documents produced by the State Defendants concerning insurance coverage of transition-related care; and documents related to appeals of denials of the Plaintiffs' requests for coverage of transition-related care.

As part of my clinical evaluation, I reviewed several of Alina's and Shannon's medical records from their physicians and therapists, and spoke with one of Shannon's prior therapists. The majority of the information used for my psychological evaluations of Alina and Shannon derives directly from face-to-face meetings with the plaintiffs. I met with Shannon for three hours and I met with Alina for 2.5 hours. The purpose of these meetings was to conduct a clinical and diagnostic interview to determine the medical necessity of transition-related care.

Based on my review of these materials and these evaluations, I render the opinions contained in this report, with a reasonable degree of professional certainty in my field of psychology. I understand that investigation and discovery is continuing in this case and may result in additional materials for me to review. I may, if necessary, supplement or amend my opinions based on such materials.

GENDER IDENTITY AND TRANSGENDER INDIVIDUALS

A. Definitions and Key Concepts

The following are several of the most up-to-date definitions and concepts related to transgender identity:

Sex: Sex refers to one's classification as male, female, or neither male or female. The term refers a person's chromosomes, hormones, reproductive organs, secondary sex characteristics, and gender identity (i.e., internal sense of gender) (Singh & dickey, 2016). The majority of individuals born with penises, testes, and XY chromosomes will identify as men and experience themselves as male. As well, the majority of individuals born with vaginas, clitorises, vulvas, ovaries, uteruses, and XX chromosomes will identify as women and experience themselves as female. Transgender individuals and those with intersex conditions and sex chromosome conditions (e.g., Turner Syndrome, Klinefelter Syndrome) will likely experience a different path with their sex (Morselli et al., 2016). There is no single sex-based characteristic that defines an individual's sex; that being said, gender identity is one of the primary factors when defining an individual's sex. When sex-related characteristics such as internal or external genitalia, reproductive capacity, chromosomes, or gender identity are inconsistent—as with many transgender people and people with intersex conditions—it is most appropriate to define sex based on the person's gender identity (Singh & dickey, 2016).

Gender: Gender refers to an individual's social, cultural, and psychological characteristics that are considered masculine or feminine based on cultural stereotypes, norms, and traits. (Gilbert & Scher, 2009).

Gender identity: Gender identity is understood in the psychological and medical professions to mean a person's internal sense of one's own sex, as it is privately experienced in one's behavior and self-awareness of being female, male, or at a defined point along a gender continuum (Singh & dickey, 2016). All human beings have a gender identity. Gender identity is innate and generally considered an immutable characteristic. Gender identity for human beings usually begins to become clear around the age of three (with some variation around this age), although many transgender individuals may not begin to recognize or express their gender identity until later in life. Neuroimaging data demonstrate strong evidence to indicate biological causes for transgender identity (see Sanchez & Pankey, 2017 for a review; Spizzirri et al., 2018). Recent neuroimaging data show that transgender women's brains are similar to cisgender women's brains (Rametti et al., 2011) and that transgender men's brains are similar to cisgender men's brains (Luders et al., 2009; Savic & Arvor, 2011).

Gender expression: Gender expression is defined as the behaviors associated with a public expression of stereotyped masculinity and/or femininity, or a rejection of these stereotypes (Brierley, 2000)**.**

Gender assigned at birth: Gender assignment is usually based on either an assessment of an infant's external genitals or a chromosome analysis. This language is also sometimes referred to as "sex assigned at birth" in the literature, but gender assignment is considered more accurate based on gender socialization and gender expectations that occur from infancy.

Transgender: Transgender identity is indicated by incongruence between a person's gender assigned at birth (male assigned at birth or female assigned at birth) and their gender identity (Singh & dickey, 2016).

Cisgender: Conversely, individuals are considered cisgender if they identify with the gender identity that corresponds with their gender assigned at birth (Singh & dickey, 2016).

Gender Transition: For most transgender individuals, a gender transition or "transitioning" is considered psychologically and medically necessary, as will be noted in the report below. Transition can take either or both of two forms: (a) social transition, and (b) medical transition (American Psychological Association, 2015).

Social Transition: A social transition is considered any aspect of identifying and expressing one's gender identity and usually does not encompass medical interventions—a social transition is considered to be medically necessary, given the psychosocial benefits of social transition (Coleman et al., 2012). An individual will typically, among other things, tell others of their gender identity (also known as coming out), use a different name than their birth name, use pronouns congruent with their gender identity, wear clothing typically associated with their gender identity, change their hairstyle, and use restrooms that fit their gender identity. This list of aspects of social transition is not exhaustive, nor are all of these steps necessary for all transgender persons.

Medical transition: A medical transition usually includes any medical procedure to assist a transgender individual with achieving primary or secondary sex characteristics that are closely aligned with their gender identity. Examples of medical transition can include hormone therapy and/or surgeries (for example, chest/breasts, internal/external genitalia, facial features, and/or body contouring). Not all transgender individuals will desire or need medical

interventions and some medical interventions, including surgeries, may not be developmentally or socially appropriate for some individuals (APA, 2015; Singh & dickey, 2016).

Hormone Therapy: Hormone therapy (HT) for transgender individuals includes the administration of feminizing or masculinizing hormones to induce changes in physical appearance (White-Hughto & Reisner, 2016). Hormone therapy is considered medically necessary for many transgender individuals due to its efficacy in relieving psychological distress associated with gender dysphoria and improving quality of life (Coleman et al., 2012; White-Hughto & Reisner, 2016). Hormone therapy is also referred to as hormone replacement therapy (HRT) in the literature.

