
No. 21-15668

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

D.H., by and through his mother, Janice Hennessy-Waller; and JOHN DOE, by his
guardian and next friend, Susan Doe,
Plaintiff-Appellants,

vs.

JAMI SNYDER,
Defendant-Appellee.

On Appeal from Order of the United States District Court
For the District of Arizona
Case No. 4:20-cv-335-SHR

**EXCERPTS OF RECORD
INDEX VOLUME**

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VOLUME 1 of 3 (ER 1 to ER 22)

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6 **IN THE UNITED STATES DISTRICT COURT**
7 **FOR THE DISTRICT OF ARIZONA**

8
9 Janice Hennessy-Waller, et al.,

10 Plaintiffs,

11 v.

12 Jami Snyder,

13 Defendant.
14

No. CV-20-00335-TUC-SHR

**Order re: Plaintiffs' Motion for
Preliminary Injunction**

15
16 Pending before the Court is Plaintiffs D.H. and John Doe's Motion for Preliminary
17 Injunction, asking the Court to enjoin Defendant Jami Snyder, Director of the Arizona
18 Health Care Cost Containment System ("AHCCCS"), "from further enforcement of" a
19 regulation that excludes gender reassignment surgery from coverage and to "order
20 AHCCCS to cover male chest reconstruction surgery for D.H. and John." (Doc. 3 ep 2.¹)
21 Defendant has responded (Doc. 18) and Plaintiffs have replied (Doc. 25.) Oral argument
22 was held on February 5, 2021. (Doc. 48.) For the reasons that follow, the Court will deny
23 Plaintiffs' Motion.

24 **I. Background**

25 The following facts are derived from Plaintiffs' Complaint (Doc. 1) and sworn
26 declarations submitted in support of their Motion for Preliminary Injunction (Docs. 4, 5).
27 Plaintiffs are minors—D.H. is seventeen and John is fifteen years old—who are enrolled

28 ¹Unless otherwise noted, "Doc." refers to documents in the CM/ECF docket online,
and "ep" refers to the electronic page number.

1 in Arizona’s Medicaid program known as AHCCCS. Plaintiffs were born as females, have
2 been diagnosed with gender dysphoria, and have since transitioned to live as males with
3 the recommendation and support of their healthcare providers. As part of their treatment
4 for gender dysphoria, Plaintiffs started taking testosterone over one year ago. Since then,
5 Plaintiffs’ healthcare providers have recommended they obtain “male chest reconstruction
6 surgery”²—that is, the permanent removal of their breasts—“to further alleviate [their]
7 gender dysphoria.”

8 AHCCCS, however, specifically excludes the following from coverage:

- 9 a. Infertility services, reversal of surgically induced infertility
10 (sterilization), and *gender reassignment surgeries*;
- 11 b. Pregnancy termination counseling services;
- 12 c. Pregnancy terminations, unless required by state or federal
13 law;
- 14 d. Services or items furnished solely for cosmetic purposes;
15 and
- 16 e. Hysterectomies unless determined medically necessary.

17 Ariz. Admin. Code R9-22-205(B)(4) (emphasis added).

18 On August 2, 2020, Plaintiffs filed their Complaint against AHCCCS Director Jami
19 Snyder, in her official capacity, alleging AHCCCS’s policy of excluding gender
20 reassignment surgery from coverage pursuant to R9-22-205(B)(4)(a) (the “Challenged
21 Exclusion”) violates various provisions of Title XIX of the Social Security Act, 42 U.S.C.
22 §§ 1396–1396w-5 (“Medicaid Act”), Section 1557 of the Patient Protection and
23 Affordable Care Act, 42 U.S.C. § 18116 (“Section 1557”), and the Equal Protection Clause
24 of the Fourteenth Amendment to the United States Constitution. In their Complaint,
25 Plaintiffs seek: (1) class certification³; (2) “preliminary and permanent injunctions

26 ²Also known as “male chest contouring” or “top surgery,” this procedure includes,
27 essentially, a double mastectomy. *See Standards of Care for the Health of Transsexual,*
28 *Transgender, and Gender Non-Conforming People 7th Version*, World Professional
Association for Transgender Health (“WPATH”), p. 63.

³Plaintiffs’ Motion for Class Certification (Doc. 40) remains pending and the Court
will address it in a separate order.

1 prohibiting Defendant from any further enforcement or application of the Challenged
2 Exclusion” and “directing Defendant and [her] agents to provide Medicaid coverage for
3 medically necessary male chest reconstruction surgery”; and (3) declaratory judgment that
4 the denial of coverage for male chest reconstruction surgery violates the Medicaid Act,
5 Section 1557, and Equal Protection Clause. (Doc. 1, ep 25-26.)

6 In their Motion for Preliminary Injunction (“Motion”), Plaintiffs seek to
7 “preliminarily enjoin Defendant[] from further enforcement of the regulation and order
8 AHCCCS to cover male chest reconstruction surgery for D.H. and John.” (Doc. 3 ep 2.)
9 In their proposed order, Plaintiffs request the Court order: (1) “Defendant[] shall be
10 immediately enjoined from further enforcement of Ariz. Admin. Code R9-22-
11 205(B)(4)(A), on the grounds that it violates the Medicaid Act’s EPSDT [Early and
12 Periodic Screening, Diagnostic and Treatment] and Comparability Requirements, Section
13 1557 of the [Patient Protection and] Affordable Care Act, and the Equal Protection Clause
14 of the United States Constitution”; and (2) the “Arizona Healthcare Cost Containment
15 System shall provide coverage for Plaintiffs’ male chest reconstruction surgeries,
16 consistent with all other requirements of federal law.” (Doc. 3-1.)

17 After oral argument,⁴ the parties submitted supplemental briefing as to whether
18 Plaintiffs were required to exhaust their administrative remedies before seeking relief in
19 court. (Docs. 62, 64.) The parties agree Plaintiffs are not required to exhaust their
20 administrative remedies because they seek injunctive relief under 42 U.S.C. § 1983. (Docs.
21 59, 64.) *See Patsy v. Bd. of Regents*, 457 U.S. 496 (1982).⁵ Accordingly, this Court has
22 jurisdiction pursuant to U.S.C. §§ 1331 and 1343(a)(3)-(4).

23 II. Preliminary Injunction Standard

24 “A preliminary injunction is ‘an extraordinary and drastic remedy, one that should
25 not be granted unless the movant, *by a clear showing*, carries the burden of persuasion.’”

26
27 ⁴The parties did not request an evidentiary hearing on the motion and, at the status
28 conference held on December 11, 2020, the parties stated such a hearing was not necessary.
(Doc. 38.)

⁵Unless otherwise noted by the Court, internal quotations and citations have been
omitted when quoting and citing case law throughout this Order.

1 *Lopez v. Brewer*, 680 F.3d 1068, 1072 (9th Cir. 2012) (quoting *Mazurek v. Armstrong*, 520
2 U.S. 968, 972 (1997) (emphasis in original)); *see also Am. Beverage Ass'n v. City & Cnty.*
3 *of S.F.*, 916 F.3d 749, 754 (9th Cir. 2019). “A plaintiff seeking a preliminary injunction
4 must establish that he is likely to succeed on the merits, likely to suffer irreparable harm in
5 the absence of preliminary relief, that the balance of equities tips in his favor, and that an
6 injunction is in the public interest.” *Monarch Content Mgmt. LLC v. Ariz. Dep't of Gaming*,
7 971 F.3d 1021, 1027 (9th Cir. 2020) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555
8 U.S. 7, 20 (2008)); *see also All. for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1132 (9th
9 Cir. 2011). A plaintiff must show more than a mere “possibility” of irreparable harm—he
10 must “demonstrate that irreparable injury is *likely* in the absence of an injunction.” *Winter*,
11 555 U.S. at 22 (emphasis in original); *see also Park Vill. Apartment Tenants Ass'n v.*
12 *Mortimer Howard Tr.*, 636 F.3d 1150, 1160 (9th Cir. 2011) (injunction will not issue if
13 party seeking injunctive relief shows “mere possibility of some remote future injury, or a
14 conjectural or hypothetical injury”). The Ninth Circuit Court of Appeals, employing a
15 sliding scale analysis, has also stated: “‘serious questions going to the merits’ and a
16 hardship balance that tips sharply toward the plaintiff can support issuance of an injunction,
17 assuming the other two elements of the *Winter* test are also met.” *Drakes Bay Oyster Co.*
18 *v. Jewell*, 747 F.3d 1073, 1085 (9th Cir. 2013) (quoting *All. for the Wild Rockies*, 632 F.3d
19 at 1132) (sliding-scale test “remains viable” after *Winter* though movants “must also satisfy
20 the other *Winter* factors”).

21 The standard a party must meet to obtain injunctive relief depends on the type of
22 injunction sought. A prohibitory injunction “restrain[s] a party from taking action and
23 effectively “freezes the positions of the parties until the court can hear the case on the
24 merits.” *Edmo v. Idaho Dep't of Corr.*, 358 F.Supp. 3d 1103, 1122 (D. Idaho 2018)
25 (quoting *Heckler v. Lopez*, 463 U.S. 1328, 1333 (1983)). In contrast, a mandatory
26 injunction is one that “orders a responsible party to take action,” *Meghrig v. KFC W., Inc.*,
27 516 U.S. 479, 484 (1996), and therefore “‘goes well beyond simply maintaining the status
28 quo [p]endente lite [and] is particularly disfavored.’” *Marlyn Nutraceuticals, Inc. v. Mucos*
Pharma GmbH & Co., 571 F.3d 873, 879 (9th Cir. 2009) (alterations in original) (quoting

1 *Anderson v. United States*, 612 F.2d 1112, 1114 (9th Cir. 1979)); *see also Stanley v. Univ.*
2 *of S. Cal.*, 13 F.3d 1313, 1320 (9th Cir. 1994) (prohibitory injunction maintains status quo,
3 whereas mandatory injunction goes well beyond maintaining status quo). “Mandatory
4 injunctions, while subject to a higher standard than prohibitory injunctions, are permissible
5 when ‘extreme or very serious damage will result’ that is not ‘capable of compensation in
6 damages,’ and the merits of the case are not ‘doubtful.’” *Hernandez v. Sessions*, 872 F.3d
7 976, 999 (9th Cir. 2017) (quoting *Marlyn Nutraceuticals*, 571 F.3d at 879); *see also*
8 *Anderson*, 612 F.2d at 1115. Therefore “[s]uch mandatory preliminary relief is subject to
9 heightened scrutiny and should not be issued unless the facts and law clearly favor the
10 moving party.” *Dahl v. HEM Pharm. Corp.*, 7 F.3d 1399, 1403 (9th Cir. 1993).

11 Defendant asserts the injunction sought here is a mandatory one and, therefore, is
12 subject to higher scrutiny. (Doc. 18 ep 8.) Plaintiffs argue it is a prohibitive injunction
13 because they seek to “enjoin Defendant from enforcing a regulation that prohibits coverage
14 for surgeries to treat gender dysphoria, including male chest reconstruction surgery.” (Doc.
15 25 ep 4.) At oral argument, Plaintiffs reiterated this, relying on *M.R. v. Dreyfus*, 697 F.3d
16 706 (9th Cir. 2012); however, this case is distinguishable. Like the instant case, plaintiffs
17 in *M.R.* sought to enjoin the state from enforcing a state Medicaid regulation. Unlike the
18 instant case, the regulation in *M.R.* was new and enacted to save money during an economic
19 downturn which would have resulted in a decrease in Medicaid benefits that beneficiaries
20 were previously receiving and were entitled to by law. Enjoining the regulation here would
21 not result in a decrease in benefits Plaintiffs are receiving—rather, the injunction seeks to
22 not only enjoin enforcement of the regulation but also to force AHCCCS to provide a
23 benefit it has never before provided. That is, the plaintiffs in *M.R.* sought to *preserve* the
24 status quo; whereas here, Plaintiffs seek to go well beyond the status quo. Additionally,
25 the plaintiffs in *M.R.* presented far more undisputed evidence in support of their claims
26 than the Plaintiffs have here.

27 At oral argument, Plaintiffs also asserted they were “seeking an opportunity to
28 demonstrate the medical necessity of male chest reconstruction surgery and are asking the
Court to enjoin enforcement of [the Challenged] [E]xclusion as to D.H. and John Doe so

1 they can demonstrate to [AHCCCS] that this procedure is, in fact, medically necessary for
2 them.” (OA Transcript Feb. 5, 2021 ep 9-10, 15.) This, however, is contrary to their
3 Motion where they specifically state: “Plaintiffs move to preliminarily enjoin Defendant[]
4 from further enforcement of the regulation and order AHCCCS to cover male chest
5 reconstruction surgery for D.H. and John.” (Doc. 3 ep 2.) Further, as noted above,
6 Plaintiffs’ proposed order would declare the Challenged Exclusion unlawful and
7 unconstitutional and would order AHCCCS to provide coverage for the surgeries Plaintiffs
8 seek. (Doc. 3-1.) By Plaintiffs’ own argument and proposed order, they seek an injunction
9 that not only enjoins Defendant from enforcing the law, but orders Defendant to take an
10 affirmative action by providing coverage for a medical procedure that would be otherwise
11 excluded, thus going well beyond the status quo. *See Meghrig*, 516 U.S. at 484; *see also*
12 *Marlyn Nutraceuticals*, 571 F.3d at 879. Therefore, the injunction sought here is a
13 mandatory one and is subject to the higher scrutiny described above. *See Heckler*, 463
14 U.S. at 1333-34 (injunction directing Secretary of Health and Human Services to pay
15 benefits on an interim basis to parties who had not yet been found to be disabled was “in
16 substance, if not in terms, a mandatory one”); *see also Katie A., ex rel. Ludin v. L.A. Cnty.*,
17 481 F.3d 1150, 1156 (9th Cir. 2007) (applying heightened standard for mandatory
18 preliminary injunction where class of children enrolled in California’s Medicaid program
19 claimed state violated Medicaid Act by failing to provide certain mental health services);
20 *Toomey v. State of Ariz., et al.*, 4:19-cv-00035-RM-LAB (Doc. 162, ep 8-9) (preliminary
21 injunction “barring [d]efendants from enforcing the categorical exclusion of coverage for
22 ‘[g]ender reassignment surgery’” is mandatory injunction because it goes beyond
23 maintaining status quo).

24 **III. Discussion**

25 **A. Likelihood of Prevailing on the Merits**

26 Based on the record before the Court, Plaintiffs have not shown they are likely to
27 prevail on the merits of their claims because they have not clearly shown the surgery they
28 seek is medically necessary for them, that it is a safe and effective treatment for gender

1 dysphoria in adolescents, or that the Challenged Exclusion violates the Medicaid Act,
2 Section 1557, or the Equal Protection Clause. *See Dahl*, 7 F.3d at 1403.

3 *1. Medicaid's EPSDT Provision*

4 The Medicaid Act provides medical assistance to eligible individuals⁶ in
5 participating states. Although states are not required to participate in the Medicaid
6 program, once a state chooses to participate and accept matching federal funds, it must
7 comply with federal Medicaid law. *See Wilder v. Va. Hosp. Ass'n*, 110 S. Ct. 2510, 2513
8 (1990). EPSDT services for eligible individuals under age 21 are among the mandatory
9 categories of medical assistance a state must provide. *Katie A.*, 481 F.3d at 1154. EPSDT
10 services are defined in § 1396(r), and include: "Such other necessary health care,
11 diagnostic services, treatment, and other measures described in subsection (a) to correct or
12 ameliorate defects and physical and mental illnesses and conditions discovered by the
13 screening services, whether or not such services are covered under the State plan."
14 § 1396d(r)(5). "Under § 1396d(r)(5), states must cover every type of health care or service
15 necessary for EPSDT corrective or ameliorative purposes that is allowable under
16 § 1396d(a). Although states have the option of not providing certain 'optional' services
17 listed in § 1396d(a) to other populations, they must provide all of the services listed in
18 § 1396d(a) to eligible children when such services are found to be medically necessary."
19 *Katie A.*, 481 F.3d at 1154. Further, Arizona law incorporates § 1396d(r)(5) by reference
20 and provides a variety of EPSDT services "are covered for a member less than 21 years of
21 age," including: "Other necessary health care, diagnostic services, treatment, and measures
22 required by 42 U.S.C. 1396d(r)(5)." Ariz. Admin. Code R9-22-213(a)(1–10).

23 Plaintiffs assert the EPSDT provisions are "extremely broad" and include the
24 surgeries they seek, as the surgeries are necessary to "correct or ameliorate" Plaintiffs'
25 gender dysphoria. (Doc. 3 ep 9-10.) Plaintiffs also assert there is "broad consensus within
26 the medical community that male chest reconstruction surgery is a safe and effective
27 treatment for gender dysphoria." (Doc. 3 ep 10.) Relying on expert declarations,

28

⁶There is no dispute Plaintiffs are eligible, enrolled members of AHCCCS.

1 Defendant counters “there is legitimate debate” about whether such surgery corrects or
2 ameliorates “the underlying conditions of persons, particularly children, who seek such
3 surgeries.” (Doc. 18 ep 12.) As to Plaintiffs’ specific case, Defendant points out Plaintiffs
4 have not provided their medical records, “have not been finally assessed for suitability for
5 surgery by the surgeon who would perform the procedures,” and have not provided a
6 declaration or opinion of any medical doctor who has treated John. (Doc. 18 ep 12-13.)
7 Defendant further asserts Plaintiffs have not demonstrated medical necessity and argues
8 AHCCCS is not required “to cover every service, especially services that have yet to be
9 determined to be safe and effective.” (Doc. 18 ep 13.) Lastly, Defendant notes that
10 although EPSDT is a mandatory set of services AHCCCS must cover, it does not
11 specifically list the services required and there is no case law recognizing gender
12 reassignment surgery as an EPSDT requirement. (Doc. 18 ep 13.)

13 As Defendant notes, a state’s obligation to cover health care or services necessary
14 for EPSDT corrective or ameliorative purposes is “subject to certain limits; for example, a
15 state need not pay for experimental medical procedures.” *Katie A.*, 481 F.3d at 1154, n.10.
16 States must also “provide such methods and procedures relating to the utilization of, and
17 the payment for, care and services available under the plan . . . as may be necessary to
18 safeguard against unnecessary utilization of such care and services to assure that payments
19 are consistent with efficiency, economy and quality of care” 42 U.S.C.
20 § 1396a(a)(30)(A). The Eighth Circuit explained this principle when it concluded states
21 were not required to cover organ transplants because they were not considered safe or
22 proven at the time: “Medicaid was not designed to fund risky, unproven procedures, but
23 to provide the largest number of necessary medical services to the greatest number of needy
24 people.” *Ellis v. Patterson*, 859 F.2d 52, 55 (8th Cir. 1988). Defendant goes on to cite
25 several cases from other jurisdictions that suggest the surgeries Plaintiffs seek here are
26 “experimental,” “risky,” or otherwise “unproven,” and, therefore asserts “it is not improper
27 to exclude coverage for a service that continues to be the subject of legitimate debate as to
28 its safety and efficacy.” (Doc. 18 ep 13-14.)

The parties have submitted several declarations in support of and opposition to the

1 Motion. Plaintiffs have submitted declarations from: D.H.; D.H.'s mother; D.H.'s
2 pediatrician, Dr. Cronyn; D.H.'s counselor, Tamar Reed⁷; John; John's caregiver; and
3 John's therapist, Mischa Cohen Peck, PhD.⁸ (Docs. 4, 5.) Plaintiffs have also provided
4 declarations from two experts retained for this litigation: Dr. Aron Janssen, a
5 child/adolescent psychiatrist, who specializes in treating children and adolescents with
6 gender dysphoria (Doc. 5-4 ep 2; Doc. 25 ep 14-30), and Dr. Loren S. Schechter, a plastic
7 surgeon who specializes in gender reassignment surgery and who would perform the
8 surgeries for Plaintiffs (Doc. 5-5 ep 2-3; Doc. 25 ep 31-44). Both experts have reviewed
9 the declarations provided by Dr. Cronyn, Reed, Dr. Peck, as well as John Doe's medical
10 records from Dr. Veenod Chulani at the Phoenix Children's Hospital Gender Support
11 Program.⁹ (Doc. 5-4 ep 6, Doc. 5-5 ep 8.) Drs. Janssen and Schechter are members of the
12 World Professional Association for Transgender Health ("WPATH") and rely on
13 WPATH's "Standards of Care for the Health of Transsexual, Transgender, and Gender
14 Non-Conforming People" ("WPATH SOC") for their opinions that the surgery Plaintiffs
15 seek is a safe and effective procedure for treating gender dysphoria in minors such as D.H.
16 and John. (Doc. 5 ep 22-33, 49-63.) According to Dr. Schechter: "The purpose of the
17 WPATH SOC is to assist health providers in delivering medical care to transgender people
18 to provide them with safe and effective treatment for gender dysphoria, in order to
19 maximize their overall health, psychological well-being, and self-fulfillment." (Doc. 5-4
20 ep 4; Doc. 5-5 ep 9.)

21 Dr. Janssen is a contributing author to the forthcoming eighth version of the

23 ⁷Reed is a Licensed Professional Counselor who specializes in working with young
24 LGBT people. (Doc. 5-2.) D.H. was diagnosed with gender dysphoria before seeing Reed;
25 Reed confirmed this diagnosis and her "treatment of D.H. focused on his gender dysphoria,
26 anxiety, trauma, and oppositional [defiant] disorder." (Doc. 5-2.)

27 ⁸Dr. Peck has a Master of Social Work and a PhD in Social Welfare, is a member
28 of WPATH, and practices as a clinical therapist specializing in issues regarding sexuality,
sexual orientation, and gender identity. (Doc. 4-2.) Dr. Peck started seeing John "to help
him address the increasing psychological distress he has experienced because of his gender
dysphoria. Although John was diagnosed with gender dysphoria before seeing Dr. Peck,
she has confirmed this diagnosis and has also diagnosed him with post-traumatic stress
disorder stemming from early life attachment trauma. (Doc. 4-2.)

⁹These records have not been disclosed to Defendant and therefore were unavailable
to Defendant's experts.

1 WPATH SOC and has treated over 300 children and adolescents with gender dysphoria.
2 (Doc. 5-4 ep 3-4.) Despite providing his detailed opinion that male chest reconstruction
3 surgery is safe and effective for adolescents and that “[c]ategorically excluding coverage
4 for male chest reconstruction surgery to treat gender dysphoria has no basis in the
5 prevailing standards of care, peer-reviewed and medical literature,” he has not opined as to
6 whether D.H. and John themselves are suitable candidates for the surgery. (Doc. 5-4 ep
7 33; Doc. 25 ep 29.) Indeed, although Dr. Janssen states “[s]urgical treatment is [] medically
8 necessary for *some* transgender youth in order to alleviate their gender dysphoria,”
9 Dr. Janssen has never met, examined, or consulted with D.H. or John to determine whether
10 surgery is medically necessary for them. (Doc. 5-4 ep 11 (emphasis added).)

11 Dr. Schechter is also a contributing author of the current version of the WPATH
12 SOC and has performed approximately 100–150 “top” surgeries on patients under the age
13 of 21. (Doc. 5 ep 4.) Dr. Schechter has provided virtual consultations to D.H. and John
14 but has not examined them in person or conducted a final consultation to assess skin
15 elasticity and other concerns, due to the circumstances of the COVID-19 pandemic. (Doc.
16 5 ep 14-16.) Dr. Schechter has opined D.H. and John “appear[] to be [] good candidate[s]
17 for male chest reconstruction surgery” and he is “confident” they are fully aware of the
18 risks and benefits of the procedure, and that the surgery “is a safe, effective, and medically
19 necessary treatment for each of them, assuming the absence of any pathology.” (Doc. 5 ep
20 15-18.)

21 Defendant has also provided declarations from two experts: Dr. Michael K.
22 Laidlaw, who is an endocrinologist, and Dr. Stephen E. Levine, a psychiatrist specializing
23 in sexuality. (Doc. 18-1 ep 30, Doc. 18-2 ep 3-4.) Dr. Laidlaw has been retained to provide
24 his expert opinion as to the standards of care for treating minors diagnosed with gender
25 dysphoria and the appropriateness of D.H. and John undergoing male chest reconstruction
26 surgery. (Doc. 18-1 ep 3-4.) According to Dr. Laidlaw, the purported “professional
27 consensus” embodied in the WPATH SOC “exists only within the confines of [WPATH]”
28 and there has been no high-quality study showing male chest reconstruction surgery is safe,
effective, or optimal for treating minors with gender dysphoria.” (Doc. 18-1 ep 12.)

Specifically, he challenges a study cited by Dr. Schechter for its flawed methodology and cites a different study that “questions the long-term effectiveness of gender reassignment surgery,” by examining the rate of completed suicides in individuals who had undergone gender reassignment surgery. (Doc. 18-1 ep 12-13.) He also points to a 2016 final decision memo in which the Centers for Medicare & Medicaid Services (“CMS”) declined to issue a National Coverage Determination on gender reassignment surgery for Medicare beneficiaries with gender dysphoria “because the clinical evidence is inconclusive for the Medicare population.” (Doc. 18-1 ep 13.) *See* CTRS. FOR MEDICARE & MEDICAID, DECISION MEMO FOR GENDER DYSPHORIA AND GENDER REASSIGNMENT SURGERY (CAG-00446N) (Aug. 30, 2016), <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282> (last visited March 17, 2021). Although that decision does not apply to Medicaid, it is instructive that CMS found the clinical evidence is “inconclusive” for the Medicare population—which is comprised of mostly adults 65 years and older and certain disabled individuals under age 65. *See* 42 U.S.C. § 1395c. This finding suggests that if the clinical evidence is inconclusive for adults, then it is likely inconclusive for children, such as Plaintiffs. Dr. Laidlaw also opines that irreversible male chest reconstruction surgery should not be performed on D.H. or John because, in the absence of any imaging, laboratory, or other objective testing, there is no way to predict whether a minor with gender dysphoria, such as D.H. or John, will outgrow the condition. (Doc. 18-1 ep 15.) Additionally, he opines such surgery is inappropriate for minors because they are “still undergoing brain development and as such they are immature with respect to intellect, emotion, judgment, and self-control” and, therefore, “there is a significant chance that a young person may later regret removing an organ that cannot be replaced.” (Doc. 18-1 ep 15.)

Dr. Levine was an early member of WPATH and Chairman of the Standards of Care Committee that developed the fifth version of the WPATH SOC.¹⁰ (Doc. 18-2 ep 3-4.) He

¹⁰Dr. Levine was a member from 1974 to 2001 before the organization changed its name to WPATH—it had previously been known as the Harry Benjamin International Gender Dysphoria Association—and he resigned his membership in 2002 “due to [his] regretful conclusion that the organization and its recommendations had become dominated

1 founded and serves as co-director of the Case Western Reserve University Gender Identity
2 Clinic, and has been retained to provide his expert opinion on the standards of care for
3 treating adolescents with gender dysphoria. (Doc. 18-2 ep 3-4, 18.) Dr. Levine explains
4 that “WPATH represents a self-selected subset of the mental health professions,
5 endocrinologists, and surgeons along with its many non-professional trans members; it
6 does not capture the clinical experiences of others.” (Doc. 18-2 ep 20.) Therefore, he
7 opines: “WPATH claims to speak for the medical profession; however, it does not
8 welcome skepticism and therefore, deviates from the philosophical core of medical
9 science.” (Doc. 18-2 ep 20.) He further opines there are no reliable scientific data to
10 support surgical intervention in adolescents with gender dysphoria. (Doc. 18-2 ep 27-34.)
11 Dr. Levine also explains chest reconstruction surgery “should not be construed as a
12 curative intervention for gender dysphoria” because it will not eliminate the incongruence
13 of female genitalia, as most transgender males do not have genital reconstruction surgery
14 because “[i]t is expensive, fraught with complications” and is “unable to produce the
15 normal functions of a penis.” (Doc. 18-2 ep 33-34.) Dr. Levine also points out the risks
16 associated with transitioning, the lack of any reliable way to predict which patients’ gender
17 dysphoria will persist or desist into adulthood, and notes several studies that indicate
18 mental health outcomes do not significantly improve for transgender individuals who
19 undergo surgery. (Doc. 18-2 ep 34-41.)

20 Defendant also provided a recent opinion from the United Kingdom’s High Court
21 of Justice, which reviewed a National Health Service (“NHS”) clinic’s practice of
22 prescribing puberty-suppressing medication to individuals under age 18 with gender
23 dysphoria. (Doc. 47.) There, claimants argued that persons under age 18 are not competent
24 to consent to such treatment and that the information being provided to such individuals
25 was insufficient and misleading to ensure they could provide informed consent. *Bell v.*
26 *Tavistock and Portman NHS Foundation Trust*, 2020 EWHC 3274 (Dec. 1, 2020). The
27 court heard testimony from several experts (one of which is a WPATH member), and

28 by politics and ideology, rather than by scientific process, as it was years earlier.” (Doc.
18-2 ep 4, 18.)

1 defendants argued the practice of prescribing puberty-suppressing medication to children
2 under age 18 was “required in accordance with the international frameworks of WPATH
3 and the Endocrine Society and by the domestic regulatory frameworks.” *Id.* ¶¶ 57, 60, 97.
4 The court nonetheless concluded: “it is right to call the treatment experimental or
5 innovative in the sense that there are currently limited studies/evidence of the efficacy or
6 long-term effects of the treatment.” *Id.* ¶ 148. Although that case did not involve surgery
7 and is not controlling authority, the UK decision regarding puberty-suppressing medication
8 being experimental suggests the irreversible surgery Plaintiffs seek here is also
9 experimental and perhaps risky, which, in turn, casts doubt on the merits of their claims.
10 *See Hernandez*, 872 F.3d at 999; *see also Dahl*, 7 F.3d at 1403.

11 Based on the record and, in particular, the conflicting opinions provided by well-
12 qualified experts and the lack of any evidence showing Plaintiffs have been evaluated by a
13 psychologist or psychiatrist, the Court finds Plaintiffs have not clearly shown the surgery
14 is medically necessary for them or that it is safe and effective for correcting or ameliorating
15 their gender dysphoria. *See Dahl*, 7 F.3d at 1403. Accordingly, the merits of Plaintiffs’
16 EPSDT claim are doubtful. *See Hernandez*, 872 F.3d at 999.

17 2. Medicaid’s Comparability Requirements

18 Under the Medicaid Act, the medical assistance made available to a qualified
19 individual enrolled in a state plan “shall not be less in amount, duration, or scope than the
20 medical assistance made available to any other such individual.” 42 U.S.C. § 1396d(n).
21 This provision is known as the “comparability requirement.” Section 1396a(10)(A) further
22 states the medical assistance made available must “at least” include “the care and services
23 listed in paragraphs (1) through (5), (17), (21), (28), and (29) of section 1396d(a),” which
24 do not expressly include gender reassignment surgery or chest reconstruction surgery,
25 generally. *See* §§ 1396d(a)(1)–(5), (17), (21), (28), (29).

26 Plaintiffs argue the Challenged Exclusion violates Medicaid’s comparability
27 requirement because “AHCCCS covers the same services when necessary to treat other
28 conditions.” (Doc. 3 ep 10-11.) In other words, Plaintiffs assert the only reason AHCCCS
will not cover the surgery is because it is prescribed to treat gender dysphoria, instead of

1 some other condition, for which the surgery would be covered. (Doc. 25 ep 7.) In support
2 of their argument, Plaintiffs cite a recent district court decision that found Wisconsin's
3 Medicaid policy that excluded transgender care had failed to make certain surgeries
4 available to transgender individuals, and therefore, discriminated on the basis of diagnosis.
5 *See Flack v. Wis. Dep't of Health Servs.*, 395 F. Supp. 3d 1001, 1019 (W.D. Wis. 2019).
6 As explained in Section III.A.3 of this Order, *Flack* is distinguishable and not controlling.

7 Defendant argues the Challenged Exclusion does not violate the comparability
8 requirement because: (1) "the exclusion applies to all transgender persons alike"; and (2)
9 the comparability requirement "requires comparable services for individuals with
10 comparable needs." (Doc. 18 ep 14.) Specifically, Defendant contends "the needs for
11 relief from gender dysphoria are unique—they are not the same as the needs of a person
12 who seeks [breast] reconstruction after a mastectomy" and this "is particularly true as to
13 children." (*Id.*) Defendant further asserts Plaintiffs' argument "begs the question whether
14 reconstruction following a mastectomy is based on the same needs as chest reconstruction
15 to treat a child's gender dysphoria." (*Id.*)

16 Based on the record at this stage of litigation, the Court concludes Plaintiffs have
17 not shown the facts clearly favor their position that the Challenged Exclusion violates
18 Medicaid's comparability requirement. *See Dahl*, 7 F.3d at 1403. Not only is it disputed
19 whether the surgery is safe and effective for minors as explained above, but Plaintiffs have
20 not clearly shown the needs of adolescent transgender boys seeking this surgery are
21 comparable to the needs of other patients who require such surgery, such as adult women
22 with breast cancer—the population that most commonly requires surgical removal of their
23 breasts, whether termed "double mastectomy" or "male chest reconstruction surgery." *See*
24 *supra* note 2. Therefore, the merits of Plaintiffs' claim here are doubtful. *See Hernandez*,
25 872 F.3d at 999.

26 3. *Equal Protection Clause and Section 1557 of the Affordable Care Act*

27 Plaintiffs are also unlikely to succeed on the merits of their claim that the Challenged
28 Exclusion violates the Equal Protection Clause of the Fourteenth Amendment and Section
1557 of the Patient Protection and Affordable Care Act (ACA). (Doc. 3 ep 11-15.) The

1 Equal Protection Clause provides: “No State shall . . . deny to any person within its
2 jurisdiction the equal protection of the laws.” U.S. CONST. amend. XIV, § 1. Similarly,
3 Section 1557 of the ACA, codified at 42 U.S.C. § 18116, provides: “an individual shall
4 not, [on the basis of sex] . . . be excluded from participation in, be denied the benefits of,
5 or be subjected to discrimination under, any health program or activity, any part of which
6 is receiving Federal financial assistance”¹¹ To prevail on their discrimination claim,
7 Plaintiffs must show: (1) AHCCCS is federally funded; (2) Plaintiffs were denied benefits
8 of or otherwise discriminated against by AHCCCS on the basis of their membership in a
9 protected class—here, on the basis of their sex; and (3) the denial of benefits or
10 discrimination was a but-for cause of Plaintiffs’ injuries. *See* 42 U.S.C. § 18116(a). The
11 parties do not dispute AHCCCS receives federal funds, but sharply dispute the other
12 elements of Plaintiffs’ claims.

13 Plaintiffs argue they were denied the benefits of and discriminated against by
14 AHCCCS because they are transgender. (Doc. 3 ep 11-12; Doc. 25 ep 8.) To support this,
15 Plaintiffs assert that under *Bostock v. Clayton Cnty., Ga.*, 140 S. Ct. 1731 (2020),
16 “[d]iscrimination because a person is transgender is discrimination because of sex.” (Doc.
17 3 ep 12.) According to Plaintiffs, the fact AHCCCS would cover the surgery “for other
18 medically necessary reasons, such as to treat breast cancer or traumatic injury, but refuses
19 to do so for the treatment of gender dysphoria, demonstrates the [Challenged Exclusion]
20 on its face discriminates based on transgender status and thus on sex.” (Doc. 3 ep 13; Doc.
21 25 ep 8.) Plaintiffs also cite several cases from other states to support their position,
22 including *Flack*, 395 F. Supp. 3d 1001, *Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wis.
23 2018), and *Kadel v. Folwell*, 446 F. Supp. 3d 1 (M.D.N.C. 2020).

24 First, Plaintiffs’ reliance on *Bostock* is unpersuasive. The Supreme Court expressly
25 limited its holding to Title VII claims involving employers who discriminated against

26
27 ¹¹Section 1557 does not expressly say “on the basis of sex,” but rather references
28 title IX of the Education Amendments of 1972, 20 U.S.C. § 1681 et seq., which provides:
“No person in the United States shall, on the basis of sex, be excluded from participation
in, be denied the benefits of, or be subjected to discrimination under any education program
or activity receiving Federal financial assistance”

1 employees because of their gay or transgender status when it wrote: “An employer who
2 fires an individual merely for being gay or transgender defies the law.” 140 S. Ct. at 1754.
3 *Bostock* did not involve or purport to deal with a state Medicaid plan exclusion for surgical
4 treatment for gender dysphoria in minors.

5 Second, Plaintiffs’ reliance on cases from other states is also unavailing. *Boyden* is
6 factually distinguishable, as plaintiffs there were adults who challenged Wisconsin’s state-
7 sponsored private health plan’s exclusion of “[p]rocedures, services, and supplies related
8 to surgery and sex hormones associated with gender reassignment.” 341 F. Supp. 3d at
9 982. It did not involve Medicaid, the plaintiffs were not minors, and the exclusion
10 challenged was significantly different than the Challenged Exclusion here. Similarly,
11 *Kadel* is distinguishable, as it also involved a challenge to a state-sponsored private health
12 plan’s exclusion of treatment sought “in conjunction with proposed gender transformation”
13 or “in connection with sex changes or modifications.” 446 F. Supp. 3d at 7. Again, that
14 exclusion is significantly different from the one here, and that case did not involve
15 Medicaid or minor plaintiffs.

16 The most similar case Plaintiffs cite is *Flack*, 395 F. Supp. 3d 1001, in which
17 transgender adults challenged a Wisconsin regulation that excludes from Medicaid
18 coverage not only surgical treatment for gender dysphoria, but also “[d]rugs, including
19 hormone therapy, associated with transsexual surgery or medically unnecessary alteration
20 of sexual anatomy or characteristics.” Wis. Admin. Code §§ DHS 107.03(23)-(24). The
21 plaintiffs there similarly argued the regulation violated the Equal Protection Clause and
22 § 1557 by discriminating on the basis of sex. *Flack*, 395 F. Supp. 3d at 1014, 1019-20.
23 There, the defendants’ only argument was the State of Wisconsin “could not have
24 understood that Title IX would impose on it a new anti-discrimination requirement when
25 this federal law passed” because “the Seventh Circuit did not hold that sexual orientation
26 and transgender status discrimination were covered under Title VII and Title IX,
27 respectively, until decades after the enactment of Title IX.” *Id.* The court found the
28 defendants’ argument unpersuasive and granted plaintiffs’ motion for summary judgment
on their Equal Protection and § 1557 claims, as well as their Medicaid comparability

1 requirement claim. *Id.* at 1014-15, 1019, 1022. In contrast, the Challenged Exclusion here
2 only excludes gender reassignment *surgery*—it does not exclude coverage for other
3 treatments for gender dysphoria such as hormone therapy. Indeed, Plaintiffs have been
4 receiving hormone therapy covered by AHCCCS for at least one year. More importantly,
5 *Flack* involved *adult* plaintiffs—not minors such as the Plaintiffs here. *See id.* at 1010.
6 Defendant argues that because AHCCCS covers hormone treatment and mental health
7 counseling for the treatment of gender dysphoria, “there is no discrimination against
8 transgender persons or the elimination of coverage for all gender transition treatment” and,
9 therefore, “Plaintiffs have failed to establish their high burden.” (Doc. 18 ep 16.) The
10 Court is inclined to agree at this stage of the litigation, especially considering Plaintiffs
11 have not clearly shown the surgery they seek is safe and effective for treating gender
12 dysphoria in adolescents.

13 Third, although Plaintiffs would be denied coverage for the surgery due to the
14 Challenged Exclusion, they have not clearly shown such a denial would be made on the
15 basis of sex. As noted, AHCCCS clearly covers certain treatments for gender dysphoria.
16 And although AHCCCS does not cover the surgery Plaintiffs seek for the purpose of
17 treating gender dysphoria, Plaintiffs have not clearly shown AHCCCS denies coverage on
18 the basis of sex and not on the basis of some other permissible rationale.

19 Finally, as explained above, *Bostock* does not apply to the ACA and, unlike the
20 Medicaid exclusions challenged in the other cases Plaintiffs cite, the Challenged Exclusion
21 here does not exclude coverage for all gender dysphoria treatments. To reiterate, Plaintiffs
22 have not clearly shown the surgical treatment they seek is safe and effective for
23 adolescents. Accordingly, the merits of Plaintiffs’ Equal Protection and § 1557 claims are
24 doubtful. *See Hernandez*, 872 F.3d at 999.

25 B. Irreparable Harm

26 Plaintiffs argue they will be irreparably harmed in the absence of an injunction
27 because such harm is “presumed for violations of constitutional rights” and the continued
28 denial of coverage for the surgery will cause them irreparable physical and emotional harm.
(Doc. 3 ep 15.) Specifically, Plaintiffs assert that without immediate relief, their gender

1 dysphoria “will become increasingly debilitating,” as both D.H. and John have histories of
2 suicidal ideation. (Doc. 3 ep 16.) Additionally, Plaintiffs contend prolonged use of the
3 chest binders they wear, “without which neither . . . would be able to function, can cause
4 significant damage to the skin and tissues,” which could result in additional scarring from
5 the surgery. (*Id.*)

6 Defendant counters the distress experienced by Plaintiffs does not rise to the level
7 of irreparable harm and argues “there is significant doubt whether Plaintiffs have a
8 constitutional right to have AHCCCS pay for this surgery.” (Doc. 18 ep 12.) Defendant
9 asserts Plaintiffs have not shown irreparable harm because, according to the Diagnostic
10 and Statistical Manual of Mental Disorders Fifth Edition (“DSM-5”), gender dysphoria
11 does not persist into adulthood for most children and, specifically, “[i]n natal females,
12 persistence has ranged from 12% to 50%.” (Doc. 18 ep 9 (quoting DSM-5 at 455).)
13 Defendant also asserts Plaintiffs have not demonstrated they are capable of providing
14 informed consent, given their “other significant psychological disorders which pre-date
15 their gender dysphoria.” (Doc. 18 ep 9.) As to Plaintiff D.H.’s assertion that wearing a
16 binder could cause irreparable harm, Defendant counters that D.H. has worn a binder for
17 five years without developing any skin conditions or exacerbating his asthma, so
18 irreparable harm is unlikely. (Doc. ep 10.) Defendant also asserts John’s long-standing
19 and pre-existing “chronic post-traumatic stress disorder from early life attachment trauma”
20 “should be addressed before irreversible surgical procedures are employed,” and notes that
21 Plaintiffs have not provided a declaration from any medical doctor who is treating John.
22 (Doc. 18 ep 10.)

23 As explained above, the Supreme Court’s “frequently reiterated standard requires
24 plaintiffs seeking preliminary relief to demonstrate that irreparable injury is *likely* in the
25 absence of an injunction.” *Winter*, 555 U.S. at 22. And because Plaintiffs seek a mandatory
26 injunction, they must demonstrate that “extreme or very serious damage will result,” that
27 such damage “is not capable of compensation in damages,” and that “the merits of the case
28 are not doubtful.” *Hernandez*, 872 F.3d at 999. Although the Court agrees the deterioration
of Plaintiffs’ mental health could *possibly* result in extreme or very serious damage,

1 Plaintiffs have not met their heightened burden under the mandatory injunction standard.
2 *See Anderson*, 612 F.2d at 1115. Furthermore, as Judge Rosemary Márquez explained in
3 her February 26, 2021 order denying a motion for preliminary injunction in a factually
4 different case that involves a similar insurance policy exclusion, it is not clear “the injury
5 complained of is [not] capable of compensation in damages,” as Plaintiffs here could
6 potentially pay for the surgeries out-of-pocket and be reimbursed by Defendant if they
7 prevail on the merits of their claims. *See Toomey v. State of Arizona, et al.*, No. CV-19-
8 00035-TUC-RM, Doc. 162 (denying motion for preliminary injunction where plaintiff
9 sought to enjoin enforcement of policy excluding coverage for gender reassignment
10 surgery in private employer-sponsored health plan).¹²

11 Furthermore, the Court will deny the motion because the preliminary injunctive
12 relief sought is identical to the ultimate relief sought in the underlying complaint. “It is so
13 well settled as not to require citation of authority that the usual function of a preliminary
14 injunction is to preserve the status quo ante litem pending a determination of the action on
15 the merits.” *Tanner Motor Livery, Ltd. v. Avis, Inc.*, 316 F.2d 804, 808 (9th Cir. 1963).
16 Therefore, “it is not usually proper to grant the moving party the full relief to which he
17 might be entitled if successful at the conclusion of a trial.” *Id.* This is particularly true
18 when the relief sought would completely change, rather than preserve, the status quo. As
19 explained above, the status quo here is that AHCCCS will not cover the surgeries Plaintiffs
20 seek because of the Challenged Exclusion. The relief sought here would not preserve the
21 status quo, but rather would completely change it and is identical to the ultimate relief
22 sought in Plaintiffs’ Complaint. Accordingly, the Court finds it premature to grant such
23 relief prior to discovery and summary judgment briefing and therefore needs not address
24 the remaining *Winter* factors. *See Monarch*, 971 F.3d at 1032, n.10; *Toomey*, No. CV-19-
25 00035-TUC-RM, Doc. 162; *see also Winter*, 555 U.S. at 20.

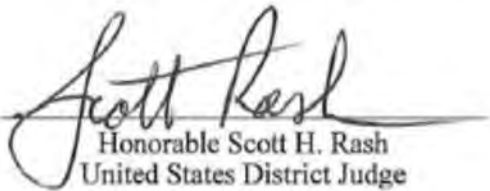
26
27 ¹²Like the Challenged Exclusion in the instant case, the health insurance policy at
28 issue in *Toomey* “specifically exclude[s] . . . (16) Gender reassignment surgery.” CV-19-
00035-TUC-RM Doc. 86-1 ep 58-59. Unlike the instant case, however, *Toomey* involves
a private employer-sponsored health plan and the plaintiff is an adult seeking coverage for
a hysterectomy—a surgery that is covered for treatment of other medical conditions.

1 **IV. Conclusion**

2 For the foregoing reasons, the Court concludes Plaintiffs have not met the
3 heightened standard for a mandatory injunction to issue. Accordingly,

4 **IT IS ORDERED** Plaintiff's Motion for Preliminary Injunction (Doc. 3) is
5 **DENIED.**

6 Dated this 30th day of March, 2021.

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11 Honorable Scott H. Rash
12 United States District Judge
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No. 21-15668

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

D.H., by and through his mother, Janice Hennessy-Waller; and JOHN DOE, by his
guardian and next friend, Susan Doe,
Plaintiff-Appellants,

vs.

JAMI SNYDER,
Defendant-Appellee.

On Appeal from Order of the United States District Court
For the District of Arizona
Case No. 4:20-cv-335-SHR

**EXCERPTS OF RECORD
VOLUME 2 of 3 (ER 23 to ER 289)**

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EXHIBIT A

AO

From: Asaf Orr AOrr@nclrights.org

Subject: Following up on last week's conversation

Date: February 26, 2021 at 10:27 AM

To: Kate King kate@burnsbarton.com, David Barton david@burnsbarton.com

Cc: Ray, Brent bray@kslaw.com, Chinsky, Andrew achinsky@kslaw.com, Daniel Barr dbarr@perkinscoie.com, JHowe JHowe@perkinscoie.com, Catherine McKee mckee@healthlaw.org, coursolle coursolle@healthlaw.org

Hi Kate and David,

I write to follow up on our conversation last Friday. We appreciate your intention to quote from our filings and the oral argument transcript to capture Plaintiffs' arguments regarding the subject of the supplemental brief—administrative exhaustion and the futility exception. That should resolve the concerns that we raised in our e-mail exchange last week. We would like to clarify, however, that quoting solely from the proposed order we submitted with Plaintiffs' Motion for Preliminary Injunction as a restatement of Plaintiffs' argument/position would still be misleading in light of our representations to the Court. Thus, to the extent that you quote from the proposed order, we ask that your supplemental brief include the necessary context to avoid any misrepresentation.

Thank you in advance for your time and attention to this matter.

Very truly yours,

Asaf

Asaf Orr, Esq. | Senior Staff Attorney & Transgender Youth Project Director

(Pronouns: He, him)

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Feminist Founded, Advocates for All

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Counsel for Plaintiffs and the Class
 (Additional Counsel on Signature Page)

**UNITED STATES DISTRICT COURT
 FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No. 4:20-cv-335-SHR

**PLAINTIFFS' RESPONSES AND
 OBJECTIONS TO
 DEFENDANT'S FIRST SET OF
 INTERROGATORIES**

1 Plaintiffs D.H. and John Doe (“Plaintiffs”), by and through their attorneys and
2 pursuant to Rules 26 and 33 of the Federal Rules of Civil Procedure, hereby object and
3 respond to Defendant’s First Set of Interrogatories (“Interrogatories”) as follows. Plaintiffs
4 respond to these Interrogatories based on their knowledge as of the date below and after a
5 reasonable inquiry. Plaintiffs reserve the right to supplement and amend their responses.
6 Each response is offered on behalf of both Plaintiffs D.H. and John Doe.

7 **GENERAL OBJECTIONS**

8 1. Plaintiffs object to each Interrogatory to the extent that it seeks to impose
9 obligations upon Plaintiffs beyond those permitted by the Federal Rules of Civil Procedure
10 and the Local Rules of the U.S. District Court for the District of Arizona.

11 2. Plaintiffs object to each Interrogatory to the extent that it asks Plaintiffs to
12 provide information which is not in their possession, custody, or control. Specifically,
13 several Interrogatories seek broad information regarding the treatment of gender dysphoria.
14 These Interrogatories are properly the subject of expert discovery, not Interrogatories
15 directed to the named Plaintiffs.

16 3. Plaintiffs object to each to Interrogatory to the extent it seeks premature
17 expert discovery. As Defendant knows, the Court has not yet issued a scheduling order on
18 discovery. In the parties’ Rule 26(f) report, Plaintiffs suggested the parties exchange expert
19 disclosures and reports on May 27, 2021. The Court has not yet issued a ruling setting these
20 deadlines. In any event, several of these Interrogatories seek expert information, and issuing
21 requests for this information outside the course of expert discovery is not the correct
22 procedural mechanism.

23 4. Plaintiffs object to the Interrogatories to the extent that they contain words
24 and phrases that are vague, ambiguous, confusing, overly broad, and/or undefined, and
25 therefore are difficult or impossible to understand.

26 5. Plaintiffs object to the Interrogatories to the extent that they are based on facts
27 not in evidence or facts that are otherwise incorrect.
28

6. Plaintiffs incorporate the foregoing General Objections into their response to each Interrogatory below, regardless of whether a particular response may repeat a particular General Objection.

INTERROGATORY NO. 1:

Please identify by name, date and author, any peer-reviewed studies that identify the long-term health benefits of male chest reconstruction surgery for individuals with gender dysphoria under the age of 21.

RESPONSE TO INTERROGATORY NO. 1:

Plaintiffs object to this Interrogatory because it seeks information which is not in Plaintiffs' possession, custody, or control. Because this Interrogatory asks for information about peer-reviewed studies on the long-term health benefits of male chest reconstruction surgery, it is properly the subject of expert discovery, not an Interrogatory to a party under Rule 33. Plaintiffs also object to this Interrogatory because the phrase "long-term health benefits" is vague, ambiguous, and capable of multiple interpretations. Plaintiffs further object as such peer-reviewed studies are publicly available, and therefore just as easily accessed by Defendant as the Plaintiffs.

Plaintiffs stand on their objections.

INTERROGATORY NO. 2:

Produce all scientific studies, research, and clinical evidence that support the allegations and conclusions found in paragraphs 38, 39, and 40 of the Complaint.

RESPONSE TO INTERROGATORY NO. 2:

Plaintiffs object to this Interrogatory because it calls for the production of documents and is therefore incapable of being "answered separately and fully in writing under oath." *See* Fed. R. Civ. P. 33(b)(3). Plaintiffs further object to the extent such scientific studies, research, and clinical evidence are publicly available, and therefore just as easily accessed by Defendant as the Plaintiffs.

Plaintiffs stand on their objections.

1 **INTERROGATORY NO. 3:**

2 Please describe the criteria that should be applied to determine that male chest
3 reconstruction surgery is medically necessary for transgender males under the age of 21
4 who suffer from gender dysphoria.

5 **RESPONSE TO INTERROGATORY NO. 3:**

6 Plaintiffs object to this Interrogatory because it seeks information that is only
7 minimally relevant to any party's claim or defense and is therefore not proportional to the
8 needs of this Lawsuit. Plaintiffs ask the Court to enjoin Defendant from enforcing the
9 Challenged Exclusion because the Exclusion violates federal law by preventing Plaintiffs
10 and similarly situated individuals from having the opportunity to demonstrate to AHCCCS
11 that male chest reconstruction is medically necessary for the treatment of their gender
12 dysphoria.

13 Additionally, because this Interrogatory asks for information about the criteria for
14 determining whether male chest reconstruction surgery is medically necessary for certain
15 individuals, to the extent it seeks relevant information at all, it is properly the subject of
16 expert discovery, not an Interrogatory to a party under Rule 33. Plaintiffs further object to
17 this Interrogatory for that reason.

18 Subject to and without waiving their objections, Plaintiffs refer Defendant to
19 paragraphs 30 through 33 of their Complaint (Dkt. 1), which describe the standards of care
20 for the treatment of gender dysphoria, including the use of medically necessary surgical
21 treatment: the World Professional Association for Transgender Health ("WPATH")
22 *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming*
23 *People* and *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An*
24 *Endocrine Society Clinical Practice Guideline*. Plaintiffs otherwise stand on their
25 objections.

INTERROGATORY NO. 4:

Please describe all efforts made by Plaintiff John Doe and Plaintiff D.H. to obtain approval of coverage for the male chest reconstruction surgery they seek by way of this Lawsuit.

RESPONSE TO INTERROGATORY NO. 4:

Plaintiffs object to this Interrogatory because it seeks information that is neither relevant to any party's claim or defense nor proportional to the needs of this Lawsuit. Plaintiffs' claims do not require administrative exhaustion, and even if they did, the futility exception to the administrative exhaustion requirement would apply to the particular circumstances of this Lawsuit and the Challenged Exclusion. *See generally* Dkt. 58-1. Any "efforts made by Plaintiff John Doe and Plaintiff D.H. to obtain approval of coverage for the male chest reconstruction surgery they seek" are therefore irrelevant to the central legal issues in the Lawsuit: whether the Challenged Exclusion violates federal law or the Constitution. Plaintiffs also object to this Interrogatory because the phrase "all efforts ... to obtain approval of coverage for the male chest reconstruction surgery they seek" is vague, ambiguous, and capable of multiple interpretations.

Subject to and without waiving their objections, Plaintiffs refer Defendant to paragraphs 75 through 87 and 96 through 103 of their Complaint (Dkt. 1), which respectively describe the efforts of Plaintiffs D.H. and John Doe to seek treatment for their gender dysphoria. Plaintiffs sought such treatment believing that AHCCCS would cover healthcare services and treatments in accordance with its legal obligations under federal law, including coverage for the medically necessary surgical care they needed. Plaintiffs only later learned that the Challenged Exclusion completely bars the possibility of their obtaining coverage for male chest reconstruction surgery regardless of whether that surgery was medically necessary. Plaintiffs otherwise stand on their objections.

INTERROGATORY NO. 5:

Please describe all efforts made by the National Center for Lesbian Rights and/or National Health Law Program to obtain a legislative or administrative change to the Challenged Exception before initiating the current Lawsuit.

RESPONSE TO INTERROGATORY NO. 5:

Plaintiffs object to this Interrogatory because it seeks information that is neither relevant to any party's claim or defense nor proportional to the needs of this Lawsuit. As an initial matter, neither the National Center for Lesbian Rights ("NLCR") nor the National Health Law Program ("NHeLP") is a party to the Lawsuit. *See* Dkt. 1; *see also* Fed. R. Civ. P. 33(a) (allowing a party to serve interrogatories "on any other party"); *id.* 33(b)(1)(A) (directing that interrogatories be answered "by the party to whom they are directed"). Additionally, Plaintiffs are aware of no substantive or procedural rule that requires them or their counsel to seek "to obtain a legislative or administrative change to" an enforced government policy before challenging the legality of that policy (*i.e.*, the Challenged Exclusion) under federal law or the Constitution. Accordingly, the information sought by this Interrogatory is irrelevant to the Lawsuit. Plaintiffs also object to this Interrogatory because the phrase "all efforts ... to obtain a legislative or administrative change to the Challenged Exception [sic]" is vague, ambiguous, and capable of multiple interpretations.

Plaintiffs stand on their objections.

INTERROGATORY NO. 6:

Please describe all efforts made by the National Center for Lesbian Rights and/or National Health Law Program to obtain a legislative or administrative change to the Medicaid Act as it pertains to gender reassignment surgeries before initiating the current Lawsuit.

RESPONSE TO INTERROGATORY NO. 6:

Plaintiffs object to this Interrogatory because it seeks information that is neither relevant to any party's claim or defense nor proportional to the needs of this Lawsuit. As an initial matter, neither NCLR nor NHeLP is a party to the Lawsuit. *See* Dkt. 1; *see also* Fed.

1 R. Civ. P. 33(a) (allowing a party to serve interrogatories “on any other party”); *id.*
2 33(b)(1)(A) (directing that interrogatories be answered “by the party to whom they are
3 directed”). Additionally, Plaintiffs’ do not seek “to obtain a legislative or administrative
4 change to the Medicaid Act as it pertains to gender reassignment surgeries” through their
5 Medicaid Act claims. Instead, Plaintiffs seek a declaration that the Challenged Exclusion
6 violates the Medicaid Act. Accordingly, the information sought by this Interrogatory is
7 irrelevant to the Lawsuit. Plaintiffs also object to this Interrogatory because the phrase “all
8 efforts ... to obtain a legislative or administrative change to the Medicaid Act as it pertains
9 to gender reassignment surgeries” is vague, ambiguous, and capable of multiple
10 interpretations.

11 Plaintiffs stand on their objections.

12 **INTERROGATORY NO. 7:**

13 If You provided anything other than an unqualified denial to Requests for Admission
14 15, 16, and 17, please, 1) provide the basis for Your denial; 2) identify the individual(s)
15 who applied for an exception or appealed a determination; and 3) provide the date of such
16 application or appeal.

17 **RESPONSE TO INTERROGATORY NO. 7:**

18 Plaintiffs hereby incorporate their objections to Defendant’s Requests for Admission
19 Nos. 15, 16, and 17. Plaintiffs also object to this Interrogatory to the extent that it seeks
20 information protected by (i) the attorney-client privilege, (ii) the work product doctrine,
21 and/or (iii) any other applicable privilege or protection.

22 Subject to and without waiving their objections, Plaintiffs hereby incorporate their
23 response to Interrogatory No. 4.

24 Plaintiffs otherwise stand on their objections.

25
26 Dated: February 24, 2021

Respectfully submitted,

27 /s/ Brent P. Ray
28 Brent P. Ray*

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Attorneys for Plaintiffs and the Class

* Admitted pro hac vice

1 **CERTIFICATE OF SERVICE**

2 I hereby that on February 24, 2021, I caused a copy of the foregoing Plaintiffs'
3 Responses and Objections to Defendant's First Set of Interrogatories to be served on the
4 following counsel via electronic mail:

5
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14 *Attorneys for Defendant*

15
16 /s/ Andrew J. Chinsky
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EXHIBIT C

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Counsel for Plaintiffs and the Class
 (Additional Counsel on Signature Page)

**UNITED STATES DISTRICT COURT
 FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No. 4:20-cv-335-SHR

**PLAINTIFFS' RESPONSES AND
 OBJECTIONS TO
 DEFENDANT'S FIRST SET OF
 REQUESTS FOR PRODUCTION**

1 Plaintiffs D.H. and John Doe (“Plaintiffs”), by and through their attorneys and
2 pursuant to Rules 26 and 34 of the Federal Rules of Civil Procedure and other applicable
3 laws, hereby object and respond to Defendant’s Requests for Production.

4 Plaintiffs submit these objections and responses (each a “Response”) without
5 conceding the relevancy or materiality of the subject matter of any Request for Production
6 (each a “Request”). These objections and responses are without Plaintiffs’ right to object to
7 the relevance, admissibility, or use of any information provided in these responses in any
8 subsequent proceeding, hearing, or trial. Plaintiffs respond to these Requests based on their
9 knowledge as of the date below and after a reasonable inquiry. Plaintiffs reserve the right
10 to supplement and amend its Responses. Each Response is offered on behalf of both
11 Plaintiffs D.H. and John Doe, except where specifically noted.

12 GENERAL OBJECTIONS

13 1. Plaintiffs object to each Request to the extent that they seek to impose
14 obligations upon Plaintiffs beyond those permitted by the Federal Rules of Civil Procedure
15 and Local Rules of the U.S. District Court for the District of Arizona.

16 2. Plaintiffs object to the Requests to the extent that they ask Plaintiffs to
17 produce information which is not in their possession, custody, or control. Specifically, many
18 of these Requests seek documents regarding the treatment of gender dysphoria or legal
19 conclusions. Such Requests are properly the subject of expert discovery or motion practice,
20 not Requests directed to the named Plaintiffs.

21 3. Plaintiffs object to these Requests as premature expert discovery. As
22 Defendants well know, the Court has not yet issued a scheduling order on discovery. In the
23 parties’ Rule 26(f) report, Plaintiffs suggested the parties exchange expert disclosures and
24 reports on May 27, 2021. The Court has not yet issued a ruling setting these deadlines. In
25 any event, the majority of these Requests seek expert information, and issuing requests for
26 this information outside the course of expert discovery is not the correct procedural
27 mechanism.

1 4. Plaintiffs object to the Requests to the extent that they contain words and
2 phrases that are vague, ambiguous, confusing, overly broad, and/or undefined, and therefore
3 are difficult or impossible to understand. Where a Request contains such objectionable
4 words and phrases, Plaintiffs have properly denied that Request.

5 5. Plaintiffs object to the Requests to the extent that they are based on facts not
6 in evidence or facts that are otherwise incorrect.

7 6. Plaintiffs incorporate the foregoing General Objections into the Responses
8 below, regardless of whether a particular Response may repeat a particular General
9 Objection.

10 **REQUEST FOR PRODUCTION NO. 1:**

11 Please produce copies of all scientific studies, research, and clinical evidence that
12 identify the long-term health benefits of male chest reconstruction surgery for individuals
13 with gender dysphoria under the age of 21.

14 **RESPONSE TO REQUEST FOR PRODUCTION NO. 1:**

15 Plaintiffs object to this Request because it asks Plaintiffs to produce information
16 which is not in their possession, custody, or control. This Request is properly the subject
17 of expert discovery, not a Request for Production under Rule 34, as it seeks scientific
18 documents regarding the treatment of gender dysphoria. The Court has not yet issued a
19 scheduling order on discovery. In the parties' Rule 26(f) report, Plaintiffs suggested the
20 parties exchange expert disclosures and reports on May 27, 2021. The Court has not yet
21 issued an order setting these deadlines. Requests for expert information outside the course
22 of expert discovery is not the correct procedural mechanism.

23 **REQUEST FOR PRODUCTION NO. 2:**

24 Please produce the complete medical records for Plaintiff John Doe and Plaintiff
25 D.H.

26 **RESPONSE TO REQUEST FOR PRODUCTION NO. 2:**

27 Plaintiffs will produce their medical records related to the Plaintiffs' treatment for
28 gender dysphoria to the extent in their possession, custody or control.

REQUEST FOR PRODUCTION NO. 3:

Please produce all documents that support the assertion of Dr. Cronyn that El Rio Health Center is treating more than 40 transgender boys who receive their health insurance through AHCCCS and need male chest reconstruction surgery. See Cronyn Declaration at ¶ 10. In producing these documents, please replace any personally identifying information with AHCCCS member identification numbers that allow the information to be verified while protecting patient privacy and mark the document “confidential” pursuant to the protective order in place in this lawsuit.

RESPONSE TO REQUEST FOR PRODUCTION NO. 3:

Plaintiffs object to this Request because it asks Plaintiffs to produce information which is not in their possession, custody, or control. This Request is properly the subject of expert or third-party discovery, not a Request for Production under Rule 34 directed to Plaintiffs. This Request seeks information that is clearly—by the terms of the Request itself—in the possession of Dr. Cronyn, not Plaintiffs.

REQUEST FOR PRODUCTION NO. 4:

Please produce a transcript of the talk “Creating a Primary Care Medical Home for Transgender Youth.” See Cronyn Declaration at ¶ 12.

RESPONSE TO REQUEST FOR PRODUCTION NO. 4:

Plaintiffs object to this Request because it asks Plaintiffs to produce information which is not in their possession, custody, or control. This Request is properly the subject of expert or third-party discovery, not a Request for Production under Rule 34 directed to Plaintiffs. This Request seeks information that is clearly—by the terms of the Request itself—in the possession of Dr. Cronyn, not Plaintiffs.

REQUEST FOR PRODUCTION NO. 5:

Please produce all generally accepted scientific guidelines, research, or publications that describe the criteria that should be applied to determine that male chest reconstruction surgery is medically necessary for transgender males under the age of 21 who suffer from gender dysphoria.

RESPONSE TO REQUEST FOR PRODUCTION NO. 5:

Plaintiffs object to this Request because it asks Plaintiffs to produce information which is not in their possession, custody, or control. This Request is properly the subject of expert discovery, not a Request for Production under Rule 34, as it seeks scientific documents regarding the treatment of gender dysphoria. The Court has not yet issued a scheduling order on discovery. In the parties' Rule 26(f) report, Plaintiffs suggested the parties exchange expert disclosures and reports on May 27, 2021. The Court has not yet issued an order setting these deadlines. Requests for expert information outside the course of expert discovery is not the correct procedural mechanism.

REQUEST FOR PRODUCTION NO. 6:

Please produce any non-privileged communications Plaintiffs and/or their guardians have had with the National Center for Lesbian Rights and/or National Health Law Program.

RESPONSE TO REQUEST FOR PRODUCTION NO. 6:

Plaintiffs object to this Request because it seeks information that is not relevant to any party's claim or defense, not remotely likely to lead to the discovery of relevant information, and it is not proportional to the needs of the case. Plaintiffs object to this request because it is overly broad and because it is vague and ambiguous.

Subject to and notwithstanding these objections, Plaintiffs respond as follows: After a diligent search and reasonable inquiry, Plaintiffs confirm that no such documents exist.

REQUEST FOR PRODUCTION NO. 7:

Please produce all documents reflecting the budget the National Center for Lesbian Rights and/or National Health Law Program have set aside to advance its agenda on transgender interests.

RESPONSE TO REQUEST FOR PRODUCTION NO. 7:

Plaintiffs object to this Request because it asks Plaintiffs to produce information which is not in their possession, custody, or control. Plaintiffs further object to this Request because it seeks information that is not relevant to any party's claim or defense, not remotely likely to lead to the discovery of relevant information, and it is not proportional to the needs

1 of the case. Plaintiffs also object to this request because it is overly broad and because it is
2 vague and ambiguous. Plaintiffs object specifically to the phrase “budget... set aside to
3 advance its agenda on transgender interests” as unintelligible as phrased.

4 **REQUEST FOR PRODUCTION NO. 8:**

5 Please produce any policy statements, letters, or documents by Plaintiffs, their
6 guardians, the National Center for Lesbian Rights, and/or the National Health Law Program
7 referencing the goals of this Lawsuit.

8 **RESPONSE TO REQUEST FOR PRODUCTION NO. 8:**

9 Plaintiffs object to this Request because it seeks information that is not relevant to
10 any party’s claim or defense, not remotely likely to lead to the discovery of relevant
11 information, and it is not proportional to the needs of the case. Plaintiffs object to this
12 request because it is overly broad and because it is vague and ambiguous. Plaintiffs object
13 specifically to the phrase “policy statements, letters, or documents... referencing the goals
14 of this Lawsuit” as unintelligible as phrased.

15 **REQUEST FOR PRODUCTION NO. 9:**

16 Please produce any studies or reports that support your contention that “Transgender
17 people ... experience disproportionately high rates of harassment and discrimination in all
18 aspects of their lives” and therefore “would be reluctant join a lawsuit that might publicize
19 their circumstances.” (Motion for Class Certification at p. 4)

20 **RESPONSE TO REQUEST FOR PRODUCTION NO. 9:**

21 Plaintiffs object to this Request because it asks Plaintiffs to produce information
22 which is not in their possession, custody, or control. This Request is properly the subject
23 of expert discovery, not a Request for Production under Rule 34, as it seeks scientific
24 documents regarding the treatment of gender dysphoria and the experiences of transgender
25 people. The Court has not yet issued a scheduling order on discovery. In the parties’ Rule
26 26(f) report, Plaintiffs suggested the parties exchange expert disclosures and reports on May
27 27, 2021. The Court has not yet issued an order setting these deadlines. Requests for expert
28 information outside the course of expert discovery is not the correct procedural mechanism.