Gender confirmation surgery: Gender confirmation surgery (GCS) includes any surgery to alter or adjust an individual's primary or secondary sex characteristics to align with their current gender identity. The most common surgeries include changes to the chest, genitals, and face/neck (Coleman et al., 2012). Gender confirmation surgery is considered medically necessary for many transgender individuals due to its efficacy in relieving psychological distress associated with gender dysphoria and improving quality of life (Coleman et al., 2012). Gender confirmation surgery (GCS) is also commonly referred to as sex reassignment surgery (SRS) or gender affirmation surgery (GAS) in the literature.

Prevalence of Transgender Individuals

Most recent population-based estimates indicate that 0.38% (approximately 1,000,000 people; Meerwijk & Sevelius, 2017) to 0.6% (approximately 2,000,000 people; Flores et al., 2016) of the United States population identifies as transgender. The Flores et al. (2016) report estimated that transgender adults comprise approximately 0.43% of the population in Wisconsin.

However, the authors of these recent publications indicate that these estimates are likely low due to population-based survey instruments that constrain the definition of transgender identity, which can have limitations on how transgender people are defined or recognized in public policy and public health.

Statistics Regarding Medical Interventions for Transgender Individuals

Many transgender people have undergone some form of medical transition, though many more may need such transition-related care than actually receive it. There have been several nation-wide publications estimating the prevalence of transgender individuals seeking or undergoing transition-related care in the United States. In the first nationwide survey of its kind, Grant et al. (2011) surveyed 6,456 participants. They reported that for medical transition-related care, 62% of participants used hormone therapy and an additional 23% planned to use hormone therapy in the future (for a total of 5,487 participants using or planning to seek hormone therapy). Transgender women reported the following information regarding gender confirmation surgery: 20% had had a vaginoplasty (surgical creation of vagina and vulva) and 60% planned to have it someday; 21% had had an orchiectomy (surgical removal of the testes) and 59% planned to have it someday; and 18% had had chest surgery and 54% planned to have it someday. Transgender men reported that 41% had had chest surgery and 51% planned to have chest surgery someday. Regarding additional surgeries for transgender men, fewer men indicated they had genital surgery (2% reported having had a phalloplasty [surgical creation of a penis]), with 26% indicating they planned to have it someday. The authors hypothesize that the difference between the number of people having had surgery and the number who plan to have it in the future might be due to financial barriers or other social barriers. Non-binary individuals' data were not analyzed in the 2011 report.

In 2016, a new report based on a survey of 27,715 transgender respondents from the United States described the health care and discrimination experiences of transgender people (James et al., 2016). In this report, 95% of transgender men and women reported they had or planned to have hormone therapy; only 49% of all respondents had had hormone therapy, despite the large numbers of individuals desiring hormone therapy. Twelve percent of transgender women indicated they had had a vaginoplasty and an additional 54% planned to have the procedure someday (with an additional 22% reporting that they were unsure about the procedure). Eleven percent of trans women had had an orchiectomy and an additional 47% planned to have the procedure someday (with an additional 22% reporting that they were unsure about the procedure). Percentages for transgender men and non-binary individuals are listed in the report on pages 101 and 102.

Clinical Diagnosis and Treatment Standards for Gender Dysphoria

Gender dysphoria (GD) is the medical and psychiatric term for the psychological distress caused by the incongruence between a transgender person's gender assigned at birth and gender identity. This psychiatric diagnosis is codified within the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The DSM-5 is widely used within psychiatry and psychology. Formal clinical training is necessary to understand and apply the manual in diagnosing psychological conditions (Black & Grant, 2014). The most recent version of the World Health Organization's International Classification of Diseases (ICD-10) uses the term gender identity disorder (GID) to describe the condition the DSM-5 calls gender dysphoria. Gender identity disorder was first identified as a mental health disorder in the DSM-III in 1973 (Zucker & Spitzer, 2005). After several iterations, GID was updated to GD in the DSM-5 in 2013 to account for recent developments in understanding and reflecting that gender

identity is not a disorder, but that the distress related to the incongruence is what leads to a diagnosis (Fraser, 2015; Regier, Kuhl, & Kupfer, 2013).

Individuals who present with gender dysphoria will likely report a variety of symptoms, but with a theme of an intense need to experience themselves as their affirmed gender identity, present themselves in accordance with their affirmed gender identity, and be viewed by others in accordance with their affirmed gender identity. When individuals diagnosed with gender dysphoria do not obtain competent and necessary treatment, serious and debilitating psychological distress (depression, anxiety, self-harm, suicidal ideation/attempts, etc.) often occurs (Bockting et al., 2016; Coleman et al., 2012; Wilson, Chen, Arayasirikul, Wenzel, & Raymond, 2015).

Under the DSM-5, the symptoms under Criterion A for identifying Gender dysphoria in adolescents and adults (302.85) include 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).

According to the DSM-5 Criterion B, a diagnosis of gender dysphoria also requires a finding of clinically significant distress or impairment in social, occupational, educational, or other important areas of functioning.

Standards of Care

The World Professional Association for Transgender Health (WPATH) publishes the Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People ("SOC"), which are considered the international standards for medical and mental health treatment for transgender individuals. The foremost medical and mental health organizations within the United States, and internationally, recognize the SOC as the authoritative standards for treatment of gender dysphoria. These standards are considered authoritative because the foremost experts in the field of transgender health articulate professional consensus regarding the most up-to-date evidence-based research on transgender health. WPATH is the largest transgender health organization in the world and is committed to promoting "evidence based care, education, research, advocacy, public policy, and respect in transgender health" (wpath.org, 2017). WPATH (originally called the Harry Benjamin International Gender Dysphoria Association) has published the SOC since 1979. The seventh and most current version of the SOC was published in 2012. The professional medical and mental health organizations

recognizing the authority of the WPATH SOC include the American Psychological Association, the American Psychiatric Association, the American Counseling Association, and the American Medical Association.

The SOC provide evidence-based protocols for mental health and medical providers to follow in determining the specific treatment regimen that will best fit the needs of the transgender individual. It has been well-established from the SOC and experts in the health care of transgender individuals that each transgender person has their own specific transition needs and that not every transition will look the same. Treatment generally consists of social, psychological, and/or medical support, as needed, which allows the individual to live and be integrated into society in accordance with their gender identity, thus relieving the distress that results from gender incongruence. Interventions are not used to change a person's gender identity; instead, they help to bring the person's external appearance and gender expression in alignment with their gender.

Medical Necessity for Treatment

To date, "every major expert medical association in the United States recognizes the medical necessity of transition-related care for improving the physical and mental health of transgender people and has called for health insurance coverage for treatment of gender dysphoria" (p. 1801, Baker, 2017). Research confirms not only the medical necessity of transition related care, but also that the procedures are safe and have high post-surgical satisfaction rates (Hess et al., 2014; Tran et al., 2018).

The WPATH Standards of Care (SOC v.7; Coleman et al., 2012) outline the specific reasons for the medical necessity of transition-related care for transgender individuals. The SOC first note the medical necessity of masculinizing hormones (for individuals assigned a female

gender at birth) and feminizing hormones (for individuals assigned a male gender at birth) to alleviate or decrease dysphoria. As noted by the SOC, the medical regimen will be individualized to each patient. The SOC note that gender confirmation surgery for transgender individuals is considered reconstructive, not cosmetic or aesthetic, "with unquestionable therapeutic results" (p. 58). As well, the SOC indicate that gender confirmation surgery has been found to alleviate gender dysphoria in many people. Specifically, for many transgender individuals "relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity" (p. 55).

According to the WPATH SOC, the primary reason for the medical necessity of hormone therapy and gender confirmation surgery is demonstrated in the psychosocial benefits of the treatments. The SOC v.7 outline 37 years of data that focus on the beneficial psychosocial outcomes of hormone therapy and gender confirmation surgery. The SOC indicate that the majority of studies demonstrate an irrefutable beneficial effect of gender confirmation surgery on postoperative outcomes (e.g., well-being and sexual functioning)." (p. 107). One of the first major retrospective studies focused on gender confirmation surgery indicated that 80.7% of transgender men reported positive outcomes (improved social and emotional adjustment) and 71.4% of transgender women reported positive outcomes (Pauly, 1981). Kuiper & Cohen-Kettenis (1988) reported that 88.6% of the sample ($N = 141$) reported feeling very/moderately happy with the results of their surgery.

Since standards of care were released in 1996, the research overwhelmingly indicates that transgender patients are satisfied with surgery and experience positive psychosocial outcomes post-hormones and post-surgery. See bibliography included as Appendix B. There are many studies that are indicative of the positive outcomes of medical treatment, such as general

satisfaction with surgery, satisfaction with sexual functioning, and improved quality of life (e.g., De Cuypere et al., 2005; Krege et al., 2001; Rehman et al., 1999; Wierckx et al., 2011).

Since the most recent version of the SOC were published in 2012, numerous other studies have been published showing even stronger treatment benefits and more specific information about the outcomes of surgery. The most up-to-date research confirms what previous research has shown regarding positive outcomes gender confirmation surgery. These studies indicate that quality of life and mental health outcomes only continue to improve after surgery and that patients do not experience regret related to the procedures (Glynn et al., 2016; van de grift, 2018).

Additional longitudinal studies have noted the importance of hormone-related care on mental health outcomes. For example, Heylens et al. (2014) indicated that hormone therapy was associated with a significant decrease in anxiety, depression, interpersonal sensitivity, and hostility. Additionally, psychopathology scores for transgender people who had received hormone therapy were compared with general population outcomes; after initiating hormones, transgender individuals reported similar levels of functioning to cisgender individuals. Similarly, Colizzi, Costa, & Todarello (2014) reported in a longitudinal study that hormone therapy was associated with lowered anxiety, depression, and general psychological symptoms.

In addition to the substantial body of literature noting the positive psychosocial outcomes of hormone therapy and gender confirmation surgery, research also shows that *failure* to provide transition-related medical care can lead to significant harm. For example, Glynn et al. (2016) report that some transgender women may engage in harmful behaviors, such as self-surgery or use of non-prescribed hormones, primarily if they are denied access to medical care and/or cannot afford the treatment(s). If individuals engage in self-prescribing hormones or in self-surgeries, serious side effects and physical health concerns can occur as a result (Rotandi et al.,

2013)—leading to additional health complications that will require additional medically necessary treatments.

Ethical Standards and Guidelines for Medical and Psychological Care

Within the medical and mental health care fields, gender-related transition care is considered medically necessary. Lambda Legal recently published a document outlining 12 United States major medical and mental health organizations' resolutions and statements documenting the medical necessity of transition-related medical care (Lambda Legal, 2017). Notably, the document indicates that the American Medical Association (AMA) has released at least 10 statements regarding accessibility of medical care for transgender individuals and as early as 2008, AMA Resolution 122, A-08 stated: "An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID... Therefore, be it RESOLVED, that the AMA supports public and private health insurance coverage for treatment of gender identity disorder; and be it further RESOLVED, that the AMA oppose categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician" (p. 2).