1 Subject to and notwithstanding these objections, Plaintiffs respond as follows:
2 Plaintiffs have already provided Defendants with documents and information responsive to
3 this request: Plaintiff John Doe's Motion to Proceed Under a Pseudonym contains reference
4 to several studies in support of this contention, *see* Dkt. 2. Likewise, Plaintiffs' declarations
5 in support of their Motion for Preliminary Injunctions, as well as the declarations submitted
6 by their providers and experts in support of that motion, support this contention, *see* Dkts.
7 4, 5, 25-1, 25-2, 32.

8 **REQUEST FOR PRODUCTION NO. 10:**

9 Please produce any documents that you relied upon, referenced, or referred to in
10 preparing your answers to Defendant's First Set of Requests for Admission, Interrogatories
11 and Requests for Production.

12 **RESPONSE TO REQUEST FOR PRODUCTION NO. 10:**

13 Plaintiffs object to this Request because it seeks information that is not relevant to
14 any party's claim or defense, not remotely likely to lead to the discovery of relevant
15 information, and it is not proportional to the needs of the case.

16 Subject to and notwithstanding these objections, Plaintiffs respond as follows: Other
17 than Plaintiffs' medical records related to the treatment of their gender dysphoria, all
18 documents referenced in Plaintiffs' answers to Defendant's First Set of Requests for
19 Admission, Interrogatories and Requests for Production have already been made available
20 to Defendant.

21
22 Dated: February 24, 2021

Respectfully submitted,

23
24 /s/ Brent P. Ray

Brent P. Ray*

Andrew J. Chinsky*

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28 * Admitted pro hac vice

CERTIFICATE OF SERVICE

I certifies that on February 24, 2021, I caused a copy of the foregoing Plaintiff's Responses and Objections to Defendant's First Set of Requests for Production to be served by email on all counsel of record.

/s/ Andrew Chinsky

EXHIBIT D

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 (Additional Counsel on Signature Page)

**UNITED STATES DISTRICT COURT
 FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No. 4:20-cv-335-SHR

**PLAINTIFFS' RESPONSES AND
 OBJECTIONS TO
 DEFENDANT'S FIRST SET OF
 REQUESTS FOR ADMISSION**

1 Plaintiffs D.H. and John Doe (“Plaintiffs”), by and through their attorneys and
2 pursuant to Rules 26 and 36 of the Federal Rules of Civil Procedure and other applicable
3 laws, hereby object and respond to Defendant’s Requests for Admission.

4 Plaintiffs submit these objections and responses (each a “Response”) without
5 conceding the relevancy or materiality of the subject matter of any Request for Admission
6 (each a “Request”). These objections and responses are without Plaintiffs’ right to object to
7 the relevance, admissibility, or use of any information provided in these responses in any
8 subsequent proceeding, hearing, or trial. Plaintiffs respond to these Requests based on their
9 knowledge as of the date below and after a reasonable inquiry. Plaintiffs reserve the right
10 to supplement and amend their Responses. Each Response is offered on behalf of both
11 Plaintiffs D.H. and John Doe, except where specifically noted.

12 GENERAL OBJECTIONS

13 1. Plaintiffs object to the Requests to the extent that they seek to impose
14 obligations upon Plaintiffs beyond those permitted by the Federal Rules of Civil Procedure
15 and Local Rules of the U.S. District Court for the District of Arizona.

16 2. Plaintiffs object to the Requests to the extent that Defendant is attempting to
17 use these Requests to obtain discovery from Plaintiffs. “Requests for admissions are not
18 principally discovery devices . . . and they are not to be treated as substitutes for discovery
19 processes to uncover evidence.” *Merkley v. Maricopa Cty. Cmty. Coll. Dist.*, No. 04-2981-
20 PHX-ROS, 2006 WL 8440535, at *5 (D. Ariz. June 29, 2006) (citing *Safeco of Am. V.*
21 *Rawstron*, 181 F.R.D. 441, 445 (C.D. Cal. 1998)). Plaintiffs will therefore answer each
22 Request in accordance with its obligations under Rule 36.

23 3. Plaintiffs object to the Requests to the extent that they ask Plaintiffs to admit
24 or deny information which is not in their possession, custody, or control. Specifically, many
25 of these Requests seek broad admissions regarding treatment of gender dysphoria or ask
26 Plaintiffs to draw legal conclusions. These Requests are properly the subject of expert
27 discovery or motion practice, not Requests directed to Plaintiffs.

1 4. Plaintiffs object to the Requests to the extent that they contain words and
2 phrases that are vague, ambiguous, confusing, overly broad, and/or undefined, and therefore
3 are difficult or impossible to understand.

4 5. Plaintiffs object to the Requests to the extent that they are based on facts not
5 in evidence or facts that are otherwise incorrect.

6 6. Plaintiffs incorporate the foregoing General Objections into the Responses
7 below, regardless of whether a particular Response may repeat a particular General
8 Objection.

9 **REQUEST NO. 1:**

10 Admit that not all natal females with gender dysphoria will seek male chest
11 reconstruction surgery.

12 **RESPONSE TO REQUEST NO. 1:**

13 Plaintiffs object to this Request because it seeks information that is neither relevant
14 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
15 object to this Request because it is properly the subject of expert discovery, not a Request
16 for Admission under Rule 36. To the extent that the term "natal females" is intended to refer
17 to individuals who are assigned female at birth, after reasonable inquiry, the information
18 Plaintiffs know or can readily obtain is insufficient to enable Plaintiffs to admit or deny this
19 Request; Plaintiffs therefore lack knowledge or information sufficient to admit or deny this
20 Request.

21 **REQUEST NO. 2:**

22 Admit that male chest reconstruction surgery is not medically necessary for all natal
23 females with gender dysphoria.

24 **RESPONSE TO REQUEST NO. 2:**

25 Plaintiffs object to this Request because it seeks information that is neither relevant
26 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
27 object to this Request because it is properly the subject of expert discovery, not a Request
28 for Admission under Rule 36. To the extent that the term "natal females" is intended to refer

1 to individuals who are assigned female at birth, after reasonable inquiry, the information
2 Plaintiffs know or can readily obtain is insufficient to enable Plaintiffs to admit or deny this
3 Request; Plaintiffs therefore lack knowledge or information sufficient to admit or deny this
4 Request.

5 **REQUEST NO. 3:**

6 Admit that the determination of whether male chest reconstruction surgery is
7 medically necessary for a natal female with gender dysphoria is a fact-intensive inquiry that
8 must take into account the unique circumstances of each individual. (Complaint ¶ 29).

9 **RESPONSE TO REQUEST NO. 3:**

10 Plaintiffs object to this Request because it seeks information that is neither relevant
11 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
12 object to this Request because it is properly the subject of expert discovery, not a Request
13 for Admission under Rule 36. Plaintiffs further object to this Request because the words
14 and phrases "fact-intensive inquiry" and "unique circumstances" are vague, ambiguous, and
15 not capable of reasonable comprehension. To the extent that the term "natal females" is
16 intended to refer to individuals who are assigned female at birth, Plaintiffs admit what is
17 stated in paragraph 29 of the Complaint:

18 Gender dysphoria is a serious medical condition recognized by the American
19 Psychiatric Association. Am. Psychiatric Ass'n, Diagnostic and Statistical
20 Manual of Mental Disorders (5th ed. 2013) ("DSM-5"). Gender dysphoria
21 refers to the distress that can result from the incongruence between a person's
22 gender identity and their assigned sex. If left untreated, gender dysphoria can
23 cause anxiety, depression, and even self-harm or suicidal ideation. Gender
24 dysphoria is often heightened "when physical interventions by means of
25 hormones and/or surgery are not available." *Id.* at 451. Access to appropriate,
26 individualized medical care can mitigate and often prevent all of those
27 symptoms.

28 Plaintiffs deny the remainder of this Request.

29 **REQUEST NO. 4:**

30 Admit that hormone treatment is one way to alleviate the effects of gender dysphoria.
(Complaint ¶ 29).

31 **RESPONSE TO REQUEST NO. 4:**

1 Plaintiffs adopt their Response to Request No. 3 as and for its Response to this
2 Request and further note that the phrase “hormone treatment” is vague, ambiguous, and
3 undefined.

4 **REQUEST NO. 5:**

5 Admit there are no studies that identify the long-term health benefits of male chest
6 reconstruction surgery for individuals under the age of 21 with gender dysphoria.

7 **RESPONSE TO REQUEST NO. 5:**

8 Plaintiffs object to this Request because it seeks information that is neither relevant
9 to any party’s claim or defense nor proportional to the needs of the case. Plaintiffs further
10 object to this Request because it is properly the subject of expert discovery, not a Request
11 for Admission under Rule 36. Plaintiffs further object to this Request because the phrase
12 “long-term health benefits” is vague, ambiguous, and not capable of reasonable
13 comprehension. After reasonable inquiry, and considering the unintelligible nature of this
14 Request, the information Plaintiffs know or can readily obtain is insufficient to enable
15 Plaintiffs to admit or deny this Request; Plaintiffs therefore lack knowledge or information
16 sufficient to admit or deny this Request.

17 **REQUEST NO. 6:**

18 Admit that there are no generally accepted guidelines or tests for medical
19 professionals to apply to determine whether male chest reconstruction surgery is medically
20 necessary for a natal female with gender dysphoria.

21 **RESPONSE TO REQUEST NO. 6:**

22 Plaintiffs object to this Request because it seeks information that is neither relevant
23 to any party’s claim or defense nor proportional to the needs of the case. Plaintiffs further
24 object to this Request because it is properly the subject of expert discovery, not a Request
25 for Admission under Rule 36. Plaintiffs further object to this Request because the phrase
26 “guidelines or tests” is vague, ambiguous, and not capable of reasonable comprehension.
27 To the extent that the term “natal female” is intended to refer to individuals who are assigned
28 female at birth, after reasonable inquiry, and considering the unintelligible nature of this

Request, the information Plaintiffs know or can readily obtain is insufficient to enable Plaintiffs to admit or deny this Request; Plaintiffs therefore lack knowledge or information sufficient to admit or deny this Request.

REQUEST NO. 7:

Admit that childhood gender dysphoria more often than not does not persist into adulthood.

RESPONSE TO REQUEST NO. 7:

Plaintiffs object to this Request because it seeks information that is neither relevant to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further object to this Request because it is properly the subject of expert discovery, not a Request for Admission under Rule 36. After reasonable inquiry, the information Plaintiffs know or can readily obtain is insufficient to enable Plaintiffs to admit or deny this Request; Plaintiffs therefore lack knowledge or information sufficient to admit or deny this Request.

REQUEST NO. 8:

Admit that adolescent gender dysphoria more often than not does not persist into adulthood.

RESPONSE TO REQUEST NO. 8:

Plaintiffs object to this Request because it seeks information that is neither relevant to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further object to this Request because it is properly the subject of expert discovery, not a Request for Admission under Rule 36. After reasonable inquiry, the information Plaintiffs know or can readily obtain is insufficient to enable Plaintiffs to admit or deny this Request; Plaintiffs therefore lack knowledge or information sufficient to admit or deny this Request.

REQUEST NO. 9:

Admit that some peer-reviewed studies show that childhood gender dysphoria not [sic] does not persist into adulthood in 97% of cases.

RESPONSE TO REQUEST NO. 9:

1 Plaintiffs object to this Request because it seeks information that is neither relevant
2 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
3 object to this Request because it is properly the subject of expert discovery, not a Request
4 for Admission under Rule 36. Plaintiffs further object to this Request because the phrase
5 "does not persist" is vague, ambiguous, and not capable of reasonable comprehension. After
6 reasonable inquiry, and considering the unintelligible nature of this Request, the
7 information Plaintiffs know or can readily obtain is insufficient to enable Plaintiffs to admit
8 or deny this Request; Plaintiffs therefore lack knowledge or information sufficient to admit
9 or deny this Request.

10 **REQUEST NO. 10:**

11 Admit that it is a generally accepted medical fact that the brains of individuals under
12 the age of 21 are still developing.

13 **RESPONSE TO REQUEST NO. 10:**

14 Plaintiffs object to this Request because it seeks information that is neither relevant
15 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
16 object to this Request because it is properly the subject of expert discovery, not a Request
17 for Admission under Rule 36. Plaintiffs further object to this Request because the phrase
18 "still developing" is vague, ambiguous, and not capable of reasonable comprehension. After
19 reasonable inquiry, and considering the unintelligible nature of this Request, the
20 information Plaintiffs know or can readily obtain is insufficient to enable Plaintiffs to admit
21 or deny this Request; Plaintiffs therefore lack knowledge or information sufficient to admit
22 or deny this Request.

23 **REQUEST NO. 11:**

24 Admit that Plaintiff D.H. suffered from "significant psychological distress"
25 including "severe anxiety and suicidal ideation" before D.H. was diagnosed with gender
26 dysphoria. (Complaint ¶¶ 6-7).

27 **RESPONSE TO REQUEST NO. 11:**

1 Plaintiffs object to this Request because it seeks information that is neither relevant
2 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
3 object to this Request because it is misleading: that a person may experience significant
4 psychological distress or severe anxiety and suicidal ideation before being formally
5 diagnosed with gender dysphoria does not mean that these symptoms are not caused by
6 gender dysphoria—it simply means that no formal diagnosis has occurred.

7 Plaintiff D.H. further answers that, subject to the foregoing objections, admitted.

8 Plaintiff John Doe further answers that, after reasonable inquiry, the information
9 Plaintiff knows or can readily obtain is insufficient to enable Plaintiff to admit or deny this
10 Request; Plaintiff therefore lacks knowledge or information sufficient to admit or deny this
11 Request.

12 **REQUEST NO. 12:**

13 Admit that no psychiatrist has recommended that Plaintiff D.H. obtain male chest
14 reconstruction surgery. (Complaint ¶ 9).

15 **RESPONSE TO REQUEST NO. 12:**

16 Plaintiffs object to this Request because it seeks information that is neither relevant
17 to any party's claim or defense nor proportional to the needs of the case. Specifically, it is
18 not relevant whether a "psychiatrist has recommended" that an individual receive male
19 chest reconstruction surgery. Plaintiffs further object to this Request because
20 "recommended" is vague, ambiguous, and not capable of reasonable comprehension,
21 particularly as used in a medical context.

22 Subject to the foregoing objections, Plaintiff D.H. admits that multiple providers
23 have assessed Plaintiff D.H. and found that Plaintiff D.H. meets the criteria for male chest
24 reconstruction surgery. *See, e.g.*, Decl. of Tamar Reed in Support of Plaintiffs' Mot. for
25 Prelim. Injunction, ¶ 10 (Dkt. 5-2); Decl. of Andrew Cronyn, M.D., in Support of Plaintiffs'
26 Mot. for Prelim. Injunction, ¶ 23 (Dkt. 5-3). *See also* Expert Decl. of Loren S. Schechter,
27 M.D., in Support of Plaintiffs' Mot. for Prelim. Injunction, ¶ 43 (Dkt. 5-5) (noting "D.H.
28 appears to be a good candidate for male chest reconstruction surgery.").

REQUEST NO. 13:

Admit that Plaintiff John Doe suffered from “depression and suicidal ideation” before John Doe was diagnosed with gender dysphoria. (Complaint ¶ 10).

RESPONSE TO REQUEST NO. 13:

Plaintiffs object to this Request because it seeks information that is neither relevant to any party’s claim or defense nor proportional to the needs of the case. Plaintiffs further object to this Request because it is misleading: that a person may experience depression and suicidal ideation before being formally diagnosed with gender dysphoria does not mean that these symptoms are not caused by gender dysphoria—it simply means that no formal diagnosis has occurred.

Plaintiff John Doe further answers that, subject to the foregoing objections, admitted.

Plaintiff D.H. further answers that, after reasonable inquiry, the information Plaintiff knows or can readily obtain is insufficient to enable Plaintiff to admit or deny this Request; Plaintiff therefore lacks knowledge or information sufficient to admit or deny this Request.

REQUEST NO. 14:

Admit that irreversible changes to one’s body can negatively affect one’s quality of life. (Complaint ¶ 27).

RESPONSE TO REQUEST NO. 14:

Plaintiffs object to this request because it is overly broad and because it is vague, ambiguous, and not capable of reasonable comprehension. Plaintiffs further object to this Request because it seeks information that is neither relevant to any party’s claim or defense nor proportional to the needs of the case. Plaintiffs admit what is stated in paragraphs 26-27 of the Complaint:

Around the onset of puberty, many transgender youth experience a level of psychological distress that significantly interferes with their overall wellbeing and ability to function. For some transgender youth, that distress becomes debilitating and can lead to a severe decline in mental health.

That distress stems, in part, from the visible physical changes that accompany puberty. Those physical changes undermine a transgender young person’s ability to live in a manner consistent with their gender identity, exacerbating their psychological distress. Even basic daily tasks, such as bathing and

1 getting dressed, can become emotionally paralyzing because those tasks are
2 painful reminders of the disconnect between a transgender young person's
3 body and their gender identity. In addition, a transgender boy who has begun
4 to develop breasts is more likely to be mistaken for female, a probability that
5 serves as a constant source of anxiety. The psychological distress transgender
youth experience is further heightened by the reality that some of those
physical changes may be irreversible, permanently constricting their future
treatment options and negatively affecting their quality of life. Consequently,
timely treatment is critical.

6 Plaintiffs deny the remainder of this Request.

7 **REQUEST NO. 15:**

8 Admit that Plaintiffs have no evidence that any transgender male under the age of 21
9 (other than Plaintiff D.H.) has applied for an individual exception to the Challenged
10 Exclusion.

11 **RESPONSE TO REQUEST NO. 15:**

12 Plaintiffs object to this Request because it seeks information that is neither relevant
13 to any party's claim or defense nor proportional to the needs of the case. None of Plaintiffs'
14 claims require them to show Plaintiffs or the class have applied for an "individual exception
15 to the Challenged Exclusion." Plaintiffs further object to the phrase "individual exception"
16 as vague, ambiguous, undefined, and not capable of reasonable comprehension.

17 Plaintiffs also object to this Request because it seeks information which would be in
18 Defendant's possession, custody, or control. Moreover, Rule 36 is not to be used as a
19 discovery device, and the information sought by this Request is subject to a pending Request
20 for Production *from Plaintiffs* to Defendant. *See* Request No. 34, Plaintiffs' First Request
21 for Production.

22 After reasonable inquiry, and considering the unintelligible nature of this Request,
23 the information Plaintiffs know or can readily obtain is insufficient to enable Plaintiffs to
24 admit or deny this Request; Plaintiffs therefore lack knowledge or information sufficient to
25 admit or deny this Request.

26 **REQUEST NO. 16:**

1 Admit that Plaintiffs have no evidence that any transgender male under the age of 21
2 enrolled in AHCCCS (other than Plaintiff D.H.) has appealed a determination that male
3 chest reconstruction surgery is not medically necessary.

4 **RESPONSE TO REQUEST NO. 16:**

5 Plaintiffs adopt their Response to Request No. 15 as their Response to this Request.

6 **REQUEST NO. 17:**

7 Admit that Plaintiffs have no evidence that any transgender male under the age of 21
8 enrolled in AHCCCS (other than Plaintiff D.H.) has appealed a determination that male
9 chest reconstruction surgery is not eligible for payment under the Challenged Exclusion.

10 **RESPONSE TO REQUEST NO. 17:**

11 Plaintiffs adopt their Response to Request No. 15 as and for its Response to this
12 Request.

13 **REQUEST NO. 18:**

14 Admit that no court of law in the United States has determined that male chest
15 reconstruction surgery is medically necessary to treat gender dysphoria in individuals under
16 the age of 21.

17 **RESPONSE TO REQUEST NO. 18:**

18 Plaintiffs object to this Request because it seeks information that is neither relevant
19 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
20 object to this Request because it seeks a legal conclusion, which is not properly the subject
21 of a Request for Admission under Rule 36. After reasonable inquiry, the information
22 Plaintiffs know or can readily obtain is insufficient to enable Plaintiffs to admit or deny this
23 Request; Plaintiffs therefore lack knowledge or information sufficient to admit or deny this
24 Request.

25 **REQUEST NO. 19:**

26 Admit that circumstances unique to Plaintiff John Doe and Plaintiff D.H. make male
27 chest reconstruction surgery medically necessary for them.

28 **RESPONSE TO REQUEST NO. 19:**

1 Plaintiffs object to this Request because it seeks information that is neither relevant
2 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
3 object to this Request because it is properly the subject of expert discovery, not a Request
4 for Admission under Rule 36. Plaintiffs further object to this Request because the phrase
5 "circumstances unique to Plaintiff John Doe and Plaintiff D.H." is vague, ambiguous, and
6 not capable of reasonable comprehension.

7 Subject to the foregoing objections, denied. Plaintiff D.H.'s and Plaintiff John Doe's
8 gender dysphoria and need for surgical treatment are described in paragraph 68-104 of the
9 Complaint. Gender-confirming medical treatments such as male chest reconstruction
10 surgery, however, are not uniquely appropriate just for Plaintiff D.H. and Plaintiff John
11 Doe. In fact, Dr. Andrew Cronyn, co-leader of transgender health care at El Rio Health
12 Center in Tuscon, Arizona, is personally aware of more than forty patients who are
13 transgender boys who receive their health insurance coverage through AHCCCS and need
14 male chest reconstruction surgery. *See* Decl. of Dr. Andrew Cronyn, ¶ 10 (Dkt. 5-3).

15 **REQUEST NO. 20:**

16 Admit that the Challenged Exclusion limits surgical treatment of issues related to the
17 care and treatment of transgender individuals beyond the surgical treatment sought by
18 Plaintiffs.

19 **RESPONSE TO REQUEST NO. 20:**

20 Plaintiffs object to this Request because it seeks information that is neither relevant
21 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
22 object to this Request because it seeks a legal conclusion, which is not properly the subject
23 of a Request for Admission under Rule 36. Plaintiffs further object to this Request because
24 the phrase "surgical treatment of issues related to the care and treatment of transgender
25 individuals" is vague, ambiguous, and not capable of reasonable comprehension. Plaintiffs
26 also object to this Request because it seeks information which would be in Defendant's
27 possession, custody, or control. Moreover, Rule 36 is not to be used as a discovery device.
28 After reasonable inquiry, and considering the unintelligible nature of this Request, the

1 information Plaintiffs know or can readily obtain is insufficient to enable Plaintiff to admit
2 or deny this Request; Plaintiffs therefore lack knowledge or information sufficient to admit
3 or deny this Request.

4 **REQUEST NO. 21:**

5 Admit that it is Plaintiffs' position that if the Court grants the relief requested by
6 Plaintiffs and strikes down the Challenged Exclusion, AHCCCS will have no ability to limit
7 coverage for any gender reassignment surgery deemed medically necessary by a healthcare
8 provider.

9 **RESPONSE TO REQUEST NO. 21:**

10 Plaintiffs object to this Request because it seeks information that is neither relevant
11 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
12 object to this Request because it contains words and phrases which are vague, ambiguous,
13 undefined, and not capable of reasonable comprehension, including to the extent it asks
14 Plaintiffs to interpret the meaning of "no ability to limit coverage." Plaintiffs further object
15 to this Request because it seeks a legal conclusion, which is not properly the subject of a
16 Request for Admission under Rule 36. After reasonable inquiry, and considering the
17 unintelligible nature of this Request, the information Plaintiffs know or can readily obtain
18 is insufficient to enable Plaintiff to admit or deny this Request; Plaintiffs therefore lack
19 knowledge or information sufficient to admit or deny this Request.

20 **REQUEST NO. 22:**

21 Admit that it is Plaintiffs' position that male chest reconstruction surgery is only a
22 small segment of the reassignment surgeries that could be medically necessary for
23 individuals with gender dysphoria.

24 **RESPONSE TO REQUEST NO. 22:**

25 Plaintiffs object to this Request because it seeks information that is neither relevant
26 to any party's claim or defense nor proportional to the needs of the case. Plaintiffs further
27 object to this Request because it contains words and phrases which are vague, ambiguous,
28 undefined, and not capable of reasonable comprehension, including to the extent it asks

1 Plaintiffs to interpret the meaning of “only a small segment of the reassignment surgeries
2 that could be medically necessary.” Plaintiffs further object to this Request because it
3 appears to be the subject of expert discovery, which is not properly the subject of a Request
4 for Admission under Rule 36. After reasonable inquiry, and considering the unintelligible
5 nature of this Request, the information Plaintiffs know or can readily obtain is insufficient
6 to enable Plaintiffs to admit or deny this Request; Plaintiffs therefore lack knowledge or
7 information sufficient to admit or deny this Request.

8 **REQUEST NO. 23:**

9 Admit that AHCCCS is not legally required to provide coverage for any medical
10 treatment that is deemed “experimental.”

11 **RESPONSE TO REQUEST NO. 23:**

12 Plaintiffs object to this Request because it contains words and phrases which are
13 vague, ambiguous, undefined, and not capable of reasonable comprehension, including to
14 the extent it asks Plaintiffs to interpret the meaning of “not legally required to provide
15 coverage” or “experimental.” Plaintiffs further object to this Request because it seeks a legal
16 conclusion, which is not properly the subject of a Request for Admission under Rule 36.
17 After reasonable inquiry, and considering the unintelligible nature of this Request, the
18 information Plaintiffs know or can readily obtain is insufficient to enable Plaintiffs to admit
19 or deny this Request; Plaintiffs therefore lack knowledge or information sufficient to admit
20 or deny this Request.

21 **REQUEST NO. 24:**

22 Admit that nothing in the Medicaid Act expressly requires AHCCCS to provide
23 coverage for gender reassignment surgeries.

24 **RESPONSE TO REQUEST NO. 24:**

25 Denied. The Challenged Exclusion violates Plaintiffs’ civil rights under the Early
26 Periodic Screening, Diagnostic and Treatment requirements of the federal Medicaid Act,
27 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); and the
28

1 comparability requirement of the Medicaid Act, *id.* § 1396a(a)(10)(B). *See* Compl. ¶¶ 41-
2 58, 115-118.

3
4 Dated: February 24, 2021

Respectfully submitted,

5
6 /s/ Brent P. Ray

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28

CERTIFICATE OF SERVICE

I certifies that on February 24, 2021, I caused a copy of the foregoing Plaintiff's Responses and Objections to Defendant's First Set of Interrogatories to be served by email on all counsel of record.

/s/ Andrew J. Chinsky

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**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
Hennessy-Waller; and John Doe, by and
through his guardian and next friend, Susan
Doe, on behalf of themselves and all others
similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona Health
Care Cost Containment System, in her
official capacity,

Defendant.

Case No. 4:20-cv-00335-SHR

**DEFENDANT'S RESPONSE TO
PLAINTIFFS' SUPPLEMENTAL
BRIEF IN SUPPORT OF MOTION
FOR PRELIMINARY INJUNCTION**

(Assigned to the Honorable Scott H.
Rash)

Defendant Jami Snyder ("Defendant") submits this response to Plaintiffs' Supplemental Brief in Support of Motion for Preliminary Injunction (Doc. 62).

Prior to the February 5, 2021 oral argument on Plaintiffs' Motion for Preliminary Injunction, the parties had not briefed the issue of whether the specific claims Plaintiffs have asserted in this case require the exhaustion of administrative remedies. Plaintiffs correctly note that "the issue of administrative appeals and exhaustion of administrative

1 remedies was not previously raised by Defendant or otherwise briefed by the parties.”
2 (Doc. 58, p. 2)

3 As a general matter, federal courts typically require the exhaustion of
4 administrative remedies before a party files a federal lawsuit. *United Farm Workers v.*
5 *Ariz. Agric. Employment Relations Bd.*, 669 F.2d 1249, 1253 (9th Cir.1982) (“The
6 purpose of the exhaustion doctrine is to allow the administrative agency in question to
7 exercise its expertise over the subject matter and to permit the agency an opportunity to
8 correct any mistakes that may have occurred during the proceeding, thus avoiding
9 unnecessary or premature judicial intervention into the administrative process”); *Lloyd C.*
10 *Lockrem, Inc. v. United States*, 609 F.2d 940, 942 (9th Cir. 1979) (“Under normal
11 circumstances, a party must exhaust its remedies before it can obtain judicial review of an
12 agency decision”); *Buckingham v. Secy of U.S. Dep’t of Agr.*, 603 F.3d 1073, 1080 (9th
13 Cir. 2010) (“The APA [Administrative Procedure Act] requires plaintiffs to exhaust their
14 administrative remedies before bringing suit in federal court”).

15 Because the issue had not been briefed, the undersigned was not aware of the cases
16 creating an exception to the general rule and finding that exhaustion of administrative
17 remedies is not required before seeking injunctive relief in a 42 U.S.C. § 1983 action
18 under the Medicaid Act. Having reviewed that law, the undersigned counsel wishes to
19 correct the record and confirm that Defendant agrees with the argument made in Section I
20 of Plaintiffs’ Supplemental Brief. (Doc. 62) Nonetheless, AHCCCS’s administrative
21 appeal process, which includes the opportunity to request an evidentiary hearing, is
22 important and relevant to this case for other reasons, as explained in more detail below.

23 As Plaintiffs correctly point out in Section II of their Supplemental Brief, the
24 AHCCCS fair hearing process works in the following manner: First, a managed care plan
25 reviews an AHCCCS-enrolled member’s request for prior authorization of a particular
26 service. If the managed care plan denies a request for prior authorization, the enrollee has
27 the right to appeal the denial with the plan itself. If the plan upholds its initial decision to
28

1 deny coverage for a particular service, the AHCCCS-enrolled member then has the right
2 to request a fair hearing with the State. The Arizona Office of Administrative Hearings
3 conducts this fair hearing. After the evidentiary hearing, the Administrative Law Judge
4 issues a written recommendation to AHCCCS. Defendant may then accept, reject, or
5 modify the ALJ's decision (and her decision is then the final decision). Alternatively, if
6 Defendant does not accept, reject, or modify the ALJ's decision within the statutory time
7 period, the ALJ's decision is certified as the final decision. The AHCCCS-enrolled
8 member may either (a) request rehearing or review of the final decision, or (b) file a
9 petition for judicial review directly to the Arizona Superior Court.

10 There is no dispute that there is a fair hearing process with an evidentiary hearing
11 whereby AHCCCS generally has the opportunity to decide disputes as to whether or not a
12 particular service or procedure is medically necessary or experimental for an AHCCCS-
13 enrolled member. *See* 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.200, *et seq.*; 42 C.F.R. §
14 438.400, *et seq.* This is a federally-required state administrative hearing process that
15 allows an AHCCCS-enrolled member to present his/her medical background and
16 information through the administrative appeal process and allows AHCCCS to determine
17 whether a service or procedure is medically necessary and effective for the member and
18 his/her unique circumstances. With respect to these two Plaintiffs, at the February 5, 2021
19 oral argument, the Court asked whether AHCCCS has “a process where it could look at
20 these particular individuals and say, okay, in this unique situation, maybe male chest
21 reconstruction surgery is medically necessary or safe and effective because of these
22 unique circumstances.” (Transcript of February 5, 2021 Oral Argument, 43:23-44:4)
23 Here, for these two Plaintiffs, the outcome of that process is undetermined because
24 Plaintiffs’ “unique circumstances” are unknown at this time. This is because, (1) none of
25 Plaintiffs’ medical records have been produced in this case, and (2) there has never been a
26 final determination of medical necessity of this surgery for Plaintiffs that has been
27
28

1 evaluated through the AHCCCS administrative review and fair hearing process.¹ But to
2 be clear, if Plaintiffs' medical records, or the administrative appeal process, reveal that
3 gender dysphoria is the only condition for which chest reconstruction surgery is
4 recommended (and that appears to be the case here), that request will be denied based
5 upon the exclusion found in A.A.C. R9-22-205(B)(4)(a).

6 Plaintiffs filed a proposed order with their motion for preliminary injunction. (Doc
7 3-1 at p. 1) Plaintiffs' proposed order asks the Court to enter the following order:

8 IT IS FURTHER ORDERED THAT:

9 (1) Defendants shall be immediately enjoined from further enforcement of
10 Ariz. Admin. Code R9-22-205(B)(4)(A), (sic) on the grounds that it violates the
11 Medicaid Act's EPSDT and Comparability Requirements, Section 1557 of the
12 Affordable Care Act, and the Equal Protection Clause of the United States
13 Constitution.

14 (2) Arizona Healthcare Cost Containment System shall provide coverage for
15 Plaintiffs' male chest reconstruction surgeries, consistent with all other
16 requirements of federal law.²

17 During the parties' meet and confer process regarding supplemental briefing
18 Plaintiffs took the position that: "quoting solely from the proposed order we submitted
19 with Plaintiffs' Motion for Preliminary Injunction as a restatement of Plaintiffs'
20 argument/position would still be misleading in light of our representations to the Court."³

21 Defendant is at a loss to understand how quoting Plaintiffs' proposed order could
22 be misleading. During the meet and confer process, Defendant invited Plaintiffs to file an
23 amended proposed order if Plaintiffs believed their existing proposed order was no longer

24 ¹ With respect to this process, Plaintiff D.H. has alleged he only requested prior
25 authorization with the managed care plan and appealed the denial of his surgery with the
26 plan. (Doc. 1, ¶¶ 9, 87) Plaintiff John Doe has apparently never requested prior
27 authorization in the first instance.

28 ² On February 26, 2021, in *Toomey v. State of Arizona*, Case No. CV-00035-RM-LAB, the
Court declined to issue the requested preliminary injunction: "First, Plaintiff and the class
members seek a mandatory injunction and have not met the heightened standard for such
relief to issue. Second, the requested injunctive relief is identical to the ultimate relief
Plaintiff and the class members seek in this litigation, and the Court finds it premature to
grant such relief prior to discovery and summary judgment briefing." (Doc. 162, pp. 8-9).
In this case, Plaintiffs' preliminary injunction motion should be denied for the same reasons.

³ See, Exhibit A, Email from Asaf Orr to Kate King, et. al. February 26, 2021.

1 accurate or mischaracterized the relief Plaintiffs are now seeking. To date, no amended
2 proposed order has been filed.⁴

3 Thus, it is not “misleading” to state that Plaintiffs have asked the Court, in their
4 proposed order on file at Doc. 3-1 to order that “(2) Arizona Healthcare Cost Containment
5 System shall provide coverage for Plaintiffs’ male chest reconstruction surgeries,
6 consistent with all other requirements of federal law.” Defendant’s position is that the
7 Court cannot order coverage to be provided to Plaintiffs without a determination of
8 medical necessity in the first instance. Plaintiffs allege chest reconstruction surgery is
9 “medical necessary” for them in no fewer than 72 places in their briefs in support of their
10 Motion for Preliminary Injunction and supporting documentation. Indeed, the first
11 paragraph of the Motion for Preliminary Injunction states as a premise, “There is broad
12 consensus within the medical community that the surgery is a safe, effective, and
13 **medically necessary** treatment for many individuals with gender dysphoria, including
14 adolescents.” (Doc 3 at p. 2 (emphasis added)). For that reason, it seems beyond dispute
15 that a determination of medical necessity is a fundamental pre-requisite for the relief
16 sought in Plaintiffs’ preliminary injunction. Under Arizona law, medical necessity is a
17 requirement for AHCCCS coverage of any medical or behavioral health service. *See*
18 A.A.C. R9-22-202. For purposes of Plaintiffs’ preliminary injunction motion,
19 Defendant’s position is that Plaintiffs cannot establish medical necessity through
20 declarations from therapists (who cannot prescribe medication) and one pediatrician that
21 were likely prepared by Plaintiffs’ counsel. Such a decision requires a fully-developed
22
23

24
25 ⁴ During the meet and confer process, Plaintiffs’ counsel referred to oral argument testimony
26 wherein Mr. Orr stated: “Plaintiffs are here today, Your Honor, seeking an opportunity to
27 demonstrate the medical necessity of male chest reconstruction surgery and are asking the
28 Court to enjoin enforcement of that exclusion as to D.H. and John Doe so they can
demonstrate to the managed care organizations that this procedure is, in fact, medically
necessary for them.” (Feb. 5, 2021 Oral Argument Transcript, at 9:23-10:5) Although
Plaintiffs indicated at oral argument they plan to demonstrate medical necessity to the
managed care organizations, Plaintiffs have not amended their proposed order.

1 record and Plaintiffs have refused to provide any information to show that male chest
2 reconstruction surgery is medically necessary and effective for them.⁵

3 In their Supplemental Brief, Plaintiffs argue “[t]he question presented is a purely
4 legal one...” (Doc. 62 at 4) and they contend that “as long as the Challenged Exclusion
5 remains in effect, requiring Plaintiffs to exhaust this procedure would force Plaintiffs to
6 pursue what would be a futile procedure.” (*Id.* at 6) It is true that pursuit of the AHCCCS
7 process may be futile,⁶ but there are two problems with the argument that the Court can
8 decide this case exclusively as a matter of law.

9 First, the Court cannot decide cases in a vacuum. To determine that the Challenged
10 Exclusion is contrary to the Medicaid Act, Affordable Care Act, or the Equal Protection
11 Clause, the Court must first decide that the Challenged Exclusion unlawfully denies
12 medically necessary care to Plaintiffs – here, D.H. and John Doe – because the law
13 requires a plaintiff to have suffered an “injury in fact” that is “concrete and particularized”
14 and “not conjectural or hypothetical.” This concept was succinctly stated by the Supreme
15 Court in *Lujan v. Defenders of Wildlife*:

16 Over the years, our cases have established that the irreducible constitutional
17 minimum of standing contains three elements. First, the plaintiff must have
18 suffered an “injury in fact”—an invasion of a legally protected interest which is (a)
19 concrete and particularized, and (b) “actual or imminent, not ‘conjectural’ or
20 ‘hypothetical.’ ” Second, there must be a causal connection between the injury and
the conduct complained of—the injury has to be “fairly ... trace[able] to the
challenged action of the defendant, and not ... th[e] result [of] the independent

21 ⁵ In response to Defendant’s discovery, Plaintiffs refused to identify or produce any studies
22 that identify the long-term health benefits of male chest reconstruction surgery for
23 individuals with gender dysphoria under the age of 21. See, Exhibit B, Plaintiffs’ Responses
24 Responses and Objections to Defendant’s First Set of Interrogatories, No. 1; Exhibit C, Plaintiffs’
25 Responses and Objections to Defendant’s First Set of Requests for Production, No. 1. Plaintiffs also refused to admit or deny that “there are no studies that identify the long-term
26 health benefits of male chest reconstruction surgery for individuals under the age of 21 with
27 gender dysphoria.” Exhibit D, Plaintiffs’ Responses and Objections to Defendant’s First
28 Set of Requests for Admission, No. 5.

⁶ Defendant *still* does not have any medical records that would provide more detailed
information about Plaintiffs’ medical conditions and Plaintiffs failed to produce any
medical records (or any other documents for that matter) in response to Defendant’s
discovery. Instead, Plaintiffs *promised* to produce a limited set of “medical records related
to the Plaintiffs’ treatment for gender dysphoria to the extent in their possession, custody or
control.” (Exhibit C, No. 2).

1 action of some third party not before the court.” Third, it must be “likely,” as
2 opposed to merely “speculative,” that the injury will be “redressed by a favorable
3 decision.”

4 The party invoking federal jurisdiction bears the burden of establishing
5 these elements. Since they are not mere pleading requirements but rather an
6 indispensable part of the plaintiff's case, each element must be supported in the
7 same way as any other matter on which the plaintiff bears the burden of proof, i.e.,
8 with the manner and degree of evidence required at the successive stages of the
9 litigation.

10 *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61, 112 S.Ct. 2130, 2136-37 (1992)
11 (internal citations omitted).

12 Second, as Defendant has demonstrated, there is simply insufficient evidence
13 before the Court to make a determination of medical necessity for D.H. and John Doe.
14 The value of an irreversible surgery in treating gender dysphoria in minors – and these
15 two Plaintiffs in particular - is legitimately questioned by the evidence Defendant has
16 submitted. Plaintiffs have failed their burden to demonstrate that male chest
17 reconstruction surgery is medically necessary and effective for D.H., John Doe - or any
18 other person under age 21. The record before this Court currently lacks the evidence that
19 would be produced through the AHCCCS fair hearing process, and the Plaintiffs’ medical
20 records. On the current record before this Court, there is simply insufficient evidence to
21 support a finding that chest reconstruction surgery is medically necessary and effective for
22 Plaintiffs.

23 RESPECTFULLY SUBMITTED this 4th day of March, 2021.

24 **BURNSBARTON PLC**

25 By /s/ David T Barton

26 David T. Barton
27 Kathryn Hackett King

28 **JOHNSTON LAW OFFICES, P.L.C.**
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**UNITED STATES DISTRICT COURT
 FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No. 4:20-cv-335-SHR

**PLAINTIFFS' SUPPLEMENTAL
 BRIEF IN SUPPORT OF
 MOTION FOR PRELIMINARY
 INJUNCTION**

1 Plaintiffs' claims in this matter are not subject to an exhaustion requirement, and
2 even if the Court were inclined to require exhaustion, exhaustion would be futile in this
3 case.

4 **I. Plaintiffs' claims do not require administrative exhaustion.**

5 It is well-settled that exhaustion of administrative remedies is not required before
6 seeking injunctive relief under 42 U.S.C. § 1983. *Patsy v. Bd. of Regents*, 457 U.S. 496
7 (1982); *see also Jones v. Blinziner*, 536 F. Supp. 1181, 1193 (N.D. Ind. 1982)
8 (“[E]xhaustion is not required in actions brought pursuant to 42 U.S.C., Section 1983, when
9 a state welfare policy or practice is at issue, particularly when the question for the courts is
10 whether such policy or practice conflicts with federal law or the Constitution.”). In addition,
11 all Circuits to consider the question have held that “the Medicaid Act does not require
12 Plaintiffs to exhaust their state administrative remedies.” *Waskul v. Washtenaw Cty. Cmty.*
13 *Mental Health*, 979 F.3d 426, 445 (6th Cir. 2020) (collecting cases); *see also Evangelical*
14 *Lutheran Good Samaritan Soc’y v. Betlach*, No. CV-16-08169-PCT-JJT, 2017 WL
15 3334870, at *5 (D. Ariz. Aug. 4, 2017) (“[E]xhaustion of state administrative remedies is
16 not required before a plaintiff brings a § 1983 claim in this Court.”); *Dual Diagnosis*
17 *Assessment & Treatment Ctr., Inc. v. Hughes*, No. CV 13-6935-SVW-VBKX, 2016 WL
18 11522965, at *7 (C.D. Cal. Sept. 27, 2016) (exhaustion is inappropriate where “the *sole*
19 remedy for the § 1983 claim against [the director] in her official capacity i[s] an
20 injunction.”) (emphasis in original); *Katie A. v. Bonta*, 433 F. Supp. 2d 1065, 1078 (C.D.
21 Cal. 2006), *rev’d and remanded on other grounds sub nom. Katie A., ex rel. Ludin v. Los*
22 *Angeles Cty.*, 481 F.3d 1150 (9th Cir. 2007) (in case challenging state’s failure to provide
23 Medicaid services to youth under EPSDT, holding that Plaintiffs were not required to seek
24 the services through the fair hearing process before bringing suit).

25 **II. Requiring Plaintiffs to exhaust administrative remedies would be futile.**

26 Imposing an exhaustion requirement in this case would be inappropriate, since any
27 effort to obtain male chest reconstruction surgery through prior authorization, an appeal,
28 and the Medicaid fair hearing process would be futile.

1 Most individuals enrolled in Medicaid in Arizona, including D.H. and John Doe,
2 receive covered services through a private managed care plan. Pursuant to their contracts
3 with the State, the plans are paid a set per-member-per-month amount to provide health care
4 services to AHCCCS enrollees. *See* Ariz. Rev. Stat. §§ 36-2903(A) (establishing AHCCCS
5 as “consisting of contracts with contractors for the provision of hospitalization and medical
6 care coverage to members), 36-2901 (defining “contractor” as a person or entity that has a
7 prepaid capitated contract with AHCCCS to provide health care to members), 36-2904. The
8 plans, in turn, enter into contracts with health care providers to reimburse the providers for
9 covered services delivered to enrollees. *See* Ariz. Admin. Code R9-22-705; *see also* Ariz.
10 Admin. Code R9-22-202(B)(1) (“Only medically necessary, cost effective, and federally-
11 reimbursable and state-reimbursable services are covered services”).

12 With respect to certain covered services, a plan will only pay a provider if the
13 provider requests authorization from the plan prior to delivering the service. *See* Ariz.
14 Admin. Code R9-22-202(C) (permitting plans to deny coverage for non-emergency care if
15 prior authorization is not obtained as specified by regulation), R9-22-712(D) (same), R9-
16 22-210(A)(4)(b) (requiring providers to obtain prior authorization for non-emergency care
17 as outlined by the terms of their contracts with the plans). Generally, the plans require
18 providers to obtain prior authorization for pre-scheduled surgeries and procedures. *See, e.g.,*
19 Arizona Complete Health, *Arizona Complete Care Plan Member Handbook* 71 (2020).¹

20 Therefore, managed care enrollees seeking coverage for a particular service must
21 fulfill three basic steps: (1) the individual’s provider determines that a service or procedure
22 is medically necessary to treat the enrollee’s condition; (2) the provider seeks prior
23 authorization from the plan to perform that service or procedure; and (3) the plan approves
24 (or denies) that request for prior authorization. If a provider wishes to perform a service and
25 requests prior authorization for a service that AHCCCS covers, the plan independently
26 assesses whether that service is medically necessary for the particular enrollee. However, if

27 ¹ Available at https://www.azcompletehealth.com/content/dam/centene/az-complete-health/pdf/member/handbooks/508_AzCH-CCP%20Member%20Handbook%20-%20ACC-%20CYE2021%20FINAL_Eng.pdf.

1 a provider requests prior authorization for a service that AHCCCS does not cover, the plan
2 simply denies coverage on that basis.

3 Under the terms of the Challenged Exclusion, *see* Ariz. Admin. Code R9-22-
4 205(B)(4)(a), the surgery Plaintiffs seek is not a covered service, meaning Plaintiffs'
5 managed care plans will not evaluate whether it is medically necessary for them and will
6 automatically deny the service as non-covered.² In other words, the Challenged Exclusion
7 prevents a plan from ever reaching the question of medical necessity—a provider's request
8 for prior authorization for male chest reconstruction surgery will always be denied *not* due
9 to an individual's lack of medical necessity, but because of the Challenged Exclusion. *See*,
10 *e.g.*, Arizona Complete Health, *Arizona Complete Care Plan Member Handbook* 35 (2020)
11 (listing "gender affirming operations" as a non-covered service);³ Care1st Health Plan
12 Arizona, *Member Handbook* 18 (2020), (listing "sex change operations" as a non-covered
13 service).⁴

14 When a managed care plan denies a request for prior authorization, the enrollee has
15 a right to appeal the denial, first with the plan itself. *See* 42 USC § 1396a(a)(3); 42 C.F.R.
16 §§ 438.400 to 438.424; Ariz. Admin. Code R9-34-201 to R9-34-225. That is exactly what
17 happened to Plaintiff D.H., whose provider requested prior authorization for the surgery,
18 which his plan denied; D.H. then appealed the denial of this surgery, but the plan upheld its
19 denial of coverage *not* because it had determined the surgery was not medically necessary
20 for D.H., but because of the Challenged Exclusion. *See* Compl. ¶ 87.

22 ² For the first time at oral argument, counsel for Defendant suggested that the Challenged
23 Exclusion is not being fully or uniformly implemented, stating that two AHCCCS enrollees
24 received coverage for male chest reconstruction surgery. Defendant did not indicate why or how
25 those two enrollees received coverage. For example, it could be that a plan or AHCCCS made an
26 administrative error. Or, it could be that a particular managed care plan decided to use its own
27 funds to cover the service in order to meet its obligations under federal law, even though the
28 plan's contract with the state excludes coverage of male chest reconstructive surgery. Regardless,
these other cases have no bearing on the legality of the Challenged Exclusion, which *is* being
enforced against Plaintiffs.

³ Available at https://www.azcompletehealth.com/content/dam/centene/az-complete-health/pdf/member/handbooks/508_AzCH-CCP%20Member%20Handbook%20-%20ACC-%20CYE2021%20FINAL_Eng.pdf.

⁴ Available at https://care1staz.com/az/pdf/member/member_handbook/2021/Care1stMemberHandbook.pdf?ver=2020.10.09

1 If the plan upholds its initial decision, the enrollee has a right to request a fair hearing
2 with the State. 42 C.F.R. §§ 438.402(c)(1)(i), 431.220; Ariz. Admin. Code R9-34-217(A).
3 The Arizona Office of Administrative Hearings conducts the fair hearing. *See* Ariz. Admin.
4 Code R9-34-202 (defining “state fair hearing” as an administrative hearing under Ariz. Rev.
5 Stat. Title 41, Chapter 6, Article 10); Ariz. Rev. Stat. §§ 41-1092 to 41-1092.12. After the
6 hearing, the administrative law judge issues a written decision and sends it to AHCCCS.
7 *See* Ariz. Rev. Stat. § 41-1092.08(A). Defendant may reject or modify the ALJ’s decision,
8 in which case her decision is the final decision; if Defendant does not reject or modify the
9 ALJ’s decision, it is final. *See id.* § 41-1092.08(B), (F). The enrollee may request rehearing
10 or review of the final decision by Defendant, *see id.* § 41-1092.09, Ariz. Admin. Code §
11 R9-34-223, or may appeal the directly to Arizona Superior Court, *see* Ariz. Rev. Stat. §§
12 41-1092.08(H); 12-905(A).

13 Requiring Plaintiffs to exhaust this procedure—including to request a fair hearing
14 with the State—is inappropriate here. The question presented is a purely legal one
15 presenting important statutory and constitutional questions that are squarely within the
16 competence of the courts to resolve. *See Skubel v. Sullivan*, 925 F. Supp. 930, 937 (D. Conn.
17 1996), *aff’d as modified sub nom. Skubel v. Fuoroli*, 113 F.3d 330 (2d Cir. 1997) (“When
18 an agency’s decision essentially turns on a question of law . . . courts generally find little or
19 no reason to require exhaustion of agency remedies, as agency expertise and an agency
20 record are of minimal value.”).

21 Moreover, Defendant has made clear her intent to enforce the Challenged Exclusion.
22 Because the State regulation prohibits AHCCCS from covering male chest reconstruction
23 surgery for Plaintiffs, an ALJ is extremely unlikely to overturn a managed care plan’s
24 refusal to cover it, and even if an ALJ did so, Defendant could simply reject the ALJ’s
25 decision and continue to enforce the regulation. *See, e.g., Tallahassee Mem’l Reg’l Med.*
26 *Ctr. v. Cook*, 109 F.3d 693, 702 (11th Cir. 1997) (“[E]ven if exhaustion were required, [the
27 Medicaid Agency]’s posture in this case indicates that reliance on administrative action
28 would be futile because Plaintiffs’ claims would likely be denied in whole or in part.”).

1 Thus, as long as the Challenged Exclusion remains in effect, requiring Plaintiffs to exhaust
2 this procedure would force Plaintiffs to pursue what would be a futile appeal—Plaintiffs
3 will not have an opportunity to make their case that the procedure is medically necessary,
4 because the appeal will necessarily fail due to the Challenged Exclusion.

5 Numerous cases have found that the “futility exception is particularly appropriate
6 where the past pattern of a plan administrator, as well as its position on the merits of a
7 current matter in litigation, reveal that any further administrative review would provide no
8 relief.” *Alday v. Raytheon Co.*, No. CV 06-32 TUCDCB, 2006 WL 2294819, at *4 (D. Ariz.
9 July 27, 2006); *see also Morgan v. Laborers Pension Tr. Fund For N. California*, 433 F.
10 Supp. 518, 529 (N.D. Cal. 1977); *Jones*, 536 F. Supp. at 1202 (Medicaid administrative
11 hearing process could not remedy state’s systemic practices). Here, Defendant has made
12 her position clear—the Challenged Exclusion does not violate federal law—such that
13 requiring Plaintiffs to access a futile hearing process “serves no purpose and resembles more
14 a scene from Kafka than a constitutional process.” *Gray Panthers v. Schweiker*, 652 F.2d
15 146, 168 (D.C. Cir. 1980). That is particularly true here where the delay would also be
16 highly prejudicial to Plaintiffs given that they filed a motion for preliminary injunction
17 seeking immediate relief from the serious irreparable harms they are currently experiencing
18 because of Defendant’s unlawful conduct.

19 This Court should proceed to a consideration of the merits of Plaintiffs’ legal claims
20 against the Challenged Exclusion.

21
22 Respectfully submitted,

23 DATED: FEBRUARY 10, 2021

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EXHIBIT 1



Neutral Citation Number: [2020] EWHC 3274 (Admin)

Case No: CO/60/2020

IN THE HIGH COURT OF JUSTICE
ADMINISTRATIVE COURT
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 01/12/2020

Before :

THE PRESIDENT OF THE QUEEN'S BENCH DIVISION
LORD JUSTICE LEWIS
MRS JUSTICE LIEVEN

Between :

(1) QUINCY BELL
(2) MRS A

Claimants

and

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST

Defendant

**NATIONAL HEALTH SERVICE COMMISSIONING BOARD (NHS
 ENGLAND)**

Interested Party

**(1) UNIVERSITY COLLEGE LONDON HOSPITALS NHS
 FOUNDATION TRUST**
(2) LEEDS TEACHING HOSPITALS NHS TRUST
(3) TRANSGENDER TREND LTD

Interveners

**Mr Jeremy Hyam QC and Mr Alasdair Henderson (instructed by Sinclairs law) for the
 Claimants**

**Ms Fenella Morris QC and Ms Nicola Kohn (instructed by DAC Beachcroft) for the
 Defendant**

The Interested Party did not appear and was not represented

Mr John McKendrick QC (instructed by Hempsons) for the First and Second Interveners

Mr Paul Skinner and Mr Aidan Wills (instructed by Ai Law) for the Third Intervener

Hearing dates: 7 and 8 October 2020

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

THE PRESIDENT OF THE QUEEN'S BENCH DIVISION
LORD JUSTICE LEWIS
MRS JUSTICE LIEVEN

Dame Victoria Sharp P., Lord Justice Lewis, Lieven J.

SECTION A: INTRODUCTION AND BACKGROUND

1. This is the judgment of the court.
2. This is a claim for judicial review of the practice of the defendant, the Tavistock and Portman NHS Foundation Trust, through its Gender Identity Development Service (GIDS) and the first and second Intervenors (the Trusts) of prescribing puberty-suppressing drugs to persons under the age of 18 who experience gender dysphoria.
3. Gender dysphoria or GD is a condition where persons experience distress because of a mismatch between their perceived identity and their natal sex, that is, their sex at birth. Such persons have a strong desire to live according to their perceived identity rather than their natal sex.
4. Those with gender dysphoria may be referred to GIDS. GIDS may, in turn, refer them to one of two NHS Trusts (the first and second Intervenors) whose clinicians may be prepared to undertake medical interventions in relation to those with gender dysphoria. We are concerned in this case with the administration of gonadotropin-releasing hormone agonists (GnRHa) which are hormone or puberty blocking drugs (also called PBs) to suppress the physical developments that would otherwise occur during puberty.
5. Puberty blocking drugs can in theory be, and have in practice been, prescribed for gender dysphoria through the services provided by the defendant to children as young as 10. It is the practice of the defendant, through GIDS, to require the informed consent of those children and young persons to whom such drugs are prescribed.
6. The issue at the heart of this claim is whether informed consent in the legal sense can be given by such children and young persons.
7. The claimants' case is that children and young persons under 18 are not competent to give consent to the administration of puberty blocking drugs. Further, they contend that the information given to those under 18 by the defendant is misleading and insufficient to ensure such children or young persons are able to give informed consent. They further contend that the absence of procedural safeguards, and the inadequacy of the information provided, results in an infringement of the rights of such children and young persons under Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (the Convention).
8. In our view, it is appropriate to consider first, whether a child under 16, or a young person between 16 and 18, can give the requisite consent; and secondly, if, in principle, they can do so, whether the information provided by the defendant and the Trusts is adequate for achieving informed consent.
9. The court in this case is concerned with the legal requirements of the process of obtaining consent for the carrying out of medical treatment. In considering this issue the court has had to consider evidence on the use of PBs, their impact on the patients, both in the short and long term, and the evidence of the efficacy of their use. The court is not deciding on the benefits or disbenefits of treating children with GD with PBs, whether in the long or short term. The court has been given a great deal of evidence

about the nature of GD and the treatments that may or may not be appropriate. That is not a matter for us. The sole legal issue in the case is the circumstances in which a child or young person may be competent to give valid consent to treatment in law and the process by which consent to the treatment is obtained.

10. We have had placed before us written evidence from a wide variety of those engaged in issues surrounding GD and a number of individuals who have been treated or are still being treated with PBs.
11. On behalf of the defendant and the Trusts there are statements from Dr Polly Carmichael, Director of GIDS, Professor Gary Butler, Consultant in Paediatric Endocrinology at University College Hospital London, and Dr Nurus-Sabah Alvi, Consultant in Paediatric Endocrinology at Leeds General Infirmary and Clinical Lead for Endocrine Liaison Clinics of the GIDS, Leeds. These witnesses describe the process that the children and young people go through at GIDS and at the Trusts. The court has also had a wide range of evidence from a variety of people concerned with the treatment of those under 18 with PBs. We will refer to that evidence and its sources as appropriate below. Our references to a child or children will be to those under the age of 16, and to young person(s) to anyone under the age of 18, save where it is clear from the context that we are referring to anyone under the age of 18.

Gender Dysphoria

12. Gender dysphoria is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) which provides for one overarching diagnosis of gender dysphoria with separate specific criteria for children and for adolescents and adults:

“In adolescents and adults gender dysphoria diagnosis involves a difference between one’s experienced gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:

1. A marked incongruence between one’s experienced / expressed gender and primary and / or secondary sex characteristics
2. A strong desire to be rid of one’s primary and / or secondary sex characteristics
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
5. A strong desire to be treated as the other gender
6. A strong conviction that one has the typical feelings and reactions of the other gender.

In children, gender dysphoria diagnosis involves at least six of the following and an associated significant distress or impairment in function, lasting at least six months:

1. A strong desire to be of the other gender or an insistence that one is the other gender
2. A strong preference for wearing clothes typical of the other gender
3. A strong preference for cross-gender roles in make-believe play or fantasy play
4. A strong preference for toys, games or activities stereotypically used or engaged in by the other gender
5. A strong preference for playmates of the other gender
6. A strong rejection of toys, games and activities typical of one's assigned gender
7. A strong dislike of one's sexual anatomy
8. A strong desire for the physical sex characteristics that match one's experienced gender."

Gender Identity Development Service (GIDS)

13. The defendant is an NHS Foundation Trust employing specialist staff including child psychologists, psychotherapists, psychiatrists, social workers, family therapists and nurses. Since 1989 it has provided a gender identity development service, a specialised service providing care to patients up to the age of 18 suffering from GD. GIDS is commissioned by the National Health Service Commissioning Board. The statutory mechanism is that under section 3B of the NHS Act 2006, the Secretary of State has the power to require NHS England to arrange services or facilities as may be prescribed by regulations. The Secretary of State has exercised that power (pursuant to Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2296, which concerns specified services for rare and very rare conditions) that NHS England must arrange for the provision of services including, pursuant to para 56 of Schedule 4, a gender identity development service specifically for children and adolescents in addition to gender dysphoria services more generally (para 57).
14. Schedule 2, Part A of the NHS Standard Contract, pursuant to which GIDS is provided, sets out the Service Specification which establishes the context of the service, its aims and objectives and the manner in which it will be delivered. As set out in the Service Specification, the service is commissioned to provide specialist assessment, consultation and care including psychological support and physical treatments. The purpose of the treatment is "*to help reduce the distressing feelings of a mismatch between their natal (assigned) sex and their gender identity.*" The service also provides support to family and carers of children and young persons so affected.
15. GIDS recognises three stages of physical intervention that may be appropriate in cases of GD. Stage 1 is the administration of GnRHa (one form of puberty blocker). This is clinically appropriate for children and young people who have reached Tanner Stage 2

of puberty and above. Tanner Stage 2 marks the beginning of the physical development of puberty. In natal girls this is the start of development of the breasts, and in boys the testicles and scrotum begin to get larger. Stage 2 of the treatment is the administration of cross-sex hormones (CSH) which can only be prescribed from around the age of 16. Stage 3 is gender reassignment surgery which is only available via adult services to people aged over 18.

16. GIDS takes referrals from across England and Wales and from a wide range of professionals in the health, social services and education sectors, and the voluntary sectors. When a referral is made, the case will be discussed with the relevant regional team. If the intake is successful, then the child will then progress to the GIDS waiting list.
17. As at November 2019 the waiting time for a first assessment at GIDS was between 22-26 months. When a young person reaches the top of the waiting list, they will be invited to the first of a number of assessment appointments at GIDS. The assessment process laid out in the Service Specification anticipates that the assessment process will typically span three to six sessions over 6 months or longer. Most young people will have more sessions than this, and the younger the age the more sessions are likely.
18. Dr Carmichael said that during assessments young persons will be asked, for example, about: the onset of their gender dysphoria; the consistency of their feelings about their gender; how they identify (cross-gender, non-binary, etc); their relationships with peers and family members; their social functioning in general, thoughts about or experience of puberty; their relationship to their bodies; their attractions or romantic relationships as appropriate based on their age and maturity; and their hopes and expectations for the future.
19. As this case is brought by way of judicial review of the GIDS policy and practice, rather than a challenge to an individual treatment decision, it is not possible to give a detailed analysis of the facts of an individual case and the degree to which all the matters referred to by Dr Carmichael were explored in the particular case. We refer at paras 78 to 89 below to the evidence of the experience of the first claimant and some of the other patients of the GIDS service.
20. Dr Carmichael sets out the broad range of professionals who work within GIDS, their specialism in working with young people with GD and the care that is taken when discussing the young person's expression of their gender identity.
21. At the end of the assessment period the clinicians will agree a care plan with the young person and their family. Where the young person fulfils the criteria in the Service Specification and has reached at least Tanner Stage 2 of puberty, they will be referred by GIDS to the first and second Interveners for consultation and/or physical assessment with endocrinologists with a view to being prescribed PBs. Dr Carmichael explains that before any referral to the Trusts, GIDS clinicians discuss the treatment with the young person, including explaining side effects.

The Age and Patient Group for Puberty Blockers

22. Until 2011 PBs were only available at GIDS for those aged 16 or older. In 2011 PBs started to be prescribed for those aged 12-15 and in mid-puberty. This was first done between 2011-14 at University College London Hospital (UCLH) under an approved research study known as the Early Intervention Study. The Study took an uncontrolled treatment cohort of 12-15 year olds with established and persistent GD in England. The Study recruited children for 3 years, but there was then a period until February 2019 when the last cohort member began the next stage of therapy (cross-sex hormones).
23. One of the issues raised in these proceedings is the non-existent or poor evidence base, as it is said to be, for the efficacy of such treatment for children and young persons with GD.
24. In that context, we note that though this research study was commenced some 9 years ago, at the time of the hearing before us the results of this research had yet to be published. Dr Carmichael says in her witness statement dated 2 February 2020 that a paper is now being finalised for publication. At the hearing we were told that that this paper had been submitted for peer-review but that Professor Viner, one of the authors of it, had yet to respond to issues raised by the reviewers, as he has been otherwise engaged in working on issues relating to the coronavirus pandemic.
25. The court was however provided with a paper entitled "*The Early Intervention Study. An evaluation of early pubertal suppression in a carefully selected group of adolescents with "Gender Identity Disorder". A statement and update on the Early Intervention Study (dated 2020)*". We refer further to this paper at para 73 below.
26. There are now two types of endocrine clinic: a clinic for under 15s, referred to as the early intervention clinic, and a clinic for over 15s. The Service Specification states that the early intervention clinic will continue to follow the 2011 Protocol, save that PBs will now be considered for any children *under the age of 12* if they are in established puberty.
27. The age distribution of those treated with PBs in each year between 2011 and 2020 was not provided to the court. Although the defendant and the Trusts said that such data was available, in the sense that the ages of the children are known, the data has not been collated for each year. However, Ms Ailsa Swarbrick, the Divisional Director of Gender Services at the Trust, has presented evidence in relation to patients referred to endocrinology services in 2019-20 and those treated in earlier years but who were discharged from GIDS in 2019-2020. This work was done in response to recommendations in the GIDS Review Action Plan 2019 (a Review commissioned by the Trust following a report by Dr David Bell) that data would help to inform clinical and service developments and a process of continuous improvement.
28. We note here that we find it surprising that such data was not collated in previous years given the young age of the patient group, the experimental nature of the treatment and the profound impact that it has.

29. As it is, for the year 2019/2020, 161 children were referred by GIDS for puberty blockers (a further 10 were referred for other reasons). Of those 161, the age profile is as follows:

3 were 10 or 11 years old at the time of referral;

13 were 12 years old;

10 were 13 years old;

24 were 14 years old;

45 were 15 years old;

51 were 16 years old;

15 were 17 or 18 years old.

For the year 2019/20, therefore, 26 of the 161 children referred were 13 or younger; and 95 of the 161 (well over 50%) were under the age of 16.

30. It follows from the information that the court does have on age distribution that some young people could be on PBs for a number of years, in the most extreme case for 5 years between the age of 10 and when they start CSH at 16.
31. Apart from the age distribution, there are other aspects of the patient group which are relevant to this case. The number of referrals to GIDS has increased very significantly in recent years. In 2009, 97 children and young people were referred. In 2018 that number was 2519.
32. Further, in 2011 the gender split was roughly 50/50 between natal girls and boys. However, in 2019 the split had changed so that 76 per cent of referrals were natal females. That change in the proportion of natal girls to boys is reflected in the statistics from the Netherlands (Brik et al "*Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*" 2018). The defendant did not put forward any clinical explanation as to why there had been this significant change in the patient group over a relatively short time.
33. It is recorded in the GIDS Service Specification and the wider literature that a significant proportion of those presenting with GD have a diagnosis of Autistic Spectrum Disorder (ASD). The Service Specification says:

"There seems to be a higher prevalence of autistic spectrum disorder (ASD) conditions in clinically referred, gender dysphoric adolescents than in the general adolescent population. Holt, Skagerberg & Dunsford (2014) found that 13.3% of referrals to the service in 2012 mentioned comorbid ASD (although this is likely to be an underestimate). This compares with 9.4% in the Dutch service; whereas in the Finnish service, 26% of adolescents were diagnosed to be on the autism spectrum (Kaltiala-Heino et al. 2015)."

34. The court asked for statistics on the number or proportion of young people referred by GIDS for PBs who had a diagnosis of ASD. Ms Morris said that such data was not available, although it would have been recorded on individual patient records. We therefore do not know the proportion of those who were found by GIDS to be *Gillick* competent who had ASD, or indeed a mental health diagnosis.
35. Again, we have found this lack of data analysis – and the apparent lack of investigation of this issue - surprising.

The process of taking consent

36. The position taken by GIDS is that they will only refer a young person for PBs if they determine that person is competent to give consent, i.e. is *Gillick* competent within the meaning of competence identified in the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112.
37. Dr Carmichael explained that GIDS takes consent from the young person to their case being referred to the Trusts for treatment; however the consent for the actual prescription of the PBs is taken separately by the clinicians working for the Trusts. She set out the careful process by which GIDS gives information to the young persons and to their parents in order to seek to ensure that the young person is in a position to give valid consent. The court was taken through the statements of Dr Carmichael and Professor Butler and various documents to show the level of information and dialogue that was involved in achieving lawful consent to the treatment. The Service Specification includes Section 3.2 on “Informed Consent”. This states “*The consequences of treatment decisions can be significant and life-changing*” and states:

“All efforts will be made to ensure that clients are aware of the longer term consequences of the endocrine treatments, including implications for fertility, and the decision of the competence of the client will be jointly made by the endocrine and psychological members of the Service’s integrated team.

The current context of treatment decisions about cross sex hormones in adolescence is that there is limited scientific evidence for the long-term benefits versus the potential harms of the intervention. There are also concerns that it is uncertain whether or not a young person will continue to identify as transgender in the future, given that some subsequently identify in a different way.”