The American Psychiatric Association's Task Force on Treatment of Gender Identity Disorder (GID) (Byne et al., 2012) indicates: "This resolution concludes that medical research demonstrates the effectiveness and necessity of mental health care, hormone therapy and SRS [sex reassignment surgery] for many individuals diagnosed with GID" (p. 768). As well, the American Psychological Association's Task Force on Gender Identity and Gender Variance (2009) report indicates: "For individuals who experience such distress, hormonal and/or surgical sex reassignment may be medically necessary to alleviate significant impairment in interpersonal

and/or vocational functioning. Indeed, when recommended in clinical practice, gender confirmation surgery is almost always medically necessary, not elective or cosmetic (Bockting & Fung, 2005; Meyer et al., 2001)" (p. 32).

Several years after the release of this Task Force report, the American Psychological Association released guidelines for psychological practice with transgender and gender non-conforming people (APA, 2015). This report also highlights the medical necessity of transition-related care. In addition, the report outlines 16 guidelines for ethical psychological practice with transgender and gender non-conforming people (TGNC). Guideline 5 indicates that psychologists should be able to recognize how discrimination and stigma affect the health and well-being of TGNC. The guidelines indicate: "psychologists are encouraged to provide written affirmations supporting TGNC people and their gender identity [as appropriate] so that they may access necessary services (e.g., hormone therapy)" (p. 841). Finally and relatedly, Guideline 11 states that psychologists should "recognize that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care" (p. 846). This guideline indicates that psychologists should be aware of the evidence indicating the positive outcomes in research literature that specifically focus on hormones and surgery and that psychologists may play an essential role in the process of facilitating access to these medically necessary treatments.

In response to some individuals and practitioners who believe that transgender people should adjust or change their gender identity to remain in their gender assigned at birth, several health organizations have indicated that this practice is harmful and unethical. For example, the WPATH Standards of Care (SOC) note that "treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been

attempted in the past without success…such treatment is no longer considered ethical" (p. 175, Coleman et al., 2012).

The American Psychological Association's statement on gender diversity and transgender identity in adolescents indicates: "attempts to force gender diverse and transgender youth to change their behavior to fit into social norms may traumatize the youth and stifle their development into healthy adults" (p. 2, Mizock, Mougianis, Meier, & Moundas, 2015).

In their *Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression,* the American Psychoanalytic Association (2012) indicates that any attempts to convert, change, or "repair" an individual's gender identity or gender expression "often results in substantial psychological pain by reinforcing damaging internalized attitudes."

The American Counseling Association's report on competencies for counseling with transgender clients (Burnes et al., 2010) indicates that counselors must: "understand that attempts by the counselor to alter or change gender identities and/or the sexual orientation of transgender clients across the lifespan may be detrimental, life-threatening, and are not empirically supported" (p. 144). As such, these organizations report that it is harmful (and thus unethical) to attempt to change a person's transgender identity.

Well-being and Mental Health

In addition to the research that shows specific positive effects on mental health and well-being directly related to hormone therapy and gender confirmation surgery, research also links the overall transition process to better outcomes in well-being. Budge, Adelson, & Howard (2013) found that transgender men and transgender women ($N = 351$) who are further along in their transition process use less avoidant coping mechanisms and have lower levels of anxiety and depression. As well, being further along in the transition process (i.e., "stage of identity")

predicted better well-being in a large community sample ($N = 571$) of transgender individuals (Barr, Budge, & Adelson, 2016).

In addition to improving well-being, several qualitative studies have noted the importance of the transition process on increasing civic engagement, such as becoming educators, activists, volunteers, and creating systems for support and connection (e.g., Budge, Thai, & Orovecz, 2015; Budge, Chin, Minero, 2017; Budge, Katz-Wise, Tebbe, Howard, Schneider, & Rodriguez, 2013).

Blanket Exclusions for Transition-Related Care

In the above sections, I discuss the substantial body of literature indicating the medical necessity of transition-related care for transgender individuals and have listed citations for that literature in Appendix B. As noted in the Plaintiffs' Amended Complaint and in the Employee Trust Funds (ETF) *Uniform Benefits: Exclusions and Limitations* document, ETF excludes all "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment." Padula, Heru, & Campbell (2016) report that, even though many insurance policies prohibit coverage for transgender individuals for transition-related care, in 2014 the U.S. Department of Health and Human Services lifted a ban on these exclusions for the Centers for Medicare and Medicaid Services (CMS) beneficiaries for two reasons: (1) that the literature demonstrates gender confirmation surgery is efficacious, safe, and effective, and that (2) because it is efficacious, safe, and effective, "exclusions of coverage are not reasonable" (p. 395).

Instead of excluding all procedures, services, and supplies related to transgender care, the WPATH SOC indicate that all treatment plans for transgender individuals should be individualized to the patient (Coleman et al., 2012). In the most recent iteration of their guidelines, the Center of Excellence for Transgender Health at the University of California-San

Francisco released recommendations based on their *Guidelines for the Primary and Gender-Affirmation Care of Transgender and Nonbinary People* (2016). Specifically, these guidelines outline how providers can create individualized treatment plans with transgender patients, noting specific health care concerns that might interact with transition-related care and how to best approach treatment plans with patients. Given the overwhelming evidence and precedent for offering transition-related care pursuant to individualized plans, there is no evidence to support insurance policies that exclude coverage for all transition-related care for transgender individuals.

Costs of Transition-Related Care

Along with transition-related care being considered medically necessary by medical and mental health experts, it is also considered cost effective for insurance companies to cover transition-related care. Padula et al. (2016) analyzed the Grant et al. (2011) dataset that sampled over 6,000 transgender individuals in the United States. Their statistical analysis indicates that it is cost-effective for the patient, the other persons insured, and the insurance company itself to cover transition-related care. They found that coverage would cost members approximately $0.016 a month. When comparing this data to the current case, the differences appear negligible. In a memo dated 9/28/2005, ETF was provided with the cost impact of covering "all surgical procedures and hormone therapies" for the state insurance. The cost impact per paying member was estimated to be $0.05 per month, indicating that the costs estimated per member are similar.

Regarding the cost to the insurance company, results also indicate that it is in the insurance company's financial interest to cover transition-related care. Padula et al. (2016) note that a reason to consider transition-related care cost-effective is that denial of coverage could be costly to payers due to morbidity of failing to provide the care. Padula & Baker (2017) note that it is more costly to deny coverage to transgender patients because denial of care is associated

with increased disparities in depression, drug abuse, HIV, and additional conditions that are costly to treat. In fact, analyses indicate that without transition-related care, the costs related to treating depression, anxiety, drug abuse, etc. are estimated to be $10,712 a year (Beck, 2015) indicating the economic benefit of insurance companies covering transgender-related care. In our study (dickey, Budge, Katz-Wise, & Garza, 2016) we discuss the disparities in health insurance coverage between transgender and cisgender individuals; we found that transgender individuals will often avoid seeking health care when they need it because they are worried about discrimination by providers or that their insurance will deny certain claims (Grant et al., 2011) and thus some health issues may be exacerbated by the lack of preventative or immediate care. This avoidance of health care has been shown to have deleterious health effects in marginalized populations (Becker, 2004)—which in turn would likely have economic consequences.

CLINICAL EVALUATION OF ALINA BOYDEN

As noted above, the American Psychological Association Task Force on Guidelines for Psychological Practice with Transgender and Gender Non-Conforming People (2015) indicate the important role psychologists have regarding transition-related care. Mental health professionals have several roles when they work with transgender clients. These roles can include (but are not limited to) the following: determining if a transgender client experiences dysphoria, if they meet criteria for a diagnosis of gender dysphoria, writing letters to physicians recommending hormones and/or surgery (if appropriate), and assisting clients with their decision-making regarding what types of transition-related care would be appropriate and necessary.

This section summarizes the information gathered from a psychological evaluation of Alina Boyden. I conducted one in-person 2.5-hour psychological evaluation of Alina Boyden on

January 28, 2018. I was asked to conduct a psychological evaluation of Alina to determine if she met criteria for gender dysphoria as well as to determine the medical necessity for gender transition-related medical care for Alina. Along with a psychological evaluation, I also reviewed: several of Alina's medical records and documents related to appeals of denials of the Plaintiffs' requests for coverage of transition-related care.

Relevant Background

Alina Boyden is a 34-year-old woman who currently lives in Madison, Wisconsin with two housemates. Alina identifies as white, heterosexual, and transgender and uses she/her/hers pronouns. She was assigned a male gender when she was born. Other than the medical conditions listed below, she does not report any current physical or cognitive disabilities. Alina is currently a doctoral student in cultural anthropology at the University of Wisconsin-Madison. She has high academic functioning; specifically she has maintained a GPA of 3.9 in graduate school and is meeting all milestones in her academic program thus far. Her current source of income is through the University of Wisconsin-Madison, where she has received a fellowship to study Urdu to prepare her for field study in the fall of 2018. She experiences support from her parents and her younger brother and has several close friendships in Madison.

Alina's Gender Identity and Gender Dysphoria Diagnosis

Alina first started to recognize her gender identity when she was around the age of 4 or 5 and "thought every boy wanted to be a girl." She began to feel mounting distress as she got older, specifically around the age of 9 she considered cutting off her genitals with a knife but was concerned about what she would tell the paramedics and decided not to follow through with cutting them off. However, the distress related to her genitals did not dissipate as she continued

to age. She learned the term "transgender" on the Internet when she was 11 years old and was able to begin to internally consider that her gender identity was female.

As part of her process of learning more about her gender identity, Alina would present as a girl online in chat rooms. She said that she remained "in the closet" in high school, mainly because she thought that being transgender was "rare" and seemed like "bad luck." All of her friends in high school were girls and she consciously sought out female support systems.

Alina came out as transgender to a close friend at the age of 18, right after beginning college at the University of California (UC) Santa Barbara. She was significantly depressed at the time. Her friend had recommended that she see a therapist and that prompted her to seek counseling at the university counseling center at UC Santa Barbara. She said: "it was 2002 and no one knew what to do"—elaborating that the therapists at the counseling center had not yet seen transgender clients at the clinic and that she felt as though she had to do "all of the educating," even though she did not know much about the process of gender transitioning. Alina said that UC Santa Barbara was also a difficult place to transition, specifically that she went to the LGBT center on campus and she was the "only out trans person."