38. The defendant has recently adopted a Standard Operating Procedure for the taking of consent in GIDS. This has taken 2 years to develop and is dated 31 January 2020. Dr Carmichael says at para 33 of her first statement:

“In advance of any referral by the Trust of a young person for consideration by an endocrinologist for GnRHa treatment, GIDS clinicians discuss treatment with the young person. This includes, checking that the young person’s hopes for treatment are realistic, explaining what the treatment can and cannot do, discussing any potential

side-effects, discussing fertility and potential impact on genital development for birth registered males. We have developed visual aids to support this process.

UCLH and LTH have collated extensive written information to help young people and their parents further understand the nature of the drugs, their limitations and the possible side effects. These written documents are given to young people at their first endocrine clinic visit. The written documents act as a reference point for patients with questions whilst they contemplate whether they would like to go ahead with the referral, and subsequently with treatment. In particular, informational slides titled “Have you thought about having children in the future?” explains the impact GnRHa treatment can have on fertility in explicit terms. Young people and their families are encouraged to raise any questions with their GIDS clinicians or at their next endocrine clinic visit.”

39. Ms Morris emphasised that the process of ensuring that consent could validly be given was a discursive and iterative one that involved multiple discussions and answering any questions the young people or their parents might raise. Dr Carmichael said at para 35: *“The GIDS clinicians make it very clear to children and young people that there are both known and unknown risks associated with GnRHa treatment.”* Further, she said at para 41: *“In my experience, those young people we see who are recommended for GnRHa treatment understand the implications and limitations of treatment with GnRHa treatment and are able to consent to this stage of treatment.”*

40. Professor Butler described the approach to consent at the Trusts as follows:

“For those under 15 years of age all the pre-assessment consultations are individual and occur with a consultant or senior clinical fellow on at least two visits. Parental support (or that of their guardian or social services where appropriate) is a pre-requisite for the under 15 year stream. On occasions, a young person is not deemed, on clinical examination, to be at an appropriate stage of puberty so further follow-up visits are arranged thereafter at 6-12 monthly intervals until a person is deemed at an appropriate physical stage for intervention and taking of consent. This also gives the opportunity to judge the level of emotional cognitive and psychosocial maturity, and capacity.

The decisions at UCLH and Leeds do not automatically follow on from those made at the GIDS Tavistock. They are a reassessment of physical maturity and cognitive capacity in their own right. They may be at odds with the Tavistock formulation (an infrequent event) and thus would be returned to the Tavistock MDT for reconsideration.”

41. Professor Butler said that in his clinic they are careful to ensure that the force behind the decision to seek treatment comes from the young person themselves and is not a consequence of pressure upon them from others around them. The Trusts work closely

with parents to reach a solution that is satisfactory to all and meets the best interests of the child. His clinic has never sought to apply to the Court under its inherent jurisdiction “against” parental opinions because he is concerned that would cause familial frictions. Equally, he suggested UCLH would not wish to have to apply to the court for consent on behalf of the child because it would delay treatment and put an additional burden on GIDS and the Trusts; and because *“it would also increase the distress suffered by the young people themselves, finding that their right to autonomous decision making had been removed from them.”*

42. Professor Butler said a full written information package is provided to older adolescents. For those under 15 there is an initial individual consultation because of the need for *“individualising the approach for very young people, taking special care to assess their level of knowledge and understanding and they are given the written information package then.”* In relation to impacts on fertility and sexual functioning he says:

“It is also relevant for the consultation purposes that matters of fertility are discussed and counselling by the team takes place, and the option of meeting a fertility specialist is offered, and often taken up. The options of fertility preservation are discussed with all the young people and it is a requirement of the consent process that they fully understand this at an age appropriate level. This understanding must include that they are unable to have the typical sexual relationship of their identified gender with another person on account of their biological sex organ development, and that other surgical procedures may be necessary later on to achieve this possibility.”

43. He then said: *“it is an absolute requirement before starting any treatment that a young person can fully understand this effect on fertility and sexual functioning according to their age and level of maturation.”*
44. The court asked for statistical material on the number, if any, of young people who had been assessed to be suitable for PBs but who were *not* prescribed them because the young person was considered not to be *Gillick* competent to make the decision, whether at GIDS or the Trusts. Ms Morris could not produce any statistics on whether this situation had ever arisen. She suggested that in the main, GIDS would work with the young person to give them further information, discuss the matter further and in some cases wait until they had achieved further maturity. The court gained the strong impression from the evidence and from those submissions that it was extremely unusual for either GIDS or the Trusts to refuse to give PBs on the ground that the young person was not competent to give consent. The approach adopted appears to be to continue giving the child more information and to have more discussions until s/he is considered *Gillick* competent or is discharged.
45. Relevant to the evidence of consent is the evidence of Professor Scott (Director of University College London’s Institute of Cognitive Neuroscience). She *“seeks to explain, from a neuroscientific point of view, why I have significant doubts about the ability of young people under the age of 18 years old to adequately weigh and*

appreciate the significant consequences that will result from the decision to accept hormonal treatment for gender dysphoria."

46. She explained the neurological development of adolescents' brains that leads to teenagers making different, more risky decisions than adults. She said further that this is backed up by behavioural studies showing that when decision making is "hot" (i.e. more emotional), under 18 year olds make less rational decisions than when the responses are made in a colder, less emotional context. Her conclusion was that:

"11. ... given the risk of puberty blocking treatment, and the fact that these will have irreversible effects, that have life-long consequences, it is my view that even if the risks are well explained, that in the light of the scientific literature, that it is very possible for an adolescent to be unable to fully grasp the implications of puberty-blocking treatment. All the evidence we have suggests that the complex, emotionally charged decisions required to engage with this treatment are not yet acquired as a skill at this age, both in terms of brain maturation and in terms of behaviour."

Parental consent

47. If a child cannot give consent for treatment because they are not *Gillick* competent then the normal position in law would be that someone with parental responsibility could consent on their behalf. Mr Hyam sought at one point to argue that a decision as to giving PBs would fall outside the scope of parental responsibility because of the nature of the treatment concerned. However, the GIDS practice in relation to acting on parental consent alone is quite clear. In the response to the pre-action protocol letter the defendant said:

"36. There is a fundamental misunderstanding in your letter, which states that parents can consent to pubertal suspension on behalf of a child who is not capable of doing so. This is not the case for this service, as is clear from the above. Although the general law would permit parent(s) to consent on behalf of their child, GIDS has never administered, nor can it conceive of any situation where it would be appropriate to administer blockers on a patient without their consent. The Service Specification confirms that this is the case."

It follows that is not necessary for us to consider whether parents could consent to the treatment if the child cannot lawfully do so because this is not the policy or practice of the defendant and such a case could not currently arise on the facts.

The effect of Puberty Blockers

48. PBs have been used for many years to stop precocious puberty. This is a condition experienced largely by children aged 7 or under when puberty commences at a very early age. This condition is seen more often in natal girls but sometimes in natal boys. PBs are used to stop this early onset of puberty and the use of them ceases when the child reaches an appropriate age for puberty. As can be seen from the evidence this use of PBs does not interfere with the onset of puberty at a normal biological age and, as such, will not interfere with normal development of puberty through adolescence.

49. The use of PBs in cases of GD is quite different. We have some evidence of the history of this treatment and the meaning of puberty from Professor Hruz (Associate Professor of Paediatrics, Endocrinology and Diabetes at Washington University, St Louis, USA) on behalf of the claimants.
50. In summary, PBs were first used for such treatment at a Dutch gender clinic in the late 1990s. That clinic developed a protocol, often referred to as the Dutch protocol. The Dutch protocol was published in the European Journal of Endocrinology in 2006 and called for puberty suppression to begin at the age of 12 after a diagnosis of GD. Puberty is understood in medicine or biology as a process of physiological change involving the process of maturation of the gonads. Hormones in a part of the brain secrete a gonadotropin-releasing hormone which, in turn, stimulates the pituitary gland to secrete other hormones. These stimulate the growth of the gonads, that is ovaries in females and testes in males. Further hormones are secreted which contribute to the further development of the primary sex characteristics, the uterus in females and the penis and scrotum in males. The hormones contribute to the development of secondary sex characteristics including breasts and wider hips in girls and wider shoulders, deeper voices and increased muscle mass in boys. Further growth hormones are released, which stimulate growth. With regular injection of the PBs there is no progression of puberty and some regression of the first stages of already developed sexual characteristics. This means that in girls *"breast tissue will become weak and may disappear completely"* and in boys *"testicular volume will regress to a lower volume."*
51. Under the Dutch protocol, the introduction of CSH starts at age 16. As Professor Hruz explained:
- "29. Then, starting at age 16, cross-sex hormones are administered while GnRH analogue treatment continues, in order to induce something like the process of puberty that would normally occur for members of the opposite sex. In female-to-male patients, testosterone administration leads to the development of "a low voice, facial and body hair growth, and a more masculine body shape" as well as to clitoral engorgement and further atrophy of breast tissue. In patients seeking a male-to-female transition, the administration of estrogens will result in "breast development and a female-appearing body shape." Cross-sex hormone administration for these patients will be prescribed for the rest of their lives."
52. There is some dispute as to the purpose of prescribing PBs. According to Dr Carmichael, the primary purpose of PBs is to give the young person time to think about their gender identity. This is a phrase which is repeated on a number of the GIDS and Trust information documents. The Health Research Authority carried out an investigation into the Early Intervention Study in 2019. Its report was somewhat critical of the description of the purpose and said:
- "The research team described the purpose of pubertal suppression as 'to induce a sex hormone-neutral environment to provide young people with space to decide whether to progress further with gender reassignment treatment as an adult.' This phrase appears to have caused confusion as it has been interpreted by some that the puberty suppression was for use in

any children presenting to the clinic, that there would be no change in the course of any gender identity dysphoria during this time, and that the child could then choose to progress to cross-sex hormone treatment or to stop treatment with subsequent onset of puberty in the birth gender. It has been noted that the participants in this study and other research involving early puberty suppression have progressed to cross-sex hormones. This has raised concerns that the treatment might be responsible for generating persistence, rather than ‘creating space to decide’.

It would have reduced confusion if the purpose of the treatment had been described as being offered specifically to children demonstrating a strong and persistent gender identity dysphoria at an early stage in puberty, such that the suppression of puberty would allow subsequent cross-sex hormone treatment without the need to surgically reverse or otherwise mask the unwanted physical effects of puberty in the birth gender. The present study was not designed to investigate the implications on persistence or desistence of offering puberty suppression to a wider range of patients, it was limited to a group that had already demonstrated persistence and were actively requesting puberty blockers.”

53. Professor Butler said that PBs:

“may have some help or advantage in the support of transgender adolescents in some aspects of mental health functioning, in particular with reducing the risk of reduction of suicidal ideation and actual suicidal actions themselves.”

54. See further the reference at para 73 below to the paper presented by Dr Carmichael and Professor Viner in 2014, referring to the Early Intervention Study and the limited evidence of psychological benefit.
55. As is clear from the literature and referred to by the HRA, the other purpose of giving PBs is stopping the development of the physical effects of puberty (something that obviously varies depending on at what age and stage in pubertal development the PBs are commenced) because slowing or preventing the early development of secondary sex characteristics during puberty can make a later transition (both medical and social) to living as the opposite sex easier.

The relationship between Puberty Blockers and Cross-Sex Hormones (CSH)

56. GIDS and the Trust place reliance on the fact that Stage 1 treatment with PBs and Stage 2 treatment (CSH) are separate. Thus, so it is said, it is possible for a young person to come off the PBs at any point and not proceed to taking CSH. On one view, this is correct. However, the evidence that we have on this issue clearly shows that practically all children / young people who start PBs progress on to CSH.

57. No precise numbers are available from GIDS (as to the percentage of patients who proceed from PBs to CSH). There was some evidence based on a random sample of those who in 2019-2020 had been discharged or had what is described as a closing summary from GIDS. However the court did have the evidence of Dr de Vries. Dr de Vries is a founding board member of EPATH (European Professional Association for Transgender Health) and a member of the WPATH (World Professional Association for Transgender Health) Committee on Children and Adolescents and its Chair between 2010 and 2016, and leads the Centre of Expertise on Gender Dysphoria at the Amsterdam University Medical Centre in the Netherlands (CEGD). This is the institution which has led the way in the use of PBs for young people in the Netherlands; and is the sole source of published peer reviewed data (in respect of the treatment we are considering) produced to the court. She says that of the adolescents who started puberty suppression, only 1.9 per cent stopped the treatment and did not proceed to CSH.
58. We were told that the defendant did not have any data recording the proportion of those on puberty blockers who progress to cross-sex hormones. We were told that in part this resulted from the fact that some would have progressed to adult services and would not be recorded by the defendant. Ms Swarbrick had carried out an analysis of a random sample of 312 of 1648 files of patients discharged from GIDS from 1st March 2019 to 4th March 2020. Dr Carmichael summarised this as:

“...based on a random sample of those referred to GIDS who had been discharged or had a closing summary from GIDS in 19-20 (analysis B) 16% of patients (49 individuals) had accessed the endocrinology service during their time with GIDS. Of those 16%, 55% (27 individuals) were subsequently approved for or accessed cross-sex hormones during their time with GIDS. This number represents 8.7% of all the patients discharged from GIDS that year. We also know that of the 49 patients who were referred to endocrinology for GnRHa whilst at GIDS, two did not commence GnRHa treatment, and a further five were discharged from GIDS without being referred on to another gender service.”

59. We find it surprising that GIDS did not obtain full data showing the figures and the proportion of those on puberty blockers who remain within GIDS and move on to cross-sex hormones. Although neither Dr Carmichael nor Professor Butler could give the equivalent figures in the United Kingdom to those from the Netherlands, the language used in their witness statements suggests that a similarly high proportion of children and young people in the United Kingdom move from PBs onto CSH.

The impact of Puberty Blockers and their reversibility

60. Both WPATH and the Endocrine Society in their documentation describe PBs as fully reversible. Professor Butler says that “*we do not know everything about the blocker and as far as we know it is a safe reversible treatment with a well-established history.*” Dr Alvi also referred to the history of the use of PBs as showing that they are fully reversible. However, it is important to note that apart from the Amsterdam study, the history of the use of PBs relied upon in this context is *from the treatment of precocious*

puberty which is a different condition from GD, and where PBs are used in a very different way.

61. Dr de Vries was somewhat more nuanced in her evidence. She said:

“Puberty blocking treatment is fully reversible (see for example section 2.0 of the Endocrine Society’s Clinical Practice Guidelines...). By fully reversible I mean that the administration of puberty blockers in young people has no irreversible physical consequences, for example for fertility, voice deepening or breast growth”.

62. At para 20 of her evidence she said:

“Ethical dilemmas continue to exist around ... the uncertainty of apparent long-term physical consequences of puberty blocking on bone density, fertility, brain development and surgical options.”

63. The GIDS Early Intervention Young Person Information Sheet states:

“What are the possible benefits of starting on hormone blockers?

We have looked at other countries who have given this treatment **and the results** suggest that:

- Hormone blockers which block the body’s natural sex hormones may improve the way you feel about yourself.
- If you decide to stop the hormone blockers early **your physical development** will return as usual in your natal gender. **As far as we are aware**, the hormone blockers will not harm your physical or psychological development.
- Hormone blockers will make you feel less worried about growing up in the wrong body and will give you more time and space to think about your gender identity.

What are the possible disadvantages and risks of the hormone blockers?

- Possible side effects from the hormone blockers are hot flushes, headache, nausea and weight gain.
- A short term effect is that your bone strength is shown not to grow as fast as it usually would whilst you are on hormone blockers. However, this will resume once your body is exposed to hormones again. That is why we have to do a bone scan every year to check the thickness of your bones. **We do not fully know how hormone blockers will affect bone strength, the development of your sexual organs, body shape or your final adult height.** There

could be other long-term effects of hormone blockers in early puberty that we don't yet know about.

- Hormone blockers could affect your memory, your concentration or the way you feel about your gender and how likely you are to change your mind about your gender identity.
- Hormone blockers could affect your ability to have a baby. It could take 6 to 12 months longer after stopping the hormone blockers before natal boys start making sperm again or natal girls start maturing eggs in their ovaries. However, hormone blockers do not work as a contraceptive. If you are sexually active, please ask your doctor for advice about birth control.” (emphasis added)

64. A number of aspects of this asserted reversibility are raised by the claimants. PBs stop the physical changes in the body when going through puberty. But in reliance on the evidence of Professor Levine (Clinical Professor of Psychiatry at Western Reserve University, Ohio) and Professor Hruz, the claimants assert that neurological and psychological changes occurring in puberty are less well understood than the physiological changes. Further, the degree to which neurological differences are caused by biological factors like hormones and genes are matters of debate. Professor Levine set out evidence on the degree to which young people mature through adolescence through both social and personal experiences. For young people on PBs that maturing process is stopped or delayed with potential social and psychological impacts which could be described as non-reversible.

65. Thus, the central point made by the claimants is that although most of the physical consequences of taking PBs may be reversible if such treatment is stopped, the child or young person will have missed a period, however long, of normal biological, psychological and social experience through adolescence; and that missed development and experience, during adolescence, can never be truly be recovered or “reversed”.

66. It is to be noted that prior to June 2020, the NHS website on PBs said:

“The effects of treatment with GnRH analogues are considered to be fully reversible, so treatment can usually be stopped at any time.”

67. In June 2020 this section was updated to read as follows:

“Little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria.

Although the Gender Identity Development Service (GIDS) advises that is a physically reversible treatment if stopped, **it is not known what the psychological effects may be.**

It's also not known whether hormone blockers affect the development of the teenage brain or children's bones. Side effects may also include hot flushes, fatigue and mood alterations.” (emphasis added)

68. A second key part of the argument about reversibility turns on the relationship between PBs and CSH and the degree to which commencing PBs in practice puts a young person on a virtually inexorable path to taking CSH. CSH are to a very significant degree not reversible. As is set out above at para 57 above, a very high proportion of those who start PBs move on to CSH and thus in statistical terms once a child or young person starts on PBs they are on a very clear clinical pathway to CSH.

Evidence base to support the use of Puberty Blockers for Gender Dysphoria

69. The claimants submit that the treatment of PBs for GD is properly described as (i) experimental (ii) a treatment with a very limited evidence base, and (iii) as a highly controversial treatment. The claimants rely on witness statements from a number of undoubted experts in various relevant fields and from academic institutions in the United Kingdom, the USA, Sweden and Australia who refer to the controversial nature of the treatment and its limited evidential support.
70. It is not however the court's role to judge the weight to be given to various different experts in a judicial review. In our view, more important is the evidence from the defendant and the evidence base it relies upon for the use of PBs. In the USA the treatment of GD is not an FDA approved use and as such PBs can only be used “off-label”. That does not prevent clinicians, whether in the USA or the United Kingdom, from using PBs for this purpose, as long as their use falls within the clinician's professional expertise. Professor Butler explained that it is very common for paediatric medicines to be used off-label and that this factor does not render the treatment in any sense experimental.
71. However, the lack of a firm evidence base for their use is evident from the very limited published material as to the effectiveness of the treatment, however it is measured.
72. Paul Jenkins, Chief Executive of the defendant said:
- “...it is correct that in recent years, some clinicians [at the Trust] have raised their concerns about the use of GnRHa for young people presenting with gender dysphoria. Indeed, some have called for the Trust to alter its practices and have done so in a variety of ways. We are keenly aware that the subject of gender dysphoria raises complex issues and that many have strong opinions about it.”
73. The Evaluation Paper on the Early Intervention Study at GIDS, referred to in para 25 above, gives some (albeit limited) material on the outcome of that study. It summarised a meeting paper presented by Dr Carmichael and Professor Viner in 2014 (but not published in a peer review journal) as follows:

“The reported qualitative data on early outcomes of 44 young people who received early pubertal suppression. It noted that 100% of young people stated that they wished to continue on GnRHa, that 23 (52%) reported an improvement in mood since starting the blocker but that 27% reported a decrease in mood. **Noted that there was no overall improvement in mood or psychological wellbeing using standardized psychological measures.**” (emphasis added)

74. Ms Morris submitted it is not for this court to determine clinical disagreements between experts about the efficacy of a treatment. We agree. That is a matter for the relevant NHS and regulatory bodies to oversee and to decide. However the degree to which the treatment is experimental and has, as yet, an unknown impact, does go to the critical issue of whether a young person can have sufficient understanding of the risks and benefits to be able lawfully to consent to that treatment.

Persistence

75. The claimants submit that there is good evidence that for a significant proportion of young people presenting with GD, the condition resolves itself through adolescence without treatment with PBs. Further, that PBs serve to increase the likelihood of GD, and, as such, can be positively harmful to the child or young person’s long-term health. According to DSM5: “*in natal males, persistence of [gender dysphoria] has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%.*” These figures need to be treated with some caution because it may be that the cohort whose persistence was being considered in these statistics was at a lower age and with less clearly established GD than the young people being treated at GIDS.
76. The Dutch study argued that adolescents who show established GD rarely identify as their biological sex. Professor Hruz suggested there may be two reasons for this. It may be that the clinicians made sound diagnoses of persistent GD. Alternatively, it may be that the very fact of the diagnosis and the course of treatment which affirmed that diagnosis (that is, both gender affirmative psychotherapy and the use of PBs) solidified the feeling of cross-gender identification and led the young people to commit to sex reassignment more strongly than they would have done if there had been a different diagnosis and treatment.
77. As already indicated, it is not our role to adjudicate on the reasons for persistence or otherwise of GD. However, the nature of this issue highlights the highly complex and unusual nature of this treatment and the great difficulty there is in fully understanding its implications for the individual young person. In short, the treatment may be supporting the persistence of GD in circumstances in which it is at least possible that without that treatment, the GD would resolve itself.

SECTION B: EVIDENCE OF THE CLAIMANTS AND OTHER INDIVIDUALS

78. The first claimant was born a female. In her witness statement in these proceedings she set out her experience of being prescribed PBs and then CSH. It should be noted that some of the details relating to her treatment and the information she was given (at GIDS and the first defendant) is disputed. This case is a judicial review of the GIDS policy,

not a tort action relating to the specific facts surrounding the first claimant's treatment and it is not necessary therefore to resolve any factual dispute. We simply record the first claimant's account. She describes a highly traumatic childhood. From the age of 4 or 5 she displayed gender non-conformity, associating more with male games and clothes. She felt highly alienated at secondary school and took birth control pills to stop her periods. She felt disgusted by her body and became depressed and highly anxious. From the age of 14 she began actively to question her gender identity and started to look at YouTube videos and do research on the internet about gender identity disorder and the transition process. She said: *"I thought I had finally found the answer as to why I felt so masculine, uncomfortable with my female body and why I was so much more similar to a stereotypical boy than to a stereotypical girl in physical expression and interests."*

79. When she was 15, the first claimant was referred to GIDS. When she was at the local Children and Adolescent Mental Health Services clinic she remembered: *"the psychiatrist attempted to talk of the gender spectrum as a way of persuading me to not pursue medical transition. I took this as a challenge to how serious I was about my feelings and what I wanted to do and it made me want to transition more. Now I wish I had listened to her."* She was first seen at GIDS aged 16 and had a number of appointments spread out over 1 year and 9 months. She was referred to UCLH in June 2013 and after three appointments commenced PBs. She was given advice about the impact on her fertility, but her priority was to move on to testosterone. She said that at 16, she was not thinking about children and, in any event, egg storage was not available on the NHS.
80. In April 2014 she was referred to an adult Gender Identity Clinic to discuss surgery. She *"was visualising myself becoming a tall, physically strong young man where there was virtually no difference between me and a biological boy."* After commencing testosterone at 17, changes to her body commenced rapidly: these changes included genital changes, her voice dropping and the growth of facial and body hair. She was on testosterone for 3 years but increasingly began to doubt the process of transition:

"27. I started to have my first serious doubts about transition. These doubts were brought on by for the first time really noticing how physically different I am to men as a biological female, despite having testosterone running through my body. There were also a lot of experiences I could not relate to when having conversations with men due to being biologically female and socialised in society as a girl. There was an unspoken "code" a lot of the time that I felt I was missing. I remember telling a close male friend at the time about these transition doubts, who responded by telling me that I was being silly and I believed him. This was reinforced by the online forums that I browsed where the consensus was that most transsexual people have doubts and that that is a normal part of transitioning, so the doubts should be ignored. I continued on, pushing the doubts in the far back of my mind and no more doubts crept in for a while."

81. Despite these doubts, when she was 20, she had a double mastectomy. In the year following this:

“31. ... I started to realise that the vision I had as a teenager of becoming male was strictly a fantasy and that it was not possible. My biological make-up was still female and it showed, no matter how much testosterone was in my system or how much I would go to the gym. I was being perceived as a man by society, but it was not enough. I started to just see a woman with a beard, which is what I was. I felt like a fraud and I began to feel more lost, isolated and confused than I did when I was pre-transition.”

82. She described facing the reality of taking a regular dose of drugs for the rest of her life to maintain her male appearance; and the need to have a hysterectomy if she remained a man because of the atrophy of her reproductive organs if she continued to take testosterone.

83. From January 2019 the first claimant stopped taking testosterone. She now wishes to identify as a woman and is seeking to change her legal sex back to that on her original birth certificate. She said:

“39. ... It is only until recently that I have started to think about having children and if that is ever a possibility, I have to live with the fact that I will not be able to breastfeed my children. I still do not believe that I have fully processed the surgical procedure that I had to remove my breasts and how major it really was. I made a brash decision as a teenager, (as a lot of teenagers do) trying to find confidence and happiness, except now the rest of my life will be negatively affected. I cannot reverse any of the physical, mental or legal changes that I went through. Transition was a very temporary, superficial fix for a very complex identity issue.”

84. The defendant submits the first claimant was given the fullest possible information after a large number of consultations (at least 10) and that she was *Gillick* competent to make the decision to take PBs. Further, the defendant produced witness statements from a number of children and young people who are strongly supportive of the treatment they have received.

85. J is a 20 year old transgender man who received PBs in 2012 at the age of 12 followed by CSH in 2015. He described how he felt a strong need to become a boy from an early age and how he was bullied at school for his behaviour. He found the onset of female puberty horrifying and unbearable. After a number of sessions at GIDS he was prescribed PBs from the age of 12.

86. According to J he was given the fullest possible information from the clinicians at GIDS as to the benefits and disbenefits of the treatment. The clinicians strongly challenged his desire to transition and why he had chosen to express his gender identity as male. He was advised as to the impact on fertility if he chose to go on to CSH and surgery. He said: *“I made the decision to proceed with pubertal suppression without pursuing egg preservation. It was a difficult decision to make because I did not know whether I would want biological children in adulthood, but I was certain I would never want to*

carry a child and give birth. Ultimately, I made the decision because I had a poor quality of life and without immediate treatment I did not feel I had a future at all.” He says: *“We discussed sex and I told them the idea of it disgusted me. I knew I would be unable to consider having a sexual relationship as an adult with my body so wrongly formed.”* He ended his witness statement by saying that he is thankful that his pubertal development was halted as it removed the distress caused by continued development, but he wishes that the PBs were started earlier which would have prevented the need for breast surgery later.

87. S is a 13 year old trans boy who is on the waiting list at GIDS. He was told that he would have to wait for approximately 24 months to be seen and with his parents decided to see a private provider, GenderGP, where he has been prescribed PBs. We note at this point that the GP in question was removed from the professional register and now operates from outside the United Kingdom. S in his witness statement said:

“13. ... I haven’t really thought about parenthood – I have been asked about it by the gender identity specialist I have mentioned but I just have no idea what me in the future is going to think. I haven’t had a romantic relationship and it’s just not a thing that is really on my radar at the moment.”

88. N, an 18 year old trans woman, who was prescribed PBs when she was 17 years old said:

“12. The treatment of hormone blockers may very well have saved my life. In the period of my life that I was prescribed them my mental health was spiralling due to my dysphoria and this impacting on my daily life, learning and social interactions. While the first injections of gonapeptyl were slow to take effect they eventually began to alleviate my dysphoria in very real ways. I had to shave less and I didn’t have to fear pubertal development anymore. I had the time necessary to think about my situation and decide on further courses of action. This also helped my mental health as it gave me significantly less issues overall allowing me to focus and concentrate on aspects in my life alongside my gender identity rather than my fears of puberty and development overtaking everything else in my life.”

89. The second claimant, Mrs A, is the mother of a 15 year old girl who has ASD. The daughter has a history of mental health and behavioural problems. She *“is desperate to run away from all that made her female”* and has been referred to CAMHS (Child and Adolescent Mental Health Services). Mrs A is very concerned that her daughter would be referred to GIDS and prescribed PBs. However the daughter has not currently been referred to GIDS and having regard to the defendant’s current practice, would not meet the criteria for PBs because her parents would not support that treatment. Mrs A’s interest in this action is therefore largely theoretical.

SECTION C: SUBMISSIONS

90. The claimants' primary case is that children or young persons under the age of 18 are not capable of giving consent to the administration of PBs. Their secondary case is that the information given by the defendant and the Interested Party is misleading and inadequate to form the basis for informed consent to be given. In their statement of issues, the claimants put issue one as the adequacy of the information and issue two whether children and young people are capable of giving consent. In our view, the first issue must be whether *Gillick* competence can be achieved, and the secondary or alternative issue, whether the information being given is adequate. We deal with the arguments in that order.
91. Mr Hyam also raised a third issue (at least in writing). This was a submission that if any young person under the age of 18 is prescribed PBs, their case should be referred to the Court of Protection. In oral argument he accepted that the Court of Protection, being a creature of statute, would have no jurisdiction to consider such referrals. We think that the substance of issue three falls within the terms of issue one.
92. Mr Hyam stressed that the claimants were not calling into question that GD existed. Nor were they questioning that it could cause extreme distress or that PBs should never be given to people under 18 or that it was never in their best interests for it to be prescribed. The central issue was whether those under 18 could give informed consent.
93. Mr Hyam submitted that a child still going through puberty is not capable of properly understanding the nature and effect of PBs and weighing the consequences and side effects properly. He pointed to the evidence of the individuals, including that put forward on behalf of the defendant, to show that children of this age cannot understand the implications of matters such as the loss of the ability to orgasm, the potential need to construct a neo-vagina, or the loss of fertility. He argued that the use of PBs to address GD does not have an adequate evidence base to support it and thus should properly be described as experimental treatment. There is evidence that PBs can have significant side effects and there is strong evidence that once a child commences on PBs they will progress to CSH which will cause irreversible changes to the child's body with lifelong medical, psychological and emotional implications for the child. He relies on the harm potentially caused to these vulnerable young people as evidenced by the witness statement of the first claimant.
94. He submitted that the advice given to the children and young persons is misleading because they are told that the PBs are fully reversible when the current evidence on reversibility or the long term implications of the treatment is limited and unclear. He said further, that the reality is that PBs pave the way for CSH which do have irreversible impacts. Further, the information provided by GIDS fails to tell the child that there are no proven benefits to this treatment in either physical or psychological terms. The information is misleading as to the reversibility of PBs, their purpose and their benefits.
95. In those circumstances he submitted that the court should be guided by the approach of the Court of Protection in its *Practice Guidance (Court of Protection: Serious Medical Treatment)* [2020] 1 WLR 641 which sets out those decisions relating to medical treatment where an application should be made to the Court of Protection.
96. Paras 10 and 11 of that Guidance state:

“10. In any case which is not about the provision of life-sustaining treatment, but involves the serious interference with the person’s rights under the ECHR, it is:

“highly probable that, in most, if not all, professionals faced with a decision whether to take that step will conclude that it is appropriate to apply to the court to facilitate a comprehensive analysis of [capacity and] best interests, with [the person] having the benefit of legal representation and independent expert advice.”

This will be so even where there is agreement between all those with an interest in the person’s welfare.

11. Examples of cases which may fall into paragraph 10 above will include, but are not limited to: (a) where a medical procedure or treatment is for the primary purpose of sterilisation; (b) where a medical procedure is proposed to be performed on a person who lacks capacity to consent to it, where the procedure is for the purpose of a donation of an organ, bone marrow, stem cells, tissue or bodily fluid to another person; (c) a procedure for the covert insertion of a contraceptive device or other means of contraception; (d) where it is proposed that an experimental or innovative treatment to be carried out; (e) a case involving a significant ethical question in an untested or controversial area of medicine.”

97. The defendant and the first and second Interveners make common cause. Ms Morris argued that the care and treatment provided at GIDS fell within the terms of the Service Specification laid down by NHS England (NHSE) as required in accordance with the international frameworks of WPATH and the Endocrine Society and by the domestic regulatory frameworks of the General Medical Council and the Care Quality Commission. The NHSE is currently undertaking a review of the efficacy of treatment for GD (the Cass Review) which will report in due course, and its findings will be reflected in the Service Specification.
98. She argued that the process at GIDS was “deeply *Montgomery* compliant” (i.e. it met the requirements for informed consent identified by the Supreme Court in *Montgomery v Lanarkshire Health Board* [2015] AC 1430) having regard to the frequent consultations, discussions and the provision of detailed, but age appropriate, information. The “vast majority” of the children referred for PBs are 15 or older she said, and the information given is varied depending on the age and maturity of the child or young person. Where the assessment is that the individual is not initially *Gillick* competent, time is taken to see if their understanding develops and competency can be achieved. The information that is given is what is salient for that individual at that age.
99. As to those between the ages of 16-18, if the young person, the parents and the clinicians are agreed then she submitted there is no justiciable issue and the court has no jurisdiction.
100. Mr McKendrick for the first and second Interveners argued that the child or young person did not need to understand the impact of CSH on their fertility because that did

not fall to be decided at the stage of prescribing PBs. The PBs provided the space for the person to think about further stages. In appropriate cases, a natal girl or young person's eggs could be harvested and preserved in order to preserve their fertility. The critical thing for the child was that s/he had GD and that there was no alternative physical treatment to PBs. Once the child or young person had reached the Endocrine Clinic at the Trust, there was no alternative psychological treatment available because that was a matter within the purview of GIDS and GIDS had referred the child for PBs, although ongoing psychological treatment is provided at GIDS alongside treatment with PBs. Therefore, the Trust clinicians were faced with a child in acute distress with no alternative treatment options. The purpose of the treatment was to alleviate distress and that, according to Mr McKendrick, had been achieved.

101. When asked by the court what evidence there was that the PBs did achieve the purpose of alleviating distress, in the light of the lack of published research, Mr McKendrick pointed to the evidence of experienced endocrinologists in both Trusts who could see the real benefits of the treatment.
102. Like Ms Morris, Mr McKendrick said the current practice was not to proceed only on parental consent. However, he did argue that if the child's consent was rendered invalid, the treatment would continue to be lawful if the parents had consented.
103. The third Intervener is Transgender Trend Ltd., an organisation that provides evidence-based information and resources for parents and schools concerning children with GD. Ms Davies-Arai is the director of that organisation and she has filed a witness statement in these proceedings. She set out concerns about the lack of evidence as to the impacts and effectiveness of PBs and in relation to which patients it is most likely to help. Much of her evidence focused on the increase of referrals to GIDS of teenage natal girls and the cultural factors, including material on the internet and social media, which may play a part in this. She said that GIDS does not offer young people with GD a range of ways to interpret their experience, and the GIDS pathway offers a minimal challenge to the beliefs and ideas of the young person.
104. Mr Skinner on behalf of Transgender Trend said the case was particularly important because it concerned the deliberate provision by the State of medical treatment to children and young people which may cause harm. The court should be anxious to ensure that vulnerable children, for example those with ASD, are provided with the full protection of the law.

SECTION D: THE LAW

105. In *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112, the House of Lords considered the lawfulness of the Secretary of State's policy on giving contraceptive advice to children without parental consent. The House of Lords held by a majority that a doctor could lawfully give contraceptive advice and treatment to a girl aged under 16 if she had sufficient maturity and intelligence to understand that nature and implications of the proposed treatment and provided that certain conditions were satisfied.
106. Lord Fraser at p. 169B-E said:

“It seems to me verging on the absurd to suggest that a girl or boy aged 15 could not effectively consent, for example, to have a medical examination of some trivial injury to his body or even to have a broken arm set. Of course the consent of the parents should normally be asked, but they may not be immediately available. Provided the patient, whether the boy or a girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises. After all, a minor under the age of 16 can, with certain limits, enter into a contract. He or she can also sue and be sued, and can give evidence on oath.”

Accordingly, I am not disposed to hold now, for the first time, that a girl less than 16 lacks the power to give valid consent to contraceptive advice or treatment, merely on account of her age.”

107. Lord Scarman at p. 186A-D said:

“The law relating to parent and child is concerned with the problems of the growth and maturity of the human personality. If the law should impose upon the process of “growing up” fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change. If certainty be thought desirable, it is better that the rigid demarcations necessary to achieve it should be laid down by legislation after a full consideration of all the relevant factors than by the courts confined as they are by the forensic process to the evidenced adduced by the parties and to whatever may properly fall within the judicial notice of judges. Unless and until Parliament should think fit to intervene, the courts should establish a principle flexible enough to enable justice to be achieved by its application to the particular circumstances proved by the evidence placed before them.”

And at p.189C-E:

“When applying these conclusions to contraceptive advice and treatment it has to be borne in mind there is much that has to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors

before he can safely proceed upon the basis that she has at law capacity to consent to contraceptive treatment. And it further follows that ordinarily the proper course will be for him, as the guidance lays down, first to seek to persuade the girl to bring her parents into consultation and, if she refuses, not to prescribe contraceptive treatment unless he is satisfied that her circumstances are such that he ought to proceed without parental knowledge and consent.”

And p. 191C-D:

“The truth may well be that the rights of parents and children in this sensitive area are better protected by the professional standards of the medical profession than by “a priori” legal lines of division between capacity and the lack of capacity to consent since any such general dividing line is sure to produce in some cases injustice, hardship, and injury to health.”

108. In *R (Axon) v Secretary of State for Health (Family Planning Association Intervening)* [2006] QB 539 Silber J considered *Gillick* in the context of Article 8 of the Convention, the United Nations Convention on the Rights of the Child (UNCRC) and the increasing emphasis on the autonomy of the child. He held that the principles set out in *Gillick* continued to apply, see para 152.
109. There are two cases dealing with children aged 16 or over who refused medical treatment in circumstances where clinicians considered it was clinically indicated. The issue in each was whether the court could nevertheless, authorise the treatment. *Re W (a Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam. 64, concerned the case of a 16 year old girl with anorexia nervosa. The local authority applied under the inherent jurisdiction of the High Court to give medical treatment to W without her consent and against her wishes. W relied on section 8 of the Family Law Reform Act 1969, which states:

“Section 8 is in these terms:

- (1) The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian. (2) In this section ‘surgical, medical or dental treatment’ includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure which is ancillary to any treatment as it applies to that treatment. (3) Nothing in this section shall be construed

as making ineffective any consent which would have been effective if this section had not been enacted.”

110. The Court of Appeal held that section 8 did not confer on a minor an absolute right to determine whether or not she received medical treatment but protected the medical practitioner from an action in trespass. Lord Donaldson analysed *Gillick* and said that Lord Scarman would necessarily have considered that the purpose of section 8 was to provide the medical practitioners treating the child with a defence to either criminal assault or a civil claim for trespass, see pages 76G-H and 78D-F. Lord Donaldson described the effect of the section as being a “*legal flak jacket*”, whereby the 16-17 year old is conclusively proved to be *Gillick* competent but this did not mean that someone else who has parental responsibility cannot give consent for the treatment.
111. When applying his analysis to the facts of W’s case, Lord Donaldson said at p. 80G-81B:

“I have no doubt that the wishes of a 16 or 17-year-old child or indeed of a younger child who is “*Gillick* competent” are of the greatest importance both legally and clinically, but I do doubt whether Thorpe J was right to conclude that W was of sufficient understanding to make an informed decision. I do not say this on the basis that I consider her approach irrational. I personally consider that religious or other beliefs which bar any medical treatment or treatment of particular kinds are irrational, but that does not make minors who hold those beliefs any the less “*Gillick* competent”. They may well have sufficient intelligence and understanding fully to appreciate the treatment proposed and the consequences of their refusal to accept that treatment. What distinguishes W from them, and what with all respect I do not think that Thorpe J took sufficiently into account (perhaps because the point did not emerge as clearly before him as it did before us), is that it is a feature of anorexia nervosa that it is capable of destroying the ability to make an informed choice. It creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective. This attitude is part and parcel of the disease and the more advanced the illness, the more compelling it may become. Where the wishes of the minor are themselves something which the doctors reasonably consider need to be treated in the minor’s own best interests, those wishes clearly have a much reduced significance.”

112. Lord Donaldson concluded at p. 84A-B that:

“No minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the courts in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor.”

113. Balcombe LJ at p. 87G-H agreed with Lord Donaldson that the parents of a 16 and 17 year old retained the right to consent to treatment even if she did not consent, and that the court could continue to exercise its inherent jurisdiction. Nolan LJ did not express a view as to whether parents could consent to treatment where the child had refused, but considered that the court under its inherent jurisdiction could continue to do so. He said, at p. 94D-E:

“To take it a stage further, if the child’s welfare is threatened by a serious or imminent risk that the child will suffer grave and irreversible mental or physical harm, then once again the court when called upon has a duty to intervene. It makes no difference whether the risk arises from the action or inaction of others, or from the action or inaction of the child. Due weight must be given to the child’s wishes, but the court is not bound by them. In the present case, Thorpe J was apparently satisfied on the evidence before him that such a risk existed. In my judgment, he was fully entitled to take this view. By the time the matter came to this court, it was impossible to take any other view. For these reasons, I would dismiss the appeal save to the extent of making the necessary variation of the order of Thorpe J.”

114. We were taken to two cases concerning the application of *Gillick* in particularly difficult medical and ethical situations, which are of some assistance in the present case. In *Re L (Medical Treatment: Gillick Competency)* [1998] 2 F.L.R. 810 Sir Stephen Brown P. considered the case of a 14 year old girl with a life threatening condition involving the possibility of a blood transfusion. L was a Jehovah’s Witness and would not consent to the blood transfusion. The court ordered that the medical treatment should take place without her consent. The expert clinician appointed by the Official Solicitor is recorded as giving the following evidence:

“He makes the point that the girl’s view as to having no blood transfusion is based on a very sincerely, strongly held religious belief which does not in fact lend itself in her mind to discussion. It is one that has been formed by her in the context of her own family experience and the Jehovah’s Witness meetings where they all support this view. He makes the point that there is a distinction between a view of this kind and the constructive formulation of an opinion which occurs with adult experience. That has not happened of course in the case of this young girl.”

115. Sir Stephen Brown then concluded at p. 813:

“It is, therefore, a limited experience of life which she has – inevitably so – but this is in no sense a criticism of her or of her upbringing. It is indeed refreshing to hear of children being brought up with the sensible disciplines of a well-conducted family. But it does necessarily limit her understanding of matters which are as grave as her own present situation. It may be that because of her belief she is willing to say, and to mean it, ‘I am willing to accept death rather than to have a blood transfusion’, but it is quite clear in this case that she has not been able to be given all the

details which it would be right and appropriate to have in mind when making such a decision.

I do not think that in this case this young girl is ‘Gillick competent’. I base that upon all the evidence that I have heard. She is certainly not ‘Gillick competent’ in the context of all the necessary details which it would be appropriate for her to be able to form a view about.”

116. *Re S (A Child) (Child Parent: Adoption Consent)* [2019] 2 Fam 177 also concerned a child under 16. In that case Cobb J considered the competence of a mother under the age of 16 to consent to her baby being placed for adoption. Cobb J held that it was appropriate and helpful in determining *Gillick* competence to read across and borrow from the relevant concepts and language in the Mental Capacity Act 2005 but cognisant of some fundamental differences, in particular that the assumption of capacity in section 1(2) of that Act did not apply and there was no requirement for any diagnostic characteristic as there is in section 2(1) of the Mental Capacity Act 2005, see paras 15,16 and 60.
117. At paras 34 to 37 Cobb J considered what test he should apply to the information that S needed to understand and then set out the information that would be relevant for the decision in question:

“34. Macur J in *LBL v RYJ and VJ* [2011] 1 FLR 1279, para 24 held that it would not be necessary for a decision-maker to be able to comprehend “all the peripheral detail” in the assessment of capacity to make the relevant decision; in a case concerning residence and the provision of education, Macur J went on to say, at para 58:

“In [the expert’s] view it is unnecessary for his determination of RYJ’s capacity that she should understand all the details within the statement of special educational needs. It is unnecessary that she should be able to give weight to every consideration that would otherwise be utilised in formulating a decision objectively in her ‘best interests’. I agree with his interpretation of the test in section 3 which is to the effect that the person under review must comprehend and weigh the salient details relevant to the decision to be made. To hold otherwise would place greater demands upon RYJ than others of her chronological age/commensurate maturity and unchallenged capacity.”

35. In the same vein, Baker J remarked in *H v A Local Authority* [2011] EWHC 1704 at [16(xi)]: “[the] courts must guard against imposing too high a test of capacity to decide issues such as residence because to do so would run the risk of discriminating against persons suffering from a mental disability.”

36. Although not cited in argument, I further remind myself of the comments of Chadwick LJ in the Court of Appeal in *Masterman-Lister v Brutton & Co (Nos 1 and 2)* [2003] 1 WLR 1511, para 79: “a person should not be held unable to understand the information relevant to a

decision if he can understand the explanation of that information in broad terms and simple language...” So, says Ms Dolan, it is not necessary for S to understand all the peripheral and non-salient information in the adoption consent form in order to be declared capacitous. Nor does she even need to fully understand the legal distinctions between placement for adoption under a placement order and not under a placement order. Indeed, Ms Dolan herself relies in this regard on *In re A (Adoption: Agreement: Procedure)* [2001] 2 FLR 455, para 43 where Thorpe LJ observes that the differences between freeing and adoption are “complex in their inter-relationship and it is not to be expected that social workers should have a complete grasp of the distinction between the two, or always to signify the distinction in their discussion with the clients” (my emphasis).” If social workers are not expected to understand the complexities of the legislation (or its predecessor) or explain the distinction accurately to the parents with whom they are working asks Ms Dolan, why should a person under the age of 16 be expected to be able to grasp them in order to be able to be declared capacitous?

37. Accordingly, argues the local authority, the salient or “sufficient” information which is required to be understood by the child parent regarding extra-familial adoption is limited to the fundamental legal consequences of the same. The factors discussed at the hearing include: (i) your child will have new legal parents, and will no longer be your son or daughter in law, (ii) adoption is final, and non-reversible; (iii) during the process, other people (including social workers from the adoption agency) will be making decisions for the child, including who can see the child, and with whom the child will live; (iv) you may obtain legal advice if you wish before taking the decision; (v) the child will live with a different family forever; you will (probably) not be able to choose the adopters; (vi) you will have no right to see your child or have contact with your child; it is highly likely that direct contact with your child will cease, and any indirect contact will be limited; (vii) the child may later trace you, but contact will only be re-established if the child wants this; (viii) there are generally two stages to adoption; the child being placed with another family for adoption, and being formally adopted; (ix) for a limited period of time you may change your mind; once placed for adoption, your right to change your mind is limited, and is lost when an adoption order is made.”

118. Cobb J’s conclusions were these:

“60... It follows that in order to satisfy the Gillick test in this context the child parent should be able to demonstrate “sufficient” understanding of the “salient” facts around adoption; she should understand the essential “nature and quality of the transaction” (per Munby J in *Sheffield City Council v E* [2005] Fam 326, para 19) and should not need to be concerned with the peripheral.

61. It will, however, be necessary for the competent child decision-maker to demonstrate a “full understanding” of the essential implications of adoption when exercising her decision-making, for the independent CAFCASS officer to be satisfied that the consent is valid. If consent is offered under section 19 and/or section 20 of the 2002 Act, it will be necessary for a form to be signed, even if not in the precise format of that identified by Practice Direction 5A. I accept that on an issue as significant and life-changing as adoption, there is a greater onus on ensuring that the child understands and is able to weigh the information than if the decision was of a lesser magnitude: see Baker J in *CC v KK and STCC* [2012] COPLR 627, para 69. This view is consistent with the Mental Capacity Act 2005 Code of Practice, which provides, at paragraph 4.19:

“a person might need more detailed information or access to advice, depending on the decision that needs to be made. If a decision could have serious or grave consequences, it is even more important that a person understands the information relevant to that decision.”

119. In determining the level of understanding that the child needs to have to consent to PBs, Mr Hyam attached considerable importance to the decision of the Supreme Court in *Montgomery v Lancashire Health Board*. That case concerned an action in negligence brought by a mother on behalf of her child. The child was disabled as a result of complications during delivery and the mother argued that she should have been advised as to the possibility of delivery by elective caesarean. The central issue for present purposes was the information that the doctor needed to have given the patient in order to establish that she had given informed consent for the treatment.

120. Lord Kerr set out the requirements placed on a doctor in providing information on risks of injury from treatment in the following terms at para 87:

“An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.”

121. Mr Hyam submitted that in determining whether a child is *Gillick* competent the court should consider what would a “reasonable person in the patient’s position understand”, and in asking that question, he submitted that the “reasonable person” is one with adult knowledge.

122. Ms Morris went to the opposite extreme. She submitted that when deciding what information needs to be given to the patient and understood by them, the test is a reasonable person in that individual’s position, i.e. a reasonable 12 year old (or other

age) with GD. She said that the “salient” information that needs to be provided is what that reasonable patient would attach importance to. She said that seeking consent, certainly for treatment with lifelong implications such as sterilisation will always involve some “*act of imagination*”. Many patients facing life changing treatment, such as the loss of fertility in cancer treatment or endometriosis, will not have had experience of what they are foregoing, for example, fertility. She submitted that the court ought not to be pronouncing on hypothetical cases: rather, it should or could consider the facts of one specific case as and when it arises.

123. Mr McKendrick submitted that the correct approach in deciding what information was material was to assume a reasonable child of the individual’s age.
124. Mr Skinner pointed out that *Montgomery* concerned an adult and therefore the presumption of capacity in the Mental Capacity Act 2005 applied. That presumption is inapplicable in a case concerning *Gillick* competency where the very issue is whether the child is competent to make the decision. The decision in *Montgomery* was of limited assistance, therefore, in the present case. In determining competence, the child must have sufficient understanding of the factors that are not just relevant to him or her now but which on an objective basis ought to be given weight in the future.
125. In our view, the following principles can be derived from the cases to which we have referred:
126. First, the question as to whether a person under the age of 16 is *Gillick* competent to make the relevant decision will depend on the nature of the treatment proposed as well as that person’s individual characteristics. The assessment is necessarily an individual one. Where the decision is significant and life changing then there is a greater onus to ensure that the child understands and is able to weigh the information, see *Re S* at para 60.
127. Secondly, however, that does not mean that it is not possible for the court to draw some lines. The Trusts themselves accept that a 7 year old being treated with PBs for precocious puberty cannot give informed consent and his or her parents must give that consent because of the young age of the child concerned and the nature of the treatment.
128. Thirdly, efforts should be made to allow the child or young person to achieve *Gillick* competency where that is possible. Clinicians should therefore work with the individual to help them understand the treatment proposed and its potential implications in order to help them achieve competence.
129. Fourthly, however, that does not mean that every individual under 16 can achieve *Gillick* competence in relation to the treatment proposed. As we discuss below, where the consequences of the treatment are profound, the benefits unclear and the long-term consequences to a material degree unknown, it may be that *Gillick* competence cannot be achieved, however much information and supportive discussion is undertaken.
130. Fifthly, in order to achieve *Gillick* competence it is important not to set the bar too high. It is not appropriate to equate the matters that a clinician needs to explain, as set out in *Montgomery*, to the matters that a child needs to understand to achieve *Gillick* competence. The consequence of Mr Hyam’s approach would be significantly to raise

the bar for competence and capacity, which would be contrary both to the common law and to a child's Article 8 rights and the importance of supporting individual autonomy.

131. We adopt the language of Chadwick LJ in *Masterman-Lister v Brutton and Co (Nos 1 and 2)* [2003] 1 WLR 151: a person should be able to “*understand an explanation of that information in broad terms and simple language*”, see *Re S* at para 36. Although this was said in a case that concerned an adult's capacity, in our judgment the same approach should be applied to a case concerning *Gillick* competence. The child or young person needs to be able to demonstrate sufficient understanding of the salient facts, see *Re S* at para 60.
132. Sixthly, we agree with Mr Skinner, that in deciding what facts are salient and what level of understanding is sufficient, it is necessary to have regard to matters which are those which objectively ought to be given weight in the future although the child might be unconcerned about them now. On the facts of this case there are some obvious examples, including the impact on fertility and on future sexual functioning.

SECTION E: CONCLUSIONS

133. The principal issue before this court is in some ways a narrow one. Can a child or young person under the age of 16 achieve *Gillick* competence in respect of the decision to take PBs for GD? The legal position of 16 and 17 year olds is different, and we deal with that below.
134. The starting point is to consider the nature of the treatment proposed. The administration of PBs to people going through puberty is a very unusual treatment for the following reasons. Firstly, there is real uncertainty over the short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it is seeking to achieve. This means it is, in our view, properly described as experimental treatment. Secondly, there is a lack of clarity over the purpose of the treatment: in particular, whether it provides a “pause to think” in a “hormone neutral” state or is a treatment to limit the effects of puberty, and thus the need for greater surgical and chemical intervention later, as referred to in the Health Research Authority report. Thirdly, the consequences of the treatment are highly complex and potentially lifelong and life changing in the most fundamental way imaginable. The treatment goes to the heart of an individual's identity, and is thus, quite possibly, unique as a medical treatment.
135. Furthermore, the nature and the purpose of the medical intervention must be considered. The condition being treated, GD, has no direct physical manifestation. In contrast, the treatment provided for that condition has direct physical consequences, as the medication is intended to and does prevent the physical changes that would otherwise occur within the body, in particular by stopping the biological and physical development that would otherwise take place at that age. There is also an issue as to whether GD is properly categorised as a psychological condition, as the DSM-5 appears to do, although we recognise there are those who would not wish to see the condition categorised in that way. Be that as it may, in our judgment for the reasons already identified, the clinical intervention we are concerned with here is different in kind to other treatments or clinical interventions. In other cases, medical treatment is used to remedy, or alleviate the symptoms of, a diagnosed physical or mental condition, and

the effects of that treatment are direct and usually apparent. The position in relation to puberty blockers would not seem to reflect that description.

136. Indeed the consequences which flow from taking PBs for GD and which must be considered in the context of informed consent, fall into two (interlinking) categories. Those that are a direct result of taking the PBs themselves, and those that follow on from progression to Stage 2, that is taking cross-sex hormones. The defendant and the Trusts argue that Stage 1 and 2 are entirely separate; a child can stop taking PBs at any time and that Stage 1 is fully reversible. It is said therefore the child needs only to understand the implications of taking PBs alone to be *Gillick* competent. In our view this does not reflect the reality. The evidence shows that the vast majority of children who take PBs move on to take cross-sex hormones, that Stages 1 and 2 are two stages of one clinical pathway and once on that pathway it is extremely rare for a child to get off it.
137. The defendant argues that PBs give the child “time to think”, that is, to decide whether or not to proceed to cross-sex hormones or to revert to development in the natal sex. But the use of puberty blockers is not itself a neutral process by which time stands still for the child on PBs, whether physically or psychologically. PBs prevent the child going through puberty in the normal biological process. As a minimum it seems to us that this means that the child is not undergoing the physical and consequential psychological changes which would contribute to the understanding of a person’s identity. There is an argument that for some children at least, this may confirm the child’s chosen gender identity at the time they begin the use of puberty blockers and to that extent, confirm their GD and increase the likelihood of some children moving on to cross-sex hormones. Indeed, the statistical correlation between the use of puberty blockers and cross-sex hormones supports the case that it is appropriate to view PBs as a stepping stone to cross-sex hormones.
138. It follows that to achieve *Gillick* competence the child or young person would have to understand not simply the implications of taking PBs but those of progressing to cross-sex hormones. The relevant information therefore that a child would have to understand, retain and weigh up in order to have the requisite competence in relation to PBs, would be as follows: (i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of patients taking PBs go on to CSH and therefore that s/he is on a pathway to much greater medical interventions; (iii) the relationship between taking CSH and subsequent surgery, with the implications of such surgery; (iv) the fact that CSH may well lead to a loss of fertility; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking PBs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain.
139. It will obviously be difficult for a child under 16 to understand and weigh up such information. Although a child may understand the concept of the loss of fertility for example, this is not the same as understanding how this will affect their adult life. A child’s attitude to having biological children and their understanding of what this really means, is likely to change between childhood and adulthood. For many children, certainly younger children, and some as young as 10 and just entering puberty, it will not be possible to conceptualise what not being able to give birth to children (or conceive children with their own sperm) would mean in adult life. Similarly, the

meaning of sexual fulfilment, and what the implications of treatment may be for this in the future, will be impossible for many children to comprehend.

140. Ms Morris submitted that many decisions about complex and long-lasting medical treatment will involve the patient having, to some degree, to imagine themselves into an uncertain future of which they have no experience. However, for the reasons that we have explained in para 135 above we consider the treatment in this case to be in entirely different territory from the type of medical treatment which is normally being considered.
141. Some of the children and young people who have been treated at GIDS say in their witness statements that the thought of sex disgusted them, or they did not really think about fertility. These normal reactions do not detract from the difficulties surrounding consent and treatment with PBs. That adolescents find it difficult to contemplate or comprehend what their life will be like as adults and that they do not always consider the longer-term consequences of their actions is perhaps a statement of the obvious.
142. These various difficulties are compounded by the particular difficulties prevalent in the cohort of children treated at GIDS. On the defendant's case, they suffer considerable psychological distress by reason of their GD and are highly vulnerable. In those circumstances, the consequences of taking PBs on their fertility for example, or on their sexual life, may be viewed as a relatively small price to pay for what may be perceived as a solution to their immediate and real psychological distress. It would not follow however that their weighing of risks and benefits when they might start taking PBs would prevail in the longer-term.
143. The difficulty of achieving informed consent in these circumstances is further exacerbated by the lack of evidence as to the efficacy of PBs in treating GD and the long-term outcomes of taking it. We entirely accept that the fact that a treatment is experimental, or that the long-term outcomes are not yet known, does not of itself prevent informed consent being given. Otherwise no experimental treatment could ever be consented to. However, the combination here of lifelong and life changing treatment being given to children, with very limited knowledge of the degree to which it will or will not benefit them, is one that gives significant grounds for concern.
144. We do not think that the answer to this case is simply to give the child more, and more detailed, information. The issue in our view is that in many cases, however much information the child is given as to long-term consequences, s/he will not be able to weigh up the implications of the treatment to a sufficient degree. There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years.
145. *Gillick* makes clear that any decision is treatment and person specific. However, for the reasons that we have set out above, we think that it is appropriate in this case to give clear guidance as to the application of the *Gillick* tests to the treatment and cohort of children in question. The conclusion we have reached is that it is highly unlikely that a child aged 13 or under would ever be *Gillick* competent to give consent to being treated with PBs. In respect of children aged 14 and 15, we are also very doubtful that a child of this age could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent. However, plainly the

increased maturity of the child means that there is more possibility of achieving competence at the older age.

146. In respect of a young person aged 16 or over, the legal position is different. There is a presumption of capacity under section 8 of the Family Law Reform Act 1969. As is explained in *Re W*, that does not mean that a court cannot protect the child under its inherent jurisdiction if it considers the treatment not to be in the child's best interests. However, so long as the young person has mental capacity and the clinicians consider the treatment is in his/her best interests, then absent a possible dispute with the parents, the court generally has no role. We do not consider that the court can somehow adopt an intrusive jurisdiction in relation to one form of clinical intervention for which no clear legal basis has been established.
147. We do however recognise that in the light of the evidence that has emerged, and the terms of this judgment, clinicians may well consider that it is not appropriate to move to treatment, such as PBs or CSH, without the involvement of the court. We consider that it would be appropriate for clinicians to involve the court in any case where there may be any doubt as to whether the long-term best interests of a 16 or 17 year old would be served by the clinical interventions at issue in this case.
148. We express that view for these reasons. First, the clinical interventions involve significant, long-term and, in part, potentially irreversible long-term physical, and psychological consequences for young persons. The treatment involved is truly life changing, going as it does to the very heart of an individual's identity. Secondly, at present, it is right to call the treatment experimental or innovative in the sense that there are currently limited studies/evidence of the efficacy or long-term effects of the treatment.
149. The position of the defendant and the Trusts is that they consider it would be an intrusion into the child or young person's autonomy if a decision about treatment with PBs were to be made by the court not by the patient. They are concerned about the use of NHS and court resources if these decisions have to be made by the court. We do not consider that this is the correct approach. In principle, a young person's autonomy should be protected and supported; however, it is the role of the court to protect children, and particularly a vulnerable child's best interests. The decisions in respect of PBs have lifelong and life-changing consequences for the children. Apart perhaps from life-saving treatment, there will be no more profound medical decisions for children than whether to start on this treatment pathway. In those circumstances we consider that it is appropriate that the court should determine whether it is in the child's best interests to take PBs. There is a real benefit in the court, almost certainly with a child's guardian appointed, having oversight over the decision. In any case, under the inherent jurisdiction concerning medical treatment for those under the age of 18, there is likely to be a conflict between the support of autonomy and the protective role of the court. As we have explained above, we consider this treatment to be one where the protective role of the court is appropriate.
150. The claimants' alternative ground is that the information provided by the defendant and the Trusts is inadequate to form the basis of informed consent. We accept that the defendant and the Trusts have in their written information, to children, young people and their parents and carers, tried hard to explain the potential consequences of PBs, including that of moving on to CSH, and to give full information. They have also

attempted to do this in an age appropriate manner. The problem is not the information given, but the ability of the children and young people, to understand and most importantly weigh up that information. The approach of the defendant appears to have been to work on the assumption that if they give enough information and discuss it sufficiently often with the children, they will be able to achieve *Gillick* competency. As we have explained above, we do not think that this assumption is correct.

OVERALL CONCLUSION

151. A child under 16 may only consent to the use of medication intended to suppress puberty where he or she is competent to understand the nature of the treatment. That includes an understanding of the immediate and long-term consequences of the treatment, the limited evidence available as to its efficacy or purpose, the fact that the vast majority of patients proceed to the use of cross-sex hormones, and its potential life changing consequences for a child. There will be enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication. It is highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers. It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences of the administration of puberty blockers.
152. In respect of young persons aged 16 and over, the legal position is that there is a presumption that they have the ability to consent to medical treatment. Given the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment.
153. We have granted a declaration to reflect the terms of this judgment.

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Attorneys for Defendant

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
Hennessy-Waller; and John Doe, by and
through his guardian and next friend, Susan
Doe, on behalf of themselves and all others
similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona Health
Care Cost Containment System, in her
official capacity,

Defendant.

Case No. 4:20-cv-00335-SHR

**DEFENDANT'S NOTICE OF
SUPPLEMENTAL AUTHORITY**

(Assigned to the Honorable Scott H.
Rash)

Defendant Jami Snyder ("Defendant") hereby provides this Notice of Supplemental Authority to the Court. Defendant is now providing the attached opinion to the Court because it was issued after the conclusion of briefing on Plaintiffs' Motion for Preliminary Injunction. *See* Exhibit 1, *Bell v. Tavistock*, Case No: CO/60/2020, Royal Courts of Justice (Dec. 1, 2020). Although the *Bell v. Tavistock* decision is not controlling, it is persuasive with respect to the issues the Court will be reviewing and evaluating during

1 oral argument on Plaintiffs' Motion for Preliminary Injunction scheduled for tomorrow,
2 February 5, 2021.

3
4 RESPECTFULLY SUBMITTED this 4th day of February, 2021.

5
6 **BURNSBARTON PLC**

7
8 By /s/ Kathryn Hackett King

9 David T. Barton
10 Kathryn Hackett King

11 **JOHNSTON LAW OFFICES, P.L.C.**
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CERTIFICATE OF SERVICE

I hereby certify that on February 4, 2021, I electronically transmitted the foregoing document to the following CM/ECF registrants.

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Attorneys for Plaintiffs and the Class

s/ Carolyn Galbreath

EXHIBIT A

From: Kate King kate@burnsbarton.com
Subject: Re: Motion for Leave to File a Supplemental Declaration
Date: November 20, 2020 at 10:34 AM
To: Asaf Orr AOr@nclrights.org
Cc: Logan Johnston ljohnston@live.com, David T Barton david@burnsbarton.com, Ray, Brent bray@kslaw.com, Chinsky, Andrew achinsky@kslaw.com, Catherine McKee mckee@healthlaw.org, Abbi Coursolle coursolle@healthlaw.org, Chris Stoll CStoll@nclrights.org, Barr, Daniel (Perkins Coie) DBarr@perkinscoie.com, Howe, Janet M. (Perkins Coie) JHowe@perkinscoie.com



Hi Asaf, Because plaintiffs have refused our reasonable requests, we will not consent to the filing of the supplemental declaration and will move to have it stricken. We will also let the Court know about our reasonable offer of a compromise that has been rejected.

Kathryn Hackett King
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2201 E. Camelback Road
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BurnsBarton

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On Nov 20, 2020, at 9:09 AM, Asaf Orr <AOr@nclrights.org> wrote:

Hi Kate,

Thanks for your response. The only assurance I can provide is that we will produce records that are responsive to your request and will only withhold documents for which we have a good-faith basis for doing so.

We intend to file the motion for leave to file the supplemental declaration by 4p MT on Friday, November 20, 2020. We will indicate that we do not object your client filing a response to the declaration. Please let us know by 3p MT on Friday, November 20, 2020, whether your client will consent to the filing.

Very truly yours,

Asaf

From: Kate King <kate@burnsbarton.com>

Sent: Thursday, November 19, 2020 12:08 PM

To: Asaf Orr <AOr@nclrights.org>

Cc: Logan Johnston <ljohnston@live.com>; David T Barton <david@burnsbarton.com>; Ray, Brent <bray@kslaw.com>; Chinsky, Andrew <achinsky@kslaw.com>; Catherine McKee <mckee@healthlaw.org>; Abbi Coursolle <coursolle@healthlaw.org>; Chris Stoll <CStoll@nclrights.org>; Barr, Daniel (Perkins Coie) <DBarr@perkinscoie.com>; Howe, Janet M. (Perkins Coie) <JHowe@perkinscoie.com>

Subject: Re: Motion for Leave to File a Supplemental Declaration

Importance: High

importance: high

Hello Asaf,

We will send you a formal request for production and consent to the filing of your supplemental declaration but we need your assurance that 1) you will provide the records, not just objections; and 2) you will produce the records at the same time you file your supplement so we can use them in our response.

Kate

Kathryn Hackett King
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received this email in error, please immediately notify the sender and delete
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On Nov 18, 2020, at 7:52 PM, Asaf Orr <AOr@nclrights.org> wrote:

Hi Kate,

Thanks for your response. Our clients would not oppose the Defendant responding to the supplemental declaration by Dr. Cronyn. With regards to the medical records, we ask that you formally request those in a request for production. That will ensure a clean record of the discovery in this matter and allow all parties to reserve their rights as they feel appropriate.

In light of our response on those two conditions, please let us know whether your client would consent to the filing of our motion.

Very truly yours,
Asaf

From: Kate King <kate@burnsbarton.com>

Sent: Tuesday, November 17, 2020 9:48 AM

To: Asaf Orr <AOr@nclrights.org>

Cc: Logan Johnston <ljohnston@live.com>; David T Barton <david@burnsbarton.com>; Ray, Brent <bray@kslaw.com>; Chinsky, Andrew <achinsky@kslaw.com>; Catherine McKee <mckee@healthlaw.org>; Abbi Coursolle <coursolle@healthlaw.org>; Chris Stoll <CStoll@nclrights.org>; Barr.

Daniel (Perkins Coie) <DBarr@perkinscoie.com>; Howe, Janet M. (Perkins Coie) <JHowe@perkinscoie.com>

Subject: Re: Motion for Leave to File a Supplemental Declaration

Importance: High

Hello Asaf, We will not oppose the filing of a supplemental declaration by Dr. Andrew Cronyn, on the condition that (1) defendant has the opportunity to respond to the supplemental declaration, and (2) we receive all of D.H.'s medical records that address this new development, along with all of the medical/healthcare records for D.H. and John Doe, which counsel for plaintiffs agreed to provide to defendant during our Oct. 29 phone call. Please let me know if you have any questions or wish to discuss this further over the telephone.