As Alina began to navigate her gender identity, it became clear to her that she needed to both socially and medically transition to lessen her dysphoria. She began taking estrogen and anti-androgens in September/October of 2002. In August 2003, she found the first medical provider (Dr. Kevin Cook) at UC Santa Barbara who felt truly affirming for her. She said that this was helpful to get medical care related to her gender identity, but that by this time, she had been experiencing significant depression and anxiety to the point where she was "almost flunking out of school." She was also prescribed several anti-depressants during this time period, but the medications were not helpful for her and did not resolve the dysphoria.

Around the fall of 2003, Alina came out to her family. Her mother had a negative reaction (e.g., wanting to throw holy water on Alina to "cure" her), her father stopped speaking to her, and her older brother made derogatory comments. She indicated that she had considered having gender confirmation surgery during this time, but she was concerned she did not have the money and she also wanted more stability with school, her family, and her mental health before pursuing surgery.

Regarding Alina's mental health, the timeframe from when she was 18-21 was when she experienced her most challenging mental health concerns. She attributes these challenges partially to not being able to medically transition easily or fully, as well as having unsupportive reactions from others. Her only source of support she felt she had during this time was Dr. Cook at UC Santa Barbara, who was assisting her with her transition process. She said: "I would be dead if it weren't for him." For example, she attempted suicide numerous times during this time period, but Dr. Cook was explicit in his desire to assist her with moving forward in her transition process. She stopped feeling suicidal and stopped attempting suicide in 2006 after her older brother completed suicide and she saw "firsthand" what happens when a person dies by suicide; though she ceased feeling suicidal, her feelings of dysphoria remained.

Alina's distress began to decrease after she had been on hormone therapy for a period of time. She also attributes her decrease in distress when she was living stealth (not telling anyone that she was transgender) and others accurately perceived her gender as a woman. Her family became more supportive and was using the correct name, Alina, and her correct pronouns (she/her/hers).

In the clinical interview conducted with Alina on January 28th, 2018, she met 6 out of 6 symptoms for Criterion A of Gender dysphoria. As noted above, Alina experiences incongruence

between her gender (female) and primary sex characteristics; she noted that this incongruence is associated with a strong desire have her genitals reconstructed since she was 9 years old. She started hormone therapy in 2002, with the intention of transforming secondary sex characteristics that are considered feminine (e.g., breasts, skin, fat distribution). She has strongly felt female since she was 4 or 5 years old and has been living as her affirmed gender since she was 18 years old. Her transition to being female was also aligned with a strong desire to be treated as a woman and she also experiences some stereotypical feelings and reactions that are associated with women and femininity.

Regarding Criterion B for gender dysphoria, Alina previously experienced and continues to experience clinically significant distress and impairment related to several areas of functioning. Of note, the time when she was most significantly distressed was when she was 18-21 years old and first beginning her gender transition. During this time, her academic functioning declined and she also experienced a substantial decline in social support as a result of coming out to others as transgender. During this time, her distress was so significant that she was "suicidal 100% of the time" and attempted suicide many times. Her dysphoria improved (though it did not completely dissipate) once she was able to stabilize her hormone therapy regimen and live her life fully as a woman. She is currently experiencing clinically significant distress derived from dysphoria related to her genitals. She is not currently experiencing a decrease in functioning related to academics, her social life, or occupational functioning; however, she notes that she is experiencing clinically significant distress related to how she was treated during specific medical appointments from 2014-2017. She has clinically significant distress related to being denied insurance coverage for gender confirmation surgery. Medical records spanning almost three

years also indicate that Alina was diagnosed with gender identity disorder/gender dysphoria from multiple providers.

Medical Necessity for Transition-Related Care

In my clinical opinion, Alina Boyden's experiences, cognitions, and emotions indicate the medical necessity for transition-related care. She was alert and able to provide informed consent related to possible future gender confirmation surgery. Alina described experiencing dysphoria since she was a child and the clinical distress related to her dysphoria has not been fully resolved by hormone therapy. As reported by Coleman et al. (2012), gender dysphoria will not be alleviated for some persons with gender dysphoria without modification of an individual's primary sex characteristics. Alina did not describe any mental health issues that would be contraindications to her having surgery and, in fact, her current dysphoric distress has a high likelihood of significantly decreasing if she were able to have gender confirmation surgery. She indicated that there is a likelihood of increased self-harm if she is not allowed access to gender confirmation surgery; this statement is congruent with one of the main reasons why surgery is considered medically necessary for many transgender individuals. It appears that Alina feels as though she has tried all avenues to receive the care she needs to decrease her dysphoria and that the barriers to this care have only exacerbated her dysphoria. A letter written by Dr. Webster on 5/19/2016 shows that he recommended genital surgery as a way of keeping her testosterone levels low, since she has experienced some difficulty regulating her testosterone levels. Thus, her medical provider has indicated additional reasons for the medical necessity of surgery for Alina.

CLINICAL EVALUATION OF SHANNON ANDREWS

In the previous section, I provide information based on the American Psychological Association's Task Force on Guidelines for Psychological Practice with Transgender and Gender

Non-Conforming People (2015) and the guidelines explicit statement of the role psychologists have regarding transition-related care. To reiterate, a psychologist's roles can include (but is not limited to) the following: determining if a transgender client experiences dysphoria, if they meet criteria for gender dysphoria, writing letters for hormones and/or surgery (if appropriate), and assisting clients with their decision-making regarding what types of transition-related care would be appropriate and necessary.