Thank you,
Kate

Kathryn Hackett King
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<image001.png>

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On Nov 16, 2020, at 9:17 PM, Asaf Orr <AOr@nclrights.org> wrote:

Hi Kate,
There has been a significant change in D.H.'s health since we filed our reply brief on the motion for preliminary injunction in October. We intend to seek leave to file a supplemental declaration from Dr. Andrew Cronyn discussing this change. I write to obtain your client's position on that motion. Please let me know so that we can correctly represent that position in our motion.
We hope this e-mail finds you well and look forward to hearing from you.
Very truly yours,
Asaf

Asaf Orr, Esq. | Senior Staff Attorney & Transgender Youth Project
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(Pronouns: He, him)
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**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
Hennessy-Waller; and John Doe, by and
through his guardian and next friend, Susan
Doe, on behalf of themselves and all others
similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona Health
Care Cost Containment System, in her
official capacity,

Defendant.

Case No. 4:20-cv-00335-SHR

**DEFENDANT'S RESPONSE TO
SUPPLEMENTAL DECLARATION
OF ANDREW CRONYN, MD, IN
SUPPORT OF D.H. AND JOHN
DOE'S MOTION FOR
PRELIMINARY INJUNCTION**

(Assigned to the Honorable Scott H.
Rash)

Defendant Jami Snyder ("Defendant") submits this Response to the Supplemental Declaration of Andrew Cronyn, MD in Support of D.H. and John Doe's Motion for Preliminary Injunction ("Supplemental Declaration"). (Doc. 32) As explained in detail below, the Supplemental Declaration does not support Plaintiffs' request for injunctive relief.

1 As an initial matter, Defendant noted in her Opposition to Plaintiffs’ Motion for
2 Preliminary Injunction that Plaintiffs refused to disclose to Defendant any of their relevant
3 medical records. (Doc. 18, p. 3) Significantly, Plaintiffs have continued to refuse to
4 produce relevant medical records. When Plaintiffs requested Defendant’s position on
5 Plaintiffs’ Motion for Leave to file the Supplemental Declaration (Doc. 26), Defendant
6 stated it would not oppose the filing of a supplemental declaration by Dr. Andrew Cronyn,
7 on the conditions that (1) Defendant has the opportunity to respond to the supplemental
8 declaration, and (2) Defendant received all of D.H.’s medical records that address the new
9 development, along with all relevant medical records for D.H. and John Doe, the
10 disclosure of which the parties had discussed during the Rule 26(f) conference. When
11 Defendant asked for Plaintiffs’ assurance on these issues, Plaintiffs would not agree to
12 produce all of the relevant medical records, and instead stated Plaintiffs would withhold
13 documents if they had a “good-faith basis for doing so.” *See* Email Correspondence dated
14 Nov. 16-20, 2020, attached as Exhibit A.

15
16 Plaintiffs now claim the Supplemental Declaration supports D.H.’s claim for
17 irreparable harm. (Doc. 26) But for the same reasons set forth in Defendant’s Opposition
18 to Plaintiff’s Motion for Preliminary Injunction (Doc. 18, p. 9-12), the Supplemental
19 Declaration does not establish irreparable harm relating to Plaintiffs’ alleged gender
20 dysphoria. By way of example, and based upon the limited records available to
21 Defendant:

- 22 • The results of an EEG are still pending to “rule out the possibility that [D.H.] had a
23 seizure” on November 2, 2020. (Doc. 32, ¶¶8-9)
- 24
25 • Dr. Cronyn states Plaintiff D.H.’s asthma and decision to “double bind”
26 contributed to the severity of the panic attack (not the alleged underlying gender
27 dysphoria, for which Defendant still has not received medical records to confirm
28 such diagnosis). (Doc. 32, ¶¶8-10)

- 1 • There are a number of important, relevant pieces of information pertaining to D.H.
2 that are glaringly omitted from the Supplemental Declaration. For example,
3 according to Paragraph 7 of the Supplemental Declaration, D.H. called emergency
4 services and was evaluated by EMTs. An important role of an EMT would be to
5 get D.H.'s vital signs (e.g., blood pressure, heart rate, respiration rate, pulse
6 oximeter level), but none of that information is in the Supplemental Declaration.
7 This information would be relevant to determine if the cause of the November 2,
8 2020 incident was something else, including an asthma attack.
9
- 10 • Paragraph 10 of the Supplemental Declaration indicates D.H.'s asthma contributed
11 to the severity of the November 2, 2020 incident. If the incident was caused by an
12 asthma attack, there are serious questions about whether D.H.'s asthma is being
13 treated adequately – e.g., does D.H. use an inhaler or take steroids or other
14 medication for asthma? Before moving forward with an irreversible surgery, it
15 would be important to know whether D.H. is correctly and regularly using an
16 inhaler, steroids, or other medication to properly treat D.H.'s asthma – specifically
17 using them according to prescribed standards.
18
- 19 • In addition, as noted in the Declaration of Dr. Michael Laidlaw, M.D., hormones
20 (such as steroids to treat asthma) can exacerbate symptoms of anxiety and panic.
21 (*See* Doc. 18-1, ¶¶ 20-21) Thus, there are unresolved questions about whether any
22 steroids or medication D.H. is on may have contributed to the severity of the
23 November 2, 2020 incident.
- 24 • The Supplemental Declaration (Paragraph 10) indicates D.H.'s asthma contributed
25 to the severity of the November 2, 2020 incident, but the Supplemental Declaration
26 does not indicate that D.H. has been referred to – or is being treated by - a
27 pulmonologist (a lung specialist). Since D.H. has asthma, is D.H. being adequately
28 treated for asthma? It could be an asthma-related issue that caused the severity of

the breathing issues on November 2, 2020 (rather than the binder), but it unclear whether D.H. is being adequately treated for D.H.'s lung/asthma issues.

- There are also unanswered questions about D.H.'s medications. Is D.H. receiving medication for panic attacks? Is D.H. taking all of the prescribed medications regularly and properly, according to prescribed standards? Again, this would be important information to evaluate before moving forward with an irreversible surgery of a teenager.
- As noted in Paragraphs 7-8 of the Supplemental Declaration, D.H. was in the emergency room and receiving fluids. But there is no indication in the Supplemental Declaration whether a toxicology screen was done to determine whether any medication caused or exacerbated the November 2, 2020 incident. There could be medications, including legally prescribed medications (e.g., pain medications), that exacerbated D.H.'s symptoms.
- There is also no indication in the Supplemental Declaration that, as part of D.H.'s work up, the providers checked for other endocrinology issues (e.g., hyperthyroidism) that could present similar symptoms.
- According to Paragraph 9 of the Supplemental Declaration, Dr. Cronyn "ensured that D.H. was continuing to have regular appointments with Tamar Reed." But Tamar Reed is a Licensed Professional Counselor ("LPC") - she is not a medical doctor or psychologist (Doc. 5-2, ¶¶ 3-4). LPC's in Arizona cannot prescribe medication, and thus Ms. Reed is not qualified to prescribe D.H. medication or evaluate D.H.'s medications. *See, e.g.*, A.R.S. §§ 32-3301, 32-1968(A)(1), 32-1921(A)(5). As noted in the Declarations of Dr. Michael Laidlaw, M.D., and Dr. Stephen Levine, M.D. (Doc. 18-1, ¶23; Doc. 18-2, ¶¶23, 27-35), before an irreversible surgery is performed on D.H., it would be important to ensure that

1 D.H. was thoroughly evaluated and treated by a qualified psychiatrist or
2 psychologist who can thoroughly address D.H.'s mental health issues, including
3 through medication.
4

5 Even without a full medical history, it is clear that Dr. Cronyn's Supplemental
6 Declaration does not establish irreparable harm resulting from D.H. not receiving
7 coverage for an irreversible chest reconstruction surgery. Accordingly, Plaintiffs' Motion
8 for Preliminary Injunction should be denied.

9 RESPECTFULLY SUBMITTED this 8th day of December, 2020.

10
11 **BURNSBARTON PLC**

12
13 By /s/ Kathryn Hackett King

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15 Kathryn Hackett King

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CERTIFICATE OF SERVICE

I hereby certifies that on December 8, 2020, I electronically transmitted the foregoing document, using the ECF System for filing and transmittal of a Notice of Electronic Filing and to ECF registrants and e-mailed a copy of the foregoing to the following:

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UNITED STATES DISTRICT COURT

DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
Hennessy-Waller, and John Doe, by his
guardian and next friend, Susan Doe, on behalf
of themselves and all others similarly situated,

Plaintiffs,

v.

Jami Snyder, Director of the Arizona Health
Care Cost Containment System, in her official
capacity,

Defendant.

No. CV-20-00335-TUC-SHR

**SUPPLEMENTAL
DECLARATION OF ANDREW
CRONYN, MD, IN SUPPORT OF
D.H. AND JOHN DOE'S MOTION
FOR PRELIMINARY
INJUNCTION**

1 I, Dr. Andrew Cronyn, hereby declare as follows:

2 1. I provide this supplemental declaration in further support of Plaintiff D.H.'s
3 request that AHCCCS cover D.H.'s male chest reconstruction surgery as a medically
4 necessary procedure to treat his gender dysphoria.

5 2. I submit this declaration based on my experience treating D.H., specifically
6 my evaluation of D.H. on November 9, 2020.

7 3. In early October 2020, D.H. started working at a local car wash. His job
8 requires him to interact with customers as well as assist in washing and drying cars.

9 4. D.H. reported that soon after starting this job he was regularly referred to as
10 female by co-workers and customers based on the appearance of his chest. His co-workers
11 would stare at his chest while making these comments. He also reported receiving similar
12 comments from customers. D.H. recounted that one customer loudly called out, "hey,
13 tranny," a derogatory word used to refer to transgender people, when D.H. didn't respond
14 to being called "ma'am."

15 5. This exacerbated D.H.'s gender dysphoria to the point that he began "double
16 binding," a practice of wearing a smaller binder over a slightly larger binder. I had heard
17 of this practice before, but had not previously seen it in my teen patients. This practice is
18 used to further flatten the chest, which serves the dual purposes of alleviating gender
19 dysphoria (because wearing a single binder is perceived as insufficient) and increasing the
20 likelihood that a transgender male will be treated as male. Given the size of D.H.'s chest
21 and the physical nature of his work, this is a dangerous practice because it greatly reduces
22 his ability to breathe properly, especially during exercise or exertion. Research shows that
23 use of chest binders is associated with abnormal lung function testing with lower lung
24 volumes which can cause other problems including shortness of breath, light-headedness,
25 and fainting. In fact, D.H. reported already being sent home early from work more than
26 once due to difficulty breathing. The constriction caused by "double binding," especially
27 when done for long periods of time, has the potential to bruise ribs. Double binding is highly
28 discouraged due to the potential of ill effects, but some transgender men will use this

1 technique to help with their gender dysphoria in times of increased stress.

2 6. On November 2, 2020, D.H. reported being misgendered by several
3 customers in a short time span, causing him to start panicking and struggling to control his
4 breathing.

5 7. Although he was able to keep working and maintain his composure until his
6 lunch break, he immediately decompensated on his way to buy lunch at a local restaurant.
7 D.H. started having difficulty breathing, which caused him to hyperventilate and feel weak.
8 He also had difficulty speaking and found himself stuttering (a problem he had not had
9 previously). D.H. called emergency services and was evaluated by EMTs. The EMTs did
10 not find any evidence of a life-threatening physical condition, like a heart arrhythmia,
11 diabetes or an infection, that would have caused the symptoms D.H. reported. They
12 recommended that D.H. go to the emergency room for further evaluation and observation
13 but felt he would be safe in a private car rather than an ambulance. He was transported to
14 a nearby hospital by his mother.

15 8. At the emergency room, D. H. was given one liter of intravenous fluids for
16 concern of dehydration. An EKG showed a normal heart rhythm, and lab work (blood
17 sugar, thyroid studies, complete blood count) were all normal as was a chest x-ray. He also
18 had a CT scan of his head/brain that showed no acute findings. The doctor who evaluated
19 D.H. at the hospital discharged him with a recommendation to follow up with his primary
20 care provider and obtain an EEG to rule out the possibility that he had a seizure.

21 9. I saw D.H. on November 9, 2020 to provide follow-up care. I conducted a
22 full evaluation of D.H.'s physical and mental health. Based on the events that preceded
23 D.H.'s symptoms, it is my opinion that D.H. had a severe panic attack. But, out of an
24 abundance of caution and based on the recommendation of the doctor who evaluated D.H.
25 in the emergency room, I also ordered an EEG for D.H., the results of which should be
26 available in a few weeks. Lastly, I ensured that D.H. was continuing to have regular
27 appointments with Tamar Reed, his mental health provider.

28 10. The fact that D.H. was "double binding," coupled with his asthma, further

1 contributed to the severity of the panic attack and the symptoms that D.H. experienced.
2 Typically during a panic attack, a person will start to breathe deeper and faster. Because
3 the binders restricted D.H.'s chest, he could not breathe deeper, only faster. As he began to
4 hyperventilate, the sensation of shortness of breath would worsen and it would continue in
5 a worsening feedback loop. As a result, I advised D.H. to stop double binding, but I am not
6 confident that D.H. will be able to comply with that advice because of his increasing gender
7 dysphoria.

8 11. D.H.'s self-treatment using "double binding" and the severe panic attack he
9 experienced both indicate that D.H.'s mental health is becoming more fragile and his
10 healthier coping mechanisms are beginning to fail. For example, now that a single binder
11 is no longer sufficient to temporarily calm D.H.'s gender dysphoria so that he can function
12 throughout the day, I am concerned that he could turn to more destructive coping
13 mechanisms to deal with his psychological distress, including self-harming behaviors.
14 Given D.H.'s prior serious suicidal ideation, his mental health could deteriorate quickly and
15 unpredictably.

16 12. This change in D.H.'s overall health and well-being make his need for male
17 chest reconstruction even more urgent.

18 I declare under penalty of perjury pursuant to the laws of the State of Arizona that
19 the foregoing is true and correct.

20 Executed this ¹⁸____th day of November, 2020 at Tucson, Arizona.

21
22 DocuSigned by:

23 *Andrew Cronyn, MD*

24 6B3AD548AAC4472...

25 Andrew Cronyn, M.D.

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**UNITED STATES DISTRICT COURT
 FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
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 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No. 4:20-cv-335-SHR

**REPLY EXPERT
 DECLARATION OF LOREN S.
 SCHECHTER, M.D. IN
 SUPPORT OF PLAINTIFFS'
 MOTION FOR PRELIMINARY
 INJUNCTION**

1 I, Loren S. Schechter, M.D., declare as follows:

2 1. I have been retained by counsel for the Plaintiffs as an expert in the above-
3 captioned lawsuit. I submitted an expert witness declaration (“Schechter Decl.”), Dkt. 5-6,
4 in connection with Plaintiffs’ motion for a preliminary injunction in this case. I submit this
5 declaration to respond to points raised in the declarations of Michael K. Laidlaw, M.D.
6 (“Laidlaw Decl.”), Dkt. 18-1] and Stephen B. Levine, M.D. (“Levine Decl.”), Dkt. 18-2,
7 which Defendants submitted in connection with their response to Plaintiffs’ motion for a
8 preliminary injunction.

9 2. My background, qualifications, and compensation for my services in this case,
10 and the bases for my opinions in this case are described in my original declaration. In
11 preparing this declaration, I was provided with and reviewed the following additional case-
12 specific materials: (1) Expert Declaration of Michael Laidlaw, MD, and accompanying
13 exhibits; and (2) Expert Declaration of Stephen Levine, MD, and accompanying exhibits.

14 3. I have personal knowledge of the matters stated in this supplemental
15 declaration.

16 4. Both Dr. Laidlaw and Dr. Levine claim that male chest reconstruction surgery
17 is not a safe and effective treatment for gender dysphoria.¹ That claim is flatly inconsistent
18 with mainstream medical standards. It is my professional opinion – supported by the
19 prevailing consensus of the medical community – that male chest reconstruction is a safe,
20 effective, and medically accepted treatment for individuals with gender dysphoria,
21 including adolescents.

22
23 ¹ Based on my review of Dr. Laidlaw’s declaration and CV, it appears that he has no clinical
24 experience treating individuals with gender dysphoria. The language Dr. Laidlaw used in
25 his declaration reflects his lack of familiarity with this area of medicine. For example, he
26 claims that treatments for individuals with gender dysphoria “must be optimal, efficacious,
27 and safe.” *Id.* ¶ 11. His use of the term “optimal” implies that there is one way to treat or
28 care for a particular condition, and that is simply not true. There are only “optimal”
treatments for a particular patient. As is the case with many medical conditions, there are
various treatments available for gender dysphoria, including surgery. As part of a surgical
consultation, surgeons discuss the risks, benefits, and options of available procedures with
their patients. This discussion includes a consideration of the patients’ medical history as
well as other factors. What is “optimal” for one person with gender dysphoria might not be
“optimal” for another person with the same medical condition.

WPATH is a Professional Medical Association

5. Both Dr. Laidlaw and Dr. Levine attempt to discount the broad medical consensus that gender confirming surgeries are medically necessary by claiming that WPATH is an “advocacy organization” and not a “purely” professional one. *See* Laidlaw Decl. ¶ 33; Levine Decl. ¶ 46. First, most medical associations and societies engage in advocacy on behalf of health care professionals, their patients, and their medical specialty generally. For example, the Endocrine Society – of which Dr. Laidlaw is a member – describes itself as devoted to “advocating on behalf of the global endocrinology community,” including patients with endocrine conditions. Endocrine Soc’y, Who We Are, <https://www.endocrine.org/about-us>; *see also* Endocrine Soc’y, Advocacy, <https://www.endocrine.org/advocacy>, Endocrine Soc’y, Shaping Healthcare and Research Policy, <https://www.endocrine.org/our-community/shaping-healthcare-and-research-policy>. Similarly, the American Society of Plastic Surgeons uses advocacy “to support its members in the provision of excellent patient care.” Am. Soc’y of Plastic Surgeons, About ASPS, <https://www.plasticsurgery.org/about-asps>. Far from being unique, engaging in advocacy is the norm among professional medical associations. *See, e.g.*, Am. Medical Ass’n, Health Care Advocacy, <https://www.ama-assn.org/health-care-advocacy>; Am. Psychiatric Ass’n, Make a Difference Through APA Advocacy, <https://www.psychiatry.org/psychiatrists/advocacy>; Am. Acad. of Pediatrics, Advocacy, <https://services.aap.org/en/advocacy/>.

6. Second, WPATH has transgender members who are licensed professionals in the wide range of specialties associated with transgender health as well as transgender members who bring the voice of the community into the organization. The presence and participation of transgender people in WPATH in no way restricts “honest and scientific debate” among professionals. *Cf.* Levine Decl. ¶ 45. To the contrary, it enriches the discussion of important topics, just as the participation of patients and patient support groups does during discussions at conferences for other professional societies to which I belong. Having transgender members is vital to WPATH and the development of the

Standards of Care, but notably, voting privileges are limited to members who are professionals. Thus, the implication that the participation of transgender members degrades WPATH's scientific integrity or impartiality has no merit.² Moreover, in conjunction with WPATH's biennial conference, it hosts a meeting that is limited to surgeons and healthcare professionals directly involved in surgical care (a meeting that I started at the 2007 WPATH Biennial meeting in Chicago, and continue to organize and participate in at each of the subsequent meetings). During the meeting, surgeons openly discuss a wide range of issues, including surgical techniques and ethical questions.

7. Finally, Dr. Laidlaw and Dr. Levine ignore that many other professional medical associations agree that gender-confirming surgery is a medically necessary treatment for individuals with gender dysphoria. *See, e.g.*, Schechter Decl. ¶ 32 (noting that the American Medical Association, American College of Obstetricians and Gynecologists, and American Academy of Pediatrics have all issued policy statements and guidelines that are in accordance with the WPATH Standards of Care); *see also* Am. Psychological Ass'n, Guidelines for Psychological Practice With Transgender and Gender Nonconforming People (2015), <https://www.apa.org/practice/guidelines/transgender.pdf>; Am. Psychiatric Ass'n, *A Guide for Working With Transgender and Gender Nonconforming Patients* (2017), <https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients>.

Male Chest Reconstruction Surgery is Safe and Effective for

Individuals who Meet the Prevailing Standards of Care

8. The WPATH Standards of Care set forth the following general criteria for individuals seeking male chest reconstruction to treat their gender dysphoria: (1) The patient has a referral from at least one mental health professional documenting the patient's necessity and preparedness for the surgery; (2) If the patient has other significant medical

² Dr. Laidlaw's complaint that WPATH's Standards of Care are developed through a consensus process among its members is curious, at best. WPATH members have dedicated a significant portion of, if not their entire professional careers, to advancing the health and wellbeing of transgender people. That level of expertise is essential in creating a standard-setting document.

1 or mental health concerns, they are reasonably well-controlled prior to surgery; and (3) The
2 patient has the capacity to make fully informed decisions and to consent for treatment.
3 WPATH, *Standards of Care for the Health of Transsexual, Transgender, and Gender-*
4 *Nonconforming People*, 59 (hereafter, “WPATH SOC”). With respect to individuals under
5 age 18, the Standards of Care indicate that it is preferable to perform male chest
6 reconstruction after the patient has had “ample time of living in the desired gender role and
7 after one year of testosterone treatment,” but that a different approach could be more
8 suitable depending on the individual needs of the patient. WPATH SOC at 21.

9 9. Dr. Laidlaw and Dr. Levine appear to misunderstand these guidelines. Both
10 declarations include an extensive discussion of treatment for gender dysphoria in children
11 (*i.e.* prior to puberty), but the SOC does not recommend surgical interventions for pre-
12 pubescent children, and in any event, the issue of what interventions are appropriate for
13 children before puberty is irrelevant to the question of whether male chest reconstruction
14 surgeries are clinically appropriate for D.H. and John Doe, both of whom have already
15 commenced puberty.

16 10. Dr. Laidlaw asserts that “any treatment which alters biological development
17 in children should be used with extreme caution.” Laidlaw Decl. ¶ 11. While any surgical
18 intervention should be approached with care, the SOC outline the clinical factors medical
19 and mental health professionals should assess when determining whether surgery is
20 medically necessary to treat a transgender young person’s gender dysphoria. Nor do the
21 SOC go beyond clinical practice in other areas for youth. Many nontransgender women
22 have breast reduction surgery before the age of 18 in order to alleviate back pain, neck pain,
23 shoulder grooving from bras straps, and/or skin irritation. Likewise, it is common for
24 nontransgender men as young as 14 to have surgery to treat gynecomastia. Accordingly, the
25 SOC recognize that male chest reconstruction is medically necessary for many adolescents
26 with gender dysphoria who are under age 18. WPATH SOC at 21; *see also* Wylie C.
27 Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons:*
28 *An Endocrine Society Clinical Practice Guideline*, 102 J. Clin. Endocrinology &

1 Metabolism 3869, 3872 (2017) (“We suggest that clinicians determine the timing of breast
2 surgery for transgender men based upon the physical and mental health status of the
3 individual. There is insufficient evidence to recommend a specific age requirement.”).

4 11. Dr. Laidlaw claims that any co-occurring mental health conditions, “should
5 be thoroughly treated first before considering hormone therapy or gender reassignment
6 surgery.” Laidlaw Decl. ¶¶ 23, 26. That position is not supported by any evidence. Co-
7 occurring mental health conditions are not uncommon in patients who need surgery,
8 including patients with gender dysphoria. The WPATH SOC recognize that. They
9 specifically indicate the importance of mental health assessments prior to surgery, as well
10 as the importance of a multi-disciplinary and collaborative approach between surgeons,
11 mental health professionals, and primary care providers. *See* WPATH SOC at 56-57.
12 Working in this interdisciplinary way, surgeons determine if a patient has any medical or
13 mental health conditions that could affect their suitability for surgery or complicate their
14 recovery after surgery. *See* WPATH SOC at 59.

15 12. In addition, it is wrong to assume that gender-affirming surgeries, like male
16 chest reconstruction surgery, cannot have a positive effect on co-occurring mental health
17 conditions. The overwhelming majority of my patients improve across multiple domains
18 after surgery. For example, before surgery, some patients are unable to exercise because
19 doing so causes intense gender dysphoria, and the size of their chest/breasts makes exercise
20 physically uncomfortable, not unlike nontransgender women seeking breast reduction
21 surgery. After surgery, they are able to exercise more comfortably and, as such, they are
22 able to improve their physical health. Research confirms that male chest reconstruction does
23 improve psychosocial and physical well-being.³

24 13. Dr. Laidlaw goes on to say that the presence of certain co-occurring mental
25 health conditions could make individuals unable to consent to gender affirming surgery.

26 ³ Agarwal, C, et al, Quality of life improvement after chest wall masculinization in female-
27 to-male transgender patients: A prospective study using the BREAST-Q and Body
28 Uneasiness Test, *J Plast Reconstr Aesthet Surg.* 2018 May; 71(5), 651-657. *See also* Tim
C. van de Grift et al., Body image in transmen: multidimensional measurement and the
effects of mastectomy, *journal of sexual medicine* 2016; 13, 1778-1786.

1 Laidlaw Decl. ¶¶ 25, 29. Dr. Laidlaw fails to recognize that when individuals under age 18
2 seek surgery, it is their parent or guardian that must provide informed consent. Of course,
3 adolescents must also assent to gender confirming surgery. Patients with co-occurring
4 mental health conditions, such as depression, anxiety, substance use disorder, and post-
5 traumatic stress disorder, regularly and appropriately assent to surgical care. Generally,
6 these conditions do not prevent patients from understanding the procedure, the risks and
7 complications of the procedure, and the benefits that they can reasonably expect to achieve
8 from surgery. *See* Schechter Decl. ¶ 38.

9 14. Dr. Laidlaw and Dr. Levine also suggest that the possible complications of
10 male chest reconstruction mean that it is not safe. *See* Laidlaw Decl. ¶ 28; Levine Decl.
11 ¶ 90. Gender confirming surgeries do not have a particularly high complication rate when
12 compared with analogous procedures for other conditions. For example, a study of 7,905
13 transgender individuals, of whom 1,047 underwent gender affirming surgery between 2009-
14 2015, revealed an overall complication rate for all surgical procedures of only 5.8%.⁴
15 Looking specifically at male chest reconstruction surgery, two recent studies reveal a
16 complication rate of between 11%-12%.⁵ In comparison, a 2005 study of cisgender women
17 undergoing breast reduction found a complication rate of 43%.⁶ Likewise, a systematic
18 review of cisgender women undergoing nipple-sparing mastectomy and immediate breast
19 reconstruction using breast implants and acellular dermal matrix, found the following
20 complication rates: 11% skin necrosis, 5% nipple necrosis, 12% infection, 1% hematoma,
21 5% seroma, 4% explantation, and 9% unplanned return to the operating room.⁷ In short, the

22 ⁴ Lane, M., et al. Trends in gender-affirming surgery in insured patients in the United States.
23 *Plastic and Reconstructive Surgery – Global Open*. 2018; 6(4), e1738.
doi:10.1097/GOX.0000000000001738.

24 ⁵ Berry, M., et al. Female-to-male transgender chest reconstruction: A large consecutive,
25 single surgeon experience. *J Plast Reconstr Aesthet Surg*. 2012 Jun; 65(6):711-9. doi:
10.1016; Agarwal, C. et al. Quality of life improvement after chest wall masculinization in
26 female-to-male transgender patients: A prospective study using the BREAST-Q and Body
Uneasiness Test. *J Plast Reconstr Aesthet Surg*. 2018 May; 71(5):651-657. doi: 10.1016.

27 ⁶ Cunningham, B., et al., Analysis of breast reduction complications derived from the
BRAVO study. *Plast Reconstr Surg*. 2005 May; 115(6):1597-604.

28 ⁷ Heidemann, L., et al. Complications following nipple-sparing mastectomy and immediate
acellular dermal matrix implant-based breast reconstruction-A systematic review and meta-
analysis. *Plast Reconstr Surg Glob Open*. 2018 Jan 12; 6(1):e1625. doi: 10.1097.

1 complication rates for gender affirming surgeries are lower than or in the same range as the
2 rates for the same surgeries performed to treat other conditions.

3 15. Moreover, Dr. Laidlaw and Dr. Levine ignore the health risks and
4 complications that can arise from withholding surgical care, including worsening gender
5 dysphoria; anxiety; depression; and self-harm, suicide attempts, and suicide.

6 16. Dr. Levine also opines that male chest reconstruction is not effective because
7 the surgery does not fully align a patient's body and gender identity, and thus, cannot
8 possibly cure their gender dysphoria. *See* Levine Decl. ¶ 82. First, Dr. Levine misconstrues
9 the purpose of male chest reconstruction. The goal of the procedure is to reduce gender
10 dysphoria. That a surgery might only alleviate – and not cure – the condition being treated,
11 does not mean that it is not medically necessary. For example, a mastectomy performed on
12 a patient who has a genetic predisposition to cancer (BRCA mutation carriers), does not
13 completely eliminate the risk that the patient will develop cancer. And, chest/breast
14 reconstruction following mastectomy does not result in anatomical structures that perfectly
15 restore those that were removed. For example, breast reconstruction surgery for cancer does
16 not restore the ability to breastfeed. Yet, there is no question that when performed in
17 accordance with the standards of care, a risk-reduction mastectomy and chest/breast
18 reconstruction is highly effective and medically necessary in a patient with one of the BRCA
19 genes. Second, many of my patients who have undergone male chest reconstruction have in
20 fact described total relief from their gender dysphoria.

21 17. Finally, both Dr. Laidlaw and Dr. Levine suggest that gender confirming
22 surgery is not safe and effective because some patients could later regret their transition and
23 the procedure. Dr. Laidlaw offers no support for his opinion. *See* Laidlaw Decl. ¶ 40. Dr.
24 Levine points to his own experience working with “multiple individuals who have
25 abandoned trans female identity after living in that identity for years,” Levine Decl. ¶ 100,
26 and vague references to stories on the internet. That Dr. Levine has seen this happen several
27 times in almost 40 years does not mean that it is a common occurrence among transgender
28 individuals generally or among those who have received gender confirming surgery. All

1 available research—as well as my own clinical experience—indicates that very few patients
2 experience regret when gender confirming surgery is provided in accordance with the
3 WPATH SOC and by a qualified surgeon. Regret of any kind is rare (0.6% in transgender
4 women and 0.3% in transgender men),⁸ but “true regrets,” as opposed to regrets due to lack
5 of social or familial acceptance, comprise an even smaller percentage (approximately half
6 this group, roughly 0.3% in transgender women and 0.15% in transgender men).⁹ Having
7 performed gender confirming surgeries for over 20 years, I have never had a patient request
8 a reversal of male chest reconstruction.

9 18. The Djordjevic study cited by Dr. Levine does nothing to undermine the
10 necessity or effectiveness of surgical care for gender dysphoria. That article discusses the
11 experiences of seven patients whose treatment leading up to surgery did not follow the
12 WPATH SOC.¹⁰ Contrary to Dr. Levine’s implication, that study reaffirms that the
13 prevailing standards of care are effective at assessing medical necessity for surgical care,
14 ensuring that surgery is not performed on patients that would not benefit from those
15 procedures. Having reviewed the declarations of Dr. Peck and Ms. Reed, and having
16 evaluated D.H. and John via tele-health (which is how I conducted all of my consultations
17 at that time and, given the ongoing concerns regarding COVID-19, tele-health consultations
18 remain routine), both D.H. and John meet each of the criteria for male chest reconstruction
19 surgery under the WPATH SOC and that procedure is medically necessary to treat their
20 gender dysphoria. If I were performing male chest reconstruction surgery on D.H. and John,
21 this is the point at which I would seek prior authorization for the procedure. Although, like

22 ⁸ Wiepjes, et. al. The Amsterdam Cohort of Gender Dysphoria Study 1972-2015: Trends in
23 Prevalence, Treatment, And Regrets. J Sex Med. 2018 Apr; 15(4):582-590. doi: 10.1016.

24 ⁹ *Id.* at 585, 587 (researchers classified “social regrets” as those experienced by individuals
25 who still identified as transwomen, but reported feeling “ignored by surroundings” or
26 regretted loss of relatives,” and classified “true regrets” as those experienced by individuals
27 who “thought gender affirming treatment would be a ‘solution’ for, for example,
28 homosexuality or [lack of] personal acceptance, but, in retrospect, regretted the diagnosis
and treatment”).

¹⁰ See Djordjevic, M., et al. Reversal Surgery in Regretful Male-to-Female Transsexuals
After Sex Reassignment Surgery. J Sex Med. 2016 Jun; 13(6):1000-7. doi: 10.1016.
Moreover, the study did not even involve individuals who had undergone male chest
reconstruction, but only considered the experience of seven transgender women who
underwent genital reconstruction surgeries. *See id.*

1 any surgeon, I would need to examine D.H. and John in person prior to proceeding with
2 surgery, it is highly unlikely, given their age and medical history, that the examination
3 would uncover an issue requiring a delay or cancellation of the surgery.

4 19. Dr. Laidlaw also makes much of the fact that if a patient does regret
5 undergoing male chest reconstruction, they will be unable to breastfeed. Laidlaw Decl. ¶ 28.
6 But, individuals are unable to breastfeed for a variety of reasons, such as insufficient
7 glandular tissue or certain medical conditions. Moreover, breast reduction surgery, which
8 as I noted above, is often performed on adolescents, can also leave patients unable to
9 breastfeed.

10 ***The Peer-Reviewed Research Indicates that Male Chest Reconstruction is Safe and***
11 ***Effective for Individuals Who Meet the Prevailing Standards of Care***

12 20. Dr. Laidlaw and Dr. Levine suggest that there is no “good quality” literature
13 showing that male chest reconstruction surgery is a safe and effective treatment for
14 individuals with gender dysphoria. Laidlaw Decl. ¶¶ 34, 40; Levine Decl. ¶¶ 69-73.
15 Notably, critical review of the scientific literature is one component as to how surgeons
16 evaluate whether a particular procedure is generally safe and effective and whether it is
17 appropriate or recommended for an individual patient. Not only do we consider the literature
18 *en masse*, but we must also account for our own clinical experience and that of our
19 colleagues, as well as our patients’ experiences and input. Here, the existing literature
20 indicates that male chest reconstruction is a safe and effective treatment for individuals with
21 gender dysphoria, including adolescents. My own experience, and the documented
22 experience of clinicians across the globe, is consistent with that literature.

23 21. Moreover, the quality of the evidence supporting gender affirming surgeries
24 is comparable to that supporting many surgeries and clinical procedures. While prospective,
25 randomized, double-blind, placebo-controlled studies are the gold standard, they cannot be
26 used to evaluate many clinical procedures. There are simply inherent limitations to our
27 ability to conduct such studies in clinical medicine. First, it is unethical to withhold
28 medically necessary care. As such, in many situations, clinicians cannot conduct a study

1 that uses a control group who is deprived of the treatment being studied. For this reason,
2 and the fact that we do not perform gender-affirming surgery on children, it is particularly
3 unsurprising that “[n]o studies show that affirmation of children (or anyone else) reduces
4 suicide, prevents suicidal ideation, or improves long-term outcomes, as compared to either
5 a ‘watchful waiting’ or a psychotherapeutic model of response.” Levine Decl. ¶ 75. No
6 institutional review board would approve such a study for adults or adolescents since
7 “watchful waiting” amounts to withholding beneficial treatment (and is not an approach
8 taken with adults), and the “psychotherapeutic model” amounts to gender identity
9 conversion efforts, an approach that has been debunked as unsound and harmful. Second, it
10 is not possible to perform a double-blind study of surgeries that modify body parts, nor is
11 there a placebo that can mimic such a surgery – unlike studies that use placebo drug
12 regimens, for example, people will know if they have had an operation or not. Third, for
13 relatively uncommon conditions like gender dysphoria, sample sizes of individuals with the
14 condition who are available to participate in a clinical study tend to be small. This is
15 especially true where treatment for a condition has not been covered by insurance programs
16 and plans, and where additional barriers (such as ongoing stigmatization) prevent patients
17 from accessing care. That very lack of access to the procedure results in there being fewer
18 people who have received treatment and who can participate in a prospective study of that
19 treatment’s effect.

20 22. Dr. Laidlaw and Dr. Levine cite a study by Dhejne *et al.* to imply that because
21 individuals who received gender confirming surgeries had higher morbidity and mortality
22 rates compared to the general population, the surgeries are not effective. Laidlaw Decl. ¶ 35;
23 Levine Decl. ¶ 74. They appear to misunderstand that study. First, the study itself clearly
24 states that it is not intended to evaluate whether gender affirming surgeries are effective
25 treatments. Dhejne *et al.* at e16885.¹¹ Second, the study includes patients who had surgery

26
27 ¹¹ See *Science AMA Series: I'm Cecilia Dhejne a fellow of the European Committee of*
28 *Sexual Medicine, from the Karolinska University Hospital in Sweden. I'm here to talk about*
transgender health, suicide rates, and my often misinterpreted study. Ask me anything!,
Reddit.com, July 27, 2017 05:14 (“Despite the paper clearly stating that the study was not
designed to evaluate whether or not gender-affirming is beneficial, it has been interpreted

1 prior to the development of the current standards of care. Third, the fact that gender
2 confirming surgeries do not entirely resolve all possible causes of morbidity and mortality
3 among transgender individuals is completely unsurprising. While surgery can treat gender
4 dysphoria by aligning transgender people's bodies with their gender identity, surgery alone
5 cannot fully eliminate the stigma and discrimination that transgender people face.

6 23. Moreover, it is rare for any surgery to eliminate morbidity and mortality. For
7 example, people who have surgery to remove a cancerous tumor may still experience higher
8 rates of morbidity and mortality than the general population, but that does not mean that
9 they should not undergo the surgery. And, those who receive such surgery generally have
10 reduced morbidity and mortality compared to those with the same condition who do not,
11 even if morbidity and mortality for both groups is higher than average. For instance, one
12 study cited by Dr. Levine concluded that gender-affirming surgeries "may reduce
13 psychological morbidity for some individuals while increasing it for others."¹² The fact that
14 surgery does not always reduce morbidity for everyone who receives it does not mean that
15 the surgery is not safe or effective, particularly given the number of potential confounding
16 factors that can impact morbidity. Similarly, the continued existence of elevated morbidity
17 and mortality rates, compared to the population at large, say nothing about whether a
18 treatment is a safe and effective way to treat a particular condition.

19 24. Dr. Laidlaw also points to a 2016 decision of the Department of Health &
20 Human Services' Centers for Medicare and Medicaid Services to support his claim that
21 gender confirming surgeries are not effective. Laidlaw Decl. ¶ 36. But, Laidlaw takes that
22 decision out of context and misrepresents its conclusions. In 2014, an impartial adjudicative
23 board in the Department of Health & Human Services concluded, based on decades of
24 studies, that surgical care to treat gender dysphoria is safe, effective, and medically

25
26
27 as such."), https://www.reddit.com/r/science/comments/6q3e8v/science_ama_series_im_cecilia_dhejne_a_fellow_of/.

28 ¹² R. K. Simonsen et al. (2016), *Long-Term Follow Up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity & Mortality*, *Nordic J. of Psychiatry* 70(4).

1 necessary.¹³ Dep't of Health & Human Servs., Departmental Appeals Bd., Appellate Div.,
2 Decision No. 2676 (May 30, 2014), [hhs.gov/sites/default/files/static/dab/decisions/board-](https://hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf)
3 [decisions/2014/dab2576.pdf](https://hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf). As a result, CMS started covering surgical care for gender
4 dysphoria and continues to provide that coverage, including for patients in my practice. The
5 decision Laidlaw cites was focused on whether to issue national standards for determining
6 the medical necessity of surgical treatment for gender dysphoria in Medicare recipients.
7 CMS declined to create those standards based on concerns that are specific to the Medicare
8 population, typically people over 65 years old, because “older adults may respond to health
9 care treatments differently than younger adults.” Ctrs. for Medicare & Medicaid Servs.,
10 Decision Memo for Gender Dysphoria and Gender Reassignment Surgery, 57 (Aug. 30,
11 2016). “These differences can be due to, for example, multiple health conditions or co-
12 morbidities, longer duration needed for healing, metabolic variances, and impact of reduced
13 mobility.” *Id.* Thus, the CMS memorandum concluded that the appropriateness of surgical
14 care for this population should be determined on an individualized basis.

15 25. Notably, I have performed gender confirming surgeries on a number of
16 Medicare beneficiaries in recent years. Indeed, most medical and surgical care provided to
17 patients should be individualized, taking into account each patient’s unique clinical
18 circumstances. In contrast, the exclusion challenged in this case does not evaluate the
19 medical necessity of surgical care for gender dysphoria on an individualized basis. It
20 categorically excludes all coverage regardless of an individualized showing of medical
21 necessity.

22 ///

23 ///

24 ///

25 _____
26 ¹³ That decision also discussed the quality of data demonstrating the efficacy of surgical
27 care to treat gender dysphoria, noting regardless of whether the studies were randomized
28 double-blind trials, there was sufficient evidence to prove “a consensus among researchers
and mainstream medical organizations that transsexual surgery is an effective, safe and
medically necessary treatment for [gender dysphoria].” Dep’t of Health & Human Servs.,
Departmental Appeals Bd., Appellate Div., Decision No. 2676, at 20 (May 30, 2014),
hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf.

D.H. and John Doe Meet the Requirements for Male Chest Reconstruction

26. Based on review of the declarations and materials provided by their treating providers and my clinical assessment of D.H. and John Doe, it is my professional opinion that male chest reconstruction surgery is a safe, effective, and medically necessary treatment for each of them. While I would need to perform an in-person exam prior to surgery, it would be highly unusual for that exam to reveal any contraindication in an adolescent patient.

27. Dr. Laidlaw baldly concludes that D.H. and John were not sufficiently evaluated and treated prior to being recommended for surgery. There is nothing in the declarations of Dr. Cronyn, Tamar Reed, and Dr. Peck, nor in the medical records from the office of Dr. Veenod Chulani, to support that assertion. Those documents indicate that D.H. and John have been evaluated and treated by medical doctors and mental health professionals who have significant experience working with transgender adolescents.

28. In addition, as I indicated in my previous declaration, I see no evidence that D.H. or John has a co-occurring mental health condition that would contraindicate surgery. *See Schechter Decl. ¶¶ 43-44.* Nor do I have any reason to suspect that these conditions render them unable to assent to male chest reconstruction surgery. *See id.*

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

Executed this 23rd th day of October, 2020 at Chicago, Illinois.

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**UNITED STATES DISTRICT COURT
 FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No. 4:20-cv-335-SHR

**REPLY EXPERT DECLARATION
 OF ARON JANSSEN, M.D. IN
 SUPPORT OF PLAINTIFFS'
 MOTION FOR PRELIMINARY
 INJUNCTION**

1 I, Aron Janssen, M.D., hereby declare as follows:

2 1. I submit this expert declaration based on my personal knowledge.

3 2. If called to testify in this matter, I would testify truthfully and based on my
4 expert opinion.

5 3. In preparing this declaration, I was provided with and reviewed the following
6 additional case-specific materials: (1) Expert Declaration of Michael Laidlaw, MD, and
7 accompanying exhibits; and (2) Expert Declaration of Stephen Levine, MD, and
8 accompanying exhibits.

9 4. The opinions contained in this declaration are based solely on the information
10 I have been provided by Plaintiffs' counsel as well as my extensive experience studying
11 and treating patients with gender dysphoria.

12 Discussion

13 *Drs. Laidlaw and Levine Lack the Necessary Expertise*

14 5. According to his CV, Dr. Laidlaw is an endocrinologist with no specific
15 training or board certification in working with pediatric or transgender patient populations.
16 Expert Declaration of Dr. Michael Laidlaw, Dkt. 18-1, at 17-19 ("Laidlaw Decl."). Yet, his
17 declaration provides extensive—and, as discussed below, unsupported—opinions about the
18 mental health dimensions of gender dysphoria and appropriate protocols for assessing a
19 patient's preparedness for male chest reconstruction surgery, an assessment he would never
20 perform as an endocrinologist and one that he does not have the formal training or
21 qualifications necessary to perform.

22 6. Although Dr. Laidlaw claims to have experience working with patients with
23 gender dysphoria, he provides no indication of whether that experience includes treatment
24 of adolescents, the subject of this case, or the depth of that experience. Laidlaw Decl. ¶ 9.
25 His claims of expertise are also belied by his lack of familiarity with the subject matter. For
26 example, Dr. Laidlaw critiques a peer-reviewed journal article on chest dysphoria because,
27 in part, the term "chest dysphoria" is not a clinical diagnosis or mentioned in the DSM-5.
28 Laidlaw Decl. ¶ 34. That term, however, was not coined by the author, but is a commonly

1 used term of art to refer to the unique psychological distress people with gender dysphoria
2 experience associated with their chest. Dr. Laidlaw also suggests that D.H.'s and John's
3 increased chest dysphoria sometime after starting testosterone is because of their co-
4 occurring conditions. Laidlaw Decl. ¶ 21. But, increased chest dysphoria is a common
5 response to starting testosterone among transgender males. A provider who regularly works
6 with transgender young people would not attribute that response to a patient's co-occurring
7 conditions. Transgender young people experience an improvement in their mental health
8 upon starting hormone-replacement therapy because that medication helps bring their body
9 into closer alignment with their gender identity. As those hormones take effect, however,
10 some transgender young people experience increased distress regarding the parts of their
11 body the hormones cannot change. This is particularly true for transgender males whose
12 voice will drop and will start growing facial hair—two visible markers of masculinity—but
13 will still have a female-appearing chest.

14 7. Likewise, when Dr. Laidlaw discussed dosing of testosterone, one of the rare
15 occasions Dr. Laidlaw opined on matters within the purview of an endocrinologist, he made
16 errors that would not have been made by a medical provider that regularly treats transgender
17 patients. Although a testosterone level of 300-1000 ng/dL would be concerning for a
18 nontransgender female, *see* Laidlaw Decl. ¶ 20, that is a typical range of testosterone in
19 males during puberty. And, likening doses of testosterone for transgender males to abusing
20 steroids, is misleading and inaccurate. *Id.* The highest dose recommended for adolescents
21 under the Endocrine Society Guidelines ranges from 100-125 mg every two weeks, which
22 is, at most, one fifth of the levels studied in the article Dr. Laidlaw cites on steroid abuse.¹
23 Not surprisingly, induction of male puberty in transgender males has the same effects as
24 those typically seen in nontransgender males (*e.g.* increased libido, potential for changes in
25 mood, and increased body hair growth). It does not cause the complications and side effects
26 that accompany steroid abuse.

27
28 ¹ Many, if not all, of the studies contained in the meta-analysis cited by Dr Laidlaw
involved nontransgender male participants whose starting levels of testosterone are much
higher than those of transgender men.

1 8. Even though Dr. Levine is a psychiatrist, he is also unqualified to make the
2 opinions asserted in his declaration. According to his CV, Dr. Levine is not board certified
3 in child and adolescent psychiatry, which requires specialized training in child development
4 that is essential for working with transgender young people and their families. Expert
5 Declaration of Stephen Levine, Dkt. 18-2, at 49 (“Levine Decl.”). His declaration and CV
6 indicate that he does not have significant clinical experience working with adolescents
7 experiencing gender dysphoria, the patient population at the heart of this case, and suggests
8 that any such experience occurred decades ago. Levine Decl. ¶ 5.

9 9. He too used language throughout his declaration that laid bare his lack of
10 expertise in treating adolescents with gender dysphoria. For example, on a number of
11 occasions, Dr. Levine referred to transgender people as “transgendered.” *See, e.g.*, Levine
12 Decl. ¶¶ 47, 78, 104. That word has long been abandoned by practitioners and researchers
13 in the field of transgender health care because it is offensive to transgender people and
14 unnecessarily confusing. Similarly, Dr. Levine’s declaration contains numerous claims that
15 are false or misleading. For example, he claims that it is inaccurate to “assert that doctors
16 ‘assign’ the sex of a child at birth.” Levine Decl. ¶ 11. Yet, approximately 1 in 1,000 babies
17 are born with intersex conditions, some of which cannot be diagnosed based on an
18 inspection of a newborn’s genitalia and others that result in a “mosaic” of sex chromosomes
19 in their cells. Doctors routinely assign these children to one gender or another at birth. Nor
20 is gender dysphoria “the only psychiatric condition to be treated by surgery.” Levine Decl.
21 ¶ 22. For example, deep brain stimulation (DBS) is a procedure that can be used to treat
22 Obsessive Compulsive Disorder and Major Depression. DBS requires a surgical procedure
23 to place a device called a neurostimulator in the brain; the neurostimulator, sometimes
24 called a “brain pacemaker,” then sends electrical impulses, through implanted electrodes,
25 to specific targets in the brain.

26 ***Diagnosis and Treatment of Gender Dysphoria in Adolescents***

27 10. Despite Drs. Laidlaw and Levine’s assertions to the contrary, scientific
28 research and clinical experience has foreclosed any credible debate about the diagnosis and

1 benefits of treatment for gender dysphoria in childhood. But, because male chest
2 reconstruction surgery is not medically appropriate until adolescence, this declaration will
3 focus primarily on their statements that apply to adolescents with gender dysphoria. As
4 such, any studies or statements not directly addressed in this declaration, such as the
5 significant misrepresentations Drs. Laidlaw and Levine make regarding the research
6 regarding “persistence” and “desistence,” should not be construed as agreement. *See*
7 Laidlaw Decl. ¶ 22; Levine Decl. ¶¶ 28, 35, 56, 58-67, 99-103.

8 11. Contrary to the portrayal in Drs. Laidlaw’s and Levine’s declarations, the
9 gender affirmative model of treatment requires a careful and thorough assessment of a
10 patient’s mental health, including co-occurring conditions, history of trauma, substance use,
11 among many other factors. Laidlaw Decl. ¶¶ 23-26; Levine Decl. ¶¶ 51, 57. That assessment
12 requires an exploration of the patient’s psychological distress surrounding their gender
13 identity, including its sources and manifestations. Without that detailed history and
14 assessment, a provider could not accurately diagnose a patient with gender dysphoria. The
15 number of sessions that assessment requires will vary greatly depending on the patient’s
16 presentation and the complexity of the issues the patient is navigating. Further, in
17 conducting that assessment, the mental health provider is drawing from their professional
18 training and experience in working with transgender young people, exercising professional
19 judgment, and tailoring the assessment to each individual patient.

20 12. That comprehensive assessment is also needed to inform possible future care,
21 specifically referrals for surgical treatment. The referral process involves an assessment of
22 the patient’s gender dysphoria, co-occurring conditions, and the surgical procedure’s likely
23 affect on the patient’s overall mental health and functioning. As part of that process, mental
24 health providers also discuss the risks, benefits, and alternatives to surgery with transgender
25 young people and their parents. This gives the mental health provider an opportunity to
26 assess whether the transgender young person’s co-occurring conditions are interfering with
27 their ability to fully assent to the procedure and whether those conditions would impede
28 their ability to comply with necessary post-surgical care.

1 13. Where the gender-affirmative model differs from other approaches is that it
2 does not presume that being transgender is incompatible with a young person's short- and
3 long-term health and wellbeing. That is consistent with DSM-5 diagnostic criteria which is
4 "focus[ed] on dysphoria as the clinical problem, not identity per se." American Psychiatric
5 Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, 451 (2013).
6 And, despite Drs. Laidlaw and Levine's characterization to the contrary, the gender-
7 affirmative model is not synonymous with a rubber-stamp recommendation that all patients
8 undergo a gender transition. See Laidlaw Decl. ¶¶ 23-25; Levine Decl. ¶¶ 51, 57. Instead,
9 the focus of the gender-affirmative model is supporting overall health and wellbeing,
10 regardless of whether the young person continues to identify as transgender. As a result, I
11 have had patients who presented with some symptoms of gender dysphoria, but who
12 ultimately did not meet the diagnostic criteria for a variety of reasons and therefore I
13 recommended treatments other than transition to alleviate their psychological distress.

14 14. The other treatment modalities outlined in Dr. Levine's declaration are
15 inconsistent with the prevailing standards of care because those modalities withhold
16 treatments known to ameliorate the patient's gender dysphoria, which is unethical and
17 contrary to a provider's oath to "first, do no harm." Levine Decl. ¶¶ 28-42. Although Dr.
18 Levine refers to his preferred modality as the "psychotherapy model," this approach is more
19 appropriately characterized as "gender identity conversion efforts" because its goal is to
20 bring the patient's gender identity into alignment with their assigned sex and forecloses
21 gender transition as a treatment for gender dysphoria. Levine Decl. ¶¶ 30-35. A recent study
22 found that experiencing those conversion efforts was associated with greater odds of
23 attempting suicide, especially for those had those experiences in childhood. Jack Turban, et
24 al., *Association between recalled exposure to gender identity conversion efforts and*
25 *psychological distress and suicide attempts among transgender adults*, 77 JAMA
26 Psychiatry 68 (2020). That conclusion is further supported by the extensive evidence that
27 rejection of a young person's gender identity from family and peers are the strongest
28 predictors for adverse mental health outcomes. This is not an appropriate therapeutic

1 modality and every leading medical and mental health organization has issued clear
2 statements that those practices are discredited, harmful, and ineffective, including the
3 American Medical Association,² the American Academy of Pediatrics,³ and the American
4 Academy of Child & Adolescent Psychiatry.⁴

5 ***Treatment for Gender Dysphoria is Evidence Based***

6 15. Many well-established treatment protocols in psychiatry—and likely in every
7 discipline of medicine—do not have the level of evidentiary support that Drs. Laidlaw and
8 Levine seek to impose on treatment for gender dysphoria. Laidlaw Decl. ¶¶ 31-34, 36-37;
9 Levine Decl. ¶ 71-77, 114. The evidentiary basis for those treatment protocols are
10 developed, and regularly updated, using a combination of peer-reviewed research and the
11 extensive clinical experience of providers who regularly treat patients with that condition.
12 Those treatment protocols are considered the standard of care and are safe and effective for
13 the conditions they are intended to treat. For example, in children, Zoloft is FDA approved
14 to treat Obsessive-Compulsive Disorder, but is also regularly used to treat depression and
15 anxiety, such that the use of Zoloft is considered the standard of care for children who
16 require medication to treat those conditions.

17 16. Although there are still no imaging or laboratory tests that assist clinicians in
18 the diagnosis and treatment of gender dysphoria, there are measurable and objective criteria
19 mental health providers use to diagnose and treat gender dysphoria, including the DSM-5
20 diagnostic criteria and the ever-growing body of research on gender dysphoria. For
21 example, studies repeatedly point to the strength of a young person's cross-gender
22 identification as an important factor in the diagnostic process. A recent study found cross-

23 ² American Medical Association, *Health care needs of lesbian, gay, bisexual and*
24 *transgender populations*, H-160.991, 2017, [https://policysearch.ama-](https://policysearch.ama-assn.org/policyfinder/detail/H-160.991%20?uri=%2FAMADoc%2FHOD.xml-0-805.xml)
25 [assn.org/policyfinder/detail/H-160.991%20?uri=%2FAMADoc%2FHOD.xml-0-805.xml](https://policysearch.ama-assn.org/policyfinder/detail/H-160.991%20?uri=%2FAMADoc%2FHOD.xml-0-805.xml)
(last visited Oct. 23, 2020).

26 ³ Jason Rafferty, et al., Ensuring comprehensive care and support for transgender and
27 gender-diverse children and adolescents, 142 *Pediatrics* (2018), available at,
28 <https://pediatrics.aappublications.org/content/pediatrics/142/4/e20182162.full.pdf> (last
visited Oct. 23, 2020).

⁴ The American Academy of Child & Adolescent Psychiatry, *Conversion Therapy* (2018),
https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx (last
visited Oct. 23, 2020).

1 gender identification of transgender children who had not yet undergone any transition to
2 be indistinguishable from that of nontransgender study participants and transgender
3 participants who had already undergone a social transition. Rae, J., et al., *Predicting early-*
4 *childhood gender transitions*, 30 Psychological Science 669 (2019); *see also* Selin Gülgöz,
5 et al., *Similarity in Transgender and Cisgender Children's Gender Development*, 116
6 *Proceedings of the Nat'l Acad. Of Sci. of the U.S.* 24480 (2019).⁵ Research also shows that
7 social transition significantly improves the mental health of transgender young people,
8 bringing their mental health profiles into alignment with their nontransgender peers.
9 Kristina Olson, et al., *Mental health of transgender children who are supported in their*
10 *identities*, 137 Pediatrics 1 (2016);⁶ *see also* Jack Turban, et al., *Pubertal suppression for*
11 *transgender youth and risk of suicidal ideation*, 145 Pediatrics 1 (2020) (transgender people
12 who accessed puberty suppression treatment were 70% less likely to contemplate suicide).
13 Those guideposts, among others, assist clinicians to differentiate a young person who shows
14 some symptoms consistent with gender dysphoria but for whom a gender transition would
15 not be recommended, and a young person who has the type of persistent gender dysphoria
16 seen in transgender people.

17 17. Another related measure is whether a young person's gender dysphoria
18 continues into or intensifies at the onset of puberty. That further confirms the accuracy of a
19 young person's gender dysphoria diagnosis. Even researchers who oppose treatment of
20 gender dysphoria in childhood adhere to the gender-affirmative model for transgender
21 adolescents and recognize the importance of medical and surgical treatments for gender
22 dysphoria in adolescence. Jack Turban, Annelou DeVries & Kenneth Zucker, *Gender*
23 *Incongruence & Gender Dysphoria*, in *Lewis's Child and Adolescent Psychiatry: A*
24 *Comprehensive Textbook*, (A Martin, et al., eds., 5th ed., 2018). A longitudinal study
25

26 ⁵ These studies also demonstrate there is no support for Dr. Levine's suggestion that social
27 transition in childhood causes transgender young people to continue identifying as
transgender into adolescence and beyond.

28 ⁶ Anxiety was the only area where transgender young people differed from the
nontransgender controls. On that measure, transgender young people showed slightly
elevated levels of anxiety, but were still in the pre-clinical range.

1 following a cohort of transgender young people in the Netherlands from puberty
2 suppression through surgical treatment found that the cohort had global functioning that
3 was equivalent to the Dutch population. Annelou De Vries, et al., *Young adult psychological*
4 *outcome after puberty suppression and gender reassignment*, 134 *Pediatrics* 696 (2014).
5 And, in fact, the cohort of transgender participants were nearly twice as likely to pursue
6 higher education (58% v. 31%). *Id.*

7 18. Drs. Laidlaw and Levine criticize the extensive body of research supporting
8 the current standard of care for the treatment of gender dysphoria based on purported
9 concerns that generally lack a sound scientific basis; at the same time, they rely heavily on
10 articles and other sources that lack peer review or other indicia of reliability to support their
11 own views. For example, in response to the brain-imaging studies identifying biological
12 sources of gender identity, Dr. Levine claims “there is no evidence that these patients have
13 any defining abnormality in brain structure that precedes the onset of gender dysphoria.”
14 Levine Decl. ¶ 24. This critique fails to account for the fact that medical providers would
15 have no basis for conducting a brain imaging study on transgender people prior to the onset
16 of gender dysphoria. Equally concerning, however, is Dr. Levine’s reliance on the Littman
17 study for his claim that gender dysphoria is driven by cultural influences. *Id.* Although
18 purporting to provide a basis for Dr. Levine’s speculations, the study was based on an
19 anonymous survey, allegedly of parents, about the etiology of their child’s gender
20 dysphoria. Participants were recruited from websites promoting this social-contagion
21 theory, and the children were not surveyed or assessed by a clinician. Those serious
22 methodological flaws render the study meaningless. The only conclusion that can be drawn
23 from that study is that a self-selected sample of anonymous people recruited through
24 websites that predisposed participants to believe that transgender identity can be influenced
25 by social factors believe those social factors influence children to identify as transgender.

26 19. Further, a significant proportion of the sources cited by Drs. Laidlaw and
27 Levine were published in nonscientific journals, including *Public Discourse*, a general-
28 interest opinion journal edited by Ryan Anderson, an outspoken opponent of treatment for

gender dysphoria who has no medical training. *See* Laidlaw Decl. at 8; Masthead – Public Discourse, <https://www.thepublicdiscourse.com/masthead/> (last visited Oct. 23, 2020).

Assessing Co-Occurring Conditions & Referrals for Surgery

20. Both Drs. Laidlaw and Levine include extensive discussions of co-occurring conditions—even suggesting diagnoses for D.H. and John without examining them. Laidlaw Decl. ¶¶ 13-26; Levine Decl. ¶¶ 19, 55. Each suggests that transgender people have an underlying psychopathology by virtue of being transgender. *See* Laidlaw Decl. ¶ 23; Levine Decl. ¶¶ 21-25, 50-51, 83. The American Psychiatric Association unequivocally repudiated that outdated view in the DSM-5, revising the diagnostic criteria (and name) to recognize the clinical distress as the focus of the treatment, not the patient’s transgender status. *See* DSM-5 at 451. As in other aspects of their declarations, Drs. Laidlaw and Levine’s reliance on scientific research is selective, cannot support their conclusions, and is inconsistent with the prevailing standards of care.

21. Studies on transgender young people have long reported data on co-occurring conditions. Johanna Olson, et al., *Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria*, 57 J. of Adol. Health 374 (2015) (finding 35% of participants with clinical levels depression and prevalence of moderate and severe depression among participants was 9% and 11%, respectively); Sari L. Reisner, et al., *Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study*, 56 J. of Adol. Health 274 (2015) (finding approximately 51% of participants had a diagnosis of depression and 27% were diagnosed with anxiety); Norman Spack, et al., *Children and Adolescents With Gender Identity Disorder Referred to a Pediatric Medical Center*, 129 Pediatrics 419 (2012) (finding 40% had mental health diagnoses prior to contact with the clinic, including, among others, depression (58%), general anxiety disorder (7%), bipolar (7%), PDD-NOS (9%), and ADHD/ADD (5%)); Brian S. Mustanski, et al., *Mental Health Disorders, Psychological Distress, and Suicidality in a Diverse Sample of Lesbian, Gay, Bisexual, and Transgender Youths*, 100 Am. J. of Pub. Health 2426 (2010) (One third of participants met criteria for

any mental disorder, 17% for conduct disorder, 15% for major depression, and 9% for posttraumatic stress disorder.). The existence—and prevalence—of co-occurring conditions among transgender young people is unsurprising. Transgender young people must cope with many stressors from the fear of rejection from family and peers to pervasive societal discrimination. Not to mention, their underlying gender dysphoria can cause significant psychological distress, which, if left untreated, can result in the co-occurring conditions identified in studies on transgender young people. And, given that transgender young people typically delay disclosing their transgender status or initially experience family rejection following disclosure, it is not uncommon for transgender young people to engage with psychological or psychiatric care for other reasons prior to being diagnosed with gender dysphoria.

22. Transgender young people, however, are not outliers in this regard. Research and clinical experience show that most psychiatric conditions are highly correlated with other co-occurring psychiatric conditions. For example, young people with depression are very likely to have at least one other diagnosable condition, most often anxiety. *See, e.g.,* E. Jane Costello, et al., *Prevalence and development of psychiatric disorders in childhood and adolescence*, 60 *Archives of Gen. Psychiatry* 837 (2003) (“There was strong heterotypic continuity from depression to anxiety” and finding approximately 30% of participants diagnosed with a depressive disorder were also diagnosed with an anxiety disorder). Likewise, a study on children diagnosed with Attention-Deficit/Hyperactivity Disorder found between 74-79% participants had additional co-occurring psychiatric conditions. Timothy Wilens, et al., *Psychiatric Comorbidity and Functioning in Clinically Referred Preschool Children and School-Age Youths With ADHD*, 41 *J. of Am. Academy of Child & Adol. Psychiatry* 262 (2002).

23. Thus, Dr. Laidlaw’s reliance on the prevalence data in the study by Kaltiala-Heino is misleading. Laidlaw Decl. ¶ 23. First and foremost, the prevalence rates reported in that study are significantly higher than other data on co-occurring conditions in transgender young people. His reliance on a single outlier study is particularly troubling

1 because the prevalence data in those other studies are largely consistent with one another,
 2 suggesting a high level of reliability. Second, the small size of the study and its design
 3 prevented its authors from drawing any causal connections between the co-occurring
 4 conditions and the medical necessity or mental health benefits of surgical care to treat the
 5 participant's gender dysphoria. Instead, the study was focused on developing categories that
 6 describe the various clinical presentations of young people with gender dysphoria in that
 7 clinic. Yet, Dr. Laidlaw cites this study as a basis for his belief that transgender young
 8 people must demonstrate their co-occurring conditions have been "thoroughly treated" prior
 9 to obtaining male chest reconstruction surgery, a conclusion that is contrary to the standards
 10 of care and the study's own conclusions. *Id.*

11 24. In suggesting D.H. and John need further assessment for co-occurring
 12 conditions, Dr. Laidlaw also implies that mental health providers who follow the gender-
 13 affirmative model of therapy do not conduct a thorough assessment of their patients.
 14 Laidlaw Decl. ¶ 23. As noted above, conducting a detailed assessment is a central feature
 15 of the gender-affirmative model, and such an assessment would have explored the
 16 categories of potential co-occurring conditions identified by Dr. Laidlaw. Based on the
 17 declarations of Dr. Peck and Ms. Reed, both have extensive experience working with
 18 transgender young people and have an extended therapist-patient relationship with John and
 19 D.H., respectively. Declaration of Dr. Mischa Cohen Peck, Dkt. 4-2, ¶¶ 6, 8 ("Peck Decl.");
 20 Declaration of Tamar Reed, Dkt. 5-2, ¶¶ 4-5. There is nothing in their declarations that
 21 suggest either conducted anything short of a comprehensive assessment of their patient's
 22 mental health.

23 25. Equally concerning is Dr. Laidlaw's assertion that John may have dissociative
 24 identity disorder (previously known as multiple personality disorder), a complex psychiatric
 25 condition, without having assessed John—an assessment he would not be qualified to
 26 conduct. Laidlaw Decl. ¶ 18 n.1. That opinion is based on John's description of his
 27 experience of puberty as "being detached" from his body. *Id.*; Peck Decl. ¶ 12. Young
 28 people commonly describe distressing or traumatic experiences as an out-of-body

1 experience; it is a coping mechanism that allows them to separate and protect themselves
2 from that experience. Given the distress the onset of puberty causes for transgender young
3 people, it is not surprising that John recounted his experience in those terms; it is an
4 experience I have heard from many of my patients, including transgender patients, both
5 around the onset of puberty and during times of stress or trauma.

6 26. Like any patient, transgender young people will develop a variety of ways to
7 cope with the psychological distress they experience, especially when untreated, to regain
8 control of their lives. Some strategies can be healthy and promote psychological and overall
9 health, like exercise and drawing, while other strategies can cause further damage, such as
10 self-harm or restricted eating. Dr. Laidlaw attempts to draw a connection between D.H.'s
11 and John's history of engaging in self-harming behaviors⁷ to a litany of psychological
12 conditions. Laidlaw Decl. ¶ 19. The suggestion that the mere presence self-harming
13 behaviors requires further assessment for the co-occurring conditions listed in his
14 declaration is inconsistent with the research on those behaviors and the prevailing standard
15 of care. Self-harming behaviors are considered a non-specific maladaptive coping
16 mechanism, meaning those behaviors are used by patients in response to a wide range of
17 psychological conditions and stressors. Because those behaviors are not associated with a
18 specific condition, the standard of care is to explore the triggers for the self-harming
19 behaviors and to help redirect patients towards positive—or, at least, less harmful—coping
20 mechanisms, while treating the underlying condition so that the triggering events are less
21 frequent.

22 27. For transgender males, the presence and appearance of their chest repeatedly
23 triggers their gender dysphoria throughout the day, from seeing their body while getting
24 dressed in the morning to being misperceived as female by others. Although therapy can
25 greatly assist transgender males in developing more positive coping mechanisms, it cannot
26 completely resolve the underlying psychological distress, thereby impairing their ability to
27 achieve sustained relief from gender dysphoria. Male chest reconstruction surgery removes
28

⁷ These behaviors are also referred to by the term non-suicidal self-injury or NSSI.

1 this significant source of dysphoria, reducing the transgender person's overall level of
2 distress and improving their psychological functioning.

3 28. Both Drs. Laidlaw and Levine, however, suggest that the existence of co-
4 occurring conditions, history of self-harming behaviors, or history of suicidal ideation or
5 attempts should disqualify D.H. and John from consideration for male chest reconstruction
6 surgery. Laidlaw Decl. ¶¶ 23-26; Levine Decl. ¶¶ 31-32. The scientific research and clinical
7 experience working with transgender young people demonstrates that the opposite is true.
8 *See, e.g.,* Richard Bränström & John E. Pachankis, *Toward Rigorous Methodologies for*
9 *Strengthening Causal Inference in the Association Between Gender-Affirming Care and*
10 *Transgender Individuals' Mental Health: Response to Letters*, 177 *Am. J. Psychiatry* 769
11 (2020);⁸ Johanna Olson-Kennedy, et al., *Chest Reconstruction and Chest Dysphoria in*
12 *Transmasculine Minors and Young Adults Comparisons of Nonsurgical and Postsurgical*
13 *Cohorts*, 172 *JAMA Pediatrics* 431, 434 (2018); Annelou De Vries, et al., *Young adult*
14 *psychological outcome after puberty suppression and gender reassignment*, 134 *Pediatrics*
15 696 (2014). In fact, transgender males who are experiencing severe chest dysphoria
16 manifesting in suicidal ideation, suicide attempts, or psychiatric hospitalizations are among
17 the most in need of male chest reconstruction surgery. For those patients, therapy and
18 medication have proved to be a temporary band aid and continuing that treatment protocol
19 would cause the patient's mental health to deteriorate further with very dangerous
20 consequences.

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22
23 ⁸ In his declaration, Dr. Laidlaw misrepresented the differences between the original
24 Bränström study and its subsequent correction. Although the correction concurred that "the
25 [study] design is incapable of establishing a causal effect of gender-affirming [surgical]
26 care on mental health treatment utilization," *id.* at 772, a re-analysis of the data supported
27 an expectation of "a reduction in mental health treatment as a function of time since
28 completing such treatment," *id.* Dr. Laidlaw's discussion of the study's conclusion,
however, makes the same analytical misstep he claimed the authors made; just as the data
could not prove a causal connection between surgery and the subsequent improvement to
the participant's mental health, it also cannot support a finding that the surgery had no
effect. *See* Laidlaw, et al., *Letter to the Editor: Gender-Affirmation Surgery Conclusion*
Lacks Evidence, 177 *Am. J. Psychiatry* 765-766 (2020). In doing so, Dr. Laidlaw glosses
over the study's conclusion that there is a positive correlation between access to surgical
treatment for gender dysphoria and improved mental health over time.

1 29. The prevailing standards of care account for the reality that transgender
2 individuals may be diagnosed with co-occurring conditions. Among the criteria for
3 assessing a transgender patient for male chest reconstruction surgery is determining whether
4 the patient’s “significant medical or mental health concerns are . . . reasonably well
5 controlled.” WPATH, *Standards of Care for the Health of Transsexual, Transgender, and*
6 *Gender-Nonconforming People*, 59 (hereafter, “WPATH SOC”).

7 30. That criteria is focused on serious conditions that would interfere with one,
8 or more, of the following: (1) the ability of the provider to accurately diagnose the patient
9 with gender dysphoria; (2) the ability of the patient to provide informed assent (for people
10 under eighteen) or consent (for parents and adults) to the surgery; or (3) the ability of the
11 patient to recover from the surgery, including compliance with post-operative care.

12 31. The conditions that typically trigger closer assessment under that criteria
13 include schizophrenia, schizoaffective disorder, dissociative identity disorder, and Down
14 Syndrome. Having those conditions—or similar ones—does not automatically preclude a
15 transgender person from undergoing treatment for gender dysphoria. Instead, assessing that
16 person requires providers who are highly specialized in working with transgender people to
17 determine whether the person’s co-occurring condition does, in fact, raise any of the
18 concerns noted above. This also means that the assessment process may take longer.

19 32. Requiring that a transgender patient resolve all co-occurring conditions prior
20 to undergoing surgical care—as suggested by Defendant’s experts—is not possible, nor is
21 it ethical. Laidlaw Decl. ¶¶ 23-26; Levine Decl. ¶¶ 29, 31, 34, 55. Nor is resolving all co-
22 occurring conditions before surgical treatment a requirement for other procedures, such as
23 surgeries for Grave’s disease or Hyperthyroidism. Gender dysphoria, by definition, is
24 accompanied by clinically significant psychological distress. That distress can take on many
25 different forms (*e.g.*, anxiety, mood disorders, and depression) and vary greatly in severity,
26 resulting in co-occurring conditions. Because psychological distress is not easily
27 compartmentalized, the distress associated with gender dysphoria can also amplify co-
28 occurring conditions that developed independently of the gender dysphoria. In either

1 situation, gender dysphoria limits the effectiveness of treatment of any co-occurring mental
2 health conditions. Thus, treating the underlying gender dysphoria is essential to alleviating
3 the psychological distress associated with co-occurring conditions.

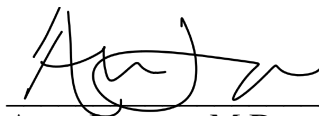
4 33. Even assuming that it was possible to cure a patient's co-occurring conditions,
5 Drs. Laidlaw and Levine fail to consider the very real harms caused by delaying treatment.
6 Therapy and medications alone are often inadequate to treat gender dysphoria in
7 transgender males. Without male chest reconstruction surgery, their gender dysphoria
8 would continue to worsen. At a minimum, that increased distress would interfere with the
9 treatment for the person's co-occurring conditions, subjecting them unnecessarily to a
10 longer course of treatment. It is far more likely that the gender dysphoria would eclipse the
11 person's co-occurring conditions, not only entirely impeding treatment of those co-
12 occurring conditions, but also resulting in an overall deterioration of their mental health.
13 The increased distress from their gender dysphoria would translate to resorting to negative
14 coping mechanisms (*i.e.* self-harm), suicidal ideation, and suicide attempts—just as it could
15 if that increased distress was attributable to a co-occurring condition.

16 34. Based on my review of the declarations submitted by D.H.'s and John's
17 healthcare providers, there is no basis to suggest that either of them has co-occurring
18 conditions that are not "reasonably well controlled" as required under WPATH Standards
19 of Care to be eligible for male chest reconstruction. WPATH SOC at 21, 59. To the contrary,
20 the professional opinions of those providers are that not only are their co-occurring
21 conditions well controlled, but that having male chest reconstruction surgery will help
22 alleviate the symptoms of those co-occurring conditions.

23 35. Thus, undergoing male chest reconstruction surgery may allow D.H. and
24 John, a transgender patient to "thoroughly treat[]" their co-occurring conditions as Dr.
25 Laidlaw envisions. Laidlaw Decl. ¶ 23. As a result, withholding or denying treatment in the
26 manner suggested by Drs. Laidlaw and Levine is irresponsible and unethical.

1 I declare under penalty of perjury under the laws of the United States that the
2 foregoing is true and correct.

3 Executed this 26th th day of October, 2020 at Chicago, Illinois.

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6 Aron Janssen, M.D.
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**UNITED STATES DISTRICT COURT
 FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No. 4:20-cv-335-SHR

**REPLY BRIEF IN SUPPORT OF
 PLAINTIFFS D.H. AND JOHN
 DOE'S MOTION FOR
 PRELIMINARY INJUNCTION**

***ORAL ARGUMENT
 REQUESTED***

I. INTRODUCTION

D.H.'s and John's treating providers are clear and consistent: delaying male chest reconstruction surgery any further will cause irreparable damage to their health and wellbeing, putting them at risk for serious negative mental health consequences. D.H. and John meet the eligibility requirements for male chest reconstruction surgery under the prevailing standards of care, and their providers have determined that it is medically necessary for them. Yet, AHCCCS's categorical exclusion singles out gender-confirmation surgeries for differential treatment. That exclusion violates the Medicaid Act and the Affordable Care Act (ACA), and serves no legitimate, much less important, state interest.

Defendant's opposition relies on the opinions of two doctors who have little, if any, experience treating transgender adolescents and whose views contradict the well-established standards of care for treating gender dysphoria in minors. Even Defendant significantly disagrees with their opinions; AHCCCS covers services, including hormone therapy, that Drs. Laidlaw and Levine believe are not safe and effective. *See, e.g.,* Michael Laidlaw, *The Pediatric Endocrine Society's Statement on Puberty Blockers Isn't Just Deceptive. It's Dangerous*, Public Discourse (2020), available at, <https://www.thepublicdiscourse.com/2020/01/59422/> (last visited Oct. 25, 2020).

Although Defendant attempts to position Drs. Laidlaw and Levine as one side of a reasoned scientific debate, the opinions they express have no credible foundation or support. The views proffered by Drs. Laidlaw and Levine contradict the well-established standards of care developed by WPATH and endorsed by the major medical associations in the United States, including the American Medical Association, American Academy of Pediatrics, American Psychiatric Association, and Endocrine Society, among many others. For that reason, other federal courts have declined to rely on Dr. Levine's opinions. *Hecox v. Little*, No. 1:20-CV-00184, 2020 WL 4760138, at *29 n.33 (D. Idaho Aug. 17, 2020); *Edmo v. Idaho Dep't of Corr.*, 358 F. Supp. 3d 1103, 1125 (D. Idaho 2018); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1188 (N.D. Cal. 2015) (Giving "very little weight" to Dr. Levine's opinion, in part, because he fabricated an anecdote in his report).

Contrary to Defendant’s suggestion, nothing in the declarations submitted by Drs. Laidlaw or Levine undermine the sufficiency of the evidence presented by Plaintiffs in support of this motion. In contrast to the substantial evidence and expert opinions submitted by D.H. and John, proffered by health care providers with extensive expertise treating transgender minors and grounded in the medical literature and standards that govern this field, Defendant has proffered doctors who lack relevant expertise and whose opinions fall well outside the views of any qualified medical experts on transgender minors. In similar cases, federal courts consistently grant preliminary injunctive relief to transgender litigants where defendants rely on the outdated and unscientific opinions of professionals like Drs. Laidlaw and Levine. *See, e.g., Hecox*, 2020 WL 4760138, at *39; *Flack v. Wis. Dep’t of Health Servs.*, 328 F. Supp. 3d 931, 934 (W.D. Wis. 2018); *Bd. of Educ. of the Highland Local Sch. Dist. v. U.S. Dep’t of Educ.*, 208 F. Supp. 3d 850, 870 (S.D. Ohio 2016); *Norsworthy*, 87 F. Supp. 3d at 1195.

Defendant cannot manufacture a “debate” where none truly exists.¹ The research on “desistance,” central to Defendant’s argument, is of questionable utility even in children, but is irrelevant for adolescents. Reply Expert Declaration of Aron Janssen (“Janssen Reply Decl.”), Doc. 25-1, ¶ 10; Reply Expert Declaration of Loren Schechter (“Schechter Reply Decl.”), Doc. 25-2, ¶ 9. There is broad consensus, even among the key authors of the studies on “desistance,” that after puberty starts, as it has for D.H. and John, it is not appropriate to withhold medical and surgical treatment for gender dysphoria. Janssen Reply Decl. ¶ 17. Defendant also repeatedly questions D.H.’s and John’s ability to consent to male chest reconstruction surgery yet fails to address the reasoned professional opinions of their treating mental health providers to the contrary, disregarding their significant experience treating transgender young people generally, and D.H. and John, specifically. *See id.* ¶ 34;

¹ Although Defendant critiques Plaintiffs for refusing to disclose their health records at this early stage, those records were irrelevant to her experts, who generally dispute the standards of care and opined that D.H.’s and John’s co-occurring conditions, which were detailed in the declarations submitted in support of the instant motion, are a sufficient basis for denying them medically necessary care. As Plaintiffs’ experts explain, there is no valid medical basis for that opinion, which contradicts well-established standards of practice and care.

1 Declaration of Dr. Mischa Peck (“Peck Decl.”), Doc. 4-2, ¶ 6; Declaration of Tamar Reed
2 (“Reed Decl.”), Doc. 5-2, ¶ 4.

3 For the reasons set forth in their opening brief and herein, Defendant is legally
4 obligated to cover D.H.’s and John’s male chest reconstruction surgery.

5 **II. ARGUMENT**

6 **A. Preliminary Injunction Standard**

7 Defendant suggests that a heightened “mandatory injunction” standard applies to
8 Plaintiffs’ motion. But Defendant is mistaken.² Plaintiffs seek a prohibitive injunction that
9 would enjoin Defendant from enforcing a regulation that prohibits coverage for surgeries
10 to treat gender dysphoria, including male chest reconstruction surgery. The injunction
11 would require Defendant to review D.H.’s and John’s authorization requests for male chest
12 reconstruction surgery to treat gender dysphoria the same way AHCCCS does for any other
13 treatment or service for beneficiaries under age 21. The fact that this injunction would result
14 in AHCCCS covering medically necessary surgeries for D.H. and John does not make it a
15 “mandatory injunction.” *Hernandez v. Sessions*, 872 F.3d 976, 998 (9th Cir. 2017) (injunction
16 to “prevent[] future constitutional violations” is “a classic form of prohibitory injunction”)
17 (citing *Ariz. Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1060–61 (9th Cir. 2014)). For
18 example, the Ninth Circuit did not apply a heightened injunction standard when it enjoined
19 a Medicaid regulation thereby requiring the state pay for services that otherwise would have
20 been denied. *M.R. Dreyfus*, 697 F.3d 706, 725 (9th Cir. 2012); *see also*, *Newton-Nations v.*
21 *Rogers*, 316 F.Supp.2d 883 (D. Ariz. 2004) (applying prohibitory injunction standard to
22 enjoin increase in co-pays, incidentally making administration of AHCCCS more costly).

23 And, even if a heightened injunction standard applies, Plaintiffs satisfy that standard.
24 Mandatory injunctions “are permissible when ‘extreme or very serious damage will result’
25 that is not ‘capable of compensation in damages,’ and the merits of the case are not

26 _____
27 ² Defendant also incorrectly asserts that granting D.H. and John’s motion would provide
28 them with all the relief they seek. Def. Br. at 2. But, D.H. and John seek class certification
and much broader injunctive relief. Thus, this motion is targeted to their urgent medical
need for male chest reconstruction surgery and will not provide complete legal relief.

1 ‘doubtful.’” *Hernandez*, 872 F.3d at 999 (quoting *Marlyn Nutraceuticals v. Mucos Pharm.*,
2 571 F.3d 873, 878-79 (9th Cir. 2009)); *see* Def. Br. at 8. Here, the merits of Plaintiffs’ case
3 are far from “doubtful,” and Plaintiffs have established that without access to medically
4 necessary male chest reconstruction surgery they are at risk of “very serious” injury that is
5 “not capable of compensation in damages.” Whatever standard is applied, a preliminary
6 injunction is warranted for the reasons set forth below and in Plaintiffs’ motion, *see* Doc. 3.

7 **B. Likelihood of Success on the Merits**

8 *1. EPSDT requires coverage of male chest reconstruction surgery.*

9 Defendant claims that “AHCCCS does not discriminate against its transgender
10 members or exclude gender dysphoria treatment . . . [it] merely draws the line at gender
11 reconstruction surgery.” But the Early and Periodic Screening, Diagnostic and Treatment
12 (EPSDT) provisions of the Medicaid Act prohibit Defendant from excluding coverage of
13 medically necessary services for individuals under age 21. *Hern v. Beye*, 57 F.3d 906 (10th
14 Cir. 1995), did not hold otherwise. *See* Def. Br. at 14. That case did not even involve an
15 EPSDT claim. *Hern*, 57 F.3d at 910-11. Under EPDST, Defendant must cover any service
16 included in the Medicaid Act when it is “necessary . . . to correct or ameliorate” an illness
17 or condition, regardless of whether and how the service is covered for adults. 42 U.S.C.
18 §§ 1396d(r)(5), 1396a(a)(10)(A), 1396d(a)(4)(B). Defendant does not argue, nor could she,
19 that male chest reconstruction surgery is not included in the Medicaid Act. *See* 42 U.S.C.
20 § 1396d(a)(2)(A) (outpatient hospital services), (5)(A) (services furnished by a physician);
21 *see also* *Flack v. Wis. Dep’t Health Servs.*, 395 F. Supp. 3d 1001 (W.D. Wis. 2019). Given
22 that male chest reconstruction surgery is necessary to correct or ameliorate Plaintiffs’
23 condition, it must be covered pursuant to EPSDT. *See Katie A., ex rel. Ludin v. L.A. County*,
24 481 F. 3d 1150, 1154 (9th Cir. 2007).

25 Defendant’s contention that there is “legitimate debate” as to the safety and efficacy
26 of the surgery has no scientific support. As explained above and in the reply expert
27 declarations, there is no such debate. Male chest reconstruction surgery is not experimental,
28 “risky,” or “unproven.” Def. Br. at 13 (citing *Ellis v. Patterson*, 859 F.2d 52, 55 (8th Cir.

1 1988)); Schechter Reply Decl. ¶ 4. Rather, “the medical profession has reached a formal
2 consensus as to the safety and efficacy of surgical treatments for severe gender dysphoria,”
3 including for adolescents like D.H. and John Doe.³ *Flack*, 395 F. Supp. 3d at 1016; *see*
4 Schechter Reply Decl. ¶ 4; Expert Declaration of Aron Janssen, Doc. 5-5, ¶ 37–47.

5 Similarly, Defendant’s claim that “neither [Plaintiff] has yet demonstrated medical
6 necessity for the service,” is inaccurate. D.H.’s and John’s mental health providers referred
7 them for male chest reconstruction and Dr. Schechter assessed D.H. and John and found
8 them to be good candidates for the surgery. They have also lived as male for multiple years
9 and started testosterone more than a year ago. Peck Decl. ¶ 14–17; Reed Decl. ¶ 10; Expert
10 Declaration of Loren Schechter, Doc. 5-6, ¶ 49. That is more than the standards of care
11 require. *See* WPATH SOC at 21. Defendant also disregards the fact that AHCCCS’s
12 categorical exclusion prevents transgender beneficiaries from establishing medical
13 necessity for male chest reconstruction surgery. EPSDT requires Defendant to remove the
14 exclusion and evaluate each Plaintiff’s request for services based on medical necessity.

15 2. *AHCCCS’s exclusion violates the Comparability Requirement.*

16 The Medicaid Act also requires AHCCCS to ensure that the “medical assistance
17 made available to any [categorically needy] individual . . . shall not be less in amount,
18 duration, or scope than the medical assistance made available to any other such individual.”
19 42 U.S.C. § 1396a(a)(10)(B); 42 C.F.R. § 440.240. Thus, Defendant’s argument that “the
20 exclusion applies to all transgender persons alike” is unavailing. Def. Br. at 14. Her
21 obligation is to ensure that AHCCCS does not “discriminat[e] among individuals with the
22 same medical needs stemming from different medical conditions.” *Davis v. Shah*, 821 F.3d
23 231, 258 (2d Cir. 2016). AHCCCS covers chest reconstruction surgery, including for
24 adolescents, when necessary to treat other conditions; accordingly, it must cover that
25

26 ³ Defendant cites *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980), for the proposition
27 that gender affirming surgery is experimental. *See* Def. Br. at 13. That case is four decades
28 old. Even assuming that the court was correct, and it was reasonable for Georgia to
characterize the service as experimental in the mid-1970s, that same determination is wholly
unreasonable today.

1 treatment for gender dysphoria. *See Flack.*, 395 F. Supp. 3d at 1019 (holding exclusion for
2 “transsexual surgery” impermissibly “discriminates on the basis of diagnosis”).

3 As Defendant correctly states, “need is the only basis upon which distinctions
4 between recipients can be made without violating the comparability requirement.” *V L. v.*
5 *Wagner*, 669 F. Supp. 2d 1106, 1117 (N.D. Cal. 2009). As described above and in the
6 extensive declarations accompanying Plaintiffs’ motion, male chest reconstruction surgery
7 is medically necessary for individuals with gender dysphoria, including some adolescents.
8 Defendant tries to circumvent her obligation to cover the surgery by arguing that individuals
9 with gender dysphoria do not have the same need for chest reconstruction surgery as
10 individuals with other conditions. But where the same service is required to treat multiple
11 medical conditions, the need for the service is rarely identical. *See Davis v. Shah*, 821 F.3d
12 231, 258 (2d Cir. 2016). Recognizing that fact, the Second Circuit held a rule that covered
13 orthopedic footwear and compression stockings to treat complications for some conditions,
14 but not others, violated the comparability requirement. *Id.* Here, Plaintiffs have established
15 that the only reason that AHCCCS will not cover the surgery they need is because it was
16 prescribed to treat gender dysphoria, instead of another condition such as breast cancer or
17 fibrocystic breast disease. That differential treatment violates the Medicaid Act.

18 3. *Section 1557 prohibits excluding surgical care for gender dysphoria.*

19 Federal courts have consistently held that discrimination against transgender people
20 is sex discrimination, including under Section 1557 of the ACA. *Prescott v. Rady*
21 *Children’s Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098–99 (S.D. Cal. 2017) (Section
22 1557); *see also Adams v. Sch. Bd. of St. Johns Cty.*, 968 F.3d 1286, 1304 (11th Cir. 2020)
23 (Title IX); *Schwenk v. Hartford*, 204 F.3d 1187, 1201–02 (9th Cir. 2000) (Gender Motivated
24 Violence Act). The Supreme Court’s decision in *Bostock v. Clayton County, Ga.* is the latest
25 in a long line of such cases. 140 S. Ct. 1731, 1737 (2020).⁴ Even before *Bostock* confirmed
26

27 ⁴ Justice Alito’s recognition of the implications of *Bostock* on health care benefits further
28 demonstrates the majority opinion’s definition of sex discrimination is to be applied
consistently across federal sex-discrimination statutes.

1 that discrimination against transgender people constitutes sex discrimination, insurance
2 exclusions that discriminated against transgender people were consistently struck down.
3 *See, e.g., Flack v. Wis. Dept. of Health Svcs.*, 395 F.Supp.3d 1001 (W.D. Wis. 2019);
4 *Boyden v. Conlin*, 341 F.Supp.3d 979 (W.D. Wis. 2018); *see also Kadel v. Folwell*, 446
5 F.Supp.3d 1 (M.D.N.C. 2020) (denying motion to dismiss on Title IX, Section 1557, and
6 equal-protection claims).

7 Defendant's claim that the exclusion is not discriminatory because AHCCCS covers
8 other treatments for gender dysphoria is without merit. Section 1557 protects individuals
9 from discrimination in covered health care settings and health insurance plans. As a covered
10 entity, AHCCCS's categorical exclusion denies D.H. and John medically necessary surgical
11 care because they are transgender. The surgery would have been covered if D.H. and John
12 were males with gynecomastia or females who required chest surgery to treat cancer or
13 traumatic injury. And, as detailed above and in the accompanying expert declarations, there
14 is no other legitimate basis for denying D.H. and John coverage for male chest
15 reconstruction surgery. Thus, AHCCCS is making an impermissible distinction based on
16 transgender status, and therefore sex. That AHCCCS covers other treatments for gender
17 dysphoria or would also discriminate transgender women seeking coverage for similar
18 treatments is no defense. To the contrary, by discriminating against transgender men and
19 transgender women equally, AHCCCS doubles its liability. *Bostock*, 140 S. Ct. at 1741.

20 The recent change in the federal regulations implementing Section 1557 does not
21 affect D.H. and John's likelihood of success on this claim. As Defendant correctly noted,
22 those regulations have been enjoined because the regulations were found to be arbitrary and
23 capricious, and "contrary to law" for failing to address the effect of *Bostock* on Section
24 1557. *Walker v. Azar*, 2020 WL 4749859, at *8–10 (E.D.N.Y. Aug. 17, 2020). But even if
25 that were not the case, the ACA prohibits discrimination based on sex, which, as the
26 Supreme Court recently affirmed, encompasses discrimination based on transgender status.
27 For reasons discussed above, any negative inference that might be drawn from the
28 regulations cannot be reconciled with the plain text of Section 1557 or the body of caselaw

1 interpreting sex-discrimination protections to prohibit discrimination against transgender
2 people, including *Bostock*. Consequently, Defendant has provided no basis to doubt that
3 D.H. and John are likely to succeed on their Section 1557 claim.

4 4. *AHCCCS's exclusion violates the Equal Protection Clause.*

5 Defendant's exclusion of coverage for gender-confirmation surgery is subject to
6 heightened scrutiny, which it cannot survive. As *Bostock* clearly holds, discrimination based
7 on transgender status is a form of sex discrimination. 140 S. Ct. at 1741; *see also Grimm v.*
8 *Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 607–08 (4th Cir. 2020); *Adams*, 968 F.3d at 1296
9 (11th Cir. 2020); *Whitaker v. Kenosha Unified Sch. Dist. No. 1*, 858 F. 3d 1034, 1051 (7th
10 Cir. 2017); *Smith v. City of Salem*, 378 F.3d 566, 572 (6th Cir. 2004). Defendant provides
11 no basis for ignoring this controlling precedent. The two cases she cites pre-date *Bostock*
12 and have been superseded by that case. *Druley v. Patton*, 601 F.App'x 632, 635 (10th Cir.
13 2015), relied on *Etsitty v. Utah Transit Authority*, 502 F.3d 1215, 1227 (10th Cir. 2007),
14 which erroneously held that Title VII does not protect transgender employees and is no
15 longer good law.⁵ In *Jamison v. Davue*, the court, in dicta, instructed a *pro se* plaintiff that
16 transgender status is not a suspect class under the Equal Protection Clause, without any
17 analysis or citation, 2012 WL 996383, *4 (E.D.Cal. 2012); this instruction was then cited
18 in the other district court decisions cited by Defendant. *See, e.g., Braninburg v. Coalinga*
19 *State Hosp.*, 2012 WL 3911910, *8 (E.D. Cal. 2012); *Kaeo-Tomaselli v. Butts*, 2013 WL
20 399184, *5 (D. Haw. 2013); *Murillo v. Parkinson*, 2015 WL 3791450, *12 (C.D. Cal.
21 2015). Plainly, however, that instruction has been superseded by *Bostock*.

22 AHCCCS's attempt to avoid heightened scrutiny by reframing its categorical
23 exclusion as “a facially neutral policy regarding one specific category of services” is
24 unavailing. The policy excludes all surgical treatments needed by transgender people to
25

26 ⁵ Defendant's reliance on *Stevens v. Williams* and *Johnston v. University of Pittsburgh* fails
27 for the same reason. Those courts also relied on cases predating, and superseded by,
28 *Bostock*. *See Johnston*, 97 F. Supp. 3d 657, 677 (W.D. Pa. 2015) (citing *Ulane v. E. Airlines,*
Inc., 742 F.2d 1081, 1086 (7th Cir. 1984)); *Stevens*, 2008 WL 916991, *13 (D. Or. 2008)
(citing *Holloway v. Arthur Andersen & Co.*, 566 F.2d 659 (9th Cir. 1977)).

1 treat gender dysphoria, while covering the same surgical treatments for non-transgender
2 people undergoing treatment for other medical conditions. As the court explained in
3 *Norsworthy v. Beard*, a policy that expressly excludes gender-confirmation surgeries is
4 discriminatory on its face. *See* 87 F. Supp. 3d 1104, 1109, 1119–20 (N.D. Cal. 2015).

5 AHCCCS cannot show that this sex-based exclusion is supported by an exceedingly
6 persuasive or even legitimate justification. AHCCCS asserts that it has a sufficient interest
7 in excluding male chest reconstructive surgery because of its cost and irreversibility. But
8 AHCCCS covers many expensive and irreversible procedures for a host of conditions, even
9 for minors. And in any case, the mere fact that denying coverage for a procedure would
10 save money cannot satisfy even rational basis review, much less the heightened scrutiny
11 that applies here. *See Diaz v. Brewer*, 656 F.3d 1008, 1014 (9th Cir. 2011). Nor can
12 AHCCCS claim a legitimate interest in excluding coverage for surgical care that is
13 supported by the well-established standards for the treatment of gender dysphoria,
14 especially when AHCCCS otherwise adheres to those standards to cover other treatments
15 for gender dysphoria. There is no legitimate, much less exceedingly persuasive, justification
16 for covering some medically necessary treatments for gender dysphoria, but not others.
17 Thus, the justifications proffered by Defendant cannot even satisfy rational basis.

18 **C. D.H. and John continue to experience irreparable harm.**

19 Defendant’s attempts to diminish the ongoing and pervasive harm D.H. and John
20 experience are inconsistent with the direct and substantial evidence before this Court.

21 Defendant seeks to minimize those harms by claiming that the “principal source” of
22 “medical harm” to D.H. and John is “the binding that each Plaintiff wears.” In fact, the
23 principal source of harm is the denial of medically needed care, which will have a permanent
24 negative impact on their mental and physical health. Defendant ignores the serious harms
25 to D.H.’s and John’s mental health due to the continued denial of care as detailed in the
26 extensive declarations by Plaintiffs, their health care providers, and experts. *See, e.g.*,
27 Declaration of D.H., Doc. 5, ¶ 9–15; Declaration of John Doe, Doc. 4, ¶ 14–17; Peck Decl.
28 ¶ 21; Reed Decl. ¶¶ 12–13; Janssen Reply Decl. ¶ 33; Schechter Reply Decl. ¶ 15. Without

1 male chest reconstruction surgery, D.H.'s and John's mental health will deteriorate, which
2 is particularly concerning given their history of self-harm, suicidal ideation, and, for D.H.,
3 psychiatric hospitalizations. The delay in obtaining this critical surgical care also impairs
4 D.H.'s and John's ability to treat their co-occurring mental health conditions, making those
5 conditions more difficult to treat. Those too are irreparable injuries.

6 Moreover, Defendant fails even to acknowledge, much less rebut, the extensive
7 evidence that the binding prevents D.H. and John from engaging in a variety of activities,
8 including sports, dancing, and other recreational and social activities that are critical to both
9 their short- and long-term health and well-being. The binding places significant limitations
10 on Plaintiffs' ability to function, preventing D.H. from fully engaging in school and
11 interfering in John's social interactions with his peers. These lost opportunities are
12 quintessential irreparable injuries; they will negatively affect Plaintiffs for their rest of their
13 lives, in ways that money damages cannot remedy. *McCormick v. Sch. Dist. of*
14 *Mamaroneck*, 370 F.3d 275 (2d Cir. 2004); *Doe v. Wood Cty. Bd. of Educ.*, 888 F. Supp. 2d
15 771 (S.D.W. Va. 2012). Defendant also dismisses the serious risk that binding will
16 exacerbate D.H.'s asthma during the pendency of this case. No amount of monetary
17 damages will give him back that lost lung capacity, which is particularly damaging for D.H.
18 because of its likely impact on his ability to return to dancing.

19 Defendant's efforts to distinguish the cases cited by Plaintiffs lack merit. The fact
20 that Plaintiffs' gender dysphoria is not as predictably lethal as AIDS once was does not
21 change the fact that D.H. and John proffered substantial evidence that they qualify for male
22 chest reconstruction under the prevailing standards of care and that their health and
23 wellbeing will be irreparably damaged, including the possibility of serious depression and
24 suicidality, if they are forced to wait until after trial for relief. *See* Def. Br. at 11 (citing
25 *Chalk v. U.S. Dist. Court Cent. Dist. of Cal.*, 840 F.2d 701 (9th Cir. 1988)). As courts have
26 recognized in other cases, the harms caused to transgender youth by denials of medically
27 needed care or by the enforcement of policies that undermine their medical treatment
28 warrant preliminary relief. *See, e.g., Whitaker v. Kenosha Unified Sch. Dist.*, Case No. 16-

CV-943-PP, 2016 WL 5239829, at *4-6 (E.D. Wis. Sept. 22, 2016) (declarations supported finding of irreparable harm if school continued to treat plaintiff differently because he is transgender), *aff'd*, 858 F.3d 1034 (7th Cir. 2017); *Highland Local Sch. Dist.*, 208 F. Supp. 3d at 870 (“Some issues in this case are difficult, but determining whether Jane has been harmed from the School District’s policy is not one of them.”).

Further, D.H. and John have established irreparable harm due to their strong likelihood of success on the merits of each of their claims. Violations of federal constitutional rights and statutory antidiscrimination protections are irreparable injuries. *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012); *see Silver Sage Partners, Ltd. v. City of Desert Hot Springs*, 251 F.3d 814, 827 (9th Cir. 2001) (recognizing presumption of irreparable injury in Fair Housing Act claim); *Smallwood v. Nat’l Can Co.*, 583 F.2d 419, 420 (9th Cir. 1978) (same, but on Title VII claim). That principle applies in full force here.

D. The balance of harms decisively favors D.H. and John.

When considering whether to issue a preliminary injunction, the Court should consider the parties’ respective “competing claims of injury,” and “the effect on each party of the granting or withholding of the requested relief.” *Arc of Cal. v. Douglas*, 757 F.3d 975, 991 (9th Cir. 2014). Contrary to Defendant’s claim, Plaintiffs have established “that chest reconstruction surgery is safe, effective, and urgent for them.” Def. Br. at 18; *see* WPATH SOC 21; Janssen Decl. ¶ 46; Schechter Decl. ¶¶ 23–37. Thus, Defendant’s suggestion that AHCCCS would be harmed by covering services that are ineffective or unsafe is not relevant here. Also, the cost of male chest reconstruction surgery for D.H. and John would be miniscule, at best, in proportion to AHCCCS’s budget, and cannot outweigh the irreparable harm to D.H. and John. *See, e.g., Flack*, 395 F. Supp. 3d at 1008.

Defendant has proffered no harm sufficient to overcome the serious physical and emotional harm D.H. and John experience due to AHCCCS’s categorical exclusion for surgical care to treat gender dysphoria. The balance of equities weighs heavily in favor of prohibiting Defendant from denying D.H. and John coverage for male chest reconstruction surgery, a critical and medically necessary treatment for their gender dysphoria.

Respectfully submitted,

DATED: OCTOBER 26, 2020

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/s/ Daniel C. Barr

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15
16
17 **IN THE UNITED STATES DISTRICT COURT**
18 **FOR THE DISTRICT OF ARIZONA**
19

20 D.H., by and through his mother, Janice
21 Hennessy-Waller; and John Doe, by and
22 through his guardian and next friend, Susan
23 Doe, on behalf of themselves and all others
24 similarly situated,

25 Plaintiffs,

26 vs.

27 Jami Snyder, Director of the Arizona Health
28 Care Cost Containment System, in her
official capacity,

Defendant.

Case No. 4:20-cv-00335-SHR

**EXPERT DECLARATION OF DR.
STEPHEN B. LEVINE, M.D.**

(Assigned to the Honorable Scott H.
Rash)

1 I, Stephen B. Levine, M.D., hereby declare as follows:

2 1. I am over the age of eighteen and submit this expert declaration based on
3 my personal knowledge and experience.

4 2. I am a Clinical Professor of Psychiatry at Case Western Reserve University
5 School of Medicine, and maintain an active private clinical practice. I received my M.D.
6 from Case Western Reserve University in 1967, and completed a psychiatric residency at
7 the University Hospitals of Cleveland in 1973. I became an Assistant Professor of
8 Psychiatry at Case Western in 1973, and became a Full Professor in 1985.

9 3. Since July 1973 my specialties have included psychological problems and
10 conditions relating to sexuality and sexual relations, therapies for sexual problems, and
11 the relationship between love and intimate relationships and wider mental health. I am a
12 Distinguished Life Fellow of the American Psychiatric Association.

13 4. I have served as a book and manuscript reviewer for numerous professional
14 publications. I have been the Senior Editor of the first (2003), second (2010) and third
15 (2016) editions of the *Handbook of Clinical Sexuality for Mental Health Professionals*. In
16 addition to five other solo-authored books, I have authored *Psychotherapeutic*
17 *Approaches to Sexual Problems*, published in 2020; it has a chapter titled "The Gender
18 Revolution."

19 5. I first encountered a patient suffering what we would now call gender
20 dysphoria in July 1973. In 1974, I founded the Case Western Reserve University Gender
21 Identity Clinic, and have served as Co-Director of that clinic since that time. Across the
22 years, our Clinic treated hundreds of patients who were experiencing a transgender
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1 identity. An occasional child was seen during this era. I was the primary psychiatric
2 caregiver for several dozen of our patients and supervisor of the work of other therapists.
3 I was an early member of the Harry Benjamin International Gender Dysphoria
4 Association (later known as WPATH) and served as the Chairman of the Standards of
5 Care Committee that developed the 5th version of its Standards of Care. In 1993 the
6 Gender Identity Clinic was renamed, moved to a new location, and became independent
7 of Case Western Reserve University. I continue to serve as Co-Director.
8

9
10 6. A review of my professional experience, publications, and awards as well
11 as identification of cases in which I have provided expert testimony within the last 13
12 years, is provided in my CV, a copy of which is attached hereto as Exhibit A.
13

14 7. I have been retained by Defendant in the above-captioned lawsuit to
15 provide an expert opinion on the standards of care for treating adolescents diagnosed
16 with gender dysphoria.

17 8. If called to testify in this matter, I would testify truthfully and based on
18 my expert opinion. The opinions and conclusions I express herein are based on a
19 reasonable degree of medical and scientific certainty.
20

21 9. In this declaration, I offer, explain, and identify my opinions and the
22 bases for my opinions in this matter. Each of the opinions set forth herein is based on
23 my professional expertise and experience as described above and I hold each of the
24 opinions set forth herein to a reasonable degree of certainty within my field. The facts
25 upon which I rely are the type of facts reasonably relied upon by experts within my
26 field.
27
28

1 10. I am being compensated at an hourly rate of \$375 per hour plus expenses
2 for my time spent preparing this declaration. My rate to prepare for and provide
3 testimony is \$500 per hour plus expenses. My compensation does not depend on the
4 outcome of this litigation, the opinions I express, or the testimony I may provide.
5

6 **I. BACKGROUND ON THE FIELD**

7 **A. The biological base-line of sex**

8 11. The sex of a human individual at its core structures the individual's
9 biological reproductive capabilities—to produce ova and bear children as a mother, or
10 to produce semen and beget children as a father. Sex determination occurs at the
11 instant of conception, depending on whether a sperm's X or Y chromosome fertilizes
12 the egg. Medical technology can be used to determine a fetus's sex before birth. It is
13 thus not literally correct to assert that doctors "assign" the sex of a child at birth;
14 anyone can identify the sex of an infant by genital inspection. What the general public
15 may not understand, however, is that every nucleated cell of an individual's body is
16 chromosomally identifiably male or female—XY or XX.
17

18 12. The self-perceived gender of a child, in contrast, arises in part from how
19 others label the infant: "I love you, son (daughter)." This designation occurs thousands
20 of times in the first two years of life when a child begins to show awareness of the two
21 possibilities. As acceptance of the designated gender corresponding to the child's sex is
22 the outcome in >99% of children everywhere, anomalous gender identity formation
23 begs for understanding. Is it biologically shaped? Is it biologically determined? Is it the
24 product of how the child was privately regarded and treated? Does it stem from
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1 trauma-based rejection of maleness or femaleness, and if so flowing from what
2 trauma? Is it a symptom of another, as of yet unrevealed emotional disturbance? Does
3 it derive from a child's (mis)understanding of future possibilities of maleness or
4 femaleness? The answers to these relevant questions are not scientifically known.
5

6 13. Under the influence of hormones secreted by the testes or ovaries,
7 numerous additional sex-specific differences between male and female bodies
8 continuously develop post-natally, culminating in the dramatic maturation of the
9 primary and secondary sex characteristics with puberty. These include differences in
10 hormone levels, height, weight, bone mass, shape and development, internal organ size,
11 musculature, body fat levels and distribution, and hair patterns, as well as physiological
12 differences such as menstruation. These are genetically programmed biological
13 consequences of sex that also serve to influence the consolidation of gender identity
14 during and after puberty.
15

16 14. Despite the increasing ability of hormones and various surgical
17 procedures to reconfigure some male bodies to visually pass as female, or vice versa,
18 the biology of the person remains as defined by his (XY) or her (XX) chromosomes,
19 including cellular, anatomic, and physiologic characteristics and the particular disease
20 vulnerabilities associated with that chromosomally-defined sex. For instance, the XX
21 (genetically female) individual who takes testosterone to stimulate certain male
22 secondary sex characteristics will nevertheless remain unable to produce sperm and
23 father children. Contrary to assertions and hopes that medicine and society can fulfill
24 the aspiration of the trans individual to become "a complete man" or "a complete
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1 woman,” this is not biologically attainable.¹ It is possible for some adolescents and
2 adults to pass unnoticed as the opposite gender that they aspire to be—but with
3 limitations, costs, and risks, as I detail later.
4

5 **B. Definition and diagnosis of gender dysphoria**

6 15. Specialists have used a variety of terms over time, with somewhat
7 shifting definitions, to identify and speak about a distressing incongruence between an
8 individual’s sex as determined by their chromosomes and their thousands of contained
9 genes, and the gender with which they eventually subjectively identify or to which they
10 aspire. Today’s American Psychiatric Association *Diagnostic and Statistical Manual of*
11 *Mental Disorders* (“DSM-5”) employs the term Gender Dysphoria and defines it with
12 separate sets of criteria for adolescents and adults on the one hand, and children on the
13 other.
14
15

16 16. The criteria used in DSM-5 to identify Gender Dysphoria include a
17 number of signs of discomfort with one’s natal sex and vary somewhat depending on the
18 age of the patient, but in all cases require “clinically significant distress or impairment in
19 . . . important areas of functioning” such as social, school, or occupational settings.
20

21 17. When these criteria in children, (or adolescents, or adults) are not met,
22 two other diagnoses may be given. These are: Other Specified Gender Dysphoria and
23 Unspecified Gender Dysphoria. Specialists sometimes refer to children who do not
24 meet criteria as being “subthreshold.”
25
26

27 ¹ S. Levine (2018), *Informed Consent for Transgendered Patients*, J. OF SEX & MARITAL THERAPY, at 6, DOI:
28 10.1080/0092623X.2018.1518885 (“*Informed Consent*”); S. Levine (2016), *Reflections on the Legal Battles Over*
Prisoners with Gender Dysphoria, J. AM. ACAD. PSYCHIATRY LAW 44, 236 at 238 (“*Reflections*”).

18. Children who conclude that they are transgender are often unaware of a vast array of adaptive possibilities for how to live life as a man or a woman—possibilities that become increasingly apparent over time to both males and females. A boy or a girl who claims or expresses interest in pursuing a transgender identity often does so based on stereotypical notions of femaleness and maleness that are based on constrictive notions of what men and women can be.² A young child's—or even adolescent's—understanding of this topic is quite limited. Nor do they have the perspective that discomfort with the body and perceived social role is not new to civilization; what is new is the option to become a trans person.

C. Impact of gender dysphoria on minority and vulnerable groups

19. In considering the appropriate response to gender dysphoria, it is important to know that certain groups of children have an increased prevalence and incidence of trans identities. These include: minority children,³ children with mental developmental disabilities⁴ including children on the autistic spectrum (at a rate more than 7x the general population),⁵ children residing in foster care homes, adopted children (at a rate more than 3x the general population),⁶ children with a prior history of

² S. Levine (2017), *Ethical Concerns About Emerging Treatment Paradigms for Gender Dysphoria*, J. OF SEX & MARITAL THERAPY at 7, DOI: 10.1080/0092623X.2017.1309482 (“Ethical Concerns”).

³ G. Rider et al. (2018), *Health and Care Utilization of Transgender/Gender Non-Conforming Youth: A Population Based Study*, PEDIATRICS at 4, DOI: 10.1542/peds.2017-1683. (In a large sample, non-white youth made up 41% of the set who claimed a transgender or gender non conforming identity, but only 29% of the set who had a gender identity consistent with their sex.)

⁴ D. Shumer & A. Tishelman (2015), *The Role of Assent in the Treatment of Transgender Adolescents*, INT. J. TRANSGENDERISM at 1, DOI: 10.1080/15532739.2015.1075929.

⁵ D. Shumer et al. (2016), *Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic*, LGBT HEALTH, 3(5) 387 at 387.

⁶ D. Shumer et al. (2017), *Overrepresentation of Adopted Adolescents at a Hospital- Based Gender Dysphoria Clinic*, TRANSGENDER HEALTH Vol. 2(1) 76 at 77.

1 psychiatric illness,⁷ and more recently adolescent girls (in a large recent study, at a rate
2 more than 2x that of boys). (G. Rider at 4.)

3
4 **D. Three competing conceptual models of gender dysphoria and transgender
5 identity**

6 20. Discussions about appropriate responses by mental health professionals
7 (“MHPs”) to actual or sub-threshold gender dysphoria are complicated by the fact that
8 various speakers and advocates (or a single speaker at different times) view
9 transgenderism through at least three very different paradigms, often without being
10 aware of, or at least without acknowledging, the distinctions.

11
12 21. Gender dysphoria is **conceptualized and described by some**
13 **professionals and laypersons as though it were a serious, physical medical illness**
14 **that causes suffering**, comparable, for example, to prostate cancer, a disease that is
15 curable before it spreads. Within this paradigm, whatever is causing distress associated
16 with gender dysphoria—whether secondary sex characteristics such as facial hair, nose
17 and jaw shape, presence or absence of breasts, or the primary anatomical sex organs of
18 testes, ovaries, penis, or vagina—should be removed to alleviate the illness. The
19 promise of these interventions is the cure of the gender dysphoria.
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23 ⁷ L. Edwards-Leeper et al. (2017), *Psychological Profile of the First Sample of Transgender Youth Presenting for*
24 *Medical Intervention in a U.S. Pediatric Gender Center*, PSYCHOLOGY OF SEXUAL ORIENTATION AND
25 GENDER DIVERSITY, 4(3) 374 at 375 (“*Psychological Profile*”); R. Kaltiala-Heino et al. (2015), *Two Years of*
26 *Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent*
27 *Development*, CHILD & ADOLESCENT PSYCHIATRY & MENTAL HEALTH 9(9) 1 at 5. (In 2015 Finland gender
28 identity service statistics, 75% of adolescents assessed “had been or were currently undergoing child and adolescent
psychiatric treatment for reasons other than gender dysphoria.”); L. Littman (2018), *Parent Reports of Adolescents &*
Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria, PLoS ONE 13(8): e0202330 at 13
(Parental survey concerning adolescents exhibiting Rapid Onset Gender Dysphoria reported that 62.5% of gender
dysphoric adolescents had “a psychiatric disorder or neurodevelopmental disability preceding the onset of gender
dysphoria.”).

1 22. It should be noted, however, that gender dysphoria is a psychiatric
2 rather than a medical diagnosis. Since its inception in DSM-III, it has always and
3 only been specified in the psychiatric DSM manuals. Notably, gender dysphoria is
4 the only psychiatric condition to be treated by surgery, even though no endocrine or
5 surgical intervention package corrects any identified biological abnormality. (Levine,
6 *Reflections*, at 240.)
7

8
9 23. Gender dysphoria is alternatively **conceptualized in developmental**
10 **terms**, as an adaptation to a psychological problem that was first manifested as a failure
11 to establish a comfortable conventional sense of self in early childhood. This paradigm
12 starts from the premise that all human lives are influenced by past processes and events.
13 Trans lives are not exceptions to this axiom. (Levine, *Reflections*, at 238.) MHPs who
14 think of gender dysphoria through this paradigm may work both to identify and address
15 causes of the basic problem of the deeply uncomfortable self, and also to ameliorate
16 suffering when the underlying problem cannot be solved. They work with the patient
17 and (ideally) family to inquire what forces may have led to the trans person repudiating
18 the gender associated with his sex. The developmental paradigm is mindful of
19 temperamental, parental bonding, psychological, sexual, and physical trauma
20 influences, and the fact that young children work out their psychological issues through
21 fantasy and play.
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25 24. In addition, the developmental paradigm recognizes that, with the
26 important exception of genetic sex, essentially all aspects of an individual's
27 multifaceted identity evolve—often markedly—across the individual's lifetime.
28

(Levine, *Psychotherapeutic Approaches to Sexual Problems*, Chapter 6 “The Gender Revolution”) This includes gender. While some advocates assert that a transgender identity is biologically caused, fixed from early life, and eternally present in an unchanging manner, this is not supported by science. Although numerous studies have been undertaken to attempt to demonstrate a distinctive physical brain structure associated with transgender identity, as of yet there is no evidence that these patients have any defining abnormality in brain structure that precedes the onset of gender dysphoria. The belief that gender dysphoria is the consequence of brain structure is challenged by the sudden increase in incidence of child and adolescent gender dysphoria over the last twenty years in North America and Europe. Meanwhile, multiple studies have documented rapid shifts in gender ratios of patients presenting for care with gender-related issues, pointing to cultural influences,⁸ while a recent study documented “clustering” of new presentations in specific schools and among specific friend groups, pointing to social influences (Littman). Both of these findings strongly suggest cultural factors. From the beginning of epidemiological research into this arena, there have always been some countries, Poland and Australia, for example, where the sex ratios were reversed as compared to North America and Europe, again demonstrating a powerful effect of cultural influences.

25. In recent years, for adolescent patients, intense involvement with online transgender communities or “friends” is the rule rather than the exception, and the MHP

⁸ Levine, *Ethical Concerns*, at 8 (citing M. Aitken, T. D. Steensma, et al. (2015), *Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria*, J. OF SEXUAL MEDICINE 12(3) 756 at 756-63).

1 will also be alert to this as a potentially significant influence on the identity development
2 of the patient.

3 26. The third paradigm through which gender dysphoria is alternatively
4 conceptualized is from a **sexual minority rights perspective**. Under this paradigm, any
5 response other than medical and societal affirmation and implementation of a patient's
6 claim to "be" the opposite gender is a violation of the individual's civil right to self-
7 expression. Any effort to ask "why" questions about the patient's condition, or to
8 address underlying causes, is viewed as a violation of autonomy and civil rights. In the
9 last few years, this paradigm has been successful in influencing public policy and the
10 education of pediatricians, endocrinologists, public school officials, and many mental
11 health professionals.

12 **E. Four competing models of therapy**

13 27. Because of the complexity of the human psyche and the difficulty of
14 running controlled experiments in this area, substantial disagreements among
15 professionals about the causes of psychological disorders, and about the appropriate
16 therapeutic responses, are not unusual. When we add to this the very different
17 paradigms for understanding transgender phenomena discussed above, it is not
18 surprising that such disagreements also exist with regard to appropriate therapies for
19 patients experiencing gender-related distress. I summarize below the leading
20 approaches, and offer certain observations and opinions concerning them.

21 **(1) The "watchful waiting" therapy model**

22 28. I review below the uniform finding of follow-up studies that the large
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majority of children who present with gender dysphoria will desist from desiring a transgender identity by adulthood if left untreated. (See *infra* ¶ 58.)

29. When a pre-adolescent child presents with gender dysphoria, a “watchful waiting” approach seeks to allow for the fluid nature of gender identity in children to naturally evolve—that is, take its course from forces within and surrounding the child. Watchful waiting has two versions:

a. Treating any other psychological co-morbidities—that is, other mental illnesses as defined by the DSM—that the child may exhibit (separation anxiety, bedwetting, attention deficit disorder, social anxiety, obsessive-compulsive disorder) without a focus on gender (model #1), and

b. No treatment at all for anything, but a regular follow-up appointment. This might be labeled a “hands off” approach (model #2).

(2) The psychotherapy model: Alleviate distress by identifying and addressing causes (model #3)

30. One of the foundational principles of psychotherapy has long been to work with a patient to identify the causes of observed psychological distress and then to address those causes as a means of alleviating the distress. The National Institute of Mental Health has promulgated the idea that 75% of adult psychopathology has its origins in childhood experience.

31. Many experienced practitioners in the field of gender dysphoria, including myself, have believed that it makes sense to employ these long-standing tools of psychotherapy for patients suffering gender dysphoria, asking the question as to what factors in the patient’s life are the determinants of the patient’s repudiation of his or her

1 natal sex. (Levine, *Ethical Concerns*, at 8.) I and others have reported success in
2 alleviating distress in this way for some patients, whether or not the patient's sense of
3 discomfort or incongruence with his or her natal sex entirely disappeared. Relieving
4 accompanying psychological co-morbidities leaves the patient freer to consider the pros
5 and cons of transition as he or she matures.

7 32. Among other things, the psychotherapist who is applying traditional
8 methods of psychotherapy may help—for example—the male patient appreciate the
9 wide range of masculine emotional and behavioral patterns as he grows older. He may
10 discuss with his patient, for example, that one does not have to become a “woman” in
11 order to be kind, compassionate, caring, noncompetitive, and devoted to others’
12 feelings and needs.⁹ Many biologically male trans individuals, from childhood to older
13 ages, speak of their perceptions of femaleness as enabling them to discuss their
14 feelings openly, whereas they perceive boys and men to be constrained from
15 emotional expression within the family and larger culture. Men, of course, can be
16 emotionally expressive, just as they can wear pink. Converse examples can be given
17 for girls and women. These types of ideas regularly arise during psychotherapies.

21 33. As I note above, many gender-nonconforming children and adolescents
22 in recent years derive from minority and vulnerable groups who have reasons to feel
23 isolated and have an uncomfortable sense of self. A trans identity may be a hopeful
24 attempt to redefine the self in a manner that increases their comfort and decreases their
25

27
28 ⁹ S. Levine (2017), *Transitioning Back to Maleness*, ARCH. OF SEXUAL BEHAVIOR at 7, DOI: 10.1007/s10508-017-1136-9 (“*Transitioning*”).

1 anxiety. The clinician who uses traditional methods of psychotherapy may not focus on
2 their gender identity, but instead work to help them to address the actual sources of
3 their discomfort. Success in this effort may remove or reduce the desire for a redefined
4 identity. This often involves a focus on disruptions in their attachment to parents in
5 vulnerable children, for instance, those in the foster care system.

6
7 34. Because “watchful waiting” can include treatment of accompanying
8 psychological co-morbidities, and the psychotherapist who hopes to relieve gender
9 dysphoria may focus on potentially causal sources of psychological distress rather than
10 on the gender dysphoria itself, there is no sharp line between “watchful waiting” and
11 the psychotherapy model in the case of prepubescent children.

12
13 35. To my knowledge, there is no evidence beyond anecdotal reports that
14 psychotherapy can enable a return to male identification for genetically male boys,
15 adolescents, and men, or return to female identification for genetically female girls,
16 adolescents and women. On the other hand, anecdotal evidence of such outcomes does
17 exist; I and other clinicians have witnessed reinvestment in the patient’s biological sex
18 in some individual patients who are undergoing psychotherapy. The Internet contains
19 many such reports, and I have published a paper recently on a patient who sought my
20 therapeutic assistance to reclaim his male gender identity after 30 years living as a
21 woman and is in fact living as a man today. (Levine, *Transitioning*, at 1.) I have seen
22 children desist even before puberty in response to thoughtful parental interactions and
23 a few meetings of the child with a therapist.

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27 **(3) The affirmation therapy model (model #4)**
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1 36. While it is widely agreed that the therapist should not directly challenge a
2 claimed transgender identity in a child, some advocates and practitioners go much
3 further, and promote and recommend that any expression of transgender identity should
4 be immediately accepted as decisive, and thoroughly affirmed by means of consistent
5 use of clothing, toys, pronouns, etc. associated with transgender identity. These
6 advocates treat any question about the causes of the child's transgender identification
7 as inappropriate, and assume that observed psychological co-morbidities in the children
8 or their families are unrelated or will get better with transition, and need not be
9 addressed by the MHP who is providing supportive guidance concerning the child's
10 gender identity.
11

12 37. Some advocates, indeed, assert that unquestioning affirmation of any
13 claim of transgender identity in children is essential, and that the child will otherwise
14 face a high risk of suicide or severe psychological damage. I address claims about
15 suicide and health outcomes in Section IV below.
16

17 38. Some advocates also assert that this "affirmation therapy" model is
18 accepted and agreed with by the overwhelming majority of mental health professionals.
19 However, one respected academic in the field has recently written that, on the contrary,
20 "almost all clinics and professional associations in the world" do not use "gender
21 affirmation" for prepubescent children and instead "delay any transitions after the onset
22 of puberty."¹⁰ The National Health Service in the United Kingdom announced on
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28 ¹⁰ J. Cantor (2019), *Transgender and Gender Diverse Children and Adolescents: Fact- Checking of AAP Policy*, J. OF SEX & MARITAL THERAPY at 1, DOI: 10.1080.0092623X.2019.1698481.

1 September 22, 2020 that they were undertaking a thorough review of how children and
2 adolescents with atypical gender identities are being treated in England. This indicates
3 a great deal of doubt about the wisdom of rapid affirmative care.
4

5 39. Even the Standards of Care published by WPATH, an organization which
6 in general leans strongly towards affirmation in the case of adults, does not specify
7 affirmation of transgender identity as the indicated therapeutic response for young
8 children, but rather calls for a careful process of discernment and decision specific to
9 each child by the family in consultation with the mental health professional.
10

11 40. Further, the DSM-5 added—for both children and adolescents—a
12 requirement that a sense of incongruence between biological and felt gender must last
13 at least six months as a precondition for a diagnosis of gender dysphoria, precisely
14 because of the risk of “transitory” symptoms and “hasty” diagnosis that might lead to
15 “inappropriate” treatments.¹¹
16

17 41. I do not know what proportion of practitioners are using which model.
18 However, in my opinion, in the case of young children, prompt and thorough
19 affirmation of a transgender identity disregards the principles of child development
20 and family dynamics, and is not supported by science. Rather, the MHP must focus
21 attention on the child’s underlying internal and familial issues. Ongoing relationships
22 between the MHP and the parents and the MHP and the child are vital to help the
23 parents, child, other family members, and the MHP to understand over time the issues
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27 ¹¹ K. Zucker (2015), *The DSM-5 Diagnostic Criteria for Gender Dysphoria*, in C. Trombetta et al. (eds.),
28 MANAGEMENT OF GENDER DYSPHORIA: A MULTIDISCIPLINARY APPROACH, DOI 10.1007/978-88-470-
5696-1_4 (Springer-Verlag Italia 2015).

1 that need to be dealt with over time by each of them.

2 42. Likewise, since the child's sense of gender develops in interaction with
3 his parents and their own gender roles and relationships, the responsible MHP will
4 almost certainly need to delve into family and marital dynamics.
5

6 **F. Understanding the WPATH and its "Standards of Care"**

7 43. In almost any discussion of the diagnosis and care of patients suffering
8 gender dysphoria or exhibiting transgender characteristics, the World Professional
9 Association for Transgender Health (WPATH) and the Standards of Care that that
10 organization publishes will be mentioned. Accordingly, I provide some context
11 concerning that private organization.
12

13 44. I was a member of the Harry Benjamin International Gender
14 Dysphoria Association from 1974 until 2001. From 1997 through 1998, I served as
15 the Chairman of the eight-person International Standards of Care Committee that
16 issued the fifth version of the Standards of Care. I resigned my membership in 2002
17 due to my regretful conclusion that the organization and its recommendations had
18 become dominated by politics and ideology, rather than by scientific process, as it
19 was years earlier. In approximately 2007, the Henry Benjamin International Gender
20 Dysphoria Association changed its name to the World Professional Association for
21 Transgender Health.
22

23 45. WPATH is a voluntary membership organization. Since at least 2002,
24 attendance at its biennial meetings has been open to trans individuals who are not
25 licensed professionals. While this ensures taking patients' needs into consideration, it
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1 limits the ability for honest and scientific debate, and means that WPATH can no
2 longer be considered a purely professional organization.

3 46. WPATH takes a decided view on issues as to which there is a wide range
4 of opinion among professionals. WPATH explicitly views itself as not merely a
5 scientific organization, but also as an advocacy organization. (Levine, *Reflections*, at
6 240.) WPATH is supportive to those who want sex reassignment surgery (“SRS”).
7 Skepticism as to the benefits of SRS to patients, and strong alternate views, are not
8 well tolerated in discussions within the organization. Such views have been known to
9 be shouted down and effectively silenced by the large numbers of nonprofessional
10 adults who attend the organization’s biennial meetings.

11 47. The Standards of Care (“SOC”) is the product of an enormous effort to
12 be balanced, but it is not a politically neutral document. WPATH aspires to be both a
13 scientific organization and an advocacy group for the transgendered. These aspirations
14 sometimes conflict. The limitations of the Standards of Care, however, are not
15 primarily political. They are caused by the lack of rigorous research in the field, which
16 allows room for passionate convictions on how to care for the transgendered.

17 48. In recent years, WPATH has fully adopted some mix of the medical and
18 civil rights paradigms. It has downgraded the role of counseling or psychotherapy as a
19 requirement for these life-changing processes. WPATH no longer considers
20 preoperative psychotherapy to be a requirement. It is important to WPATH that the
21 person has gender dysphoria; the pathway to the development of this state is not.
22 (Levine, *Reflections*, at 240.) The trans person is assumed to have thoughtfully
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1 considered his or her options before seeking hormones, for instance. Many have
2 wondered whether adolescents are developmentally capable of a prudent consideration
3 of the consequences of their decisions.
4

5 49. Most psychiatrists and psychologists who treat patients suffering
6 sufficiently severe distress from gender dysphoria to seek inpatient psychiatric care are
7 not members of WPATH. Many psychiatrists and psychologists who treat some patients
8 suffering gender dysphoria on an outpatient basis are not members of WPATH.
9 WPATH represents a self-selected subset of the mental health professions,
10 endocrinologists, and surgeons along with its many non-professional trans members; it
11 does not capture the clinical experiences of others. WPATH claims to speak for the
12 medical profession; however, it does not welcome skepticism and therefore, deviates
13 from the philosophical core of medical science.
14
15

16 50. For example, in 2010 the WPATH Board of Directors issued a
17 statement advocating that incongruence between sex and felt gender identity should
18 cease to be identified in the DSM as a pathology.¹² This position was debated but not
19 adopted by the (much larger) American Psychiatric Association, which maintained
20 the definitions and diagnoses of gender dysphoria as a pathology in the DSM-5
21 manual issued in 2013.
22

23 51. In my experience most current members of WPATH have little ongoing
24 experience with the mentally ill, and many trans care facilities are staffed by MHPs
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27 ¹² WPATH *De-Psychopathologisation Statement* (May 26, 2010), available at
28 wpath.org/policies (last accessed January 21, 2020).

1 who are not deeply experienced with recognizing and treating frequently associated
2 psychiatric co-morbidities. Because the 7th version of the WPATH SOC deleted the
3 requirement for therapy, trans care facilities that consider these Standards sufficient are
4 permitting patients to be counseled to transition by means of social presentation,
5 hormones, and surgery by individuals with masters rather than medical or PhD clinical
6 psychology degrees. As a result of the downgrading of the role of the psychiatric
7 assessment of patients, new “gender affirming” clinics have arisen in many urban
8 settings that quickly (sometimes within an hour’s time) recommend transition.
9 Concerned parents who came wanting to know what is going on in their children are
10 overwhelmed, and feel disoriented, fearful for the health and safety of their children,
11 and dependent on the professional.

12 **II. PATIENTS DIFFER WIDELY AND MUST BE CONSIDERED** 13 **INDIVIDUALLY.**

14
15 52. In my opinion, it is not possible to make a single, categorical statement
16 about the proper treatment of children presenting with gender dysphoria or other
17 gender-related issues. Indeed, a MHP cannot responsibly opine on the proper treatment
18 of a particular child presenting with gender dysphoria unless and until he or she has had
19 more than one working session with that child, and has taken a thorough developmental
20 history of the child’s gender-related issues (or has reviewed such a history prepared by
21 another MHP). This is so for multiple reasons.

22
23 53. There is no single pathway of development and outcomes governing
24 transgender identity, nor one that predominates over the large majority of cases.
25 Instead, as individuals grow up and age, depending on their differing psychological,
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1 social, familial, and life experiences, their outcomes differ widely.

2 54. As to causes in children, details about the onset of gender dysphoria may
3 be found in an understanding of family relationship dynamics. In particular, the
4 relationship between the parents and each of the parents and the child, and each of the
5 siblings and the child should be well known by the MHP.

6 55. Further, a disturbingly large proportion of children who seek professional
7 care in connection with gender issues have a wider history of psychiatric co-
8 morbidity. (*See supra* n. 7.) A 2017 study from the Boston Children's Hospital
9 Gender Management Service program reported that: "Consistent with the data reported
10 from other sites, this investigation documented that 43.3% of patients presenting for
11 services had significant psychiatric history, with 37.1% having been prescribed
12 psychotropic medications, 20.6% with a history of self-injurious behavior, 9.3% with a
13 prior psychiatric hospitalization, and 9.3% with a history of suicide attempts." (L.
14 Edwards-Leeper, *Psychological Profile*, at 375.) It seems likely that an even higher
15 proportion will have had prior undiagnosed psychiatric conditions.

16 56. As to outcomes, as I explain below, for pre-pubertal children, desistance
17 from transgender identification in favor of a gender corresponding to the child's sex,
18 during or within a few years of puberty, is a likely outcome absent intervention. (*Infra*
19 Section III.)

20 57. Because the causes, characteristics, social and relational context, and
21 likely future course of gender dysphoria vary widely from individual to individual, it is
22 essential that the MHP spend significant time with an individual patient over multiple
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1 sessions to take a careful developmental history, before attempting to decide on a
2 course of therapy for that individual.

3 **III. SOCIAL TRANSITION OF PRE-PUBERTAL CHILDREN IS A**
4 **MAJOR, EXPERIMENTAL, AND CONTROVERSIAL**
5 **INTERVENTION THAT SUBSTANTIALLY CHANGES**
6 **OUTCOMES.**

7 58. A distinctive and critical characteristic of juvenile gender dysphoria is
8 that multiple studies from separate groups and at different times have reported that in
9 the large majority of patients, absent a substantial intervention such as social transition
10 and/or hormone therapy, gender dysphoria does *not* persist through puberty. A recent
11 article reviewed all existing follow-up studies that the author could identify of children
12 diagnosed with gender dysphoria (11 studies), and reported that “every follow-up study
13 of GD children, without exception, found the same thing: By puberty, the majority of
14 GD children ceased to want to transition.” (Cantor at 1.) Another author reviewed the
15 existing studies and reported that in “prepubertal boys with gender discordance . . . the
16 cross gender wishes usually fade over time and do not persist into adulthood, with only
17 2.2% to 11.9% continuing to experience gender discordance.”¹³ A third summarized the
18 existing data as showing that “Symptoms of GID at prepubertal ages decrease or
19 disappear in a considerable percentage of children (estimates range from 80-95%).”¹⁴
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23 59. It is not yet known how to distinguish those children who will desist
24 from that small minority whose trans identity will persist. (Levine, *Ethical*
25

26 ¹³ S. Adelson & American Academy of Child & Adolescent Psychiatry (2012), *Practice Parameter on Gay, Lesbian,*
27 *or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents*, J. AM.
ACAD. CHILD ADOLESCENT PSYCHIATRY 51(9) 957 at, 963 (“Practice Parameter”).

28 ¹⁴ P. T. Cohen-Kettenis, H. A. Delemarre-van de Waal et al. (2008), *The Treatment of Adolescent Transsexuals:*
Changing Insights, J. SEXUAL MEDICINE 5(8) 1892 at 1895.

Concerns, at 9.)¹⁵

60. Desistance within a relatively short period may also be a common outcome for post-pubertal youths who exhibit recently described “rapid onset gender disorder.” I observe an increasingly vocal online community of young women who have reclaimed a female identity after claiming a male gender identity at some point during their teen years. However, data on outcomes for this age group with and without therapeutic interventions are not yet available to my knowledge.

61. In contrast, there is now data that suggests that a therapy that encourages social transition dramatically changes outcomes. A prominent group of authors has written that “The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood.”¹⁶ Similarly, a comparison of recent and older studies suggests that when an “affirming” methodology is used with children, a substantial proportion of children who would otherwise have desisted by adolescence—that is, achieved comfort identifying with their natal sex—instead persist in a transgender identity. (Zucker, *Myth of Persistence*, at 7.)¹⁷

62. Indeed, a review of multiple studies of children treated for gender

¹⁵ It is also apparent in the adolescent phenomenon of rapid onset of gender dysphoria following a gender normative childhood that childhood gender identity is not inherently stable in either direction.

¹⁶ C. Guss et al. (2015), *Transgender and Gender Nonconforming Adolescent Care: Psychosocial and Medical Considerations*, CURR. OPIN. PEDIATR. 26(4) 421 at 421 (“TGN Adolescent Care”).

¹⁷ One study found that social transition by the child was found to be strongly correlated with persistence for natal boys, but not for girls. K. Zucker (2018), *The Myth of Persistence: Response to “A Critical Commentary on Follow-Up Studies & ‘Desistance’ Theories about Transgender & Gender Non-Conforming Children” by Temple Newhook et al.*, INT’L J. OF TRANSGENDERISM at 5, DOI: 10.1080/15532739.2018.1468293 (“Myth of Persistence”) (citing T.D. Steensma, J.K. McGuire et al. (2013), *Factors Associated with Desistance & Persistence of Childhood Gender Dysphoria: A Qualitative Follow-up Study*, J. OF THE AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 52, 582.)