This section summarizes the information gathered from a psychological evaluation of Shannon Andrews and reviews of her records and communications with her other providers. I conducted one in-person 3-hour psychological evaluation of Shannon Andrews on January 27, 2018. I was asked to conduct a psychological evaluation of Shannon to determine if she met criteria for gender dysphoria as well as to determine the medical necessity for gender transition-related care for Shannon. Along with conducting a psychological evaluation, I also reviewed several of Shannon's medical records, specifically letters from her former therapist and from a psychologist and documents related to appeals of denials of the Plaintiffs' requests for coverage of transition-related care. I also spoke with her former therapist, Nyle Biondi, MA, LMFT.

Shannon Andrews is a 35-year-old woman who currently lives in Madison, Wisconsin with her girlfriend and a housemate. Shannon was assigned a male gender at birth. She identifies as a white, bisexual or lesbian, transgender woman and uses she/her/hers pronouns. She did not report any cognitive or physical disabilities during her clinical interview. Shannon grew up in Sun Prairie, Wisconsin, and moved away for educational reasons before moving back to Wisconsin. Shannon is currently a researcher at the Carbone Cancer Center at the University of Wisconsin-Madison. She enjoys the work she does, feels efficacious in her work, and receives

positive feedback about her employment. Shannon has several sources of support, namely her girlfriend, a close friend, and work colleagues.

Shannon's Gender Identity and Gender Dysphoria Diagnosis

Shannon did not learn about what the word transgender meant until she was a teenager. She remembers dressing in her mother's clothing when she was young, around the age of 4. She had a sense that she should not tell people about her feelings about being a girl when she was young, so she made a conscious effort to not talk about her gender identity with others. The first time she realized that there might be a word to describe her identity was when she was in 7th grade and she saw a movie that referenced transgender people in a derogatory manner.

When Shannon first started to understand her gender identity, she began to feel depressed and suicidal. She said she had been taught to feel ashamed of her identity and that there was something "wrong" with people who were like her. When she told her mother about her gender identity the first time when she was young, her mother did not react positively and Shannon told her mother that she would never dress in feminine clothes again (since she had been borrowing feminine clothes at home and secretly wearing them) and that she needed to "try to be normal" and pushed her identity aside.

She tried to ignore her gender identity for a couple of years, but she heard a couple of fellow high school students discussing the concept of gender confirmation surgery at school, which helped her realize that "being a trans woman was possible" and that she distinctly remembers thinking "I wish I could do that [have surgery]." However, she was reminded about how marginalized transgender women are and she was frightened for her future. She also felt as though she wanted to be taken seriously as a scientist and was worried that she would not be able to pursue a career in science if she transitioned in high school. Despite these fears, she "almost

came out as trans" at the age of 17 due to experiencing "turmoil," including significant depression and feelings of withdrawal and alienation.

Shannon felt as though she was able to suppress her gender identity until around the years of 2007/2008. She thought she might be having a "nervous breakdown" about concealing her identity, but she met a woman whom she started dating and felt as though the timing was not right for her to begin transitioning. In 2009, she moved back to Wisconsin after completing a Ph.D. at Princeton University. Over the next couple of years, she was experiencing panic attacks related to concealing her identity from others. During this time, she was working as a post-doc at the University of Wisconsin-Madison and her distress related to concealing her gender identity was significantly impacting her ability to work. She said that she was in a "deep depression." Throughout her post-doc years, she was starting to feel that it was "too late" to transition and contemplated suicide regularly. When the funding for her post-doc ended and she was no longer employed, she said "I felt like I lost everything and it felt like I would either die or be homeless." This low point in her life prompted her to see at therapist in Madison.

Shannon started coming out to others as a woman and began her medical transition in 2012. She received her first official diagnosis of gender dysphoria from her therapist, Nyle Biondi, MS, LMFT. She began hormone therapy in 2012 when she sought services from a medical provider in Chicago. She was hired at the Wisconsin Institute for Discovery (WID) at the University of Wisconsin-Madison in October of 2013. During her employment, she experienced difficulties with a supervisor described as "hostile" and her employment was terminated in December of 2013. At this time, her mental health was steadily declining and she felt as though hormones were "my only lifeline." Two months after her employment ended at

WID, she was hired at the Carbone Research Center at the university, which felt "like a turning point."

When Shannon was hired in her current employment, she felt as though she was appreciated at work and she was able to excel at her job. Having this comfort of performing well at work increased her confidence to begin telling more people about her gender identity. She started telling friends and gave them permission to tell others within their social circle. She also came out to her parents who "took it well, were upset for a day, but were supportive after that." After her probationary period ended at her current place of employment, she came out to her supervisors, both of whom were "very supportive."

After having been on hormones and coming out to most people in her life, 2014 felt like the year when she could truly be herself. She started changing her name in legal documents. Susanne Gill, Ph.D., a psychologist, wrote a letter on 7/6/2015 confirming Shannon's gender identity disorder (now known as gender dysphoria) diagnosis and recommended gender confirmation surgery for Shannon. Her therapist, Nyle Biondi, MA, LMFT, also wrote a letter confirming the diagnosis on 6/17/15 and recommended surgery as the appropriate next step in her transition process. Shannon then took funds out of her retirement account and funded gender confirmation surgery, which took place in 2015.