1 dysphoria across the last three decades found that early social transition to living as
2 the opposite sex severely reduces the likelihood that the child will revert to identifying
3 with the child's natal sex, at least in the case of boys. That is, while, as I review above,
4 studies conducted before the widespread use of social transition for young children
5 reported desistance rates in the range of 80-98%, a more recent study reported that
6 fewer than 20% of boys who engaged in a partial or complete social transition before
7 puberty had desisted when surveyed at age 15 or older. (Zucker, *Myth of Persistence*,
8 at 7; Steensma (2013).)¹⁸ Some vocal practitioners of prompt affirmation and social
9 transition even claim that essentially *no* children who come to their clinics exhibiting
10 gender dysphoria or cross-gender identification desist in that identification and return
11 to a gender identity consistent with their biological sex.¹⁹ This is a very large change
12 as compared to the desistance rates documented apart from social transition. Some
13 researchers who generally advocate prompt affirmation and social transition also
14 acknowledge a causal connection between social transition and this change in
15 outcomes.²⁰

18 Only 2 (3.6%) of 56 of the male desisters observed by Steensma et al. had made a complete or partial transition prior to puberty, and of the twelve males who made a complete or partial transition prior to puberty, only two had desisted when surveyed at age 15 or older. Steensma (2013) at 584.

19 See, e.g., B. Ehrensaft (2015), *Listening and Learning from Gender-Nonconforming Children*, THE PSYCHOANALYTIC STUDY OF THE CHILD 68(1) 28 at 34: "In my own clinical practice . . . of those children who are carefully assessed as transgender and who are allowed to transition to their affirmed gender, we have no documentation of a child who has 'desisted' and asked to return to his or her assigned gender."

20 See Guss, *TGN Adolescent Care*, at 2. "The gender identity affirmed during puberty appears to predict the gender identity that will persist into adulthood." "Youth with persistent TNG [transgender, nonbinary, or gender-nonconforming] identity into adulthood . . . are more likely to have experienced social transition, such as using a different name . . . which is stereotypically associated with another gender at some point during childhood."

1 63. Accordingly, I agree with a noted researcher in the field who has
2 written that social transition in children must be considered “a form of psychosocial
3 treatment.”²¹

4 64. So far as I am aware, no study yet reveals whether the life-course mental
5 and physical health outcomes for this relatively new class of “persisters” are more
6 similar to those of the general non-transgender population, or to the notably worse
7 outcomes exhibited by the transgender population generally.

8 65. However, I agree with Zucker who has written, “...we cannot rule out
9 the possibility that early successful treatment of childhood GID [Gender Identity
10 Disorder] will diminish the role of a continuation of GID into adulthood. If so,
11 successful treatment would also reduce the need for the long and difficult process of
12 sex reassignment which includes hormonal and surgical procedures with substantial
13 medical risks and complications.”²² By the same token, a therapeutic methodology for
14 children that *increases* the likelihood that the child will continue to identify as the
15 opposite gender into adulthood will *increase* the need for the long and potentially
16 problematic processes of hormonal and genital and cosmetic surgical procedures.

17 66. Not surprisingly, given these facts, encouraging social transition in
18 children remains controversial. Supporters of such transition acknowledge that
19 “Controversies among providers in the mental health and medical fields are
20 abundant . . . These include differing assumptions regarding . . . the age at which

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27 ²¹ K. Zucker (2019), *Debate: Different Strokes for Different Folks*, CHILD & ADOLESCENT MENTAL HEALTH, at 1, DOI: 10.1111/camh.12330 (“Debate”).

28 ²² Zucker, *Myth of Persistence*, at 8 (citing H. Meyer-Bahlburg (2002), *Gender Identity Disorder in Young Boys: A Parent- & Peer-Based Treatment Protocol*, CLINICAL CHILD PSYCHOLOGY & PSYCHIATRY 7, 360 at 362.).

1 children . . . should be encouraged or permitted to socially transition . . . These are
2 complex and providers in the field continue to be at odds in their efforts to work in
3 the best interests of the youth they serve.”²³
4

5 67. In sum, therapy for young children that encourages transition cannot be
6 considered to be neutral, but instead is an experimental procedure that has a high
7 likelihood of changing the life path of the child, with highly unpredictable effects on
8 mental and physical health, suicidality, and life expectancy. Claims that a civil right is
9 at stake do not change the fact that what is proposed is a social and medical
10 experiment. (Levine, *Reflections*, at 241.) Ethically, then, it should be undertaken only
11 subject to standards, protocols, and reviews appropriate to such experimentation.
12

13 **IV. THE AVAILABLE DATA DOES NOT SUPPORT THE**
14 **CONTENTION THAT “AFFIRMATION” OF TRANSGENDER**
15 **IDENTITY REDUCES SUICIDE OR RESULTS IN BETTER**
16 **PHYSICAL OR MENTAL HEALTH OUTCOMES GENERALLY.**

17 68. I am aware that organizations including The Academy of Pediatrics and
18 Parents, Families and Friends of Lesbians and Gays (PFLAG)) have published
19 statements that suggest that all children who express a desire for a transgender identity
20 should be promptly supported in that claimed identity. This position appears to rest on
21 the belief—which is widely promulgated by certain advocacy organizations—that
22 science has already established that prompt “affirmance” is best for all patients,
23 including all children, who present indicia of transgender identity. As I discuss later
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28 ²³ A. Tishelman et al. (2015), *Serving Transgender Youth: Challenges, Dilemmas and Clinical Examples*, PROF. PSYCHOL. RES. PR. at 11, DOI: 10.1037/a0037490 (“*Serving TG Youth*”).

1 below, this belief is scientifically incorrect, and ignores both what is known and what
2 is unknown.

3 69. The knowledge-base concerning the causes and treatment of gender
4 dysphoria has low scientific quality.

5 70. In evaluating claims of scientific or medical knowledge, it is
6 important to understand that it is axiomatic in science that no knowledge is
7 absolute, and to recognize the widely accepted hierarchy of reliability when it
8 comes to “knowledge” about medical or psychiatric phenomena and treatments.
9 Unfortunately, in this field opinion is too often confused with knowledge, rather
10 than clearly locating what exactly is scientifically known. In order of increasing
11 confidence, such “knowledge” may be based upon data comprising:
12
13
14

15 a. Expert opinion—it is perhaps surprising to educated laypersons that
16 expert opinion standing alone is the lowest form of knowledge, the least likely
17 to be proven correct in the future, and therefore does not garner as much respect
18 from professionals as what follows.
19

20 b. A single case or series of cases (what could be called anecdotal
21 evidence); (Levine, *Reflections*, at 239.)
22

23 c. A series of cases with a control group;

24 d. A cohort study;

25 e. A randomized double-blind clinical trial;

26 f. A review of multiple trials;
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28

1
2 g. A meta-analysis of multiple trials that maximizes the number of
3 patients treated despite their methodological differences to detect trends
4 from larger data sets.

5
6 71. Prominent voices in the field have emphasized the severe lack of
7 scientific knowledge in this field. The American Academy of Child and Adolescent
8 Psychiatry has recognized that “Different clinical approaches have been advocated for
9 childhood gender discordance. . . . There have been no randomized controlled trials of
10 any treatment. . . . [T]he proposed benefits of treatment to eliminate gender
11 discordance...must be carefully weighed against... possible deleterious effects.”
12 (Adelson et al., *Practice Parameter*, at 968–69.) Similarly, the American Psychological
13 Association has stated, “...because no approach to working with [transgender and
14 gender nonconforming] children has been adequately, empirically validated, consensus
15 does not exist regarding best practice with pre-pubertal children.”²⁴

16
17 72. Critically, “there are no randomized control trials with regard to
18 treatment of children with gender dysphoria.” (Zucker, *Myth of Persistence*, at 8.)
19 On numerous critical questions relating to cause, developmental path if untreated,
20 and the effect of alternative treatments, the knowledge base remains primarily at
21 the level of the practitioner’s exposure to individual cases, or multiple individual
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28 ²⁴ American Psychological Association, *Guidelines for Psychological Practice with Transgender & Gender Nonconforming People* (2015), AM. PSYCHOLOGIST 70(9) 832 at 842.

1 cases. As a result, claims to certainty are not justifiable. (Levine, *Reflections*, at
2 239.)

3
4 73. Large gaps exist in the medical community's knowledge regarding
5 the long-term effects of SRS and other gender identity disorder treatments in relation
6 to their positive or negative correlation to suicidal ideation, attempts, and completion.
7 What is known, however, is not encouraging.

8
9 74. With respect to suicide, individuals with gender dysphoria are well
10 known to commit suicide or otherwise suffer increased mortality before and after not
11 only social transition, but also before and after SRS. (Levine, *Reflections*, at 242.)
12 For example, in the United States, the death rates of trans veterans are comparable to
13 those with schizophrenia and bipolar diagnoses—20 years earlier than expected.
14 These crude death rates include significantly elevated suicide rates. (Levine, *Ethical*
15 *Concerns*, at 10.) Similarly, researchers in Sweden and Denmark have reported on
16 almost all individuals who underwent sex-reassignment surgery over a 30-year
17 period.²⁵ The Swedish follow-up study found a suicide rate in the post-SRS
18 population 19.1 times greater than that of the controls; both studies demonstrated
19 elevated mortality rates from medical and psychiatric conditions. (Levine, *Ethical*
20 *Concerns*, at 10.)

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23 75. Advocates of immediate and unquestioning affirmation of social
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27 ²⁵ C. Dhejne et al. (2011), *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLOS ONE 6(2) e16885 ("Long Term"); R. K. Simonsen et al. (2016), *Long-Term Follow-Up of Individuals Undergoing Sex Reassignment Surgery: Psychiatric Morbidity & Mortality*, NORDIC J. OF PSYCHIATRY 70(4).

1 transition in children who indicate a desire for a transgender identity sometimes assert
2 that any other course will result in a high risk of suicide in the affected children and
3 young people. Contrary to these assertions, no studies show that affirmation of children
4 (or anyone else) reduces suicide, prevents suicidal ideation, or improves long-term
5 outcomes, as compared to either a “watchful waiting” or a psychotherapeutic model of
6 response, as I have described above.²⁶

7
8 76. I will also note that any discussion of suicide when considering younger
9 children involves very long-range and very uncertain prediction. Suicide in pre-
10 pubescent children is rare and the existing studies of gender identity issues in pre-
11 pubescent children do not report significant incidents of suicide. The estimated suicide
12 rate of trans adolescents is the same as teenagers who are in treatment for serious
13 mental illness. What trans teenagers do demonstrate is more suicidal ideation and
14 attempts (however serious) than other teenagers.²⁷

15
16 77. In sum, claims that affirmation will reduce the risk of suicide for children
17 are not based on science. Such claims overlook the lack of even short-term supporting
18 data as well as the lack of studies of long-term outcomes resulting from the affirmation
19 or lack of affirmation of transgender identity in children. It also overlooks the other
20 tools that the profession does have for addressing depression and suicidal thoughts in a
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22
23
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25 ²⁶ A recent article, J. Turban et al. (2020), *Puberty Suppression for Transgender Youth and Risk of Suicidal Ideation*,
26 PEDIATRICS 145(2), DOI: 10.1542/peds.2019-1725 (“*Puberty Suppression*”), has been described in press reports as
27 demonstrating that administration of puberty suppressing hormones to transgender adolescents reduces suicide or
28 suicidal ideation. The paper itself does not make that claim, nor permit that conclusion.

²⁷ A. Perez-Brumer, J. K. Day et al. (2017), *Prevalence & Correlates of Suicidal Ideation Among Transgender Youth in Cal.: Findings from a Representative, Population-Based Sample of High Sch. Students*, J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 56(9), 739 at 739.

1 patient once that risk is identified. (Levine, *Reflections*, at 242.)

2 78. A number of data sets have also indicated significant concerns about
3 wider indicators of physical and mental health, including ongoing functional
4 limitations;²⁸ substance abuse, depression, and psychiatric hospitalizations;²⁹ and
5 increased cardiovascular disease, cancer, asthma, and COPD.³⁰ Worldwide estimates of
6 HIV infection among transgendered individuals are up to 17-fold higher than the
7 cisgender population. (Levine, *Informed Consent*, at 6.)

8
9
10 79. Meanwhile, no studies show that affirmation of pre-pubescent children
11 leads to more positive outcomes (mental, physical, social, or romantic) by, e.g., age 25
12 or older than does “watchful waiting” or ordinary therapy. Because children’s
13 affirmation, social transition, and the use of puberty blockers for transgender children
14 are a recent phenomenon, it could hardly be otherwise.

15
16 80. Thus, transition of any sort must be justified, if at all, as a life-enhancing
17 measure, not a lifesaving measure. (Levine, *Reflections*, at 242.) In my opinion, this is
18 an important fact that patients, parents, and even many MHPs fail to understand.

19
20 81. The long-term benefits of SRS on the mental health of individuals
21 diagnosed with gender dysphoria are widely assumed to be positive, but in fact are
22 scientifically and clinically unknown. Several studies (Turban et al, *JAMA Psychiatry*,
23 77(1) (2020); Turban et al, *Puberty Suppression* (*supra* n.26); Bränström & Pachankis
24

25
26 ²⁸ G. Zeluf, C. Dhejne et al. (2016), *Health, Disability and Quality of Life Among Trans People in Sweden—A Web-Based Survey*, BMC PUBLIC HEALTH 16(903), DOI: 10.1186/s12889-016-3560-5.

27 ²⁹ C. Dhejne, R. Van Vlerken et al. (2016), *Mental Health & Gender Dysphoria: A Review of the Literature*, INT’L REV. OF PSYCHIATRY 28(1) 44.

28 ³⁰ C. Dragon, P. Guerino, et al. (2017), *Transgender Medicare Beneficiaries & Chronic Conditions: Exploring Fee-for-Service Claims Data*, LGBT HEALTH 4(6) 404, DOI: 10.1089/lgbt.2016.0208.

1 *Am J Psychiatry*, 177: 727-724 (2020)) have been undertaken because this uncertainty
2 is now widely recognized among researchers. These studies either claimed positive
3 mental health outcomes or that psychotherapy interventions had negative outcomes.
4 Each has been been soundly criticized. Criticisms about the Bränström & Pachankis
5 publication caused the editor of the journal to have the data reanalyzed by two new
6 consultants who agreed that the authors' conclusions were invalid (*see* August 2020
7 issue of the *Am J Psychiatry*). Every person's life has multiple dimensions--vocational,
8 educational, interpersonal, romantic, familial, mental health, physical health, substance
9 dependence, etc. Previous studies of adjustment after SRS rested on the infrequency of
10 regret for having undergone surgery. There is already much evidence that the long-term
11 outcome of SRS is not favorable for many gender dysphoric individuals. Providing
12 SRS to an adolescent further commits the young person to a pathway that is known to
13 have innumerable challenges. Many of these adolescents who appear quite certain
14 about what they need to be happier cannot envision the unique challenges they will
15 face, let alone master these developmental challenges.

16 82. If trans male identified adolescents have their breasts removed, they will
17 have a male appearing chest and female genitalia. This surgery will initially make
18 them happy about their chest per se, but they still will experience gender dysphoria
19 because of the presence of the female genitalia. This anatomic source of incongruence
20 will continue to limit intimate dimensions of their life possibilities. Genital
21 reconstruction of male appearing genitalia is unable to produce the normal functions of
22 a penis. It is expensive, fraught with complications, and leaves a significant scarring of
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1 a limb. Most trans males do not undergo this arduous procedure. This makes the
2 incongruence a permanent feature. Bilateral mastectomies should not be construed as a
3 curative intervention for gender dysphoria. It only eradicates the displeasure of having
4 female breasts.

5
6 **V. KNOWN, LIKELY, OR POSSIBLE DOWNSIDE RISKS ATTENDANT**
7 **ON MOVING QUICKLY TO “AFFIRM” TRANSGENDER IDENTITY**
8 **IN CHILDREN.**

9 83. The multiple studies from different nations that have documented the
10 increased vulnerability of the adult transgender population to substance abuse, mood
11 and anxiety disorders, suicidal ideation, and other health problems warn that assisting
12 the child down the road to becoming a transgender adult is a very serious decision, and
13 stand as a reminder that a casual assumption that transition will improve the child’s life
14 is not justified based on numerous scientific snapshots of cohorts of trans adults and
15 teenagers.

16
17 84. The possibility that steps along this pathway, while lessening the pain of
18 gender dysphoria, could lead to additional sources of crippling emotional and
19 psychological pain, are too often not considered by advocates of social transition and
20 not considered at all by the trans child. (Levine, *Reflections*, at 243.)

21
22 85. I detail below several classes of predictable, likely, or possible
23 harms to the patient associated with transitioning to live as a transgender
24 individual.

25
26 **A. Physical risks associated with transition**

27 86. Sterilization. Obviously, SRS that removes testes, ovaries, or the uterus is
28

1 inevitably sterilizing. While by no means all transgender adults elect SRS, many
2 patients do ultimately feel compelled to take this serious step in their effort to live fully
3 as the opposite sex. More immediately, practitioners recognize that the administration
4 of cross-sex hormones, which is often viewed as a less “radical” measure, and is now
5 increasingly done to minors, creates at least a risk of irreversible sterility.³¹ As a result,
6 even when treating a child, the MHP, patient, and parents must consider loss of
7 reproductive capacity—sterilization—to be one of the major risks of starting down the
8 road. The risk that supporting social transition may put the child on a pathway that
9 leads to intentional or unintentional permanent sterilization is particularly concerning
10 given the disproportionate representation of minority and other vulnerable groups
11 among children reporting a transgender or gender-nonconforming identity. (*See supra* ¶
12 19.)

16 87. Loss of sexual response. Puberty-blockers prevent maturation of the sexual
17 organs and response. Some and perhaps many transgender individuals who transitioned
18 as children and thus did not go through puberty consistent with their sex face
19 significantly diminished sexual response as they enter adulthood, and are unable ever to
20 experience orgasm. To my knowledge, data quantifying this impact has not been
21 published.

24 88. Other effects of hormone administration. While it is commonly said that the
25 effects of puberty blockers are reversible after cessation, in fact controlled studies have

27 ³¹ See C. Guss et al., *TGN Adolescent Care* at 4 (“a side effect [of cross-sex hormones] may be infertility”) and 5
28 (“cross-sex hormones . . . may have irreversible effects”); Tishelman et al., *Serving TG Youth* at 8 (Cross-sex hormones
are “irreversible interventions” with “significant ramifications for fertility”).

1 not been done of how completely this is true. However, it is well known that many effects
2 of cross-sex hormones cannot be reversed should the patient later regret his transition.
3 After puberty, the individual who wishes to live as the opposite sex will in most cases
4 have to take cross-sex hormones for life.
5

6 89. The long-term health risks of this major alteration of hormonal levels have
7 not yet been quantified in terms of exact risk.³² However, a recent study found greatly
8 elevated levels of strokes and other acute cardiovascular events among male-to-female
9 transgender individuals taking estrogen. Those authors concluded, “it is critical to keep
10 in mind that the risk for these cardiovascular events in this population must be weighed
11 against the benefits of hormone treatment.”³³ Another group of authors similarly noted
12 that administration of cross-sex hormones creates “an additional risk of thromboembolic
13 events”—i.e., blood clots (Guss et al., *TGN Adolescent Care* at 5), which are associated
14 with strokes, heart attack, and lung and liver failure. Clinicians must distinguish the
15 apparent short-term safety of hormones from likely or possible long-term consequences,
16 and help the patient or parents understand these implications as well. The young patient
17 may feel, “I don’t care if I die young, just as long I get to live as a woman.” The mature
18 adult may take a different view.
19
20
21

22 90. Health risks inherent in complex surgery. Complications of surgery exist
23 for each procedure,³⁴ and complications in surgery affecting the breasts and chest can
24

25
26 ³² See Tishelman et al., *Serving TG Youth* at 6-7 (Long-term effect of cross-sex hormones “is an area where we currently have little research to guide us”).

27 ³³ D. Getahun et al. (2018), *Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study*, ANNALS OF INTERNAL MEDICINE at 8, DOI:10.7326/M17- 2785.

28 ³⁴ Levine, *Informed Consent*, at 5 (citing T. van de Grift, G. Pigot et al. (2017), *A Longitudinal Study of Motivations Before & Psychosexual Outcomes After Genital Gender- Confirming Surgery in Transmen*, J. SEXUAL MEDICINE

1 have significant anatomical and functional complications for the patient's quality of life.

2 Genital surgeries carry even more significant short and long term complication risks.

3
4 91. Disease and mortality generally. The MHP, the patient, and in the case of a
5 child the parent, must also be aware of the wide sweep of strongly negative health outcomes
6 among transgender individuals, as I have detailed above.

7
8 **B. Social risks associated with transition**

9 92. Family and friendship relationships. Gender transition routinely leads to
10 isolation from at least a significant portion of one's family in adulthood. In the case of a
11 juvenile transition, this will be less dramatic while the child is young, but commonly
12 increases over time. In adulthood, the friendships of transgender individuals tend to be
13 confined to other transgender individuals (often "virtual" friends known only online)
14 and a generally more limited set of others. (Levine, *Ethical Concerns*, at 5.)

15
16 93. Long term psychological and social impact of sterility. The life-long
17 negative emotional impact of infertility on both men and women has been well studied.
18 While this impact has not been studied specifically within the transgender population,
19 the opportunity to be a parent is likely a human, emotional need, and so should be
20 considered an important risk factor when considering gender transition for any patient.
21 However, it is particularly difficult for parents of a young child to seriously
22 contemplate that child's potential as a future parent and grandparent. This makes it all
23 the more critical that the MHP spend substantial and repeated time with parents to help
24 them see the implications of what they are considering.
25
26

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14(12) 1621.).

1 94. Sexual-romantic risks associated with transition. After adolescence,
2 transgender individuals can find the pool of individuals willing to develop a romantic and
3 intimate relationship with them to be greatly diminished. (Levine, *Ethical Concerns*, at 5,
4 13).³⁵

6 95. Social risks associated with delayed puberty. The social and psychological
7 impact of remaining puerile for, e.g., three years while one's peers are undergoing
8 puberty, and of undergoing puberty at a substantially older age, have not been
9 systematically studied, although clinical mental health professionals often hear of
10 distress and social awkwardness in those who naturally have a delayed onset of puberty.
11 In my opinion, individuals in whom puberty is delayed multiple years are likely to
12 suffer at least subtle negative psychosocial and self-confidence effects as they stand on
13 the sidelines while their peers are developing the social relationships (and attendant
14 painful social learning experiences) that come with adolescence. (Levine, *Informed*
15 *Consent*, at 9.)

19 **C. Mental health costs or risks**

20 96. One would expect the negative physical and social impacts reviewed
21 above to adversely affect the mental health of individuals who have transitioned.

22 97. In addition, individuals often pin excessive hope in transition,
23 believing that transition will solve what are in fact ordinary social stresses associated
24 with maturation, or mental health co-morbidities. Thus, transition can result in
25

26
27
28 ³⁵ S. Levine, *Barriers to Loving: A Clinician's Perspective*, at 40 (Routledge, New York 2013).

1 deflection from mastering personal challenges at the appropriate time, or addressing
2 conditions that require treatment.

3
4 98. Whatever the reason, transgender individuals including transgender
5 youth certainly experience greatly increased rates of mental health problems. I have
6 detailed this above with respect to adults living under a transgender identity. Indeed,
7 Swedish researchers in a long- term study (up to 30 years since SRS, with a median
8 time since SRS of > 10 years) concluded that individuals who have SRS should have
9 postoperative lifelong psychiatric care. (Dhejne, *Long Term*, at 6-7.) With respect to
10 youths a cohort study found that transgender youth had an elevated risk of depression
11 (50.6% vs. 20.6%) and anxiety (26.7% vs. 10.0%); a higher risk of suicidal ideation
12 (31.1% vs. 11.1%), suicide attempts (17.2% vs. 6.1%), and self-harm without lethal
13 intent (16.7% vs. 4.4%) relative to the matched controls; and a significantly greater
14 proportion of transgender youth accessed inpatient mental health care (22.8% vs.
15 11.1%) and outpatient mental health care (45.6% vs. 16.1%) services.³⁶

16
17
18
19 **D. Regret following transition is not an infrequent phenomenon.**

20 99. The large numbers of children and young adults who have desisted as
21 documented in both group and case studies each represent “regret” over the initial
22 choice in some sense.

23
24 100. The phenomenon of desistance or regret experienced *later* than
25 adolescence or young adulthood, or among older transgender individuals, has to my
26

27 ³⁶ S. Reisner et al. (2015), *Mental Health of Transgender Youth in Care at an Adolescent Urban Community Health*
28 *Center: A Matched Retrospective Cohort Study*, J. OF ADOLESCENT HEALTH 56(3) at 6,
DOI:10.1016/j.jadohealth.2014.10.264; see also *supra* ¶ 19.

1 knowledge not been quantified or well studied. However, it is a real phenomenon. I
2 myself have worked with multiple individuals who have abandoned trans female
3 identity after living in that identity for years, and who would describe their
4 experiences as “regret.”

6 101. I have seen several Massachusetts inmates and trans individuals in the
7 community abandon their [trans] female identity after several years. (Levine,
8 *Reflections*, at 239.) In the gender clinic which I founded in 1974 and to this day, in a
9 different location, continue to co-direct, we have seen many instances of individuals
10 who claimed a transgender identity for a time, but ultimately changed their minds and
11 reclaimed the gender identity congruent with their sex.

13 102. More dramatically, a surgical group prominently active in the SRS
14 field has published a report on a series of seven male-to-female patients requesting
15 surgery to transform their surgically constructed female genitalia back to their
16 original male form.³⁷

18 103. I noted above an increasingly visible online community of young women
19 who have desisted after claiming a male gender identity at some point during their teen
20 years. (*See supra* ¶ 60.) Given the rapid increase in the number of girls presenting to
21 gender clinics within the last few years, the phenomena of regret and desistance by
22 young women deserves careful attention and study by MHPs.

24 104. Thus, one cannot assert with any degree of certainty that once a
25

27
28 ³⁷ Djordjevic et al. (2016), *Reversal Surgery in Regretful Male-to-Female Transsexuals After Sex Reassignment Surgery*, J. Sex Med. 13(6) 1000, DOI: 10.1016/j.jsxm.2016.02.173.

1 transgendered person, always a transgendered person, whether referring to a child,
2 adolescent, or adult, male or female.

3 VI. MEDICAL ETHICS & INFORMED CONSENT

4 A. The obligation of the mental health professional to enable and 5 obtain informed consent

6 105. I have reviewed above the knowledge and experience that, in my view, a
7 mental health professional should have before undertaking the responsibility to counsel
8 or treat a child who is experiencing gender dysphoria or transgender identification. The
9 MHP who undertakes this type of responsibility must also be guided by the ethical
10 principles that apply to all health care professionals. One of the oldest and most
11 fundamental principles guiding medical and psychological care—part of the
12 Hippocratic Oath—is that the physician must “first, do no harm.” This states an ethical
13 responsibility that cannot be delegated to the patient. Physicians themselves must weigh
14 the risks of treatment against the harm of not treating. If the risks of treatment outweigh
15 the benefits, ethics prohibit the treatment.
16

17 106. A distinct ethical responsibility of physicians, when a significant risk
18 exists of adverse consequences to any procedure or therapy, is to ensure that the patient
19 understands and is legally able to consent to the treatment, and does consent. To
20 achieve informed consent, the MHP must do at least the following:
21

22 a. The MHP must reasonably inform himself regarding the particular
23 situation of his patient;
24

25 b. The MHP must reasonably inform himself concerning the state of
26 knowledge concerning relevant methodologies and outcomes;
27
28

1 c. The MHP must honestly inform the patient concerning not only the
2 benefits of treatment, but also the risks and downsides of treatment, and
3 alternative treatments;
4

5 d. The MHP must conclude that the patient (or the decision maker,
6 such as parent or healthcare power of attorney) has comprehended what he or
7 she has been told and possesses a cognitive capacity to make a decision based
8 on an adequate understanding of his or her unique life circumstances.
9

10 107. Perfunctory “consent” is inadequate to fulfill the professional’s ethical
11 obligation to obtain informed consent. At the very least, a patient (or parent)
12 considering the life-altering choice of transition should be helped or indeed required
13 by their clinicians to grapple with four relevant questions:
14

15 a. “What benefits do you expect that the consolidation of this
16 identity, gender transition, hormones, or surgery will provide?
17

18 b. “What do you understand of the social, educational,
19 vocational, and psychological risks of this identity consolidation and
20 gender role transition?
21

22 c. “What do you understand about the common and rare, short- and
23 long-term medical and health risks of hormone and surgical interventions?
24

25 d. “What have you considered the nature of your life will be in 10 to 20
26 years?” (Levine, *Informed Consent*, at 3.)
27

28 108. The answers of the patient will enable the professional to make a
judgment about how realistic he or she is being. For example, the biological boy who

1 envisions himself as a happy, attractive, socially accepted 21-year-old girl in future
2 college years has probably not been adequately informed of—or has mentally
3 blocked—hard data concerning the mental health and social wellbeing of the
4 transgender population in their 20s, and is failing to consider the material risk that he,
5 as a transgender individual, will not be perceived as attractive to either sex, and the
6 impact that this may have on his future well-being.
7

8 109. Most commonly, meaningful engagement with difficult and painful
9 questions such as those above requires a process that will consist of multiple
10 discussions in a psychotherapeutic or counseling context, not merely “disclosure” of
11 facts. In my experience, a too-rapid or too-eager attachment to some outcome is a red
12 warning flag that the patient is not able to tolerate knowledge of the risks and
13 alternative approaches.
14
15

16 110. In my experience, in the area of transgender therapy, rather than the
17 type of information and engagement that I have described, even mental health
18 professionals too often encourage or permit decisions based on a great deal of patient
19 and professional blind optimism about the future. (Levine, *Ethical Concerns*, at 3-4.)
20

21 **B. The interests of the patient, as well as necessary disclosures and**
22 **consent, must be considered from a life course perspective.**

23 111. The psychiatrist or psychologist treating a child must have in view not
24 merely (or not even primarily) making the child “happy” now, but making him or her
25 as healthy and happy as possible across the entire trajectory of life, to the extent that is
26 predictable. Certainly, avoiding suicide is one important aspect of a “life course”
27 analysis, and recognizes that “today” is not the only goal. But as I have reviewed
28

1 above, there is much more across the future decades of the patient's life that also needs
2 to be taken into account.

3 112. Further, I do not believe that a patient can meaningfully be said to know
4 what will make him "happy" over the long term, prior to receiving, understanding, and
5 usually discussing the type of information that I have described above in connection
6 with informed consent. With respect to children who are not equipped to understand,
7 evaluate, and feel the life implications of such information, it is doubtful that there is
8 any meaningful way in which they can be said to "know" what will make them happy
9 over the long term. It is for similar reasons that parents ordinarily make a great many
10 decisions, both large and small, for their young children.

13 C. Special concerns and ethical rules

14 113. When psychiatric or medical research is done on subjects the informed
15 consent process is far more rigorous than in ordinary medical and psychiatric
16 procedures. For example, in a recent study of an agent to assist women who are
17 distressed by their lack of sexual desire that I was a part of, the Informed Consent
18 document was 19 pages long.

19 114. The absence of long-term studies in the arena of childhood gender
20 dysphoria or the more recently documented phenomenon of "rapid onset gender
21 dysphoria" among adolescents means that therapeutic responses to these conditions are
22 still at a primitive stage of development, and must be considered to be experimental,
23 rendering adequately informed consent all the more essential, and all the more difficult
24 to obtain. (Levine, *Reflections*, at 241.)
25
26
27
28

D. The inability of children to understand major life issues and risks complicates informed consent

115. Obviously, most children cannot give legally valid consent to a medical procedure.³⁸ This is not a mere legal technicality. Instead, it is a legal reflection of a reality of human development that is highly relevant to the ethical requirement of informed consent quite apart from law. The argument that the child is consenting to the transition by his happiness ignores the fact just described.

116. Each age group poses different questions about risk comprehension. (Levine, *Informed Consent*, at 3.)

117. In my experience, when clinicians actually attempt to understand patients' motives for the repudiation of their natal gender, the developmental lack of sophistication underlying their reasons can become apparent. What must a 12-year-old, for example, understand about masculinity and femininity that enables the conviction that "I can never be happy in my body?" (Levine, *Ethical Concerns*, at 8.)

118. Similarly, one cannot expect a 17-year-old to grasp the complexity of married life with children when 38. One cannot expect a ten-year-old to understand the emotional growth that comes from a first long term love relationship including sexual behavior. One cannot expect a six-year-old to comprehend the changes in his psyche that may come about as the result of puberty.

³⁸ I recognize that in some States or under some circumstances "mature minors" may be legally empowered to grant consent to certain medical procedures.

1 I declare under penalty of perjury that the foregoing is true and correct to
2 the best of my knowledge and belief.

3
4 Executed this 28th day of September, 2020 at Beachwood, Ohio.

5
6 *Stephen B. Levine MD*

7 Stephen B. Levine, M.D.
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Declaration of Stephen B. Levine Sept 26

Final Audit Report

2020-09-28

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EXHIBIT A

Stephen B. Levine, M.D.

Curriculum Vita

Brief Introduction

Dr. Levine is Clinical Professor of Psychiatry at Case Western Reserve University School of Medicine. He is the solo author of four books, Sex Is Not Simple in 1989 (translated to German in 1992 and reissued in English in 1997 as Solving Common Sexual Problems); Sexual Life: A clinician's guide in 1992; Sexuality in Midlife in 1998 and Demystifying Love: Plain talk for the mental health professional in 2006; Barriers to Loving: A clinician's perspective in October 2013. He is the Senior Editor of the first (2003), second (2010) and third (2016) editions of the Handbook of Clinical Sexuality for Mental Health Professionals. Psychotherapeutic Approaches to Sexual Problems: An Essential Guide For Mental Health Professionals will be published in the fall 2019. He has been teaching, providing clinical care, and writing since 1973 and has generated original research, invited papers, commentaries, chapters, and book reviews. He has served as a journal manuscript and book prospectus reviewer for many years. He was co-director of the Center for Marital and Sexual Health/ Levine, Risen & Associates, Inc. in Beachwood, Ohio from 1992-2017. He and two colleagues received a lifetime achievement Masters and Johnson's Award from the Society for Sex Therapy and Research in March 2005.

Personal Information

Date of birth 1/14/42

Medical license no. Ohio 35-03-0234-L

Board Certification 6/76 American Board of Neurology and Psychiatry

Education

1963 BA Washington and Jefferson College

1967 MD Case Western Reserve University School of Medicine

1967-68 internship in Internal Medicine University Hospitals of Cleveland

1968-70 Research associate, National Institute of Arthritis and Metabolic Diseases, Epidemiology Field Studies Unit, Phoenix, Arizona, United States Public Health Service

1970-73 Psychiatric Residency, University Hospitals of Cleveland

1974-77 Robert Wood Johnson Foundation Clinical Scholar

Appointments at Case Western Reserve University School of Medicine

1973 - Assistant Professor of Psychiatry

1979 - Associate Professor

1982 - Tenure

1985 - Full Professor

1993 - Clinical Professor

Honors

Summa Cum Laude, Washington & Jefferson

Teaching Excellence Award - 1990 and 2010 (residency program)

Visiting Professorships:

- Stanford University-Pfizer Professorship program (3 days) - 1995
- St. Elizabeth's Hospital, Washington, DC - 1998
- St. Elizabeth's Hospital, Washington, DC - 2002

Named to America's Top Doctors consecutively since 2001

Invitations to present various Grand Rounds at Departments of Psychiatry and Continuing Education Lectures and Workshops

Masters and Johnson Lifetime Achievement Award from the Society of Sex Therapy and Research, April 2005 along with Candace Risen and Stanley Althof

2006 SSTAR Book Award for The Handbook of Clinical Sexuality for Mental Health Professionals: Exceptional Merit

2018 - Albert Marquis Lifetime Achievement Award from Marquis Who's Who. (excelling in one's field for at least twenty years)

Professional Societies

1971 - American Psychiatric Association; fellow

2005 - American Psychiatric Association - **Distinguished Life Fellow**

1973 - Cleveland Psychiatric Society

1973 - Cleveland Medical Library Association

- 1985 - Life Fellow
- 2003 - Distinguished Life Fellow

1974 - Society for Sex Therapy and Research

- 1987-89 - President

1983 - International Academy of Sex Research

1983 - Harry Benjamin International Gender Dysphoria Association

- 1997-98 - Chairman, Standards of Care Committee

1994-99 - Society for Scientific Study of Sex

Community Boards

1999-2002 - Case Western Reserve University Medical Alumni Association

1996-2001 - Bellefaire Jewish Children's Bureau

1999-2001 - Physicians' Advisory Committee, The Gathering Place (cancer rehabilitation)

Editorial Boards

1978-80 Book Review Editor Journal Sex and Marital Therapy

Manuscript Reviewer for:

- Archives of Sexual Behavior
- Annals of Internal Medicine
- British Journal of Obstetrics and Gynecology
- JAMA
- Diabetes Care
- American Journal of Psychiatry
- Maturitas
- Psychosomatic Medicine
- Sexuality and Disability
- Journal of Nervous and Mental Diseases
- Journal of Neuropsychiatry and Clinical Neurosciences
- Neurology
- Journal Sex and Marital Therapy
- Journal Sex Education and Therapy
- Social Behavior and Personality: an international journal (New Zealand)
- International Journal of Psychoanalysis
- International Journal of Transgenderism
- Journal of Urology
- Journal of Sexual Medicine
- Current Psychiatry
- International Journal of Impotence Research
- Postgraduate medical journal
- Academic Psychiatry

Prospectus Reviewer for:

- Guilford
- Oxford University Press

- Brunner/Routledge
- Routledge

Administrative Responsibilities

Co-director, Center for Marital and Sexual Health/ Levine, Risen & Associates, Inc. until June 30, 2017

Principal Investigator of approximately 70 separate studies involving pharmacological interventions for sexual dysfunction since 1989.

Co-leader of case conferences at DELRLLC.com

Recent Expert Witness Appearances

US District Court, Judge Mark L. Wolf's witness in Michelle Kosilek vs. Massachusetts Dept of Corrections et al. case (transsexual issue) in Boston 2007

Deposition in the Battista vs. Massachusetts Dept of Corrections case (transsexual issue) in Cleveland October 2009

Witness for Massachusetts Dept. of Corrections in their defense of a lawsuit brought by prisoner Katheena Soneeya. March 22, 2011 Deposition in Boston and October 2018 in Cleveland

Witness for State of Florida vs. Reyne Keohane July 2017

Expert testimony by deposition and at trial in *In the Interests of the Younger Children*, Dallas, TX, 2019.

Consultancy

Massachusetts Department of Corrections - evaluation of 12 transsexual prisoners and the development of a Gender Identity Disorders Program for the state prison system. Monthly consultation with the GID treatment team since February 2009 and the GID policy committee since February 2010

California Department of Corrections and Rehabilitation; 2012-2015; education, inmate evaluation, commentary on inmate circumstances, suggestions on future policies

Virginia Department of Corrections - evaluation of an inmate

New Jersey Department of Corrections - evaluation of an inmate

Idaho Department of Corrections - workshop 2016

Grant Support/Research Studies

TAP - studies of Apomorphine sublingual in treatment of erectile dysfunction

Pfizer - Sertraline for premature ejaculation

Pfizer - Viagra and depression; Viagra and female sexual dysfunction; Viagra as a treatment for SSRI-induced erectile dysfunction

NIH - Systemic lupus erythematosus and sexuality in women

Sihler Mental Health Foundation

- Program for Professionals
- Setting up of Center for Marital and Sexual Health
- Clomipramine and Premature ejaculation
- Follow-up study of clergy accused of sexual impropriety
- Establishment of services for women with breast cancer

Alza - controlled study of a novel SSRI for rapid ejaculation

Pfizer - Viagra and self-esteem

Pfizer - double-blind placebo control studies of a compound for premature ejaculation

Johnson & Johnson - controlled studies of Dapoxetine for rapid ejaculation

Proctor and Gamble - multiple studies to test testosterone patch for post menopausal sexual dysfunction for women on and off estrogen replacement

Lilly-Icos - study of Cialis for erectile dysfunction

VIVUS - study for premenopausal women with FSAD

Palatin Technologies - studies ofbremelanotide in female sexual dysfunction—first intranasal then subcutaneous administration

Medtap - interview validation questionnaire studies

HRA - quantitative debriefing study for Female partners of men with premature ejaculation, Validation of a New Distress Measure for FSD,

Boehringer-Ingelheim - double blind and open label studies of a prosexual agent for hypoactive female sexual desire disorder

Biosante - studies of testosterone gel administration for post menopausal women with HSDD

J&J - a single-blind, multi-center, in home use study to evaluate sexual enhancement effects of a product in females.

UBC - Content validity study of an electronic FSEP-R and FSDD-DAO and usability of study PRO measures in premenopausal women with FSAD, HSDD or Mixed FSAD/HSDD

National registry trial for women with HSDD

Endoceutics - two studies of DHEA for vaginal atrophy and dryness in post menopausal women

Palatin - study of SQ Bremelanotide for HSDD and FSAD

Trimel - a double-blind, placebo controlled study for women with acquired female orgasmic disorder.

S1 Biopharma - a phase 1-B non-blinded study of safety, tolerability and efficacy of Lorexys in premenopausal women with HSDD

HRA - qualitative and cognitive interview study for men experiencing PE

Publications

A) Books

- 1) Pariser SR, Levine SB, McDowell M (eds.), Clinical Sexuality, Marcel Dekker, New York, 1985
- 2) Sex Is Not Simple, Ohio Psychological Publishing Company, 1988; Reissued in paperback as: Solving Common Sexual Problems: Toward a Problem Free Sexual Life, Jason Aronson, Livingston, NJ. 1997
- 3) Sexual Life: A Clinician's Guide. Plenum Publishing Corporation. New York, 1992
- 4) Sexuality in Midlife. Plenum Publishing Corporation. New York, 1998
- 5) Editor. Clinical Sexuality. Psychiatric Clinics of North America, March, 1995.
- 6) Editor, (Candace Risen and Stanley Althof, associate editors) Handbook of Clinical Sexuality for Mental Health Professionals. Routledge, New York, 2003
 - (a) 2006 SSTAR Book Award: Exceptional Merit
- 7) Demystifying Love: Plain Talk For The Mental Health Professional. Routledge, New York, 2006
- 8) Senior editor, (Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals. 2nd edition Routledge, New York, 2010. See review by Pega Ren, JSex&Marital Therapy
- 9) Barriers to Loving: A Clinician's Perspective. Routledge, New York, 2014.
- 10) Senior editor Candace B. Risen and Stanley E. Althof, Associate editors), Handbook of Clinical Sexuality for Mental Health Professionals. 3rd edition Routledge, New York, 2016

B) Research and Invited Papers

(When his name is not listed in a citation, Dr. Levine is either the solo or the senior author)

- 1) Sampliner R. Parotid enlargement in Pima Indians. Annals of Internal Medicine 1970; 73:571-73
- 2) Confrontation and residency activism: A technique for assisting residency change: World Journal of Psychosynthesis 1974; 6: 23-26
- 3) Activism and confrontation: A technique to spur reform. Resident and Intern Consultant 173; 2
- 4) Medicine and Sexuality. Case Western Reserve Medical Alumni Bulletin 1974:37:9-11.

- 5) Some thoughts on the pathogenesis of premature ejaculation. J. Sex & Marital Therapy 1975; 1:326-334
- 6) Marital Sexual Dysfunction: Introductory Concepts. Annals of Internal Medicine 1976;84:448-453
- 7) Marital Sexual Dysfunction: Ejaculation Disturbances 1976; 84:575-579
- 8) Yost MA: Frequency of female sexual dysfunction in a gynecology clinic: An epidemiological approach. Archives of Sexual Behavior 1976;5:229-238
- 9) Engel IM, Resnick PJ, Levine SB: Use of programmed patients and videotape in teaching medical students to take a sexual history. Journal of Medical Education 1976;51:425-427
- 10) Marital Sexual Dysfunction: Erectile dysfunction. Annals of Internal Medicine 1976;85:342-350
- 11) Articles in Medical Aspects of Human Sexuality
 - (a) Treating the single impotent male. 1976; 10:123, 137
 - (b) Do men enjoy being caressed during foreplay as much as women do? 1977; 11:9
 - (c) Do men like women to be sexually assertive? 1977;11:44
 - (d) Absence of sexual desire in women: Do some women never experience sexual desire? Is this possibility genetically determined? 1977; 11:31
 - (e) Barriers to the attainment of ejaculatory control. 1979; 13:32-56.
 - (f) Commentary on sexual revenge.1979;13:19-21
 - (g) Prosthesis for psychogenic impotence? 1979;13:7
 - (h) Habits that infuriate mates. 1980;14:8-19
 - (i) Greenberger-Englander, Levine SB. Is an enema an erotic equivalent?1981; 15:116
 - (j) Ford AB, Levine SB. Sexual Behavior and the Chronically Ill Patients. 1982; 16:138-150
 - (k) Preoccupation with wife's sexual behavior in previous marriage 1982; 16:172
 - (l) Co-existing organic and psychological impotence. 1985;19:187-8
 - (m) Althof SE, Turner LA, Kursh ED, Bodner D, Resnick MI, Risen CB. Benefits and Problems with Intracavernosal injections for the treatment of impotence. 1989;23(4):38-40
- 12) Male Sexual Problems. Resident and Staff Physician 1981:2:90-5
- 13) Female Sexual Problems. Resident and Staff Physician 1981:3:79-92
- 14) How can I determine whether a recent depression in a 40 year old married man is due to organic loss of erectile function or whether the depression is the source of the

- dysfunction? Sexual Medicine Today 1977;1:13
- 15) Corradi RB, Resnick PJ Levine SB, Gold F. For chronic psychologic impotence: sex therapy or psychotherapy? I & II Roche Reports; 1977
 - 16) Marital Sexual Dysfunction: Female dysfunctions 1977; 86:588-597
 - 17) Current problems in the diagnosis and treatment of psychogenic impotence. Journal of Sex & Marital Therapy 1977; 3:177-186
 - 18) Resnick PJ, Engel IM. Sexuality curriculum for gynecology residents. Journal of Medical Education 1978; 53:510-15
 - 19) Agle DP. Effectiveness of sex therapy for chronic secondary psychological impotence Journal of Sex & Marital Therapy 1978; 4:235-258
 - 20) DePalma RG, Levine SB, Feldman S. Preservation of erectile function after aortoiliac reconstruction. Archives of Surgery 1978; 113-958-962
 - 21) Conceptual suggestions for outcome research in sex therapy Journal of Sex & Marital Therapy 1981; 6:102-108
 - 22) Lothstein LM. Transsexualism or the gender dysphoria syndrome. Journal of Sex & Marital Therapy 1982; 7:85-113
 - 23) Lothstein LM, Levine SB. Expressive psychotherapy with gender dysphoria patients Archives General Psychiatry 1981; 38:924-929
 - 24) Stern RG Sexual function in cystic fibrosis. Chest 1982; 81:422-8
 - 25) Shumaker R. Increasingly Ruth: Towards understanding sex reassignment surgery Archives of Sexual Behavior 1983; 12:247-61
 - 26) Psychiatric diagnosis of patients requesting sex reassignment surgery. Journal of Sex & Marital Therapy 1980; 6:164-173
 - 27) Problem solving in sexual medicine I. British Journal of Sexual Medicine 1982; 9:21-28
 - 28) A modern perspective on nymphomania. Journal of Sex & Marital Therapy 1982; 8:316-324
 - 29) Nymphomania. Female Patient 1982;7:47-54
 - 30) Commentary on Beverly Mead's article: When your patient fears impotence. Patient Care 1982; 16:135-9
 - 31) Relation of sexual problems to sexual enlightenment. Physician and Patient 1983 2:62
 - 32) Clinical overview of impotence. Physician and Patient 1983; 8:52-55.
 - 33) An analytical approach to problem-solving in sexual medicine: a clinical introduction to the psychological sexual dysfunctions. II. British Journal of Sexual Medicine

- 34) Coffman CB, Levine SB, Althof SE, Stern RG Sexual Adaptation among single young adults with cystic fibrosis. *Chest* 1984; 86:412-418
- 35) Althof SE, Coffman CB, Levine SB. The effects of coronary bypass in female sexual, psychological, and vocational adaptation. *Journal of Sex & Marital Therapy* 1984; 10:176-184
- 36) Letter to the editor: Follow-up on Increasingly Ruth. *Archives of Sexual Behavior* 1984; 13:287-9
- 37) Essay on the nature of sexual desire *Journal of Sex & Marital Therapy* 1984; 10:83-96
- 38) Introduction to the sexual consequences of hemophilia. *Scandanavian Journal of Haemology* 1984; 33:(supplement 40).75-
- 39) Agle DP, Heine P. Hemophila and Acquired Immune Deficiency Syndrome: Intimacy and Sexual Behavior. National Hemophilia Foundation; July, 1985
- 40) Turner LA, Althof SE, Levine SB, Bodner DR, Kursh ED, Resnick MI. External vacuum devices in the treatment of erectile dysfunction: a one-year study of sexual and psychosocial impact. *Journal of Sex & Marital Therapy*
- 41) Schein M, Zyzanski SJ, Levine SB, Medalie JH, Dickman RL, Alemagno SA. The frequency of sexual problems among family practice patients. *Family Practice Research Journal* 1988; 7:122-134
- 42) More on the nature of sexual desire. *Journal of Sex & Marital Therapy* 1987; 13:35-44
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- 45) Sexuality, Intimacy, and Hemophilia: questions and answers . National Hemophilia Foundation January, 1988
- 46) Prevalence of sexual problems. *Journal Clinical Practice in Sexuality* 1988;4:14-16.
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- 50) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DR, Resnick MI. Intracavernosal injections in the treatment of impotence: A prospective study of sexual, psychological, and marital functioning. *Journal of Sex & Marital Therapy* 1987; 13:155-167

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- 53) Is it time for sexual mental health centers? *Journal of Sex & Marital Therapy* 1989;
- 54) Althof SE, Turner LA, Levine SB, Risen CB, Bodner D, Kursh ED, Resnick MI. Sexual, psychological, and marital impact of self injection of papaverine and phentolamine: a long-term prospective study. *Journal of Sex & Marital Therapy*
- 55) Althof SE, Turner LA, Levine SB, Risen CB, Bodner D, Kursh ED, Resnick MI. Why do so many men drop out of intracavernosal treatment? *Journal of Sex & Marital Therapy*. 1989; 15:121-9
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- 59) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. Through the eyes of women: the sexual and psychological responses of women to their partners' treatment with self-injection or vacuum constriction therapy. *International Journal of Impotence Research (supplement 2)*1990; 346-7.
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- 61) Kursh E, Turner L, Bodner D, Althof S, Levine S. A prospective study on the use of the vacuum pump for the treatment of impotence. *International Journal of Impotence Research (supplement 2)*1990; 340-1.
- 62) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. Long term use of intracavernous therapy in the treatment of erectile dysfunction in *Journal of Sex & Marital Therapy* 1991; 17(2):101-112
- 63) Althof SE, Turner LA, Levine SB, Risen CB, Bodner DB, Kursh ED, Resnick MI. Long term use of vacuum pump devices in the treatment of erectile dysfunction in *Journal of Sex & Marital Therapy* 1991;17(2):81-93
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- comparison of the effectiveness of two treatments for erectile dysfunction: self injection vs. external vacuum devices. *Urology* 1992;39(2):139-44
- 65) Althof SE, The pathogenesis of psychogenic impotence. *J. Sex Education and Therapy*. 1991; 17(4):251-66
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 - 67) Successful Sexuality. Belonging/Hemophilia. (Caremark Therapeutic Services), Autumn, 1991
 - 68) Psychological intimacy. *Journal of Sex & Marital Therapy* 1991; 17(4):259-68
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 - 70) Althof SE, Turner LA, Levine SB, Bodner DB, Kursh E, Resnick MI. Through the eyes of women: The sexual and psychological responses of women to their partner's treatment with self-injection or vacuum constriction devices. *Journal of Urology* 1992; 147(4):1024-7
 - 71) Curry SL, Levine SB, Jones PK, Kurit DM. Medical and Psychosocial predictors of sexual outcome among women with systemic lupus erythematosus. *Arthritis Care and Research* 1993; 6:23-30
 - 72) Althof SE, Levine SB. Clinical approach to sexuality of patients with spinal cord injury. *Urological Clinics of North America* 1993; 20(3):527-34
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 - 74) Curry SL, Levine SB, Jones PK, Kurit DM. The impact of systemic lupus erythematosus on women's sexual functioning. *Journal of Rheumatology* 1994; 21(12):2254-60
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 - 76) Risen CB, Althof SE. Professionals who sexually offend: evaluation procedures and preliminary findings. *Journal of Sex & Marital Therapy* 1994; 20(4):288-302
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 - 79) "Love" and the mental health professions: Towards an understanding of adult love. *Journal of Sex & Marital Therapy* 1996; 22(3):191-20
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- treatments. Medscape Mental Health 2(8):1997 on the Internet. September, 1997.
- 81) Discussion of Dr. Derek Polonsky's SSTAR presentation on Countertransference. Journal of Sex Education and Therapy 1998; 22(3):13-17
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EXHIBIT A

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Attorneys for Defendant

**IN THE UNITED STATES DISTRICT COURT
 FOR THE DISTRICT OF ARIZONA**

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by and
 through his guardian and next friend, Susan
 Doe, on behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona Health
 Care Cost Containment System, in her
 official capacity,

Defendant.

Case No. 4:20-cv-00335-SHR

**EXPERT DECLARATION OF
 MICHAEL K. LAIDLAW, M.D.**

(Assigned to the Honorable Scott H.
 Rash)

I, Michael K. Laidlaw, M.D., hereby declare as follows:

1. I am over the age of eighteen and submit this expert declaration based on my personal knowledge and experience.
2. I am a board-certified endocrinologist. I received my medical degree from the University of Southern California in 2001. I completed my residency in internal medicine at Los Angeles County/University of Southern California Medical Center in

1 2004. I also completed a fellowship in endocrinology, diabetes and metabolism at Los
2 Angeles County/University of Southern California Medical Center in 2006.

3
4 3. I have been board certified by (1) the National Board of Physicians and
5 Surgeons for Endocrinology, Diabetes & Metabolism, (2) the National Board of
6 Physicians and Surgeons for Internal Medicine, (3) the American Board of Internal
7 Medicine for Internal Medicine, and (4) the American Board of Internal Medicine for
8 Endocrinology, Diabetes, and Metabolism.

9
10 4. The information provided regarding my professional background are
11 detailed in my curriculum vitae. A true and correct copy of my curriculum vitae is
12 attached as Exhibit A.

13 5. In my clinical practice as an endocrinologist, I evaluate and treat patients
14 with hormonal and/or gland issues. Hormone and gland disorders can cause or be
15 associated with psychiatric symptoms, such as depression, anxiety, and other psychiatric
16 symptoms. Therefore, I frequently assess and treat patients demonstrating psychiatric
17 symptoms and determine whether their psychiatric symptoms are being caused by a
18 hormonal issue, gland issue, or something else.

19 6. I have been retained by Defendant in the above-captioned lawsuit to provide
20 an expert opinion on (1) the standards of care for treating minors diagnosed with gender
21 dysphoria, including considerations of various proposed treatments, and (2) the
22 appropriateness of D.H. and John Doe receiving bilateral mastectomy surgery at this time.

23
24 7. If called to testify in this matter, I would testify truthfully and based on my
25 expert opinion. The opinions and conclusions I express herein are based on a reasonable
26 degree of scientific certainty.

1 8. I am being compensated at an hourly rate of \$367 per hour plus expenses for
2 my time spent preparing this declaration, and to prepare for and provide testimony in this
3 matter. My compensation does not depend on the outcome of this litigation, the opinions
4 I express, or the testimony I may provide.
5

6 9. My opinions contained in this report are based on: (1) my clinical
7 experience as an endocrinologist; (2) my clinical experience evaluating individuals who
8 have or have had gender incongruence and/or gender dysphoria; (3) my knowledge of
9 research and studies regarding the treatment of gender dysphoria, including for minors;
10 and (4) my review of the various declarations submitted by Plaintiffs D.H. and John Doe
11 in the present lawsuit, *D.H. and John Doe v. Snyder*, Case No. 4:20-cv-00335-SHR
12 (pending in the U.S. District Court for the District of Arizona).

13 10. I was provided with and reviewed the following case-specific materials: (1)
14 the declarations of D.H. and John Doe, and their respective guardians Janice Hennessy-
15 Waller and Susan Doe; (2) the declarations of D.H.'s and John Doe's respective treating
16 providers, Tamar Reed, LPC, Dr. Andrew Cronyn, M.D., and Dr. Mischa Cohen Peck,
17 PhD; and (3) the expert declarations of Dr. Aron Janssen, M.D. and Dr. Loren S.
18 Schechter, M.D.
19

20 11. In my professional opinion, treatment interventions on behalf of children
21 diagnosed with gender dysphoria must be held to the same scientific standards as other
22 medical treatments. These interventions must be optimal, efficacious, and safe. Any
23 treatment which alters biological development in children should be used with extreme
24 caution.

25 12. Based on the materials I have reviewed and in my professional opinion,
26 there is an insufficient clinical basis to conclude that either D.H. or John Doe will suffer
27 imminent, irreparable harm if they do not receive bilateral mastectomy with chest wall
28

1 recontouring surgery prior to the conclusion of this case. To the contrary, in my
2 professional opinion, this irreversible surgery should not be performed on minors D.H.
3 and John Doe. I reach this opinion for the following reasons.

4
5 13. A high percentage of children diagnosed with gender dysphoria have
6 depression, anxiety, or other mental health disorders separate and apart from gender
7 dysphoria. *See infra* ¶23. According to the declarations I reviewed, both D.H. and John
8 Doe have a significant and lengthy history of psychiatric issues separate and apart from
9 gender dysphoria.

10 14. According to the declarations of Janice Hennessy-Waller and Tamar Reed,
11 D.H. has been hospitalized, including in intensive psychiatric care, four times since age 11
12 for treatment of significant psychological distress, including severe anxiety and suicidal
13 ideation. D.H. has a history of pervasive anxiety, chronic suicidal ideations and attempts,
14 and related self-harm issues (including cutting, burning and hair pulling). D.H. also has
15 oppositional defiant disorder, which the Diagnostic and Statistical Manual of Mental
16 Disorders, Fifth Edition (“DSM-5”) defines as “a frequent and persistent pattern of
17 angry/irritable mood, argumentative/defiant behavior, or vindictiveness.” In addition, the
18 declaration of Tamar Reed states that D.H. currently has “anxiety and psychological
19 distress caused by prior trauma.”

20 15. According to the declaration of Janice Hennessy-Waller, D.H. was in
21 intensive in-patient psychiatric care for severe anxiety and suicidal ideation beginning in
22 2014. There is no indication gender dysphoria was being evaluated, discussed, or
23 addressed at this time. It was not until two years later (in 2016) that D.H. identified as
24 transgender to another person (D.H.’s mom).

25
26 16. According to the declaration of Susan Doe, John Doe’s biological parents
27 were unable to care for John Doe and provide John Doe with a stable home environment.
28 According to the declaration of Mischa Cohen Peck, John Doe was diagnosed with post-

1 traumatic stress disorder (“PTSD”) stemming from early-life attachment trauma.

2 Although not defined in the declarations, the term “early-life attachment trauma” indicates
3 that John Doe likely suffered abuse or neglect at a young age.

4
5 17. According to John Doe’s declaration, John Doe has been depressed, suffered
6 from anxiety, engaged in self-harm through cutting and burning, distanced from friends
7 and family, lost interest in activities, and lost a significant amount of weight in a very
8 short period of time because of limited food intake. John Doe also contemplated suicide.

9 18. According to the declaration of Mischa Cohen Peck, John Doe has not been
10 successfully treated for the trauma underlying John Doe’s PTSD. In addition, John Doe
11 describes “being detached” from John Doe’s own body.¹

12 19. According to several of the declarations that I reviewed, both D.H. and John
13 Doe have engaged in non-suicidal self-injury (“NSSI”), which is associated with multiple
14 types of psychiatric disorders. As one article has noted, “[t]he age onset of NSSI most
15 often occurs in early adolescence, between 12 and 14 years (Nock et al., 2006;
16 Muehlenkamp and Gutierrez, 2007; Cerutti et al., 2011), but findings have also reported
17 NSSI behavior in children under the age of 12 (Barrocas et al., 2012). The most common
18 method was self-cutting (over 70%) followed by head banging, scratching, hitting and
19

20 ¹ Although I did not review or have access to John Doe’s medical records, I note there is
21 one psychiatric disorder, dissociative identity disorder, which the American Psychiatric
22 Association describes as follows: “People with dissociative identity disorder may feel that
23 they have suddenly become observers of their own speech and actions, or their bodies may
24 feel different (e.g., like a small child, like the opposite gender, huge and muscular).”
25 Further, (1) “Dissociative identity disorder is associated with overwhelming experiences,
26 traumatic events and/or abuse that occurred in childhood”; (2) “People who have
27 experienced physical and sexual abuse in childhood are at increased risk of dissociative
28 identity disorder. The vast majority of people who develop dissociative disorders have
experienced repetitive, overwhelming trauma in childhood. Among people with
dissociative identity disorder in the United States, Canada and Europe, about 90 percent had
been the victims of childhood abuse and neglect”; and (3) “Suicide attempts and other self-
injurious behavior are common among people with dissociative identity disorder. More than
70 percent of outpatients with dissociative identity disorder have attempted suicide.” See
American Psychiatric Association, “What Are Dissociative Disorders?” (Aug. 2018), at
[https://www.psychiatry.org/patients-families/dissociative-disorders/what-are-dissociative-
disorders](https://www.psychiatry.org/patients-families/dissociative-disorders/what-are-dissociative-disorders) (last visited Sept. 22, 2020). This issue should be fully explored by a psychiatrist
for John Doe.

1 burning (Briere and Gil, 1998; Laye-Gindhu and Schonert-Reichl, 2005; Gratz, 2006;
2 Whitlock et al., 2006).” Further, “[s]elf injury has long been linked to other disorders as
3 well, including post-traumatic stress disorder (Briere and Gil, 1998; Bolognini et al.,
4 2003), depressive disorders (Darche, 1990), obsessive-compulsive disorder (Bolognini et
5 al., 2003), anxiety disorder (Darche, 1990; Simeon and Favazza, 2001), borderline
6 personality disorder (BPD) (Klonsky et al., 2003; Nock et al., 2006), and eating disorder
7 (Iannaccone et al., 2013).” Cipriano, Cella, & Cotrufo, “Nonsuicidal Self-injury: A
8 Systematic Review,” *Front Psychol.* 2017; 8: 1946 (Nov. 8, 2017). The link between self-
9 injury and these psychiatric disorders warrant a full evaluation by a clinical psychiatrist
10 and psychologist for John Doe and D.H.

11
12 20. According to several of the declarations, D.H. and John Doe have both been
13 prescribed hormone-replacement therapy (i.e., testosterone) to develop a more masculine
14 appearance. A typical dose of hormone-replacement for female-to-male transition is a
15 high dose. Normal female testosterone levels are 10-50 ng/dL. The Endocrine Society
16 Clinical Guidelines advise bringing these to 300-1000 ng/dL, which are values typically
17 found with androgen-secreting tumors. See Laidlaw, Van Meter, Hruz, Van Mol, &
18 Malone, “Letter to the Editor: Endocrine Treatment of Gender-Dysphoria/Gender-
19 Incongruent Persons: An Endocrine Society Clinical Practice Guideline,” *J Clin*
20 *Endocrinol Metab*, 104(3) (March 2019). This is 6 to 100 times higher than the natal
21 female body typically contains. According to research, high doses of testosterone have
22 been shown to predispose individuals towards mood disorders, psychosis, and psychiatric
23 disorders. The “most prominent psychiatric features associated with AAS [anabolic-
24 androgenic steroids, i.e. testosterone] abuse are manic-like presentations defined by
25 irritability, aggressiveness, euphoria, grandiose beliefs, hyperactivity, and reckless or
26 dangerous behavior. Other psychiatric presentations include the development of acute
27 psychoses, exacerbation of tics and depression, and the development of acute
28 confusional/delirious states.” Moreover, “[s]tudies . . . of medium steroid use (between

1 300 and 1000 mg/week of any AAS) and high use (more than 1000 mg/week of any AAS)
2 have demonstrated that 23% of subjects using these doses of steroids met the DSM-III-R
3 criteria for a major mood syndrome (mania, hypomania, and major depression) and that
4 3.4%–12% developed psychotic symptoms.” Hall, Hall & Chapman, “Psychiatric
5 Complications of Anabolic Steroid Abuse,” *Psychosomatics* 46:4 (July-August 2005).
6 Thus, hormone treatments can exacerbate any underlying psychiatric problems of a child,
7 including D.H. and John Doe.

8
9 21. According to several of the declarations, D.H. and John Doe originally felt
10 better after receiving the hormones, but then subsequently felt worse. In my professional
11 opinion, it is likely D.H. and John Doe originally felt better because of the side effect of
12 euphoria elicited by high doses of testosterone, as noted above. It is also likely D.H. and
13 John Doe may have later started feeling worse because either (1) the high dose of
14 testosterone ultimately exacerbated their mental health issues, or (2) their underlying
15 psychiatric issues, separate from the gender dysphoria, were never actually resolved (or a
16 combination of the two).

17 22. There are no laboratory, imaging, or other objective tests to predict whether
18 children with gender dysphoria will outgrow the condition. “Children with [gender
19 dysphoria] will outgrow this condition in 61% to 98% of cases by adulthood. There is
20 currently no way to predict who will desist and who will remain dysphoric.” Laidlaw, Van
21 Meter, Hruz, Van Mol, & Malone, “Letter to the Editor: Endocrine Treatment of Gender-
22 Dysphoria/Gender-Incongruent Persons: An Endocrine Society Clinical Practice
23 Guideline,” *J Clin Endocrinol Metab*, 104(3) (March 2019).

24 23. A key study from Finland indicated that 68% of children with gender
25 dysphoria had already been to psychiatric care for reasons other than gender identity
26 issues. Kaltiala-Heino, Sumia, Työläjäarvi, & Lindberg, “Two years of gender identity
27 service for minors: overrepresentation of natal girls with severe problems in adolescent
28

development,” *Child & Adolescent Psychiatry & Mental Health* (2015) 9:9 (“Of the applicants, 68% (32/47) had had their first contact with psychiatric services due to other reasons than gender identity issues”; in addition, “[s]eventy-five per cent of the applicants (35/47) had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria when they sought referral to [sex reassignment] assessment”). Therefore, in my professional opinion, a child’s psychological disorders should be thoroughly treated first before considering hormone therapy or gender reassignment surgery. Based on the declarations I reviewed, there is insufficient evidence to establish that D.H.’s and John Doe’s psychiatric issues have been thoroughly evaluated and adequately treated by a qualified psychiatrist or clinical psychologist.

24. In addition to the information identified above, the declarations do not contain pertinent historical information regarding whether or not D.H. or John Doe are (or have been) on any psychiatric or other medication or have been provided other adequate treatments to treat any of their significant psychological issues.

25. The declarations are also missing pertinent history as to whether or not D.H. or John Doe have had any history of substance use or abuse. Many individuals with the disorders identified above may also have a history of substance abuse. The National Institutes of Health recommends that “people entering treatment either for a substance use disorder or for another mental disorder should be assessed for the co-occurrence of the other condition.” Additionally, “as many as 6 in 10 people with an illicit substance use disorder also suffer from another mental illness.” National Institute on Drug Abuse, “Principles of Drug Addiction Treatment: A Research-Based Guide” (3rd ed.) (Jan. 2018), located at <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/how-do-other-mental-disorders-coexisting-drug-addiction> (last accessed Sept. 25, 2020). A history of substance use or abuse would be important to clarify as substance use or abuse could impair

1 judgment with respect to informed consent for a procedure. Thus, it should be thoroughly
2 examined and ruled out before any irreversible surgery is performed.

3
4 26. Depression, if not properly treated before surgery, may result in an increase
5 in morbidity and mortality post-surgery: "Several studies reported increased rate of
6 postoperative infections in patients suffering from depression." With respect to
7 depression treatment for patients before major surgery, where it is "[n]on-alleviated, it
8 may predict increased morbidity and mortality after the operation. It may be associated
9 with greater postoperative pain, higher incidence of postoperative infections, progression
10 of malignant tumors, poor health-related quality of life as well as other complications."
11 Ghoneim & O'Hara, "Depression and Postoperative complications: an overview," *BMC*
12 *Surg.* 2016; 16:5 (Feb. 2, 2016).