In the clinical interview conducted with Shannon on January 27, 2018, she met 6 out of 6 symptoms for Criterion A of gender dysphoria. Shannon expressed incongruence between her experienced gender (female) and primary sex characteristics. When asked specifically about her primary sex characteristics, Shannon said that the genitals she was born with felt like an "alien entity that had been grafted onto my body." As a young child, she experienced her genitals feeling "out of place," but they significantly distressed her when she began puberty. As Shannon

began puberty and continued through her 20's, she expressed having a strong desire to not have her genitals any longer, resulting in her seeking gender confirmation surgery in 2015. Her dysphoria was related to additional characteristics prior to starting hormone therapy or having surgery, such as discomfort when her chest was bare (which felt inappropriate to her), discomfort with body hair, wanting to hide her facial features, discomfort with the breadth of her shoulders and rib cage. She also expressed some dysphoria related to her voice, her hair, and how she felt in masculine clothes. Some of her dysphoria has dissipated with time, since she has experienced positive outcomes from hormone therapy, training her voice, and expressing her gender through feminine clothing. It was clear from the clinical interview that she has felt female from a young age and that she has been living as her affirmed gender for several years. When describing "typical" feelings related to being a woman, Shannon said that she knows there is not a "correct way to be a woman"; however, she has always been drawn to femininity and expressions that explicitly are not male.

Regarding Criterion B for gender dysphoria, Shannon was formerly and continues to be clinically significantly distressed. She has had previous experiences of impairment related to several areas of functioning and she also continues to experience impairment in several areas of functioning. When describing distress and impairment, her gender-related distress was so strong when she was younger that she started feeling suicidal at 8 years old. Throughout childhood and young adulthood, she assumed she would kill herself at some point, due to not being able to be herself. As noted above, she experienced impairment in functioning related to employment at several points in her life due to gender-related distress. She also continues to experience impairment in social functioning, specifically related to social anxiety and fears of how people perceive her gender.

According to her records, Shannon was given a diagnosis of gender dysphoria in June 2015 from her therapist, Nyle Biondi, MS LMFT. A separate record indicates she was also given a diagnosis of gender identity disorder in June 2015 from Susanne Gill, PhD.

Medical Necessity for Transition-Related Care

In my clinical opinion, Shannon Andrews reports experiences, cognitions, and emotions that indicated the medical necessity for previous (hormone therapy and genital surgery) and indicate the need for future (facial feminization surgery) transition-related care. Shannon describes experiencing dysphoria since she was a child. She reported that a significant amount of her distress was alleviated through hormone therapy and genital surgery; she anticipates that her remaining dysphoria related to her facial features will decrease after her planned surgery in February 2018. The past and anticipated reduction in dysphoria is in alignment with Coleman et al.'s (2012) indication that surgery to reconstruct one's secondary sex characteristics can be medically necessary to reduce dysphoria. She was alert and able to provide informed consent related to facial feminization surgery. Shannon continues to experience symptoms of anxiety, which are closely related to her experiences of dysphoria. Shannon does not describe any mental health issues that would have contraindicated her gender confirmation surgery or would be a contraindication for her having facial feminization surgery. It does appear that she will have a reduction in her remaining dysphoria after she is able to access the surgery in February 2018.

When asked about her perception of the medical necessity of transitioning, Shannon said that the medical necessity of these treatments was clear to her. After she began hormone therapy, it was like "the blood was removed from my body and replaced with lightening…everything was sharper, clearer, and more immediately present." When describing her experiences after having genital surgery, she said: "this feeling of low-grade omnipresent horror was gone and the world

made sense for the first time." She compared the feeling to being buried alive but then exhumed and able to breathe. When asked what would have happened if she had not been able to access hormone therapy or genital surgery, she said: "I would have killed myself if I had not been able to transition. No question. The choice was clear between transition and suicide and no third option…life would not be worth living." When speaking with her former therapist, Nyle Biondi, MA, LMFT, he confirmed what Shannon had said in the clinical interview. He said, with confidence, that Shannon would "not be alive today if she had not been able to transition." He also confirmed that it was medically necessary for Shannon to have facial feminization surgery to reduce her remaining dysphoria.

Conclusion

I was retained as an expert witness to answer the following questions: (1) is transition-related medical care for transgender individuals medically necessary? (2) is there a health care justification for a policy of excluding coverage of all "procedures, services, and supplies related to surgery and sex hormones associated with gender reassignment" (ETF Uniform Benefits: Exclusions and Limitations, p. 39)? (3) is there evidence indicating that covering transition-related care will be costly to insurance providers? (4) does Alina Boyden meet criteria for gender dysphoria? (5) does Shannon Andrews meet criteria for gender dysphoria? and (6) if either or both individuals meet criteria for gender dysphoria, would transition-related care for the plaintiffs be considered medically necessary?

Above, I outlined the evidence indicating that transition-related medical care is medically necessary for many transgender individuals. Notably, every major psychological and medical association in the United States indicates that transition-related medical and mental health care is necessary for improving mental and physical health for many transgender individuals (Baker,

2017). The preeminent international organization (World Professional Association for Transgender Health) focused on transgender related care has outlined the wide basis of evidence indicating why these treatments are considered medically necessary (see Coleman et al., 2012) and this report outlines more recent evidence that continues to support the necessity and efficacy of these treatments. In addition, there is no evidence to support ETF excluding coverage for all transition-related care for transgender individuals. As well, the evidence indicates that the cost of covering transition-related care for transgender individuals is minimal. It is my professional opinion that both Alina Boyden and Shannon Andrews currently meet criteria for gender dysphoria and have met criteria for gender dysphoria for many years. Both Alina and Shannon report information that is consistent with the medical necessity for transition-related medical care, including hormone therapy, gender confirmation surgery and, for Shannon, facial feminization surgery. Notably, they also report that not being able to access transition-related care exacerbated and exacerbates their symptoms of dysphoria.

Respectfully submitted,

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Stephanie Budge, Ph.D.

DATE:_____02/19/2018____