13 27. As Dr. Loren Schechter (plastic surgeon) confirms in her declaration (p. 16,
14 ¶ 45) "[t]o make a final assessment of D.H.'s and John Doe's suitability for surgery, I
15 would need to perform an in-person exam." Dr. Schechter acknowledges that before any
16 individual can be determined suitable for surgery, a final assessment which requires an in-
17 person exam, is required. But Dr. Schechter confirms he has not conducted a final
18 assessment of John Doe and D.H.'s suitability for surgery. None of the other declarations
19 indicate a final assessment or physical examination has been conducted on either D.H. or
20 John Doe. As Dr. Schechter notes, a final assessment is necessary to assess skin elasticity
21 and also to rule out any pathology, such as breast masses, lumps, and nipple retraction. A
22 full work up for John Doe and D.H. has not been completed.

23 28. A mastectomy surgery is irreversible. If a patient later regrets the decision
24 and decides to resume living as their natal sex (female), she will not be able to ever
25 breastfeed a child, because her functional organs have been removed and can never be
26 replaced. Possible complications of this procedure (bilateral mastectomy with chest wall
27
28

29. I have significant concerns about the ability of two minors with histories of significant underlying psychiatric issues, separate and apart from gender dysphoria, to provide informed consent to undergo an irreversible sex reassignment surgery.

30. While the Endocrine Society has issued “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,” these are only “guidelines.” The Endocrine Society’s guidelines specifically note the “guidelines cannot guarantee any specific outcome, nor do they establish a standard of care.” Wylie C. Hembree, et al., “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,” *The Journal of Clinical Endocrinology & Metabolism*, Volume 102, Issue 11 (Nov. 1, 2017).²

31. In the Endocrine Society’s guidelines, the quality of evidence for the treatment of adolescents is rated “very low-quality evidence” and “low quality evidence.” (p. 3871-72).

32. “The Endocrine Society has published revised clinical guidelines in 2017 on the treatment of gender dysphoric persons including adolescents (Hembree et al. 2017). The quality of evidence for [puberty blocking agents] is noted to be low. In fact, all of the evidence in the guidelines with regard to treating children/adolescents by [gender affirmative therapy] is low to very low because of the absence of proper studies.”

² The Endocrine Society guidelines (p.3380) note “in some forms of [gender dysphoria]/gender incongruence, psychological interventions may be useful and sufficient,” before ever needing to proceed with medicalized treatments. Further, the guidelines (p. 3894) note “some transgender male adolescents” may “consider mastectomy 2 years after they begin androgen [testosterone] therapy.” But according to John Doe’s declaration, John Doe began hormone replacement therapy in June 2019; thus, John Doe has not been on hormone therapy for two years.

1 Laidlaw, Cretella & Donovan, “The Right to Best Care for Children Does Not Include the
2 Right to Medical Transition,” *The American Journal of Bioethics*, 19:2, 75-77 (Feb. 20,
3 2019). Unlike other recommendations for adolescent transition, the Endocrine Society’s
4 guidelines do not include any grading of the quality of evidence specifically for
5 adolescent mastectomy.

6
7 33. The declarations of Dr. Aron Janssen and Dr. Loren Schechter cite to the
8 World Professional Association for Transgender Health’s (“WPATH”) “Standards of Care
9 for the Health of Transsexual, Transgender, and Gender Non-Conforming People.”
10 According to their declarations, Dr. Janssen is a member of WPATH, Dr. Schechter is on
11 the Board of Directors of WPATH, and both have been contributing authors to WPATH’s
12 “Standards of Care.” WPATH’s “Standards of Care” were prepared within their advocacy
13 organization and are purported to be a “professional consensus about the psychiatric,
14 psychological, medical, and surgical management of gender dysphoria.” However, the
15 “professional consensus” exists only within the confines of its organization. Furthermore,
16 their “Standards of Care,” unlike the Endocrine Society’s guidelines, do not have a
17 grading system for either the strength of their recommendations or the quality of the
18 evidence presented.

19 34. Good quality studies specifically showing that mastectomy surgery is safe,
20 effective, and optimal for treating minors with gender dysphoria do not exist. The
21 declaration of Dr. Loren Schechter refers to the article *Chest Reconstruction and Chest*
22 *Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and*
23 *Postsurgical Cohorts*, 172 JAMA Pediatrics 431, 434 (2018), and quotes the conclusion
24 that “Chest dysphoria was high among presurgical transmasculine youth, and surgical
25 intervention positively affected both minors and young adults.” However, there are a
26 number of problems with this study. First, the term “chest dysphoria” is a creation of the
27 study authors and is not found as a diagnosis or even referenced in the DSM-5. Second the
28 “chest dysphoria scale” is a measuring tool created by the authors, but which the authors

1 state “is not yet validated.” (p. 435) Third, the mastectomies were performed on girls as
2 young as 13 and 14 years old and who thereby lacked the maturity and capacity of good
3 judgement for truly informed consent for this life altering procedure. For this reason, in
4 my professional opinion, the research and surgeries performed were flawed and unethical.

5
6 35. There is also evidence that questions the long-term effectiveness of gender
7 reassignment surgery. A Swedish study in 2011 (Dhejne, et al., “Long-Term Follow-
8 Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort
9 Study in Sweden,” *PLoS One*, vol. 6, issue 2 (Feb. 22, 2011)) examined data over
10 a 30-year period. The Dhejne team made extensive use of numerous Swedish registries
11 and examined data from 324 patients in Sweden over 30 years who underwent sex
12 reassignment surgery. They used population controls matched by birth year, birth sex, and
13 reassigned sex. When followed out beyond ten years, the sex-reassigned group had
14 nineteen times the rate of completed suicides and nearly three times the rate of all-
15 cause mortality and inpatient psychiatric care compared to the general population.

16 36. The Centers for Medicare and Medicaid Services (“CMS”) has found
17 “inconclusive” clinical evidence regarding gender reassignment surgery. Specifically, the
18 CMS Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-
19 00446N) (June 19, 2019) states: “The Centers for Medicare & Medicaid Services (CMS)
20 is not issuing a National Coverage Determination (NCD) at this time on gender
21 reassignment surgery for Medicare beneficiaries with gender dysphoria because the
22 clinical evidence is inconclusive for the Medicare population.”

23 37. Hayes Directories, Inc. is an internationally recognized research and
24 consulting firm dedicated to promoting better health outcomes by assessing quality
25 evidence. In 2014, the Hayes Directory conducted a comprehensive review and evaluation
26 of the scientific literature regarding the treatment of gender dysphoria in adults and
27 children. It concluded the practice of using hormones and sex reassignment surgery to
28

1 treat gender dysphoria is based on “very low” quality of evidence. For sex reassignment
2 surgery (“SRS”) to treat gender dysphoria in adolescents, it received a Hayes Rating of
3 D2 (which is “insufficient evidence”): “This rating reflects the paucity of data of SRS in
4 adolescents.” “Sex Reassignment Surgery for the Treatment of Gender Dysphoria,” *Hayes*
5 *Medical Technology Directory*, p. 3-4 (May 15, 2014).

6
7 38. Recently, a major correction was issued by the American Journal of
8 Psychiatry. The editors of an October 2019 study, titled “Reduction in mental health
9 treatment utilization among transgender individuals after gender-affirming surgeries: a
10 total population study” (Bränström study) retracted their original primary conclusion. The
11 Bränström team reanalyzed the data and the results demonstrated “no advantage to
12 [gender reassignment] surgery” for their three endpoints in the subject population
13 (prescriptions for antidepressants and anti-anxiety medications, healthcare visits for mood
14 or anxiety disorders, and post-suicide attempt hospitalizations). Specifically, the
15 correction stated, “the results demonstrated no advantage of surgery in relation to
16 subsequent mood or anxiety disorder-related health care visits or prescriptions or
17 hospitalizations following suicide attempts in that comparison. Given that the study used
18 neither a prospective cohort design nor a randomized controlled trial design, the
19 conclusion that ‘the longitudinal association between gender-affirming surgery and lower
20 use of mental health treatment lends support to the decision to provide gender-affirming
21 surgeries to transgender individuals who seek them’ is too strong.” “Correction to
22 Bränström and Pachankis,” *Am J Psychiatry*, 177:8 (Aug. 2020).

23 39. For these reasons, in my professional opinion, an irreversible chest
24 reconstruction surgery should not be performed on minors D.H. and John Doe.

25 40. Based on the studies and research cited above, in my professional opinion
26 there is insufficient quality of evidence at this time demonstrating the benefit of bilateral
27 mastectomy with chest wall recontouring surgery on individuals diagnosed with gender
28

1 dysphoria in any age group. For those under 21, there is an additional reason to avoid
2 irreversible procedures: there are no laboratory, imaging, or other objective tests to predict
3 whether a young person with gender dysphoria will outgrow this condition. Because this
4 age group is still undergoing brain development and as such they are immature with
5 respect to intellect, emotion, judgment, and self-control, in my professional opinion this
6 means there is a significant chance that a young person may later regret removing an
7 organ that cannot be replaced. Thus, in my professional opinion, it is never appropriate to
8 provide bilateral mastectomy with chest wall recontouring surgery on individuals
9 diagnosed with gender dysphoria - particularly those under the age of 21.

10 I declare under penalty of perjury that the foregoing is true and correct to the best
11 of my knowledge and belief.

12 Executed this 27th day of September, 2020 at Rocklin, California.

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14 
15 Michael K. Laidlaw, M.D.
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EXHIBIT A

Michael K. Laidlaw, M.D.

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EMPLOYMENT

2006-Present Michael K Laidlaw, MD Inc. Private Practice – Endocrinology, Diabetes, and Metabolism. Rocklin, CA

EDUCATION

2004-2006 Endocrinology and Metabolism Fellowship - Los Angeles County/University of Southern California Keck School of Medicine
2001-2004 Internal Medicine Residency - Los Angeles County/University of Southern California Keck School of Medicine
1997-2001 University of Southern California Keck School of Medicine
Doctor of Medicine Degree May 2001
1990-1997 San Jose State University
Bachelor of Science Degree in Biology with a concentration in Molecular Biology, Cum Laude

LICENSURE

National Board of Physicians and Surgeons - Endocrinology, Diabetes, & Metabolism 2018-2022
National Board of Physicians and Surgeons - Internal Medicine 2018-2022
Diplomate in Endocrinology, Diabetes, and Metabolism – American Board of Internal Medicine - Certified 2006
Diplomate in Internal Medicine - American Board of Internal Medicine - Certified 2005
California Medical License – Physician and Surgeon: # A81060: Nov 6, 2002. Exp 5/31/2022.
Certification in Diagnostic Thyroid Ultrasound and Biopsy – AACE 2005

PROFESSIONAL AFFILIATIONS

Endocrine Society 2006-2020

HONORS AND RECOGNITION

2010	Endocrine Society Harold Vigersky Practicing Physician Travel Award
2004-2005	Vice President - Joint Council of Interns and Residents
2002-2004	Council Member – Joint Council of Interns and Residents
1996, 1997	Dean’s Scholar, San Jose State University
1995	Golden Key National Honor Society

RESEARCH & PUBLICATIONS

2020	<u>Publication</u> – Van Mol A, Laidlaw MK, Grossman M, McHugh P. "Correction: Transgender Surgery Provides No Mental Health Benefit." Public Discourse, 13 Sep 2020. https://www.thepublicdiscourse.com/2020/09/71296/
2020	<u>Publication</u> – VanMol A, Laidlaw MK, Grossman M, McHugh P.. "Gender-affirmation surgery conclusion lacks evidence (letter)". Am J Psychiatry 2020; 177:765–766.
2020	<u>Publication</u> – Laidlaw MK. "The Pediatric Endocrine Society’s Statement on Puberty Blockers Isn’t Just Deceptive. It’s Dangerous." Public Discourse. 13 Jan 2020. https://www.thepublicdiscourse.com/2020/01/59422/
2019	<u>Expert Witness Affidavit</u> – Laidlaw MK. Court of Appeal File No. CA45940, Vancouver Registry. B.C. Supreme Court File No. E190334, between A.B. Respondent/Claimant, and C.D. Appellant/Respondent, and E.F. Respondent/Respondent. 24 Jun 2019.
2019	<u>Publication</u> – Laidlaw MK, Cretella M, Donovan K. "The Right to Best Care for Children Does Not Include the Right to Medical Transition". The American Journal of Bioethics. Volume 19. Published online 20 Feb 2019. 75-77. https://doi.org/10.1080/15265161.2018.1557288
2018	<u>Brief of Amicus Curiae</u> – Alliance Defending Freedom, Campbell, James A., Grossman, Miriam, Laidlaw, Michael K., McCaleb, Gary S., Van Meter, Quentin L., Van Mol, Andre. Brief of Amicus Curiae. United States Court of Appeals for the Eleventh Circuit. Drew Adams, Plaintiff-Appellee, v. School Board of St. Johns County, Florida, Defendant-Appellant. 12/27/2018.
2018	<u>Publication</u> – Laidlaw MK, Van Meter QL, Hruz PW, Van Mol A, Malone WJ. Letter to the Editor: “Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline.” The Journal of Clinical Endocrinology & Metabolism, Volume 104, Issue 3, 1 March 2019, Pages 686–687, https://doi.org/10.1210/jc.2018-01925 (first published on-line 11/2018)
2018	<u>Publication</u> – Laidlaw MK. "The Gender Identity Phantom". gdworkinggroup.org, 24 Oct 2018. http://gdworkinggroup.org/2018/10/24/the-gender-identity-phantom/
2018	<u>Publication</u> – Laidlaw MK. “Gender Dysphoria and Children: An Endocrinologist’s Evaluation of ‘I am Jazz’”. Public Discourse, 5 Apr 2018. https://www.thepublicdiscourse.com/2018/04/21220/
2013	<u>Abstract</u> – Poster presentation Jun 2013. Endocrine Society Annual Meeting. A 12 Step Program for the Treatment of Type 2 Diabetes and Obesity.
2011	<u>Abstract</u> – Poster presentation Nov 2011. Journal of Diabetes Science and

- Technology. A Video Game Teaching Tool for the Prevention of Type 2 Diabetes and Obesity in Children and Young Adults.
- 2011 Abstract – Journal of Diabetes Science and Technology. A Web-Based Clinical Software Tool to Assist in Meeting Diabetes Guidelines and Documenting Patient Encounters.
- 2008 Abstract - Accepted to Endocrine Society Annual Meeting 2008. Hypercalcemia with an elevated 1,25 dihydroxy-Vitamin D level and low PTH due to granulomatous disease.
- 2005-2006 Clinical Research - University of Southern California – Utility of Thyroid Ultrasound in the Detection of Thyroid Cancer. Study involving the use of color flow/power doppler ultrasound and ultrasound guided biopsy to detect the recurrence of thyroid cancer in patients with total thyroidectomies.
- 2002-2005 Clinical Research - University of Southern California - Determining the Role of Magnesium in Osteoporosis. Study involved collecting and analyzing patient data related to patient characteristics, laboratory results, bone mineral density exams, nutrition analysis, and genetic analysis in order to determine a link between magnesium deficiency and osteoporosis.
- 1996 Research Assistant - San Jose State University - Role of the suprachiasmatic nucleus pacemaker in antelope ground squirrels.
- 1995-1996 Research Assistant - San Jose State University/NASA. Acoustic tolerance test and paste diet study for space shuttle rats.

PERSONAL

Languages: Conversational Spanish, French

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Computers: Ruby, Rails, Javascript, C++, C, Java, and HTML programming

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14 *Attorneys for Defendant*

15 **IN THE UNITED STATES DISTRICT COURT**
16 **FOR THE DISTRICT OF ARIZONA**

17 D.H., by and through his mother, Janice
18 Hennessy-Waller; and John Doe, by and
19 through his guardian and next friend, Susan
20 Doe, on behalf of themselves and all others
21 similarly situated,

22 Plaintiffs,

23 vs.

24 Jami Snyder, Director of the Arizona Health
25 Care Cost Containment System, in her
26 official capacity,

27 Defendant.

Case No. 4:20-cv-00335-SHR

**DEFENDANT'S OPPOSITION TO
PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION**

(Assigned to the Honorable Scott H.
Rash)

1 Defendant Jami Snyder, Director of the Arizona Health Care Cost Containment
2 System (“AHCCCS”), submits this Opposition to Plaintiffs’ Motion for Preliminary
3 Injunction. (Doc. 3) D.H. and John Doe - minors with gender dysphoria - are demanding
4 that AHCCCS, Arizona’s Medicaid program, provide them coverage for gender
5 reassignment surgery – specifically, chest reconstruction surgery. But Plaintiffs have not
6 established this irreversible, expensive surgery is legally required or medically appropriate
7 or effective for children generally or for themselves in particular; nor have they
8 established their own ability to provide informed consent. Also, the relief sought would
9 effectively decide the case at this point, as it would result in all the relief Plaintiffs seek in
10 this case, and this is a highly disfavored result. Plaintiffs fail to meet the exceedingly high
11 standards required for a mandatory injunction. Thus, the Court should deny the motion.

12 I. BACKGROUND

13 a. Plaintiffs D.H. and John Doe

14 Plaintiffs are minors - D.H. is 17 years old, and John Doe is 15 years old. (Doc. 1,
15 ¶¶1, 21-22) Plaintiffs allege they are enrolled in AHCCCS “due to [their] family’s limited
16 income.” (*Id.*) Plaintiffs have been diagnosed with gender dysphoria; they were identified
17 as female at birth, but have since transitioned to live as male. (*Id.* ¶5) Plaintiffs seek
18 “declaratory and injunctive relief to enjoin Arizona from continuing to deny them
19 medically necessary treatment” – specifically, chest reconstruction surgery (permanent
20 removal of breasts with chest wall reconstruction surgery). (Doc. 1, ¶¶1, 4, 17; Doc. 5-4,
21 ¶35). The motion seeks to “enjoin Defendant from further enforcement of the regulation
22 and order AHCCCS to cover male chest reconstruction surgery for D.H. and John,” which
23 they claim is “medically necessary.” (Doc. 3, p.2; Doc. 1, ¶¶1, 17)

24 Plaintiffs’ claims are based on Arizona Administrative Code (“A.A.C.”) R9-22-
25 205-B.4, which contains several AHCCCS coverage exclusions, including for: “(a)
26 Infertility services, reversal of surgically induced infertility (sterilization), and gender
27 reassignment surgeries; (b) Pregnancy termination counseling services; (c) Pregnancy
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1 terminations, unless required by state or federal law; (d) Services or items furnished solely
2 for cosmetic purposes; and (e) Hysterectomies unless determined medically necessary.”
3 While “gender reassignment surgeries” are excluded from coverage, other services for the
4 treatment of gender dysphoria - hormone treatments and behavioral health/counseling -
5 are not excluded. *Id.* D.H. claims prior authorization for chest reconstruction surgery was
6 denied because of the exclusion, but the Complaint does not allege John sought prior
7 authorization. (Doc. 1, ¶9)

8 Plaintiffs filed nine declarations (five from healthcare providers) in support of the
9 motion. Plaintiffs gave their providers their medical records for review. *See, e.g.,*
10 Declaration of Dr. Andrew Cronyn (Doc. 5-3, ¶5) Expert Declaration of Aron Janssen,
11 M.D. (Doc. 5-4, ¶19); Expert Declaration of Loren Schechter, M.D. (Doc. 5-5, ¶18) And
12 Plaintiffs argue relief should be granted because chest reconstruction surgery is
13 “medically necessary” for them. For this reason, and in order to respond to the motion,
14 Defendant requested Plaintiffs produce the medical records their providers/experts
15 reviewed, explaining (1) the documents are relevant, (2) the prior authorization process
16 requires AHCCCS to review relevant medical records, and (3) AHCCCS would hold the
17 documents confidential. But Plaintiffs have obstinately refused to disclose any of these
18 relevant medical records to Defendant.

19 **Plaintiff D.H.:** According to the Complaint, D.H. had “significant psychological
20 distress at an early age, including severe anxiety and suicidal ideation” and was placed “in
21 a psychiatric treatment facility on several occasions.” (Doc. 1, ¶6) As a young child, D.H.
22 “began exhibiting signs of significant psychological distress including depression,
23 prolonged crying episodes, anxiety, and insomnia.” (*Id.*, ¶69) At the age of 11, D.H. had
24 “other stressors D.H. was trying to navigate” (beyond any stress related to gender
25 identity), which caused him to start losing his hair. D.H. was hospitalized, including in
26 intensive psychiatric care, four times beginning at age 11 for depression and suicidal
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1 ideation.¹ (Doc. 5-1, ¶¶5, 12; Doc. 1, ¶¶70, 78, 84) D.H. has a history of pervasive
2 anxiety, chronic suicidal ideations and attempts, and related self-harm issues (including
3 cutting, burning and hair pulling). (Doc. 5-2, ¶6) In addition, D.H. currently has “anxiety
4 and psychological distress caused by prior trauma.”² (*Id.* ¶13) Also, D.H. has a history of
5 “oppositional disorder” (*Id.* ¶8), which the Diagnostic and Statistical Manual of Mental
6 Disorders, 5th Edition (“DSM-5”) defines as “a frequent and persistent pattern of
7 angry/irritable mood, argumentative/defiant behavior, or vindictiveness.”

8 At 13, D.H. informed his mother he is transgender and began seeing a therapist,
9 Tamar Reed, who “recommended that D.H. begin to transition to living as male;” D.H.
10 then began to socially transition to male and started hormone-replacement therapy
11 (testosterone) that D.H. alleges “masculinize[d] his body.” (Doc. 1, ¶¶7, 75, 79, 80)

12 **Plaintiff John Doe:** In his early years, “John’s biological parents were unable to
13 care for him and provide a stable home environment.” (Doc. 4-1, ¶5) John’s guardian is
14 his grandmother. (Doc. 1, ¶89) John has been diagnosed with PTSD: “chronic post-
15 traumatic stress disorder stemming from early-life attachment trauma.” (Doc. 4-2, ¶11).
16 The term “early-life attachment trauma” means John suffered abuse or neglect at a young
17 age. Laidlaw Decl. at ¶16. John has been depressed, suffered from anxiety, engaged in
18 self-harm through cutting and burning,³ distanced from friends and family, lost interest in
19 activities, and lost significant weight in a short period of time because of limited food
20 intake. John also contemplated suicide. (Doc. 4, ¶5) According to John’s clinical therapist,
21 Mischa Cohen-Peck, John continues to suffer from PTSD. She notes he is currently
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24 ¹ D.H. was in intensive in-patient psychiatric care for severe anxiety and suicidal ideation
25 beginning in 2014. There is no indication gender dysphoria was being evaluated,
26 discussed, or addressed at this time. It was not until two years later (in 2016) that D.H.
disclosed to another person that he was transgender. (Doc. 5-1, ¶¶5, 7); Expert Declaration
of Dr. Michael Laidlaw, M.D., Exhibit A (“Laidlaw Decl.”) at ¶15.

27 ² The Declaration of Tamar Reed does not specify the nature of the “prior trauma.”

28 ³ Both D.H. and John have engaged in non-suicidal self-injury, which is associated with
multiple types of psychiatric disorders (e.g., PTSD, depression, anxiety, and obsessive-
compulsive, borderline personality, and eating disorders). Laidlaw Decl. at ¶19.

involved in “treatment of the trauma underlying his PTSD.” (Doc. 4-2, ¶20) Thus, John has not been successfully treated for the trauma underlying his PTSD.⁴

At about age 11, John began to socially transition to male. (Doc. 1, ¶¶10-11) At 13, John began visiting a gender support program and then began hormone-replacement therapy (testosterone) and medicine to stop John’s menstrual cycle. (*Id.* ¶¶96-97)

b. Treatment Standards

There are no laboratory, imaging, or other objective tests to predict whether children with gender dysphoria will outgrow the condition; a large majority of children with gender dysphoria outgrow the condition by adulthood. Expert Declaration of Dr. Stephen B. Levine, M.D. (Exhibit B) (“Levine Decl.”), at ¶¶28, 56, 58-60; Laidlaw Decl. at ¶¶22, 40. Treatment interventions on behalf of children diagnosed with gender dysphoria must be held to the same scientific standards as other medical treatments; they must be optimal, efficacious, and safe, and any treatment that alters biological development in children should be used with extreme caution.⁵ Laidlaw Decl. at ¶ 12.

A high percentage of children diagnosed with gender dysphoria have depression, anxiety, or other mental health disorders, and many had their first contact with psychiatric services for reasons other than gender identity issues. Laidlaw Decl. at ¶¶13, 23; Levine Decl. at ¶55 and n.7.⁶ Both D.H. and John have a significant and lengthy history of significant psychiatric issues separate and apart from gender dysphoria. Laidlaw Decl. at ¶¶13-19. In addition, they have both been prescribed hormone-replacement therapy (i.e., testosterone). A typical dose of hormone-replacement therapy is very high (6 to 100 times

⁴ In addition, John describes “being detached” from his body. (Doc. 4-2, ¶12) One psychiatric disorder, dissociative identity disorder (often associated with traumatic events and/or physical or sexual abuse in childhood) causes people’s bodies to feel different (like the opposite gender); also, suicide attempts and self-injurious behavior are common among people with this disorder. Laidlaw Decl. at ¶18.

⁵ Indeed, Dr. Levine explains the “affirmation therapy” model for treating gender dysphoria disregards the principles of child development and family dynamics, and is not supported by science. Levine Decl. at ¶¶36-42, 61-67.

⁶ Certain groups of children have an increased prevalence and incidence of trans identities, including children who are minorities, have mental developmental disabilities, are in foster homes or adopted, have a prior history of psychiatric illness, and adolescent girls. Levine Decl. at ¶19.

1 higher than the typical natal female body); significantly, high doses of testosterone
2 predispose individuals towards mood disorders, psychosis, and psychiatric disorders, and
3 thus hormone treatments can exacerbate a patient's underlying psychiatric problems.
4 Laidlaw Decl. at ¶20. Plaintiffs claim they first felt better after the hormones, but later felt
5 worse. It is likely they originally felt better because of the side effect of euphoria from
6 high doses of testosterone; it is likely they later felt worse because (1) the high dose
7 ultimately exacerbated their mental health issues, or (2) their underlying psychiatric issues
8 were never actually resolved (or both). Laidlaw Decl. at ¶21.

9 A child's psychological disorders should be thoroughly treated before considering
10 gender reassignment surgery, but there is insufficient evidence D.H. and John's
11 psychiatric issues have been thoroughly evaluated and treated by a qualified
12 psychiatrist/psychologist. Laidlaw Decl. at ¶23; Levine Decl. at ¶¶23, 27-35. In addition,
13 there is nothing in the record to establish Plaintiffs (1) have been adequately treated or
14 received medication to treat their psychological issues; (2) have had a thorough
15 psychiatric evaluation; and (3) do not have a history of substance use/abuse (as is common
16 in individuals with these types of disorders). Laidlaw Decl. at ¶¶23-25. This is all relevant
17 as to whether two minors can provide informed consent for an irreversible surgery.
18 Laidlaw Decl. at ¶¶25, 29; Levine Decl. at ¶¶105-118. If a patient later regrets the
19 decision and decides to resume living as their natal sex (female), the patient will not be
20 able to breastfeed a child. And like any surgery, it can result in damage to the nerves,
21 trouble healing, scarring, and infections. Laidlaw Decl. at ¶¶26, 28; Levine Decl. at ¶90.
22 Also, a final assessment (in-person exam) has not even been conducted on Plaintiffs to
23 determine suitability for surgery.⁷ Laidlaw Decl. at ¶27; Doc. 5-5, ¶45.

24 Gender dysphoria is the only psychiatric condition to be treated by surgery. Levine
25 Decl. at ¶¶21-22. But quality studies showing that chest reconstruction surgery is safe,
26 effective, and optimal for treating minors with gender dysphoria do not exist; also, there is

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28 ⁷ Hennessy-Waller's declaration claims a plastic surgeon indicated D.H. was "a good candidate" for surgery, but there are no records or evidence of an in-person exam.

evidence that questions the long-term effectiveness of gender reassignment surgery.⁸ Laidlaw Decl. at ¶¶30-38; Levine Decl. at ¶¶69-82, 96-98, 113-114. Indeed, the Centers for Medicare and Medicaid Services has found “inconclusive” clinical evidence regarding gender reassignment surgery. Laidlaw Decl. at ¶36. There are no tests to predict whether a young person will outgrow the gender dysphoria; and the under 21 age group is still undergoing brain development and are immature with respect to intellect, emotion, judgment, and self-control. Thus, there is a significant chance a young person may later regret removing an organ that cannot be replaced. Laidlaw Decl., at ¶40; Levine Decl., at ¶¶99-104. Plaintiffs have not established that an irreversible chest reconstruction surgery is safe, medically necessary, or effective to treat their gender dysphoria, or that they have the ability to provide informed consent for an irreversible surgery of this nature. Laidlaw Decl. at ¶¶12, 39-40; Levine Decl. at ¶¶14, 18, 69-82, 96-98, 113-114.

II. LEGAL ARGUMENT

a. Requirements to obtain a preliminary injunction

A preliminary injunction is extraordinary and drastic relief that a court may grant only in limited circumstances and after the moving party meets exacting requirements. “A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the

⁸ Plaintiffs cite the World Professional Association for Transgender Health’s (WPATH) “Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People” (7th ed., 2011) (“SOC”). But as Drs. Laidlaw and Levine note, (1) WPATH’s SOC were prepared within an organization whose mission includes advocacy, (2) there are limitations on the SOC that have been caused by a lack of rigorous research in the field, (3) the SOC does not capture the clinical experiences of many in the medical profession, (4) because the latest SOC deleted the requirement for therapy, facilities are allowing patients to be counseled to transition by individuals with masters rather than medical or PhD clinical psychology degrees, and (5) there are serious questions about WPATH’s scientific process; for example, unlike other organization’s guidelines, WPATH does not have a grading system for the strength of their recommendations or quality of evidence. Levine Decl., at ¶¶43-51; Laidlaw Decl., at ¶33. Nonetheless, even under the SOC (p.59), the criteria for chest surgery are (1) the patient has “[c]apacity to make a fully informed decision and to give consent for treatment;” and (2) “If significant medical or mental health concerns are present, they must be reasonably well-controlled.” Plaintiffs have not established they have capacity to provide informed consent or their other conditions have been reasonably well-controlled. Laidlaw Decl., at ¶¶14-21, 23-25, 29. For example, D.H. has ongoing anxiety and psychological distress from prior trauma; John is currently in treatment for trauma underlying his PTSD. (Doc. 4-2, ¶20; Doc. 5-2, ¶13)

merits, likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” *Monarch Content Mgmt. v. Ariz. Dep’t of Gaming*, 971 F.3d 1021, 1027 (9th Cir. 2020) (citing *Winter v. Nat. Res. Def. Council*, 555 U.S. 7, 20 (2008)). The Supreme Court has emphasized a moving party must clearly prove each of these elements: “It frequently is observed that a preliminary injunction is an extraordinary and drastic remedy, one that should not be granted unless the movant, *by a clear showing*, carries the burden of persuasion.” *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (quoting 11A *C. Wright, A. Miller, & M. Kane, Federal Prac. & Proc.* § 2948, pp. 129–130 (2d ed.1995) (emphasis in *Mazurek*; footnotes omitted)). This is particularly true in cases, like this one, where the moving party seeks a “mandatory” rather than a “prohibitory” injunction. Mandatory injunctions require a party to “take action”⁹ and are “particularly disfavored” by courts. *Marlyn Nutraceuticals v. Mucos Pharm.*, 571 F.3d 873, 878–79 (9th Cir. 2009). Mandatory injunctions are “subject to heightened scrutiny and should not be issued unless the facts and law clearly favor the moving party.” *Dahl v. HEM Pharm*, 7 F.3d 1399, 1403 (9th Cir.1993); *Marlyn*, 571 F.3d at 878–79. In *Anderson v. United States*, 612 F.2d 1112, 1115 (9th Cir. 1979) the Ninth Circuit described this “heightened scrutiny” as follows:

Courts are more reluctant to grant a mandatory injunction than a prohibitory one and . . . generally an injunction will not lie except in prohibitory form. Such mandatory injunctions, however, are not granted unless extreme or very serious damage will result and **are not issued in doubtful cases** or where the injury complained of is capable of compensation in damages.

(Emphasis added.) This language was repeated in *Marlyn* (vacating a mandatory injunction). Plaintiffs’ motion should be denied because there is more than a little doubt that Plaintiffs in this case are likely to succeed on the merits or suffer irreparable harm in the absence of a preliminary injunction.

⁹ Among other things, Plaintiffs would have this Court enter an order that AHCCCS “shall provide coverage for Plaintiffs’ male chest reconstruction surgeries, consistent with all other requirements of federal law.” (Doc. 3-1 at p. 1)

b. Plaintiffs have not established irreparable harm

Plaintiffs argue if the Court does not grant a preliminary injunction, they will suffer medical harm. The principal source of this harm is the binding that each Plaintiff wears to disguise their breasts. But a careful review of the facts presented demonstrates why there is no medical emergency that warrants immediate relief. The DSM-5 (p. 451) defines gender dysphoria as “distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.” In the context of a preliminary injunction, the Court must consider whether this “distress” amounts to irreparable harm. Another important aspect of gender dysphoria in the context of this case is that, more often than not, gender dysphoria in children does not persist into adulthood. The DSM-5 (p. 455) says: “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%.” Dr. Laidlaw agrees, noting “[t]here are no laboratory, imaging, or other objective tests to predict whether children with gender dysphoria will outgrow the condition.” Laidlaw Decl. at ¶22. Thus, the distress Plaintiffs currently experience may very well dissipate over time, which argues in favor of the Court adopting a deliberate rather than emergency pace here.

Dr. Laidlaw points to another concern related to the Plaintiffs in this case. Both suffer from other significant psychological disorders which pre-date their gender dysphoria. As Dr. Laidlaw notes, this history of psychiatric disorders calls into question the ability of these minors to provide true informed consent: “I have significant concerns about the ability of two minors with histories of significant underlying psychiatric issues, separate and apart from gender dysphoria, to provide informed consent to undergo an irreversible sex reassignment surgery.” Laidlaw Decl. at ¶29. Our country does not allow children under 18 to vote. In Arizona, children under 16 cannot drive. Yet Plaintiffs would require the state to approve irreversible surgery for even younger children.

1 **D.H.:** D.H., who is 17 years, first came out as transgender in about 2016. (Doc. 5-
2, ¶¶5-6) According to Dr. Cronyn, he has been binding for five years now. (Doc. 5-3,
3 ¶26) Despite this lengthy period of binding, D.H. has not reported any of the skin
4 conditions Plaintiffs argue could develop into more serious medical issues. (*Id.* ¶26)
5 Similarly, the back pain that DH complains of is relieved by stretching and removing the
6 binder. (*Id.* ¶¶19-20) And although Dr. Cronyn opines that continued use of the binder
7 “will exacerbate the symptoms of his asthma” that exacerbation has apparently not
8 occurred to date. (*Id.* ¶23).

9 **John Doe:** John is 15 years old. John has suffered from “chronic post-traumatic
10 stress disorder from early life attachment disorder.” (Doc. 4-2, ¶11) Long-standing and
11 pre-existent conditions should be addressed *before* irreversible surgical procedures are
12 employed. Laidlaw Decl. at ¶¶11-29; Levine Decl. at ¶¶30-35, 75, 111-112. The Court
13 should also note John’s therapist is the only medical professional to provide a declaration
14 in support of his need for surgery. Plaintiffs provide no declaration from a medical doctor
15 who has actually treated John to support immediate and irreversible surgery for John.

16 In light of these facts, the cases Plaintiffs cite provide little support for a
17 preliminary injunction. *Bowen v. City of New York*, 476 U.S. 467, 484 (1986) was a
18 lawsuit brought by New York and eight disabled individuals who alleged the Social
19 Security Administration was denying benefits based upon an unwritten policy that was
20 contrary to published regulations. *Id.* at 473–74. The injunction at issue was not a
21 preliminary injunction (the court’s decision followed a seven-day trial) but rather the court
22 entered an order requiring the agency to “reopen the decisions denying or terminating
23 benefits, and to redetermine eligibility.” *Id.* at 476. Nor were the *Bowen* plaintiffs seeking
24 a mandatory injunction. As the court noted, the plaintiffs “neither sought nor were
25 awarded benefits in the District Court, but rather challenged the Secretary’s failure to
26 follow the applicable regulations.” *Id.* at 483. And finally, it should be noted the district
27 court’s finding of irreparable harm was not challenged on appeal. *Id.* at 484. Further,
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1 *Edmo v. Corizon*, 935 F.3d 757 (9th Cir. 2019) was an 8th Amendment claim brought by a
2 prisoner. The court's decision was issued only after the court allowed the parties four
3 months of factual and expert discovery followed by a three-day evidentiary hearing. *Id.* at
4 775. This process allowed the court to make an evidentiary finding of irreparable harm
5 based upon "Edmo's severe, ongoing psychological distress and the high risk of self-
6 castration and suicide she faces absent surgery." *Id.* at 797. The importance of an
7 evidentiary hearing was emphasized in *Thomas v. Cty. of Los Angeles*, 978 F.2d 504 (9th
8 Cir. 1992), as amended (Feb. 12, 1993). *Thomas* was a Section 1983 class action by
9 Black and Hispanic residents who alleged deputy sheriffs were utilizing terrorist-type
10 tactics to cause them irreparable physical and emotional injuries. *Id.* at 511. Importantly,
11 the 9th Circuit vacated the preliminary injunction entered by the District Court because
12 "[b]efore issuing its preliminary injunction, the district court did not conduct evidentiary
13 proceedings to resolve any of the disputed matters." *Id.* at 509.

14 Plaintiffs' remaining cases are also not dispositive. In *Chalk v. U.S. Dist. Court*
15 *Cent. Dist. of Cal.*, 840 F.2d 701 (9th Cir. 1988), a teacher diagnosed with AIDS brought
16 a claim under the Rehabilitation Act. The 9th Circuit found irreparable harm because the
17 Rehabilitation Act allows the recovery of emotional distress damages (*Id.* at 710) and
18 because, given the lethality of AIDS at the time, Chalk did not have time to wait for trial:
19 "Presently Chalk is fully qualified and able to return to work; but his ability to do so will
20 surely be affected in time. A delay, even if only a few months, pending trial represents
21 precious, productive time irretrievably lost to him." *Id.* Neither factor is present in this
22 case. And finally, Plaintiffs' reliance on *Whitaker v. Kenosha*, 858 F.3d 1034 (7th Cir.
23 2017) is misplaced for the simple reason that in *Whitaker*, the requested remedy was not
24 an expensive, irreversible surgery of questionable value for two minors who have not
25 established the ability to provide informed consent, but simply the ability to use a school
26 restroom of the transgender student's choosing. *Id.* at 1042.

1 Plaintiffs contend the deprivation of constitutional rights constitutes irreparable
2 injury. But they first have to prove a deprivation of their constitutional rights; as
3 demonstrated in section II(c)(4) there is significant doubt whether Plaintiffs have a
4 constitutional right to have AHCCCS pay for this surgery. This case is not like *Melendres*
5 *v. Arpaio*, 695 F.3d 990 (9th Cir. 2012) in which Latino drivers were stopped just because
6 of their race. Nor is it similar to *Edmo*, in which discovery and a lengthy evidentiary
7 hearing demonstrated that a prisoner's 8th Amendment rights had been violated. Here, the
8 Court must grapple with the difficult question of whether AHCCCS should be required to
9 provide medically questionable, irreversible surgeries to children. That complex and
10 difficult question cannot be resolved on the record before this Court. Laidlaw Decl. at ¶12.

11 **c. Likelihood of success on the merits**

12 *1. Plaintiffs fail to demonstrate the challenged rule violates EPSDT*

13 AHCCCS does not discriminate against its transgender members or exclude gender
14 dysphoria treatment - for example, AHCCCS covers medically necessary hormone
15 treatments and mental health counseling. The challenged rule merely draws the line at
16 gender reconstruction surgery. As set forth above and in the declarations of Drs. Laidlaw
17 and Levine, there is legitimate debate about whether such surgery should be covered,
18 particularly for children. The question is: Does such surgery correct or ameliorate the
19 underlying conditions of persons, particularly children, who seek such surgeries?

20 We do not know Plaintiffs' circumstances beyond what they allege in their
21 Complaint, motion, and attached declarations. EPSDT covers treatment of defects,
22 illnesses, or conditions that are "discovered by the [EPSDT] screening services," not
23 simply asserted in expert declarations. 42 U.S.C. § 1396d(r)(5). Plaintiffs have been
24 unwilling to produce the medical records upon which their expert declarations rely, and
25 even their own declarations disclose Plaintiffs have not been finally assessed for
26 suitability for surgery by the surgeon who would perform the procedures. (Doc. 5-5, ¶45)

1 D.H. alleges he sought chest reconstruction surgery from AHCCCS in 2019, and
2 appealed the denial to his health plan but no further. (Doc. 5-1, ¶¶14-15) Apparently,
3 D.H.'s next step was to seek not the review afforded by state law, but this Court's
4 intervention instead. John does not allege he ever sought AHCCCS coverage of chest
5 reconstruction surgery. Even interpreting the Complaint as a "request" for such
6 authorizations, neither has yet demonstrated medical necessity for the service.

7 Although EPSDT coverage is broad, it is not unlimited. The 9th Circuit has stated,
8 "[u]nder § 1396d(r)(5), states must cover every type of health care or service necessary
9 for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a)", but
10 the court immediately noted, "[t]his is subject to certain limits; for example, a state need
11 not pay for experimental medical procedures." *Katie A., ex rel. Ludin v. Los Angeles Cty.*,
12 481 F.3d 1150, 1154, n.10 (9th Cir. 2007). Medicaid does not require states to cover every
13 service, especially services that have yet to be demonstrated to be safe and effective.
14 States may limit the amount, duration, and scope of the services they cover. 42 U.S.C. §
15 1396d(a). States are required to limit utilization of services. 42 U.S.C. § 1396a(a)(30)(A)
16 (state plans must "provide such methods and procedures relating to the utilization of, and
17 the payment for, care and services available under the plan ... as may be necessary to
18 safeguard against unnecessary utilization of such care and services"); *Rush v. Parham*,
19 625 F.2d 1150, 1156 (5th Cir. 1980) ("Georgia's definition of medically necessary
20 services can reasonably exclude experimental treatment" when confronted with plaintiff's
21 complaint that Georgia refused to pay for "transsexual surgery" prescribed by doctor);
22 *Miller v. Whitburn*, 10 F.3d 1315, 1321 (7th Cir. 1993). As noted above and in the
23 attached declarations, there is reason to question the "broad consensus" Plaintiffs allege as
24 to its safety and efficacy. (Doc. 3, at 8) "Medicaid was not designed to fund risky,
25 unproven procedures, but to provide the largest number of necessary medical services to
26 the greatest number of needy people." *Ellis v. Patterson*, 859 F.2d 52, 55 (8th Cir. 1988).
27 "It may be that, pursuant to a generally applicable funding restriction or utilization control
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1 procedure, a participating state could deny coverage for a service deemed medically
2 necessary in a particular case.” *Hern v. Beye*, 57 F.3d 906, 911 (10th Cir. 1995).

3 Further, while EPSDT is a mandatory set of services under Medicaid that is
4 covered by AHCCCS, the services that correct or ameliorate a child’s condition are not
5 specifically listed. Defendant has not located any decision, nor have Plaintiffs cited one,
6 that has found gender reassignment surgery to be recognized as an EPSDT requirement.
7 Thus, it is not improper to exclude coverage for a service that continues to be the subject
8 of legitimate debate as to its safety and efficacy.

9
10 *2. Plaintiffs fail to demonstrate violation of comparability requirement*

11 42 U.S.C. § 1396a(a)(10)(B)(i) provides “the medical assistance made available to
12 any individual described in subparagraph (A)--(i) shall not be less in amount, duration, or
13 scope than the medical assistance made available to any other such individual.” The
14 exclusion does not violate this requirement. First, the exclusion applies to all transgender
15 persons alike. Second, the rule requires comparable services for individuals with
16 comparable needs. “[N]eed is the only basis upon which distinctions between recipients
17 can be made without violating the comparability requirement.” *V.L. v. Wagner*, 669 F.
18 Supp. 2d 1106, 1117 (N.D.Cal. 2009). As noted in the declarations of Drs. Laidlaw and
19 Levine, the needs for relief from gender dysphoria are unique – they are not the same as
20 the needs of a person who seeks reconstruction after a mastectomy. This is particularly
21 true as to children. Nor does AHCCCS “arbitrarily deny or reduce the amount, duration,
22 or scope of a required service . . . to an otherwise eligible beneficiary solely because of the
23 diagnosis, type of illness, or condition.” 42 C.F.R. § 440.230(c). Plaintiffs argue
24 AHCCCS is denying “comparable services for individuals with comparable needs,” but
25 this begs the question whether reconstruction following a mastectomy is based on the
26 same needs as chest reconstruction to treat a child’s gender dysphoria.

27 *3. Plaintiffs fail to demonstrate a violation of §1557 of the ACA*
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1 The exclusion does not violate the Affordable Care Act (“ACA”), which prohibits
2 discrimination “on the basis of sex.” 42 U.S.C. §18116(a) (incorporating 20 U.S.C.
3 §1681(a)). The federal rules implementing §1557 were amended effective Aug. 18, 2020
4 with the intent that “each State may balance for itself the various sensitive considerations
5 relating to medical judgment and gender identity, within the limits of applicable Federal
6 statutes (which are to be read according to their plain meaning).” *Fed. Reg.*, Vol. 85, No.
7 119 at 37162 (June 24, 2020). Further, “[t]he Department does not and need not take a
8 definitive view on any of the medical questions raised in these comments about treatments
9 for gender dysphoria. The question is whether Title IX and Section 1557 require
10 healthcare professionals, as a matter of nondiscrimination, to perform such procedures or
11 provide such treatments. The answer is they do not.” *Id.* at 37188 (emphasis in original).
12 Also, a “medical provider may rightly judge a hysterectomy due to the presence of
13 malignant tumors to be different in kind from the removal of properly functioning and
14 healthy reproductive tissue for psychological reasons, even if the instruments used are
15 identical.” *Id.* at 37187.¹⁰ The new rule supports the ability of a state to exclude chest
16 reconstruction for gender dysphoria while covering it to treat a mastectomy.

17 Plaintiffs allege the exclusion discriminates against them because they are
18 transgender, relying on *Bostock v. Clayton Cty., Georgia*, 140 S. Ct. 1731 (2020). But
19 *Bostock* is not dispositive. In *Bostock*, the Court held “[a]n employer who fires an
20 employee for being ... transgender” has violated Title VII, relying on the traditional
21 meaning of “sex” as “biological distinctions between male and female.” *Id.* at 1737, 1739.
22 *Bostock* restated the long-standing principle that Title VII protects employees from
23 discrimination if they are treated differently because of their sex. *Id.* at 1741-42. As
24 Justices Alito and Thomas explained in their dissent there are still unsettled areas of law:

25
26 ¹⁰ The new rules were challenged, and the E.D.N.Y issued a preliminary injunction against
27 the Department’s repeal of its prior rules (*Walker v. Azar*, 2020 WL 4749859, at *10
28 (E.D.N.Y. Aug. 17, 2020)), but there is not any current affirmative requirement for
coverage of gender reassignment surgery.

1 After *Bostock*, “healthcare benefits may emerge as an intense battleground under the
2 Court’s ruling.” *Id.* at 1781 (Alito, J.). *Bostock* did not mandate anything with respect to
3 coverage for transgender individuals under the ACA, and no court has determined
4 *Bostock*’s impact on health coverage. AHCCCS’s exclusion for “gender reassignment
5 surgeries” applies to all members, regardless of sex (it applies to males transitioning to
6 female, and vice versa). Thus, it is not discrimination “on the basis of sex.”

7 Plaintiffs also rely on the denial of a motion to dismiss in *Toomey v. Arizona*, 2019
8 WL 7172144 (D.Ariz. 2019). But a motion to dismiss evaluates whether a plaintiff has
9 stated a claim “that is plausible on its face,” accepting all allegations and reasonable
10 inferences as true, *see Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). This stands in sharp
11 contrast to a motion for preliminary injunction, which evaluates, under exacting standards,
12 whether a claim is *clearly* likely to succeed on the merits based on the evidence presented.

13 Plaintiffs’ other cases are from outside this jurisdiction (not precedent for this
14 Court), and they are inapposite. None required a plan to provide coverage of gender
15 reassignment surgeries for children or addressed a facially neutral policy regarding one
16 specific category of services. *Prescott v. Rady*, 265 F.Supp.3d 1090, 1099 (S.D.Cal. 2017)
17 (staff “continuously referr[ed] to him with female pronouns, despite knowing that he was
18 a transgender boy” and “refused to treat Kyler as a boy”); *Flack v. Wisc. Dep’t of Health*,
19 395 F.Supp.3d 1001 (W.D. Wis. 2019) (involved adult plaintiffs, and the plan contained a
20 broad exclusion for transition coverage - not just surgery); *Boyden v. Conlin*, 341
21 F.Supp.3d 979 (W.D. Wis. 2018) (involved adult plaintiffs, and coverage excluded all
22 services associated with gender reassignment); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir.
23 2011) (employment termination of plaintiff). Here, coverage is provided for hormone
24 treatments and mental health counseling; thus, there is no discrimination against
25 transgender persons or the elimination of coverage for all gender transition treatment.
26 Plaintiffs have failed to establish their high burden.

27
28 *4. Plaintiffs fail to establish an equal protection violation*

1 The Equal Protection Clause (U.S. Const. Amend. XIV, §1) states, “[n]o State
2 shall . . . deny to any person within its jurisdiction the equal protection of the laws.” This
3 provision “does not forbid classifications. It simply keeps governmental decisionmakers
4 from treating differently persons who are in all relevant respects alike.” *Nordlinger v.*
5 *Hahn*, 505 U.S. 1, 10 (1992). A “classification neither involving fundamental rights nor
6 proceeding along suspect lines is accorded a strong presumption of validity”; such a
7 provision is subject to rational basis review. *Heller v. Doe*, 509 U.S. 312, 319-21 (1993);
8 *McGowan v. State of Md.*, 366 U.S. 420, 425-26 (1961) (“State legislatures are presumed
9 to have acted within their constitutional power despite the fact that, in practice, their laws
10 result in some inequality. A statutory discrimination will not be set aside if any state of
11 facts reasonably may be conceived to justify it.”). Multiple courts have applied rational
12 basis to classifications based on transgender status. *Druley v. Patton*, 601 F.App’x 632,
13 635 (10th Cir. 2015); *Murillo v. Parkinson*, 2015 WL 3791450, *12 (C.D. Cal. 2015);
14 *Kaeo-Tomaselli v. Butts*, 2013 WL 399184, *5 (D. Haw. 2013); *Jamison v. Davue*, 2012
15 WL 996383, *4 (E.D.Cal. 2012); *Brainburg v. Coalinga State Hosp.*, 2012 WL 3911910,
16 *8 (E.D. Cal. 2012); *Stevens v. Williams*, 2008 WL 916991, *13 (D. Or. 2008); *Johnston*
17 *v. Univ. of Pittsburgh*, 97 F. Supp. 3d 657, 668 (W.D. Pa. 2015).

18 Plaintiffs have not cited any U.S. Supreme Court case that changes the rational
19 basis standard for claims brought by transgender individuals. While Plaintiffs cite
20 *Bostock*, that case involved statutory interpretation of Title VII – it did not (i) involve an
21 equal protection claim, (ii) hold transgender persons constitute a suspect or quasi-suspect
22 class for equal protection claims, or (iii) create a new protected class for transgender
23 persons. *See Bollfrass v. City of Phoenix*, 2020 WL 4284370, at *1 (D. Ariz. 2020)
24 (declining to reconsider equal protection claim after *Bostock* which “involved a matter of
25 statutory interpretation”). *Bostock* does not support heightened review here. In addition,
26 Plaintiffs’ cases from other jurisdictions (i) are not precedent for this Court, (ii) are
27 inapposite, (iii) did not mandate coverage of gender reassignment surgery for children,
28

1 and (iv) did not address a facially neutral policy regarding one specific category of
2 services. *F.V. v. Barron*, 286 F.Supp.3d 1131 (D.Id. 2018) (policy categorically denied
3 transgender people from changing sex on birth certificates); *Norsworthy v. Beard*, 87 F.
4 Supp. 3d 1104 (N.D.Cal. 2015) (denying motion to dismiss on claims involving 8th
5 Amendment and deliberate indifference to medical needs of prison inmate); *Whitaker*, 858
6 F.3d 1034 (plaintiff had to complete surgical transition to access boys restroom); *Glenn*
7 (*supra*); *Smith v. City of Salem*, 378 F.3d 566 (6th Cir. 2004) (employee suspension).¹¹

8 Under rational basis review, Plaintiffs simply cannot overcome the “strong
9 presumption of validity” of the exclusion. Here, there are “plausible reasons for [the state]
10 action,” and thus the “inquiry is at an end.” *U.S. Railroad Retirement Bd. v. Fritz*, 449
11 U.S. 166, 179 (1980). The government has a legitimate interest in not providing an
12 expensive, irreversible surgery of questionable value for minors, including Plaintiffs who
13 have a history of underlying unresolved psychiatric conditions and have not established
14 the ability to provide informed consent.¹² In addition, there is no evidence the exclusion
15 was motivated by animosity towards a protected class. The Court should apply the
16 presumption of validity because there is a “plausible reason” supporting the classification
17 and it is rationally related to a legitimate government interest.

18 **d. Balance of equities**

19 Based on the record, Plaintiffs have failed to establish that chest reconstruction
20 surgery is safe, effective, and urgent for them. Balanced against this is the well-
21 established caution courts exercise in granting mandatory injunctive relief, particularly
22 relief that involves an irreversible surgery for children. In addition, AHCCCS has a
23 significant interest in not providing expensive services that have not been shown to be
24

25 ¹¹ Plaintiffs again rely on the denial of a motion to dismiss in *Toomey*. That order not only
26 involved a completely different standard (motion to dismiss), but *Toomey* also does not
involve minor plaintiffs with the medical history and background of Plaintiffs in this case.

27 ¹² Rational basis review applies, *supra*. But even if intermediate scrutiny applies, Plaintiffs
28 still cannot obtain a preliminary injunction because the classification is substantially related
to this important government interest. See *U.S. v. Virginia*, 518 U.S. 515 (1996).

1 medically necessary, particularly irreversible surgeries on minors that carry significant
2 risks, and for which there is questionable scientific evidence about its effectiveness and
3 long-term benefits for children. Plaintiffs have failed to demonstrate that the balance of
4 equities is in their favor.

5 **III. CONCLUSION**

6 Plaintiffs cannot meet the exceedingly high standards required for a mandatory
7 injunction. Thus, Defendant requests the Court deny Plaintiffs' motion.

8 RESPECTFULLY SUBMITTED this 28th day of September, 2020.

9
10 **BURNSBARTON PLC**

11
12 By /s/ Kathryn Hackett King

13 David T. Barton
14 Kathryn Hackett King

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CERTIFICATE OF SERVICE

I hereby certifies that on September 28, 2020, I electronically transmitted the foregoing document, using the ECF System for filing and transmittal of a Notice of Electronic Filing and to ECF registrants and e-mailed a copy of the foregoing to the following:

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No. 21-15668

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

D.H., by and through his mother, Janice Hennessy-Waller; and JOHN DOE, by his
guardian and next friend, Susan Doe,
Plaintiff-Appellants,

vs.

JAMI SNYDER,
Defendant-Appellee.

On Appeal from Order of the United States District Court
For the District of Arizona
Case No. 4:20-cv-335-SHR

EXCERPTS OF RECORD
VOLUME 3 of 3 (ER 290 to ER 588)

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IN THE UNITED STATES DISTRICT COURT
 FOR THE DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others similarly
 situated,

Plaintiffs,

v.

Jami Snyder, Director of the Arizona Health
 Care Cost Containment System, in her
 official capacity,

Defendant.

Case No. 4:20-cv-00335-SHR

**ANSWER TO COMPLAINT FOR
 DECLARATORY AND INJUNCTIVE
 RELIEF**

(Assigned to the Honorable Scott H.
 Rash)

Defendant Jami Snyder, Director of the Arizona Health Care Cost Containment System, in her official capacity (“Defendant”), for her Answer to Plaintiff’s Complaint, hereby admits, denies, and alleges as follows. Defendant denies all allegations in the Complaint that are not specifically admitted herein.

Gender dysphoria is a sensitive and personal issue that involves individualized assessment and care. Moreover, medical science is still evaluating the effectiveness, impact and results of gender reassignment surgery – particularly in juvenile populations.

1 For these reasons Defendant will deny any allegation in the Complaint that attempts to
2 make broad generalizations about gender dysphoria or the efficacy of specific treatments
3 on groups of individuals.

4 **PRELIMINARY STATEMENT**

5 1. D.H. is a seventeen-year-old transgender Arizona resident enrolled in
6 Arizona's Medicaid program, known as the Arizona Health Care Cost Containment
7 System ("AHCCCS"). John Doe is a fifteen-year-old transgender Arizona resident
8 enrolled in AHCCCS. D.H. and John bring this lawsuit on behalf of themselves and
9 similarly situated individuals to challenge Arizona's categorical prohibition of coverage of
10 medically necessary treatments for gender dysphoria, specifically, male chest
11 reconstruction surgery.

12 **Answer to Paragraph 1: Defendant lacks sufficient knowledge or**
13 **information to admit or deny the allegations in Paragraph 1 of the Complaint, and**
14 **therefore denies them.**

15 2. Gender dysphoria refers to the distress that can result from the incongruence
16 between a person's gender identity and their assigned sex at birth. Gender dysphoria is a
17 serious medical condition that, if left untreated, can cause anxiety, depression, and even
18 self-harm or suicidal ideation.

19 **Answer to Paragraph 2: Defendant notes the Diagnostic and Statistical**
20 **Manual of Mental Disorders, 5th Edition ("DSM-V"), which Plaintiff cites in the**
21 **Complaint, contains a definition and diagnostic criteria of "gender dysphoria" that**
22 **differs from that stated in Paragraph 2 of the Complaint. Defendant therefore denies**
23 **the allegations contained in Paragraph 2 of the Complaint.**

24 3. Gender-confirming medical treatments - including male chest reconstruction
25 surgery - are safe, effective, and medically necessary to treat gender dysphoria in many
26 transgender individuals, including adolescents.

1 **Answer to Paragraph 3: Plaintiffs have not demonstrated medical necessity**
2 **for chest reconstruction surgery, but Defendant makes no answer with respect to**
3 **unknown individuals, and therefore, Defendant denies the allegations contained in**
4 **Paragraph 3 of the Complaint.**

5 4. A longstanding Arizona regulation, promulgated in 1982 and enforced by
6 AHCCCS, expressly prohibits Medicaid coverage for “Gender Reassignment surgeries.”
7 Ariz. Admin. Code R9-22-205-B.4(a) (“Challenged Exclusion”). Because of the
8 Challenged Exclusion, D.H., John, and Similarly situated individuals have been denied or
9 prevented from obtaining Medicaid coverage for medically necessary male chest
10 reconstruction surgery.

11 **Answer to Paragraph 4: Defendant admits Arizona Administrative Code**
12 **(“A.A.C.”) R-9-22-205(B)(4)(a) provides, “The following services are excluded from**
13 **AHCCCS coverage: . . . gender reassignment surgeries,” and this regulation was**
14 **promulgated in 1982. Defendant lacks sufficient knowledge or information to admit**
15 **or deny the remaining allegations contained in Paragraph 4 of the Complaint, and**
16 **therefore denies them.**

17 5. Both D.H. and John have been diagnosed with gender dysphoria. Although
18 identified as female at birth, D.H. and John are male and live as male in every aspect of
19 their lives.

20 **Answer to Paragraph 5: Plaintiffs have not provided their medical records to**
21 **Defendant, who lacks sufficient knowledge or information to admit or deny the**
22 **allegations contained in Paragraph 5 of the Complaint, and therefore Defendant**
23 **denies the allegations in Paragraph 5 of the Complaint.**

24 6. D.H. first became aware of his male gender identity around the age of four.
25 Frustrated and angry at his inability to communicate that he was transgender to his
26 mother, D.H. developed significant psychological distress at an early age, including
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1 severe anxiety and suicidal ideation. Concerned for his safety and well-being, D.H.'s
2 mother, Janice, placed him in a psychiatric treatment facility on several occasions.

3 **Answer to Paragraph 6: Defendant lacks sufficient knowledge or information**
4 **to admit or deny the allegations contained in Paragraph 6 of the Complaint, and**
5 **therefore denies them.**

6 7. At thirteen, D. H. developed the confidence to tell Janice that he is
7 transgender. Janice then arranged for D.H. to see a mental health provider with
8 experience working with transgender youth. With the recommendation and support of his
9 health care providers, D.H. began to transition to live in accordance with his gender
10 identity. As part of the treatment for his gender dysphoria, D.H. started taking
11 testosterone to masculinize his body.

12 **Answer to Paragraph 7: Defendant lacks sufficient knowledge or information**
13 **to admit or deny the allegations contained in Paragraph 7 of the Complaint, and**
14 **therefore denies them.**

15 8. Just before turning thirteen, D.H. started wearing a binder to flatten his
16 chest, which alleviates his gender dysphoria, but significantly impairs his ability to
17 function. The pain and discomfort caused by wearing the binder interferes with D.H.'s
18 ability to focus on school and homework. The binder also prevents him from engaging in
19 prolonged or intense physical activity, especially dance, which had previously been a
20 source of relief for D.H.

21 **Answer to Paragraph 8: Defendant lacks sufficient knowledge or information**
22 **to admit or deny the allegations contained in Paragraph 8 of the Complaint, and**
23 **therefore denies them.**

24 9. Last year, D.H.'s pediatrician and his therapist recommended that he obtain
25 male chest reconstruction surgery to further alleviate his gender dysphoria. However,
26 prior authorization for this surgery was denied due to the Challenged Exclusion.
27
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1 **Answer to Paragraph 9: Defendant lacks sufficient knowledge or information**
2 **to admit or deny the allegations contained in Paragraph 9 of the Complaint, and**
3 **therefore denies them.**

4 10. John started becoming aware of his male gender identity when he was about
5 eleven years old and his body began showing the first signs of puberty. Worried that his
6 family would reject him for being transgender, John kept everything he was going through
7 to himself and began to experience depression and suicidal ideation.

8 **Answer to Paragraph 10: Defendant lacks sufficient knowledge or**
9 **information to admit or deny the allegations contained in Paragraph 10 of the**
10 **Complaint, and therefore denies them.**

11 11. After about six months, John recognized that he needed help and reached
12 out to his sister, and then eventually told his grandmother, Susan, both of whom were
13 supportive. John started using a male name and pronouns, which helped to alleviate his
14 gender dysphoria to some degree.

15 **Answer to Paragraph 11: Defendant lacks sufficient knowledge or**
16 **information to admit or deny the allegations contained in Paragraph 11 of the**
17 **Complaint, and therefore denies them.**

18 12. In November 2018, John began seeing a specialist at the Gender Support
19 Program at Phoenix Children's Hospital.

20 **Answer to Paragraph 12: Defendant lacks sufficient knowledge or**
21 **information to admit or deny the allegations contained in Paragraph 12 of the**
22 **Complaint, and therefore denies them.**

23 13. Like D.H., John also wears a binder, which is very tight and restrictive.
24 Even with the binder, John feels uncomfortable being outside without layers of clothing.
25 He wears a hooded sweatshirt nearly every day, including in the summer. John's chest
26 also hinders his social interactions. For example, John wears his binder and a t-shirt when
27
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1 at the pool, often having to answer uncomfortable questions about why he insists on
2 wearing a t-shirt in the water.

3 **Answer to Paragraph 13: Defendant lacks sufficient knowledge or**
4 **information to admit or deny the allegations contained in Paragraph 13 of the**
5 **Complaint, and therefore denies them.**

6 14. Around February 2020, John's health care providers recommended that he
7 pursue male chest reconstruction surgery to further alleviate his gender dysphoria.
8 However, due to the Challenged Exclusion, John cannot receive the surgery.

9 **Answer to Paragraph 14: Defendant lacks sufficient knowledge or**
10 **information to admit or deny the allegations contained in Paragraph 14 of the**
11 **Complaint, and therefore denies them.**

12 15. The Challenged Exclusion unlawfully denies medically necessary surgical
13 care to transgender beneficiaries on AHCCCS. Arizona disregards the transition-related
14 health care needs of Medicaid's transgender beneficiaries. In doing so, Arizona exposes
15 transgender people to significant and avoidable harms to their health and well-being, in
16 violation of the U.S. Constitution and federal law.

17 **Answer to Paragraph 15: Defendant denies the allegations contained in**
18 **Paragraph 15 of the Complaint.**

19 16. The Challenged Exclusion violates Plaintiffs' civil rights under Section
20 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116 ("Section
21 1557"); the Early and Periodic Screening, Diagnostic and Treatment requirements of the
22 federal Medicaid Act, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B),
23 1396d(r); the comparability requirement of the Medicaid Act, *id.* § 1396a(a)(10)(B); and
24 the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution.

25 **Answer to Paragraph 16: Defendant denies the allegations contained in**
26 **Paragraph 16 of the Complaint.**

1 17. D.H. and John further seek immediate declaratory and injunctive relief to
2 enjoin Arizona from continuing to deny them medically necessary treatment in violation
3 of federal law. Without the injunctive relief sought in this lawsuit, the Challenged
4 Exclusion will prevent effective treatment of D.H.'s and John's gender dysphoria, causing
5 them irreparable physical and psychological harm.

6 **Answer to Paragraph 17: Defendant admits D.H. and John are seeking**
7 **declaratory and injunctive relief, but denies that D.H. and John are entitled to a**
8 **declaratory judgment, injunction, or any other relief whatsoever.**

9 **JURISDICTION AND VENUE**

10 18. The Court has jurisdiction over the claims asserted herein pursuant to 28
11 U.S.C. §§ 1331, 1343(a)(3)-(4).

12 **Answer to Paragraph 18: Defendant admits jurisdiction is proper in this**
13 **Court.**

14 19. Plaintiffs' claims for declaratory and injunctive relief are authorized by 28
15 U.S.C. §§ 2201, 2202 and 42 U.S.C. § 1983.

16 **Answer to Paragraph 19: Defendant admits Plaintiffs are seeking declaratory**
17 **and injunctive relief, but denies that Plaintiffs are entitled to a declaratory**
18 **judgment, injunction, or any other relief whatsoever.**

19 20. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(b) because
20 Plaintiffs reside within this judicial district and D.H. resides within the Tucson division,
21 the events giving rise to this action occurred in this judicial district, and the Defendant is
22 subject to personal jurisdiction in this judicial district.

23 **Answer to Paragraph 20: Defendant lacks sufficient knowledge or**
24 **information to admit or deny the allegations contained in Paragraph 20 of the**
25 **Complaint, and therefore denies them.**

THE PARTIES

21. Plaintiff D.H. is a seventeen-year-old boy who has been diagnosed with gender dysphoria. D.H. resides in Pima County, Arizona and brings this action through his mother, Janice Hennessy-Waller. Due to his family's limited income, D.H. is eligible for Arizona's Medicaid program. D.H. has been enrolled in Arizona's Medicaid program at relevant times.

Answer to Paragraph 21: Defendant lacks sufficient knowledge or information to admit or deny the allegations contained in Paragraph 21 of the Complaint, and therefore denies them.

22. Plaintiff John Doe is a fifteen-year-old boy who has been diagnosed with gender dysphoria. John resides in Maricopa County, Arizona and brings this action through his grandmother and legal guardian, Susan Doe. Due to his family's limited income, John is eligible for Arizona's Medicaid program. John has been enrolled in Arizona's Medicaid program at all relevant times.

Answer to Paragraph 22: Defendant lacks sufficient knowledge or information to admit or deny the allegations contained in Paragraph 22 of the Complaint, and therefore denies them.

23. Defendant Jami Snyder is the Director of AHCCCS, the single-state agency that administers Arizona's Medicaid program. As such, she has a duty to ensure that the AHCCCS program is administered in accordance with federal Medicaid law. Defendant Snyder is sued in her official capacity.

Answer to Paragraph 23: Defendant admits Defendant Snyder is the Director of AHCCCS, the state agency that administers Arizona's Medicaid program, and her job duties include, among other things, ensuring the AHCCCS program is administered in accordance with federal Medicaid law. Upon information and belief, Defendant admits Plaintiffs have filed this lawsuit against Defendant in her official capacity.

STATEMENT OF FACTS

Gender Identity and Gender Dysphoria

24. Gender identity is an innate, internal sense of one's sex-*i.e.*, being male or female-and is a core, hard-wired aspect of a person's identity. Everyone has a gender identity. Most people's gender identity is consistent with the sex they were assigned at birth ("assigned sex"). Transgender people, however, have a gender identity that differs from their assigned sex. A transgender man is a man who was assigned female at birth but has a male gender identity. A transgender woman is a woman who was assigned male at birth but has a female gender identity.

Answer to Paragraph 24: Defendant notes the DSM-V, which Plaintiffs cite in the Complaint, contains definitions of "gender identity" and "transgender" that differ from those stated in Paragraph 24 of the Complaint. Defendant therefore denies the allegations contained in Paragraph 24 of the Complaint.

25. Gender identity and transgender status are inextricably linked to one's sex and are sex-related characteristics.

Answer to Paragraph 25: Defendant denies the allegations contained in Paragraph 25 of the Complaint.

26. Around the onset of puberty, many transgender youth experience a level of psychological distress that significantly interferes with their overall wellbeing and ability to function. For some transgender youth, that distress becomes debilitating and can lead to a severe decline in mental health.

Answer to Paragraph 26: Defendant denies the allegations contained in Paragraph 26 of the Complaint.

27. That distress stems, in part, from the visible physical changes that accompany puberty. Those physical changes undermine a transgender young person's ability to live in a manner consistent with their gender identity, exacerbating their psychological distress. Even basic daily tasks, such as bathing and getting dressed, can

1 become emotionally paralyzing because those tasks are painful reminders of the
2 disconnect between a transgender young person's body and their gender identity. In
3 addition, a transgender boy who has begun to develop breasts is more likely to be
4 mistaken for female, a probability that serves as a constant source of anxiety. The
5 psychological distress transgender youth experience is further heightened by the reality
6 that some of those physical changes may be irreversible, permanently constricting their
7 future treatment options and negatively affecting their quality of life. Consequently,
8 timely treatment is critical.

9 **Answer to Paragraph 27: Defendant lacks sufficient knowledge or**
10 **information to admit or deny the allegations relating to the “psychological distress”**
11 **and “physical changes” of “many transgender youth” and “some transgender youth”**
12 **contained in Paragraph 27 of the Complaint, and therefore Defendant denies all**
13 **allegations in Paragraph 27 of the Complaint.**

14 28. This significant increase in distress causes many transgender youth who had
15 previously delayed disclosing that they are transgender to set aside their fears of rejection
16 and ask for help from family. With the permission of their parents or legal guardians, a
17 transgender young person can begin accessing the health care services needed to alleviate
18 their psychological distress. That distress is commonly referred to as gender dysphoria.

19 **Answer to Paragraph 28: Defendant denies the allegations contained in**
20 **Paragraph 28 of the Complaint.**

21 29. Gender dysphoria is a serious medical condition recognized by the
22 American Psychiatric Association. Am. Psychiatric Ass'n, *Diagnostic and Statistical*
23 *Manual of Mental Disorders* (5th ed. 2013) (“DSM-5”).¹ Gender dysphoria refers to the
24

25 ¹ Earlier editions of the DSM included a diagnosis referred to as “Gender Identity
26 Disorder.” The DSM-5 noted that Gender Dysphoria “is more descriptive than the
27 previous DSM-IV term gender identity disorder and focuses on dysphoria as the clinical
28 problem, not identity per se.” Being diagnosed with gender dysphoria “implies no
impairment in judgment, stability, reliability, or general social or vocational capabilities.”
Am. Psychiatric Ass'n, Position Statement on Discrimination Against Transgender &

1 distress that can result from the incongruence between a person's gender identity and their
2 assigned sex. If left untreated, gender dysphoria can cause anxiety, depression, and even
3 self-harm or suicidal ideation. Gender dysphoria is often heightened "when physical
4 interventions by means of hormones and/or surgery are not available." *Id.* at 451. Access
5 to appropriate, individualized medical care can mitigate and often prevent all of those
6 symptoms.

7 **Answer to Paragraph 29: Defendant states the DSM-V manual speaks for**
8 **itself. Defendant further states the DSM-V manual (p. 451) defines "gender**
9 **dysphoria" as follows: "*Gender dysphoria* refers to the distress that may accompany**
10 **the incongruence between one's experienced or expressed gender and one's assigned**
11 **gender. Although not all individuals will experience distress as a result of such**
12 **incongruence, many are distressed if the desired physical interventions by means of**
13 **hormones and/or surgery are not available." Defendant denies the remaining**
14 **allegations contained in Paragraph 29 of the Complaint.**

15 30. Gender dysphoria is highly treatable. As with other medical conditions,
16 health care providers follow a well-established standard of care when working with
17 patients with gender dysphoria. The World Professional Association for Transgender
18 Health ("WPATH"), and its predecessors, has set those standards for over four decades.

19 **Answer to Paragraph 30: Defendant states the World Professional**
20 **Association for Transgender Health ("WPATH") has issued a "Standards of Care**
21 **for the Health of Transsexual, Transgender, and Gender-Nonconforming People,"**
22 **and that this document speaks for itself. Defendant further states WPATH has**
23 **issued several versions of the "Standards of Care" over the years. Defendant denies**
24 **the remaining allegations contained in Paragraph 30 of the Complaint.**

25 31. WPATH is an international, multidisciplinary, professional association of
26 medical providers, mental health providers, researchers, and others, with a mission of

27
28

Gender Variant Individuals (2012), at <https://goo.gl/iXBM0S>.

1 promoting evidence-based care and research for transgender health, including the
2 treatment of gender dysphoria. WPATH published the seventh and most recent edition of
3 the Standards of Care in 2011.

4 **Answer to Paragraph 31: Defendant states WPATH's website**
5 **(<https://www.wpath.org/about/mission-and-vision>) (last visited Sept. 13, 2020)**
6 **indicates its "Mission" is "[t]o promote evidence based care, education,**
7 **research, public policy, and respect in transgender health," and its "Goals and**
8 **Tasks" are described as follows: "As an international interdisciplinary, professional**
9 **organization, [WPATH] will work to further the understanding and treatment of**
10 **gender dysphoria by professionals in medicine, psychology, law, social work,**
11 **counseling, psychotherapy, family studies, sociology, anthropology, sexology, speech**
12 **and voice therapy, and other related fields." Upon information and belief,**
13 **Defendant admits WPATH published the seventh and most recent addition of the**
14 **"Standards of Care for the Health of Transsexual, Transgender, and Gender-**
15 **Nonconforming People" in or around 2011. Defendant lacks sufficient knowledge or**
16 **information to admit or deny the remaining allegations in Paragraph 31 of the**
17 **Complaint, and therefore denies them.**

18 32. Building on those standards and incorporating the most current research and
19 clinical experience, the Endocrine Society released the Endocrine Treatment of Gender-
20 Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice
21 Guideline in September 2017. Those guidelines reaffirm the WPATH Standards of Care
22 and offer medical providers practical guidance on providing transition-related care to
23 patients with gender dysphoria, including young people.

24 **Answer to Paragraph 32: Defendant admits the "Endocrine Treatment of**
25 **Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical**
26 **Practice Guideline" was released in or around 2017. Defendant states the "Endocrine**
27 **Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine**
28

1 **Society Clinical Practice Guideline” document speaks for itself. Defendant further**
2 **states WPATH’s “Standards of Care” document speaks for itself, WPATH has**
3 **issued several versions of “Standards of Care,” and it is unknown which version**
4 **Plaintiffs are referencing in Paragraph 32 of the Complaint. Defendant lacks**
5 **sufficient knowledge or information to admit or deny the remaining allegations**
6 **identified in Paragraph 32 of the Complaint, and therefore deny them.**

7 33. The WPATH and the Endocrine Society standards have been adopted by
8 many major associations of healthcare professionals, including the American Medical
9 Association, American Psychiatric Association, and American psychological Association,
10 as well as associations of healthcare professionals focused on youth and adolescents, such
11 as the American Academy of Pediatrics, American Association of Child and Adolescent
12 Psychiatrists, and the Pediatric Endocrine Society. Federal courts across the country have
13 also recognized the standards of these medical societies as setting the prevailing standard
14 of care for the treatment of gender dysphoria.

15 **Answer to Paragraph 33: Defendant lacks sufficient knowledge or**
16 **information to admit or deny the allegations relating to unspecified standards of**
17 **WPATH and the Endocrine Society that have been “adopted” by associations and**
18 **unspecified “federal courts across the country” “recogniz[ing]” standards of**
19 **WPATH and the Endocrine Society identified in Paragraph 33 of the Complaint,**
20 **and therefore Defendant denies all allegations in Paragraph 33 of the Complaint.**

21 34. A key component of treating gender dysphoria is a “social transition,” in
22 which the individual lives in accordance with their gender identity in all aspects of life.
23 Though specific to each person, a social transition typically includes adopting a new first
24 name, using and asking others to use pronouns reflecting the individual’s true gender,
25 wearing clothing typically associated with that gender, and using sex-specific facilities
26 corresponding to that gender.
27
28

1 **Answer to Paragraph 34: Defendant admits a social transition is specific to**
2 **each person. Defendant denies the remaining allegations contained in Paragraph 34**
3 **of the Complaint.**

4 35. Studies and anecdotal evidence demonstrate the tremendous mental health
5 benefits transgender youth experience following a social transition. One study found that
6 the mental health profile of transgender children who underwent a social transition was
7 nearly identical to that of their nontransgender peers. Kristina Olson et al., *Mental Health*
8 *of Transgender Children Who Are Supported in Their Identities*, 137 *Pediatrics* 1 (2016).
9 Another study found that transgender young people who were referred to by the correct
10 name and pronoun throughout their daily lives demonstrated a seventy-seven percent
11 decrease in severe depressive symptoms. Stephen Russell et al., *Chosen Name Use is*
12 *Linked to Reduced Depressive Symptoms, Suicidal Ideation and Behavior among*
13 *Transgender Youth*, 63 *J. of Adolescent Health* 503 (2018). The success of a social
14 transition hinges on parents, extended family, peers, and others in the community treating
15 the individual consistently with their gender identity.

16 **Answer to Paragraph 35: Defendant states the articles Plaintiffs cite in**
17 **Paragraph 35 speak for themselves. Defendant denies the remaining allegations**
18 **contained in Paragraph 35 of the Complaint.**

19 36. Consistent with the standard of care, many transgender individuals also need
20 health care services that alter their physical characteristics to bring their outer appearance
21 into alignment with their gender identity. The purpose of the services is to enable a
22 transgender person to live consistently with their gender identity in every aspect of their
23 life. This alleviates a transgender individual's gender dysphoria by reducing the
24 incongruence between their assigned sex and gender identity. Those treatments also
25 ensure that they are seen by others in a way that reflects their true gender, addressing a
26 significant source of distress.

Answer to Paragraph 36: Defendant denies the allegations contained in Paragraph 36 of the Complaint.

37. For transgender youth who have entered puberty, these health care services may include hormone-replacement therapy and surgery. Hormone-replacement therapy ensures that transgender people develop physical sex characteristics typical of their gender identity - not their assigned sex - such as facial and body hair in boys and breasts in girls.

Answer to Paragraph 37: Defendant denies the allegations contained in Paragraph 37 of the Complaint.

38. The prevailing standards of care for the treatment of gender dysphoria recognize that transgender males may need male chest reconstruction surgery before turning eighteen. A prerequisite for male chest reconstruction surgery is a referral letter from the young person's treating mental health provider. That letter provides the surgeon with a psychological assessment of the patient and the clinical rationale(s) for the referral and confirms that the patient is capable of consenting to the procedure.

Answer to Paragraph 38: Defendant denies the allegations contained in Paragraph 38 of the Complaint.

39. The purpose of the surgery is functional. Following the surgery, a transgender male is more readily seen as male, improving the effectiveness of their social transition because they are less likely to be mistaken for female, which can significantly reduce the anxiety and dysphoria they experience. The surgery also improves their self-image because they no longer have to see or wear a binder to hide a part of their body that causes so much physical pain and psychological distress. As a result, transgender males who have had male chest reconstruction surgery experience fewer barriers to engaging in physical activity, among other physical and mental health benefits.

Answer to Paragraph 39: Defendant denies the allegations contained in Paragraph 39 of the Complaint.

1 40. As with other treatments for gender dysphoria, both scientific research and
2 clinical evidence highlight the importance of male chest reconstruction surgery in the
3 treatment of gender dysphoria in transgender males.

4 **Answer to Paragraph 40: Defendant denies the allegations contained in**
5 **Paragraph 40 of the Complaint.**

6 *The Federal Medicaid Act*

7 41. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396w-5, creates
8 the Medicaid program-a cooperative federal-state program that provides health care
9 services to specified categories of individuals meeting income and other criteria. The
10 objective of Medicaid is to enable states to “furnish [] medical assistance” to individuals
11 “whose income and resources are insufficient to meet the cost of the necessary medical
12 services” and to provide “rehabilitation and other services to help such families and
13 individuals attain or retain capability for independence or self-care.” 42 U.S.C. § 1396-1.

14 **Answer to Paragraph 41: Defendant admits that the statutes speak for**
15 **themselves as to Medicaid’s services and objective.**

16 42. States are not required to participate in the Medicaid program. States that
17 choose to participate must comply with the federal Medicaid Act and its implementing
18 regulations.

19 **Answer to Paragraph 42: Defendant admits the allegations in Paragraph 42 of**
20 **the Complaint.**

21 43. In return, the federal government reimburses each participating state for a
22 substantial portion of the cost of providing medical assistance. *See id.* §§ 1396b(a),
23 1396d(b), 1396(c).

24 **Answer to Paragraph 43: Defendant admits the allegations in Paragraph 43 of**
25 **the Complaint.**

1 44. The Medicaid Act requires each participating state to establish or designate
2 a single state agency that is responsible for administering or supervising the
3 administration of the state's Medicaid program. *Id.* § 1396a(a)(5); 42 C.F.R. § 431.10.

4 **Answer to Paragraph 44: Defendant admits the allegations in Paragraph 44**
5 **of the Complaint.**

6 45. In addition, each participating state must maintain a comprehensive plan for
7 medical assistance approved by the Secretary of the U.S. Department of Health and
8 Human Services. *Id.* § 1396a. The plan must describe the state's program and affirm its
9 commitment to comply with the Medicaid Act and its implementing regulations.

10 **Answer to Paragraph 45: Defendant admits the allegations in Paragraph 45**
11 **of the Complaint.**

12 46. While a state is entitled to delegate certain of its responsibilities to other
13 entities, such as local agencies or Medicaid managed care plans, the single state agency is
14 ultimately responsible for ensuring compliance with all aspects of federal Medicaid law.
15 *See, e.g.*, 42 C.F.R. §§ 438.100(a)(2), 438.100(d).

16 **Answer to Paragraph 46: Defendant admits the allegations of Paragraph 46**
17 **are generally correct but states the cited rules speak for themselves.**

18 47. Under the Medicaid Act, a participating state must provide medical
19 assistance to certain eligibility groups. *Id.* § 1396a(a)(10)(A)(i). One mandatory
20 eligibility category is children and adolescents under age 18 whose household income is
21 below 133% of the federal poverty level. *Id.* §§ 1396a(a)(10)(A)(i)(VI)-(VII), 1396a(l).

22 **Answer to Paragraph 47: Defendant admits the allegations in Paragraph 47 of**
23 **the Complaint.**

24 ***The Medicaid Early and Periodic Screening, Diagnostic and Treatment***
25 ***Requirements***

26 48. The Medicaid Act requires state to cover certain services and gives them the
27 option to cover other services. *Id.* §§ 1396a(a)(10)(A), 1396d.
28

Answer to Paragraph 48: Defendant admits the allegations in Paragraph 48 of the Complaint.

49. Each participating state must cover Early and Periodic Screening, Diagnostic and Treatment (“EPSDT”) for individuals under age 21. *Id.* §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

Answer to Paragraph 49: Defendant admits the allegations in Paragraph 49 of the Complaint.

50. EPSDT’s fundamental purpose is to “[a]ssure that health problems are diagnosed and treated early, before they become more complex and their treatment more costly.” Ctrs. For Medicare & Medicaid Servs., *State Medicaid Manual* § 5010.B.

Answer to Paragraph 50: Defendant admits only that the State Medicaid Manual speaks for itself as to the purposes of EPSDT.

51. As part of providing EPSDT, states must:

- a. Inform all persons in the state who are under the age of 21 and who are eligible for Medicaid of the availability of EPSDT as described in 42 U.S.C. § 1396d(r);
- b. Provide or arrange for screening services in all cases where they are requested as required by § 1396d(r)(5); and
- c. Arrange for (directly or through referral) corrective treatment for any conditions identified by the screening services as required by § 1396a(a)(43)(C).

Answer to Paragraph 51: Defendant admits that the statutes speak for themselves as to Medicaid’s requirements.

52. Pursuant to the EPSDT requirements, states must cover four specific, separate categories of screening services: medical, vision, dental, and hearing. 42 U.S.C. § 1396d(r)(1)-(4).

1 **Answer to Paragraph 52:** Defendant alleges that the cited statute speaks for
2 itself but admits medical, vision, dental and hearing services can be covered under
3 the EPSDT program.

4 53. States also must cover “[s]uch other necessary health care, diagnostic
5 services, treatment, and other measures described in [§ 1396d(a)] to correct or ameliorate
6 defects and physical and mental illnesses and conditions discovered by the screening
7 services, whether or not such services are covered under the State plan.” *Id.* §
8 1396d(r)(5). In other words, the EPSDT mandate requires states to cover all necessary
9 Medicaid services for individuals under age 21.

10 **Answer to Paragraph 53:** Defendant admits the first sentence in Paragraph
11 53 of the Complaint, but denies the allegations of the second sentence in Paragraph
12 53 of the Complaint.

13 54. EPSDT services must be initiated in a timely manner, as the individual
14 needs of the child require, and must be consistent with accepted medical standards, no
15 later than six months from the date of request. 42 C.F.R. § 441.56e.

16 **Answer to Paragraph 54:** Defendant alleges that the cited rule speaks for
17 itself and denies the remaining allegations of Paragraph 54 of the Complaint.

18 55. Surgery to treat gender dysphoria, including male chest reconstruction
19 surgery, is an EPDST service under § 1396d(r)(5).

20 **Answer to Paragraph 55:** Paragraph 55 contains a legal conclusion to which
21 no response is necessary. To the extent a response is deemed necessary, Defendant
22 denies the allegations in Paragraph 55 of the Complaint.

23 ***The Medicaid Comparability Requirement***

24 56. Under the Medicaid Act, “the medical assistance made available to any
25 individual . . . shall not be less in amount, duration or scope than the medical assistance
26 made available to any other such individual.” *Id.* § 1396a(a)(10)(B)(i). *See also* 42
27 C.F.R. § 440.240(b).
28

1 **Answer to Paragraph 56: Defendant admits the allegations in Paragraph 56 of**
2 **the Complaint.**

3 57. A state “Medicaid agency may not arbitrarily deny or reduce the amount or
4 scope of a required service . . . to an otherwise eligible recipient solely because of the
5 diagnosis, type of illness, or condition.” 42 C.F.R. § 440.230(c).

6 **Answer to Paragraph 57: Defendant admits the allegations in Paragraph 57**
7 **of the Complaint.**

8 58. States must also ensure that “[e]ach service must be sufficient in amount,
9 duration, and scope to reasonably achieve its purpose.” 42 C.F.R. § 440.230(b).

10 **Answer to Paragraph 58: Defendant alleges that the full rule cited speaks for**
11 **itself.**

12 *The Arizona Medicaid Program*

13 59. Arizona participates in Medicaid, calling its program the Arizona Health
14 Care Cost Containment System (“AHCCCS”). Ariz. Rev. Stat. §§ 36-2901 to 2972.

15 **Answer to Paragraph 59: Defendant admits the allegations in Paragraph 59**
16 **of the Complaint.**

17 60. AHCCCS is also the name of the single-state Medicaid agency that is
18 responsible for administering and implementing Arizona’s Medicaid program consistent
19 with the requirements of federal law. *See* 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10.

20 **Answer to Paragraph 60: Defendant admits the allegations in Paragraph 60**
21 **of the Complaint.**

22 61. AHCCCS contracts with private managed care plans to provide health care
23 services to Medicaid enrollees. *See* AHCCCS, Available Health Plans,
24 [https://www.azahccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.ht](https://www.azahccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.html)
25 [ml](https://www.azahccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.html) (listing the eight Medicaid managed care plans operating in the State).

26 **Answer to Paragraph 61: Defendant admits it contracts with managed care**
27 **plans to provide services to some, but far from all, Medicaid enrollees.**
28

1 62. The federal government reimburses Arizona for approximately seventy
2 percent of its expenditures on health care services. U.S. Dep’t of Health & Human Servs.,
3 Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares
4 for Medicaid, the Children’s Health Insurance Program, and Aid to Needy Aged, Blind, or
5 Disabled Person for October 1, 2020 Through September 30, 2021, 84 Fed. Reg. 66204,
6 66204 (Dec. 3, 2019).

7 **Answer to Paragraph 62: Defendant admits the allegations in Paragraph 62 of**
8 **the Complaint.**

9 *Arizona’s Exclusion on Surgical Care for Transgender Medicaid Beneficiaries*

10 63. Since 1982, an Arizona regulation (the “Challenged Exclusion”) has
11 prohibited AHCCCS coverage for “gender reassignment surgeries.” Ariz. Admin. Code
12 R9-22-205-B.4(a). The Challenged exclusion has been applied since that time to deny
13 coverage to transgender AHCCCS beneficiaries seeking male chest reconstruction
14 surgery.

15 **Answer to Paragraph 63: Defendant admits Arizona Administrative Code**
16 **(“A.A.C.”) R-9-22-205(B)(4) excludes several services from AHCCCS coverage.**
17 **Defendant further admits A.A.C. R-9-22-205(B)(4)(a) provides, “The following**
18 **services are excluded from AHCCCS coverage: . . . gender reassignment surgeries,”**
19 **and this regulation was promulgated in 1982. Defendant lacks sufficient knowledge**
20 **or information to admit or deny the remaining allegations contained in Paragraph 63**
21 **of the Complaint, and therefore denies them.**

22 64. Arizona has singled out transition-related surgical care for an express
23 exclusion even though AHCCCS covers the same surgical services to treat other health
24 conditions. *See, e.g.*, Ariz. Admin. Code R9-22-2004(A)(4), AHCCCS Medical Policy
25 Manual, § 310-C Breast Reconstruction After Mastectomy (2018),
26 <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310C.pdf>.
27
28

Answer to Paragraph 64: Defendant denies the allegations contained in Paragraph 64 of the Complaint.

65. The Challenged Exclusion has no medical or scientific basis. To the contrary, for many transgender people, including adolescents, surgical care is medically necessary to treat gender dysphoria.

Answer to Paragraph 65: Defendant denies the allegations contained in Paragraph 65 of the Complaint.

66. Contrary to the prevailing standard of care for the treatment of gender dysphoria, Defendant continues to enforce the Challenged Exclusion against transgender Medicaid recipients, even those covered under EPSDT, including D.H. and John.

Answer to Paragraph 66: Defendant denies the allegations contained in Paragraph 66 of the Complaint.

67. On information and belief, many transgender AHCCCS recipients have been deterred from seeking prior authorization for transition-related surgeries because of their knowledge, or the knowledge of their medical providers, that the Challenged Exclusion would make such requests futile.

Answer to Paragraph 67: Defendant lacks sufficient knowledge or information to admit or deny the allegations contained in Paragraph 67 of the Complaint, and therefore denies them.

D.H.'s Gender Dysphoria and Need for Surgical Treatment

68. D.H. was identified as female at birth but has known that he is male since age four.

Answer to Paragraph 68: Defendant lacks sufficient knowledge or information to admit or deny the allegations contained in Paragraph 68 of the Complaint, and therefore denies them.

69. As a young child, D.H. struggled to express to his mother that he is male. Nothing he said or did got the result he had hoped for; Janice, D.H.'s mother, continued to

1 treat him as a girl. As a result, D.H. began exhibiting signs of significant psychological
2 distress including, depression, prolonged crying episodes, anxiety, and insomnia. The
3 severity of D.H.'s distress led his mother to seek the advice of mental health
4 professionals.

5 **Answer to Paragraph 69: Defendant lacks sufficient knowledge or**
6 **information to admit or deny the allegations contained in Paragraph 69 of the**
7 **Complaint, and therefore denies them.**

8 70. When he was about eleven years old, the stress related to his gender
9 identity-combined with the other stressors D.H. was trying to navigate-was so
10 overwhelming that D.H. started losing his hair. He was eventually hospitalized for
11 intensive psychiatric treatment.

12 **Answer to Paragraph 70: Defendant lacks sufficient knowledge or information**
13 **to admit or deny the allegations contained in Paragraph 70 of the Complaint, and**
14 **therefore denies them.**

15 71. Following his hospitalization, Janice enrolled D.H. in dance class, hoping it
16 would provide D.H. a healthy way to cope with his distress. The movements were like
17 therapy to him. Dance also became a social outlet; he made friends and felt a sense of
18 belonging. It was the only thing in his life that could make him b=feel better. By the
19 following year, D.H. was enrolled in three different dance classes: ballet, modern, and
20 jazz.

21 **Answer to Paragraph 71: Defendant lacks sufficient knowledge or**
22 **information to admit or deny the allegations contained in Paragraph 71 of the**
23 **Complaint, and therefore denies them.**

24 72. That euphoria ended later that year once puberty began. Because of D.H.'s
25 increasing chest size, dance no longer provided the same psychological release it once
26 had. D.H. hated his body and everything that came with it. His thoughts and fears about
27 experiencing puberty-with its associated physical changes that would take his body even
28

1 further out of alignment with his gender identity-became all-consuming and significantly
2 affected his ability to function. D.H. hid his changing body under baggy clothes and hated
3 being perceived as a girl at school.

4 **Answer to Paragraph 72: Defendant lacks sufficient knowledge or information**
5 **to admit or deny the allegations contained in Paragraph 72 of the Complaint, and**
6 **therefore denies them.**

7 73. D.H. began using a variety of methods to flatten his chest, from multiple
8 sports bras and Ace bandages to duct tape, so that his appearance better aligned with his
9 gender identity. Those initial attempts were extremely uncomfortable and irritated his
10 skin. Needing a better and safer solution, D.H. secretly bought his first binder, an article
11 of clothing that compresses a person's chest, giving the appearance of a flat chest. Putting
12 on the binder gave D.H. a sense of relief that no amount of therapy or medication had ever
13 given him. It also eventually helped him gain the confidence to tell his mother what he
14 struggled to express as a child: "I am a boy."

15 **Answer to Paragraph 73: Defendant lacks sufficient knowledge or information**
16 **to admit or deny the allegations contained in Paragraph 73 of the Complaint, and**
17 **therefore denies them.**

18 74. Janice was supportive but sought out the advice of health care providers
19 with experience working with transgender youth before making any decisions regarding
20 next steps.

21 **Answer to Paragraph 74: Defendant lacks sufficient knowledge or information**
22 **to admit or deny the allegations contained in Paragraph 74 of the Complaint, and**
23 **therefore denies them.**

24 75. Soon after disclosing to his mother that he is transgender at age thirteen,
25 D.H. started seeing Tamar Reed, a therapist who specializes in treating gender dysphoria
26 in children and adolescents. After carefully assessing D.H.'s mental health, Ms. Reed
27 recommended that D.H. begin to transition to living as male. D.H. started using a male
28

1 name and asked that others refer to him using that name and masculine pronouns. He also
2 changed his hairstyle and started wearing boys' clothing.

3 **Answer to Paragraph 75: Defendant lacks sufficient knowledge or information**
4 **to admit or deny the allegations contained in Paragraph 75 of the Complaint, and**
5 **therefore denies them.**

6 76. D.H.'s social transition provided him with much-needed psychological
7 relief. He was regularly being referred to by a male name and pronouns and treated as
8 male by those around him.

9 **Answer to Paragraph 76: Defendant lacks sufficient knowledge or information**
10 **to admit or deny the allegations contained in Paragraph 76 of the Complaint, and**
11 **therefore denies them.**

12 77. Nevertheless, D.H.'s distress continued to build.

13 **Answer to Paragraph 77: Defendant lacks sufficient knowledge or**
14 **information to admit or deny the allegations contained in Paragraph 77 of the**
15 **Complaint, and therefore denies them.**

16 78. A few months before his fourteenth birthday, the depression and suicidal
17 ideation became overwhelming. Janice noticed a change in D.H.'s personality and that he
18 had started distancing himself from his peers and activities that had previously brought
19 him joy. Then, following a dance competition in January 2017, D.H.'s mental health
20 decompensated significantly. Out of concern for his safety and wellbeing, D.H. was
21 admitted to a ten-day intensive psychiatric treatment program.

22 **Answer to Paragraph 78: Defendant lacks sufficient knowledge or information**
23 **to admit or deny the allegations contained in Paragraph 78 of the Complaint, and**
24 **therefore denies them.**

25 79. Following that treatment program, his health care providers recommended
26 that he start hormone-replacement therapy to further his social transition-that treatment
27 would both halt the effects of estrogen and make his appearance more typically masculine.
28

1 D.H.'s pediatrician referred him to a pediatric endocrinologist for this treatment and
2 related specialty care. D.H. received his first shot of testosterone in November 2017.

3 **Answer to Paragraph 79: Defendant lacks sufficient knowledge or information**
4 **to admit or deny the allegations contained in Paragraph 79 of the Complaint, and**
5 **therefore denies them.**

6 80. The testosterone has caused D.H.'s voice to deepen, he has grown facial
7 hair, and he has developed a more masculine musculature. The testosterone, however,
8 cannot reverse the physical changes that had already occurred prior to D.H.'s transition,
9 particularly chest development.

10 **Answer to Paragraph 80: Defendant lacks sufficient knowledge or information**
11 **to admit or deny the allegations contained in Paragraph 80 of the Complaint, and**
12 **therefore denies them.**

13 81. Because of the prominent appearance of his chest, D.H.'s binder continues
14 to be one of his most important pieces of clothing. Although binders are not supposed to
15 be worn for more than seven to eight hours a day, D.H. regularly wears his binder for ten
16 hours a day, and at least twice per week D.H. wears it for longer than ten hours. On
17 occasion, D.H. has worn his binder for multiple consecutive days. He even struggles to
18 take the binder off at home, where he feels the most comfortable being himself.

19 **Answer to Paragraph 81: Defendant lacks sufficient knowledge or information**
20 **to admit or deny the allegations contained in Paragraph 81 of the Complaint, and**
21 **therefore denies them.**

22 82. Keeping the binder on that long is uncomfortable and painful. The effort is
23 takes to ignore the pain interferes with D.H.'s ability to focus on school, particularly
24 homework, as D.H.'s discomfort compounds throughout the day. The compression from
25 the binder also prevents him from breathing too deeply. In fact, D.H.'s current
26 pediatrician, Dr. Andrew Cronyn, remarked that D.H.'s binder contributed to him
27
28

1 developing asthma in adolescence and needing an inhaler to engage in extended physical
2 activity.

3 **Answer to Paragraph 82: Defendant lacks sufficient knowledge or information**
4 **to admit or deny the allegations contained in Paragraph 82 of the Complaint, and**
5 **therefore denies them.**

6 83. While taking testosterone and using the binder have improved D.H.'s mental
7 health, D.H. continues to experience significant gender dysphoria because of his chest.
8 The benefits of using a binder were - and continue to be - temporary and imperfect. The
9 binder dampens the distress D.H. feels during the day, but once he removes the binder at
10 night, D.H.'s distress intensifies. And, even with the binder, D.H. continues to be
11 mistaken for female, exacerbating his anxiety around interacting with unfamiliar people.

12 **Answer to Paragraph 83: Defendant lacks sufficient knowledge or information**
13 **to admit or deny the allegations contained in Paragraph 83 of the Complaint, and**
14 **therefore denies them.**

15 84. D.H.'s distress began compounding again and, in September 2018, D.H. was
16 placed in an intensive psychiatric treatment program for a third time due to suicidal
17 ideation. D.H. was fifteen-years old at that time.

18 **Answer to Paragraph 84: Defendant lacks sufficient knowledge or information**
19 **to admit or deny the allegations contained in Paragraph 84 of the Complaint, and**
20 **therefore denies them.**

21 85. The mental health treatment D.H. received following that hospitalization
22 helped him develop more effective strategies for coping with the distress caused by
23 gender dysphoria and the appearance of his chest. Even with those strategies, D.H.'s
24 distress still has a significant effect on his mental health, daily life, and ability to function.
25 D.H. still struggles with an ever-present anxiety that the appearance of his chest will cause
26 others to treat him as female. This prevents him from participating in social activities
27 with his friends and caused him to quit dance over a year ago because he gets winded too
28

1 easily to dance with a binder, but the dysphoria is too great for him to dance without one.
2 His dysphoria also makes him extremely uncomfortable revealing his body even when he
3 is by himself or in a doctor's office.

4 **Answer to Paragraph 85: Defendant lacks sufficient knowledge or information**
5 **to admit or deny the allegations contained in Paragraph 85 of the Complaint, and**
6 **therefore denies them.**

7 86. In 2019, D.H.'s pediatrician referred D.H. to a surgeon, Dr. Ethan Larson,
8 who could perform male chest reconstruction surgery. D.H.'s health care providers
9 determined that the surgery was medically necessary to alleviate D.H.'s gender dysphoria.
10 Dr. Larson evaluated D.H. and agreed he would be a good candidate for the surgery.

11 **Answer to Paragraph 86: Defendant lacks sufficient knowledge or**
12 **information to admit or deny the allegations contained in Paragraph 86 of the**
13 **Complaint, and therefore denies them.**

14 87. Dr. Larson requested prior authorization for the surgery from
15 UnitedHealthcare, D.H.'s Medicaid managed care plan. UnitedHealthcare denied prior
16 authorization for the surgery. D.H. appealed the denial of the surgery, and on July 5,
17 2019, UnitedHealthcare upheld its denial of coverage pursuant to the Challenged
18 Exclusion.

19 **Answer to Paragraph 87: Defendant lacks sufficient knowledge or**
20 **information to admit or deny the allegations contained in Paragraph 87 of the**
21 **Complaint, and therefore denies them.**

22 88. Due to her income, Janice cannot afford to pay for John to undergo male
23 chest reconstruction surgery without AHCCCS covering the procedure.

24 **Answer to Paragraph 88: Defendant lacks sufficient knowledge or**
25 **information to admit or deny the allegations contained in Paragraph 88 of the**
26 **Complaint, and therefore denies them.**

27 *John's Gender Dysphoria and Need for Surgical Treatment*
28

1 89. John was identified as female at birth. His grandmother, Susan, has cared
2 for him since he was two years old and continues to be his legal guardian.

3 **Answer to Paragraph 89: Defendant lacks sufficient knowledge or**
4 **information to admit or deny the allegations contained in Paragraph 89 of the**
5 **Complaint, and therefore denies them.**

6 90. As a child, John did not like dresses or typical girl toys, but was never able
7 to pinpoint a reason.

8 **Answer to Paragraph 90: Defendant lacks sufficient knowledge or**
9 **information to admit or deny the allegations contained in Paragraph 90 of the**
10 **Complaint, and therefore denies them.**

11 91. Approximately three years ago, just before John turned twelve, he started
12 experiencing the first signs of puberty. Those signs were coupled with an almost
13 immediate and significant decline in his mental health. He experienced symptoms of
14 severe depression, such as a constant and overwhelming sadness, distancing himself from
15 his friends, and suicidal ideation. Unable to describe his feelings and uncertain about how
16 Susan would respond even if he could, John kept those emotions bottled up.

17 **Answer to Paragraph 91: Defendant lacks sufficient knowledge or**
18 **information to admit or deny the allegations contained in Paragraph 91 of the**
19 **Complaint, and therefore denies them.**

20 92. Worried about how Susan and others in his family might react, especially
21 given their strong religious faith, John waited nearly six months before telling his older
22 sister that he is transgender. He eventually told Susan as well.

23 **Answer to Paragraph 92: Defendant lacks sufficient knowledge or**
24 **information to admit or deny the allegations contained in Paragraph 92 of the**
25 **Complaint, and therefore denies them.**
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1 93. Over the course of the following year, John's 7th grade year, Susan and John
2 had many extensive conversations to help her better understand what he was experiencing
3 and how she could help him.

4 **Answer to Paragraph 93: Defendant lacks sufficient knowledge or**
5 **information to admit or deny the allegations contained in Paragraph 93 of the**
6 **Complaint, and therefore denies them.**

7 94. John continued to experience significant gender dysphoria throughout his 7th
8 grade year. Although John continued to wear the boys' clothes he always had and started
9 using a male name, his peers, teachers, and family did not consistently refer to him by that
10 name and male pronouns. Not being consistently treated as male caused Joh to be stressed
11 the entire school year.

12 **Answer to Paragraph 94: Defendant lacks sufficient knowledge or**
13 **information to admit or deny the allegations contained in Paragraph 94 of the**
14 **Complaint, and therefore denies them.**

15 95. Wanting to prevent a repeat of the prior year, in the summer prior to starting
16 8th grade, John e-mailed each of his teachers to inform them that he is transgender and ask
17 that they refer to him as John and by male pronouns. This helped set the tone; in 8th
18 grade, John was more regularly referred to by the correct name and pronouns-both in
19 school and out.

20 **Answer to Paragraph 95: Defendant lacks sufficient knowledge or**
21 **information to admit or deny the allegations contained in Paragraph 95 of the**
22 **Complaint, and therefore denies them.**

23 96. Around that same time, at thirteen years old, John's pediatrician referred
24 him to the Gender Support Program at Phoenix Children's Hospital, a clinic specializing
25 in healthcare services for transgender young people.
26
27
28

1 **Answer to Paragraph 96: Defendant lacks sufficient knowledge or**
2 **information to admit or deny the allegations contained in Paragraph 96 of the**
3 **Complaint, and therefore denies them.**

4 97. John had his first appointment at Phoenix Children's Hospital in November
5 2018, where he began to see Dr. Veenod Chulani, an adolescent-medicine specialist. Dr.
6 Chulani referred John to a mental health provider, who formally diagnosed John with
7 gender dysphoria. Soon thereafter John started taking medication to stop his menstrual
8 cycle, which helped relieve some of the gender dysphoria he was experiencing at the time.
9 In May 2019, Dr. Chulani and John's therapist determined that it was medically necessary
10 for him to start taking testosterone, which he started the following month. John is pleased
11 with how the testosterone therapy has changed his voice and other aspects of his body.
12 Transitioning has also boosted his confidence, and now far fewer people mistake him for
13 female.

14 **Answer to Paragraph 97: Defendant lacks sufficient knowledge or**
15 **information to admit or deny the allegations contained in Paragraph 97 of the**
16 **Complaint, and therefore denies them.**

17 98. His transition and testosterone treatment, however, have not lessened the
18 intense dysphoria he experiences regarding the appearance of his chest. Starting in 2018,
19 John began binding his chest using a variety of methods, such multiple sports bras and
20 constrictive undergarments. He bought his first binder in December 2019.

21 **Answer to Paragraph 98: Defendant lacks sufficient knowledge or**
22 **information to admit or deny the allegations contained in Paragraph 98 of the**
23 **Complaint, and therefore denies them.**

24 99. Every morning, the first thing John does is to put on a binder, which he
25 often wears for longer than the recommended eight-hour maximum. Even with the
26 binder, John still feels uncomfortable being outside without multiple layers of clothing,
27 including a hooded sweatshirt that he wears nearly every day. The binder constricts his
28

1 breathing, which in combination with his asthma, requires him to take far more breaks
2 than his peers when engaging in physical activity.

3 **Answer to Paragraph 99: Defendant lacks sufficient knowledge or**
4 **information to admit or deny the allegations contained in Paragraph 99 of the**
5 **Complaint, and therefore denies them.**

6 100. Although the binder sometimes allows him to forget about his chest-a sense
7 of relief he treasures-the hardest part of John's daily routine is removing his binder. The
8 dysphoria John experiences regarding his chest comes flooding back, a difficult reminder
9 that his body still does not match who he is. John's chest-related dysphoria keeps him
10 awake at night at least once a week; putting on his binder temporarily is the only way he
11 can calm his distress, a task he often tries to do without opening his eyes or turning on the
12 lights so that he does not have to see his bare chest.

13 **Answer to Paragraph 100: Defendant lacks sufficient knowledge or**
14 **information to admit or deny the allegations contained in Paragraph 100 of the**
15 **Complaint, and therefore denies them.**

16 101. Having top surgery would have a significant positive impact on John's life.
17 John would finally be able to look at himself in the mirror and be in public without having
18 to wear so many layers of clothing on top of his binder, which would benefit both is
19 mental and physical health. John would gain confidence that will help improve his social
20 functioning and broaden his horizons, challenging himself to try to (do) new things.

21 **Answer to Paragraph 101: Defendant lacks sufficient knowledge or**
22 **information to admit or deny the allegations contained in Paragraph 101 of the**
23 **Complaint, and therefore denies them.**

24 102. Around February 2020, Dr. Chulani recommended that John undergo male
25 chest reconstruction surgery to alleviate the dysphoria caused by the shape and appearance
26 of his chest. At that time, Dr. Chulani Also referred John to another mental health
27 provider to assist John with the increased psychological distress he was experiencing and
28

1 to evaluate John for male chest reconstruction surgery as required by the prevailing
2 standards of care.

3 **Answer to Paragraph 102: Defendant lacks sufficient knowledge or**
4 **information to admit or deny the allegations contained in Paragraph 102 of the**
5 **Complaint, and therefore denies them.**

6 103. On July 2, 2020, John received a referral letter from his mental health
7 provider for the surgery, as required by the standards of care.

8 **Answer to Paragraph 103: Defendant lacks sufficient knowledge or**
9 **information to admit or deny the allegations contained in Paragraph 103 of the**
10 **Complaint, and therefore denies them.**

11 104. Due to her income, Susan cannot afford to pay for John to undergo male
12 chest reconstruction surgery without AHCCCS covering the procedure.

13 **Answer to Paragraph 104: Defendant lacks sufficient knowledge or**
14 **information to admit or deny the allegations contained in Paragraph 104 of the**
15 **Complaint, and therefore denies them.**

16 **CLASS ACTION ALLEGATIONS**

17 105. Plaintiffs, on behalf of themselves and all similarly situated individuals,
18 bring their claims for declaratory and injunctive relief as a class action under Fed. R. Civ.
19 P. 23(a) and 23(b)(2).

20 **Answer to Paragraph 105: Defendant admits Plaintiffs are attempting to**
21 **bring this action on behalf of themselves and a proposed class, but denies that class**
22 **certification is appropriate or permissible. Defendant denies the remaining**
23 **allegations in Paragraph 105 of the Complaint.**

24 106. Plaintiffs request that the Court certify the following class ("Class") under
25 Fed. R. Civ. P. 23(b)(2).

26 All transgender individuals under age 21 who are or will be enrolled in AHCCCS,
27 have or will have a diagnosis of gender dysphoria, and are seeking or will seek
28 coverage for male chest reconstruction surgery following a determination by their

1 respective health care providers that the procedure is necessary to treat their gender
2 dysphoria.

3 **Answer to Paragraph 106: Defendant admits Plaintiffs have defined a**
4 **proposed class as set forth in Paragraph 106, but denies that class certification for**
5 **this proposed class is appropriate. Defendant denies the remaining allegations in**
6 **Paragraph 106 of the Complaint.**

7 107. Plaintiffs are adequate representatives of the Class. Plaintiffs are transgender
8 individuals under the age 21 who are enrolled in AHCCCS, have been diagnosed with
9 gender dysphoria, and are seeking coverage for male chest reconstruction surgery to treat
10 their dysphoria.

11 **Answer to Paragraph 107: Defendant denies that Plaintiffs are adequate**
12 **representatives of the proposed class set forth in Paragraph 106 of the Complaint.**
13 **Defendant lacks sufficient knowledge or information to admit or deny the remaining**
14 **allegations contained in Paragraph 107 of the Complaint, and therefore denies them.**

15 108. The Class satisfies the requirements of Fed. R. Civ. P. 23(a)(1) because the
16 class is so numerous that joinder of all members is impracticable. There are at least one
17 hundred transgender males under age 21 who are enrolled in AHCCCS and who require
18 male chest reconstruction surgery to treat their gender dysphoria. In addition, because of
19 the transient nature of the AHCCCS population, in part because individuals' income may
20 make them eligible or ineligible for Medicaid at various points in their lives, it is
21 impractical to join all transgender individuals under age 21 (who may live in various parts
22 of Arizona) with gender dysphoria who may be denied AHCCCS coverage by the
23 Challenged Exclusion at some point.

24 **Answer to Paragraph 108: Defendant denies the allegations in Paragraph 108**
25 **of the Complaint.**

26 109. The Class satisfies the commonality requirements of Fed R. Civ. P. 23(a)(2)
27 because there are questions of law and fact common to the Class. Pursuant to the
28 Challenged Exclusion, Defendant has acted or refused to act on grounds generally

1 applicable to the Class. This action raises questions of law common to all members of the
2 Class, including: (a) whether the Challenged Exclusion, facially and as applied to
3 members of the Class, violates the EPSDT and comparability provisions of the federal
4 Medicaid Act; (b) whether the Challenged Exclusion, facially and as applied to members
5 of the Class, violates the prohibition on sex discrimination under Section 1557 of the
6 Patient Protection and Affordable Care Act; and (c) whether the Challenged Exclusion,
7 facially and as applied to members of the Class, violates the Equal Protection Clause of
8 the Fourteenth Amendment to the U.S. Constitution. All members of the Class share a
9 common question of fact: Would their male chest reconstruction surgery be covered by
10 AHCCCS but for Defendant's continuing enforcement of the Challenged Exclusion?

11 **Answer to Paragraph 109: Defendant denies the allegations in Paragraph 109**
12 **of the Complaint.**

13 110. The Class satisfies the typically requirements of Fed. R. Civ. P. 23(a)(3)
14 because the named Plaintiffs' claims are typical of the claims of the Class. Plaintiffs are
15 members of the Class, are individuals who have been unable and will be unable to obtain
16 AHCCCS coverage for medically necessary male chest reconstruction surgery because of
17 the Challenged Exclusion, and as a result, have faced or will face delayed or denied access
18 to these medically necessary treatments. Plaintiffs and members of the Class share the
19 same legal claims under Section 1557, the Medicaid Act, and the Equal Protection Clause
20 of the Fourteenth Amendment to the U.S. Constitution.

21 **Answer to Paragraph 110: Defendant denies the allegations in Paragraph 110**
22 **of the Complaint.**

23 111. The Class satisfies the adequacy requirements of Fed. R. Civ. P. 23(a)(4)
24 because the class representatives will fairly and adequately represent the interests of the
25 Class. The named Plaintiffs seek the same declaratory and injunctive relief as the other
26 members of the Class: a declaratory judgment that the Challenged Exclusion violates the
27 Medicaid Act, Section 1557, and the Equal Protection Clause, and preliminary and
28

1 permanent injunctions enjoining Defendant from enforcing the Challenged Exclusion.
2 The named Plaintiffs seek this relief to benefit themselves and to protect other low-
3 income transgender Arizona residents who are or will be enrolled in AHCCCS. In
4 asserting their own rights, the named Plaintiffs will vindicate the rights of all members of
5 the Class fairly and adequately. The class representatives have no interests that are
6 antagonistic to the interests of other members of the Class.

7 **Answer to Paragraph 111: Defendant denies the allegations in Paragraph 111**
8 **of the Complaint.**

9 112. The Class further satisfies the requirements of Fed. R. Civ. P. 23(a)(4)
10 because counsel for the Class will fairly and adequately represent the interests of the
11 Class. The Class is represented by counsel from King & Spalding LLP and Perkins Coie
12 LLP, two of the largest law firms in the country; the National Center for Lesbian Rights
13 (“NCLR”), a legal organization dedicated to advancing the civil and human rights of the
14 LGBTQ community; and the National Health Law Program (“NHeLP”), a non-profit law
15 firm dedicated to protecting and advancing the health rights of low-income and
16 underserved individuals and families. Collectively, counsel has significant experience
17 litigating civil rights cases, including transgender rights cases, Medicaid EPSDT cases,
18 and complex class actions in federal court.

19 **Answer to Paragraph 112: Defendant admits Plaintiffs are represented by**
20 **counsel from King & Spalding, LLP, Perkins Coie, LLP, the National Center for**
21 **Lesbian Rights, and the National Health Law Program. Defendant lacks sufficient**
22 **knowledge or information to admit or deny the remaining allegations contained in**
23 **Paragraph 112 of the Complaint, and therefore denies them.**

24 113. The Class also satisfies the requirements of Fed. R. Civ. P. 23(b)(2) because
25 Defendant has acted or refused to act on grounds that apply generally to the Class, so that
26 final injunctive or corresponding declaratory relief is appropriate respecting the class as a
27 whole. The Class exhibits sufficient cohesiveness because its members have suffered
28

group, as opposed to individual, injuries, namely, the Challenged Exclusion's categorical denial of male chest reconstructive surgery. Members of the Class are bound together by the significant common traits that they are all transgender, they have gender dysphoria, and they need male chest reconstruction surgery to treat their gender dysphoria.

Answer to Paragraph 113: Defendant denies the allegations in Paragraph 113 of the Complaint.

114. Further, by definition, members of the Class are low-income individuals who would otherwise have difficulty affording counsel to individually challenge the Challenged Exclusion. Therefore, a class action is the ideal - and the only - method by which the Class may vindicate the denial of their civil rights.

Answer to Paragraph 114: Defendant denies the allegations contained in Paragraph 114 of the Complaint.

COUNT I

(Violation of the Medicaid Act's EPSDT Requirements, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(A)-(C), 1396d(a)(4)(B), and 1396d(r)(5))

115. Plaintiffs reallege and incorporate by reference paragraphs 1 to 144 of this Complaint.

Answer to Paragraph 115: Defendant incorporates her responses to each and every allegation in the Complaint as if fully set forth herein.

116. The Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), and Defendant's refusal, based on the Challenged Exclusion, to provide coverage for surgical treatments and services for gender dysphoria to Plaintiffs and members of the Class, violate the Medicaid Act's EPSDT requirements, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(A)-(C), 1396d(a)(4)(B), and 1396d(r)(5), which are enforceable by Plaintiffs under 42 U.S.C. § 1983.

Answer to Paragraph 116: Defendant denies the allegations in Paragraph 116 of the Complaint.

COUNT II

(Violation of the Medicaid Act's Comparability Requirement, 42 U.S.C. § 1396a(a)(10)(B))

117. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

Answer to Paragraph 117: Defendant incorporates her responses to each and every allegation in the Complaint as if fully set forth herein.

118. The Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), and Defendant's refusal, based on the Challenged Exclusion, to provide coverage for surgical treatments and services for gender dysphoria to Plaintiffs and members of the Class, while covering the same services for other AHCCCS beneficiaries with different diagnoses, violate the Medicaid Act's comparability requirement, 42 U.S.C. § 1396a(a)(10)(B), which is enforceable by Plaintiffs under 42 U.S.C. § 1983.

Answer to Paragraph 118: Defendant denies the allegations in Paragraph 118 of the Complaint.

COUNT III

(Unlawful Discrimination on the Basis of Sex in Violation of Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116)

119. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

Answer to Paragraph 119: Defendant incorporates her responses to each and every allegation in the Complaint as if fully set forth herein.

120. Under Section 1557 of the Affordable Care Act, "an individual shall not...be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, and part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by and Executive Agency or any entity established under this title (or amendments)" on the basis of sex. 42 U.S.C. § 18116.

1 **Answer to Paragraph 120:** Defendant admits that 42 U.S.C. § 18116(a) states,
2 in its entirety, “Except as otherwise provided for in this title (or an amendment made
3 by this title), an individual shall not, on the ground prohibited under title VI of the
4 Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education
5 Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42
6 U.S.C. 6101 et seq.), or section 794 of Title 29, be excluded from participation in, be
7 denied the benefits of, or be subjected to discrimination under, any health program
8 or activity, any part of which is receiving Federal financial assistance, including
9 credits, subsidies, or contracts of insurance, or under any program or activity that is
10 administered by an Executive Agency or any entity established under this title (or
11 amendments). The enforcement mechanisms provided for and available under such
12 title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes
13 of violations of this subsection.”

14 121. Section 1557’s prohibitions on sex discrimination are enforceable by
15 Plaintiffs in a judicial action under 20 U.S.C. § 1683, which Section 1557 incorporates by
16 reference. 42 U.S.C. § 18116(a). The Challenged Exclusion, Arizona Administrative
17 Code R9-22-205-B.4(a), on its face and as applied to Plaintiffs and members of the Class,
18 violates Section 1557’s prohibition against discrimination on the basis of sex in a health
19 program or activity receiving federal financial assistance.

20 **Answer to Paragraph 121:** Defendant denies the allegations in Paragraph 121
21 of the Complaint.

22 122. Plaintiffs and the Class have been and are continuing to be injured by
23 Defendants’ application of the Challenged Exclusion to deny them AHCCCS coverage for
24 surgical treatments for gender dysphoria.

25 **Answer to Paragraph 122:** Defendant denies the allegations in Paragraph 122
26 of the Complaint.
27
28

COUNT IV

**(Violation of the Equal Protection Clause of the
Fourteenth Amendment of the United States Constitution)**

123. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

Answer to Paragraph 123: Defendant incorporates her responses to each and every allegation in the Complaint as if fully set forth herein.

124. First, the Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), on its face and as applied to Plaintiffs and members of the Class, impermissibly discriminates against Plaintiffs and members of the Class on the basis of sex and violates their right to equal protection of the laws under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

Answer to Paragraph 124: Defendant denies the allegations in Paragraph 124 of the Complaint.

125. Second, the Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), on its face and as applied to Plaintiffs, impermissibly discriminates against Plaintiffs and members of the Class for being transgender and violates their right to equal protection of the laws under the Fourteenth Amendment to the United States Constitution.

Answer to Paragraph 125: Defendant denies the allegations in Paragraph 125 of the Complaint.

126. Defendant's promulgation and continued enforcement of the Challenged Exclusion did not, and does not, serve any rational, legitimate, important, or compelling state interest. Rather, the Challenged Exclusion serves only to prevent Plaintiffs and members of the Class from obtaining medically necessary surgical care and services to treat their gender dysphoria, complete their gender transitions, and live as their authentic selves.

Answer to Paragraph 126: Defendant denies the allegations in Paragraph 126 of the Complaint.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

A. Certify a Class consisting of: All transgender individuals under age 21 who are or will be enrolled in AHCCCS, have or will have a diagnosis of gender dysphoria, and are seeking or will seek male chest reconstruction surgery following a determination by their respective health care providers that the procedure is necessary to treat their gender dysphoria.

B. Name D.H. and John as representatives of the Class, and appoint Plaintiffs' counsel as King & Spalding LLP, Perkins Coie LLP, the NCLR, and NHeLP;

C. On behalf of Plaintiffs and all similarly situated individuals, issue preliminary and permanent injunctions prohibiting Defendant from any further enforcement or application of the Challenged Exclusion, Arizona Administrative Code R9-22-2-5-B.4(a), and directing Defendant and their agents to provide Medicaid coverage for medically necessary male chest reconstruction surgery;

D. On behalf of Plaintiffs and all similarly situated individuals, enter a declaratory judgment that the denial of coverage for male chest reconstruction surgery:

1. Violates the Medicaid Act's EPSDT requirements, 42 U.S.C. §§ 1396a(a)(10)(B);
2. Violates the Medicaid Act's comparability requirement, 42 U.S.C. § 1396a(a)(10)(B);
3. Violates Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116, by discriminating against Plaintiffs and all similarly situated individuals on the basis of sex; and
4. Violates the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution by discrimination against Plaintiffs and all similarly situated individuals on the basis of sex (including sex stereotyping, gender identity,

being transgender, and undergoing a gender transition), and for being transgender;

E. Waive the requirement for the posting of a bond of security for the entry of temporary and preliminary relief;

F. Award Plaintiffs their reasonable attorneys' fees, costs, and expenses under 42 U.S.C. § 1988 or other applicable statutes; and

G. Award such other and further relief as the Court may deem just and proper.

Answer to Prayer for Relief: Defendant denies the allegations in the Prayer for Relief and denies that Plaintiff is entitled to any relief whatsoever.

AFFIRMATIVE DEFENSES

A. Plaintiffs' Complaint fails to state a claim upon which relief may be granted.

B. The Complaint should be dismissed for failure to exhaust administrative remedies, including by D.H. failing to timely appeal from the alleged health plan denial.

C. Plaintiffs' claims may be barred by applicable statutes of limitations.

D. Plaintiffs' claims may be barred by the doctrines of waiver, laches, and/or estoppel.

E. Defendant has fulfilled all obligations imposed on her by law.

F. Plaintiffs' claims are barred because the decision about which they complain was made on the basis of reasonable factors other than Plaintiffs' sex.

G. Defendant's actions were not designed, intended, or used to discriminate because of sex.

H. Any action taken by Defendant was rationally related to a legitimate government interest.

I. Any action taken by Defendant was reasonable and necessary to serve, and substantially related to, an important government purpose.

- 1 J. Any action taken by Defendant was narrowly tailored to serve a compelling
2 government interest.
- 3 K. Plaintiffs' claims may be barred for lack of standing.
- 4 L. Plaintiffs cannot satisfy the prerequisites for class certification and,
5 therefore, lack standing and cannot represent the interests of others.
- 6 M. Class certification may be inappropriate due to conflicts of interest between
7 Plaintiffs and purported class members, or between and among purported
8 class members.
- 9 N. Plaintiffs cannot satisfy the prerequisites under Federal Rule of Civil
10 Procedure 23 to certify this action as a class action.
- 11 O. Plaintiffs have failed to provide their medical records to support their
12 allegations regarding chest reconstruction surgery for Plaintiffs.
- 13 P. Plaintiff John Doe does not appear to have requested chest reconstruction
14 surgery from AHCCCS or any health plan and John Doe's allegations are
15 therefore premature.
- 16

17 Defendant has not knowingly or intentionally waived any applicable affirmative
18 defenses. Defendant reserves the right to amend her Answer to add such affirmative
19 defenses as may become available or apparent during this proceeding and discovery.

20 **WHEREFORE**, Defendant demands judgment against Plaintiffs as follows:

- 21 A. Dismissing the Complaint with prejudice;
- 22 B. For costs, disbursements and attorney fees; and
- 23 C. For such other relief as the Court deems just and equitable.
- 24
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1 RESPECTFULLY SUBMITTED this 28th day of September, 2020.

2
3 **BURNSBARTON PLC**

4
5 By /s/ Kathryn Hackett King

6 David T. Barton
7 Kathryn Hackett King

8 **JOHNSTON LAW OFFICES, P.L.C.**
9 Logan T. Johnston
10 14040 N. Cave Creek Rd., Suite 309
11 Phoenix, Arizona 85022

CERTIFICATE OF SERVICE

I hereby certify that on September 28, 2020 I electronically transmitted the foregoing document to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants.

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Counsel for Plaintiffs and the Class

UNITED STATES DISTRICT COURT
 DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No.

**EXPERT DECLARATION OF
 LOREN S. SCHECHTER, M.D.
 IN SUPPORT OF PLAINTIFFS'
 MOTION FOR PRELIMINARY
 INJUNCTION**

1 I, Loren S. Schechter, M.D., declare as follows:

2 1. My name is Loren S. Schechter, M.D. I am a board certified plastic surgeon.
3
4 I specialize in performing gender confirming surgeries (including chest reconstruction
5 surgeries, genital reconstruction surgeries, and other procedures to feminize or
6 masculinize the body, as described in more detail below),¹ and I am a recognized expert
7 in this field.
8

9 2. I have been retained by counsel for Plaintiffs in the above-captioned lawsuit
10 to provide an expert opinion on the standards of care for treating individuals diagnosed
11 with gender dysphoria. In particular, I have been asked whether: (1) male chest
12 reconstruction surgeries are a safe, effective, and medically accepted treatment for gender
13 dysphoria experienced by transgender individuals, including adolescents up to age 21; and
14 (2) a categorical exclusion on Medicaid coverage for gender confirming surgeries violates
15 the prevailing standards of care for treating transgender adolescents who have been
16 diagnosed with gender dysphoria. In addition, counsel for Plaintiffs have requested that I
17 evaluate whether chest reconstruction surgery would be a safe and effective treatment for
18 D.H. and John Doe.
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22 3. I have personal knowledge of the matters stated in this declaration.
23

24 ¹ I refer to this family of procedures as gender-confirmation or gender-affirming surgeries because they are one of
25 the therapeutic tools used to enable people to live in accordance with their gender identities. None of the myriad
26 other labels I've heard for these procedures—sex-reassignment surgery, gender-reassignment surgery, and sex-
27 change operation, to name a few—is as accurate when it comes to describing what is actually taking place. Most, if
28 not all, the other names used for these procedures suggest that a person is making a choice to switch genders, or that
there is a single “surgery” involved. From the hundreds of discussions I have had with patients over the years,
nothing could be further from the truth. This is not about choice; it’s about using one or more surgical procedures as
therapeutic tools to improve a patient’s functioning and enable people to live authentically.

Background and Qualifications

4. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae. A true and correct copy of my CV is attached as Exhibit A.

5. I received my medical degree from the University of Chicago, Pritzker School of Medicine. I completed my residency and chief residency in plastic and reconstructive surgery and a fellowship in reconstructive microsurgery at the University of Chicago Hospitals.

6. I am currently a Clinical Professor of Surgery at the University of Illinois at Chicago and an attending surgeon at Rush University Medical Center in Chicago. I also maintain a clinical practice in plastic surgery in Illinois where I treat patients from around the world.

7. I have been performing gender confirming surgeries for over 20 years. For the past four or five years, I have been performing approximately 150 gender confirming procedures every year. I have performed over 1,000 gender confirming surgeries during my medical career. Currently, approximately 90-95 percent of the patients in my clinical practice are transgender individuals seeking gender confirmation surgeries. Of my patients who are seeking gender confirmation surgeries, about 50 percent are transgender men, and about two-thirds of those individuals are seeking male chest reconstruction surgery. I perform gender confirming procedures on patients ranging from age 14 to age 75.

1 8. In 2014 there was a large increase in patients seeking gender-affirming
2 surgery as both Medicare and many private health plans removed their coverage
3 restrictions for those surgical treatments. I began to see more adolescent patients after
4 2014, and over the last three or four years, adolescent patients have become quite common.
5 At this time, approximately 15-20 percent of the top surgeries I perform for transgender
6 men are performed on patients under age 21. I have performed about 100-150 top surgeries
7 for patients under age 21 to date, and that number continues to grow. Currently, such
8 surgeries constitute a significant part of my practice.
9
10

11 9. I was a contributing author to the Seventh Version (current) of the World
12 Professional Association for Transgender Health's (WPATH) *Standards of Care for the*
13 *Health of Transsexual, Transgender, and Gender-Nonconforming People* (hereafter,
14 "WPATH SOC"). In particular, I wrote the section focused on the relationship of the
15 surgeon with the treating mental health professional and the physician prescribing
16 hormone therapy. WPATH is in the midst of drafting the eighth version of the WPATH
17 SOC. I am the co-lead on the surgical and postoperative care chapter in the eighth version.
18
19

20 10. The WPATH SOC provides clinical guidance for health professionals based
21 on the best available science and expert professional consensus. The purpose of the
22 WPATH SOC is to assist health providers in delivering medical care to transgender people
23 to provide them with safe and effective treatment for gender dysphoria, in order to
24 maximize their overall health, psychological well-being, and self-fulfillment.
25
26
27
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1 11. In addition, I have written a number of peer-reviewed journal articles and
2 chapters in professional textbooks about gender confirmation surgeries. In 2016, I
3 published *Surgical Management of the Transgender Patient*, the first surgical atlas (a
4 reference guide for surgeons on how to perform surgical procedures using safe, well-
5 established techniques) dedicated to gender confirming surgeries. I published a second
6 book, *Gender Confirmation Surgery, Principles and Techniques for an Emerging Field*,
7 earlier this year. A full and complete list of my publications is included in my CV.
8
9

10 12. I am a guest reviewer for several peer-reviewed medical journals, including
11 the *Journal of Plastic and Reconstructive Surgery*, the *Journal of Reconstructive*
12 *Microsurgery*, the *Journal of the American College of Plastic Surgeons*, the *Journal of*
13 *Plastic and Reconstructive Surgery*, *The Journal of Plastic and Aesthetic Research*, and
14 the *Journal of Sexual Medicine*. I also serve on the editorial board of both *Transgender*
15 *Health* and the *International Journal of Transgender Health*. Each of these publications
16 is a peer-reviewed medical journal. A full and complete list of my reviewerships and
17 editorial roles is included in my CV.
18
19

20 13. I am actively involved in training other surgeons to perform gender
21 confirming surgeries. In 2017, I started the surgical fellowship in gender surgery, now
22 placed at Rush University Medical Center in Chicago. I am also the Medical Director of
23 the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. In addition, I
24 am the site director for a fellowship in reconstructive urology and gender surgery at Weiss
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1 Memorial Hospital, under the auspices of the Department of Urology at the University of
2 Illinois at Chicago.

3 14. I have given dozens of public addresses, seminars, and lectures on gender
4 confirming surgery, including many through the American Society of Plastic Surgeons. I
5 have also taught a number of courses through WPATH's Global Education Initiative,
6 which provides training courses toward a member certification program in transgender
7 health for practitioners around the world. In addition, in 2018, I co-directed the first live
8 surgery course in gender confirming procedures at Mount Sinai Hospital in New York
9 City. Also, in 2018, I presented on "Gender Dysphoria Across Development:
10 Multidisciplinary Perspectives on the Evidence, Ethics, and Efficacy of Gender
11 Transition, Gender Confirming Care in Adolescence: Evidence, Timing, Options, and
12 Outcomes," at the American Academy of Child and Adolescent Psychiatry's 65th Annual
13 Meeting in Seattle. In 2019, I directed the inaugural Gender Affirming Breast, Chest, and
14 Body Master Class for the American Society of Plastic Surgeons. This Master Class
15 included a panel on surgeries for adolescents.

16 15. I am also a former member of the Board of Governors of the American
17 College of Surgeons and a current member of the Board of Directors of WPATH.

18 16. I am being compensated at an hourly rate of \$400/hour plus expenses for
19 my time spent preparing this declaration and providing local testimony (including
20 deposition or providing hearing testimony by telephone or video-teleconference). My
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1 compensation does not depend on the outcome of this litigation, the opinions I express, or
2 the testimony I may provide.

3 17. In the previous four years, I have given expert testimony by declaration on
4 behalf of the plaintiff in *Edmo v. Idaho Dept. of Corrs.* in the U.S. District Court for the
5 District of Idaho; for the plaintiffs in *Flack v. Wisconsin Dept. of Health Servs.* in the U.S.
6 District Court for the Western District of Wisconsin; for the plaintiff in *Bruce v. South*
7 *Dakota* in the U.S. District Court for the District of South Dakota; for the plaintiff in
8 *Fletcher v. State of Alaska* in the U.S. District Court for the District of Alaska; for the
9 plaintiff in *Lange v. Houston County Georgia* in the U.S. District Court for the Middle
10 District of Georgia; for the plaintiff in *Being v. Crum* in the U.S. District Court for the
11 District of Alaska; for the plaintiffs in *Boyden v. State of Wisconsin* in the U.S. District
12 Court for the Western District of Wisconsin; for the defendant in *Royin Herrin v. Crane*
13 in the Superior Court of California for the County of San Francisco; and for the plaintiff
14 in *Paige v. Maercks* in Florida Circuit Court. I do not remember giving expert testimony
15 at a trial or at a deposition in any other case in the last four years.

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20 **Basis for Opinions**

21 18. My opinions contained in this report are based on: (1) my clinical experience
22 as a surgeon performing gender confirming surgeries for patients, including adolescents
23 and young adults; (2) my knowledge of the peer-reviewed research, including my own,
24 regarding gender confirming surgeries, which reflects the clinical advancements in these
25 procedures and the corresponding growth in research related to their safety and
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effectiveness in treating gender dysphoria; (3) my work as a contributing author of the WPATH SOC; (4) my work as an author and teacher of surgical techniques used in gender confirming surgeries; (5) my review of the statements provided by Tamar Reed, Dr. Andrew Cronyn, and Dr. Mischa Cohen Peck, and medical records from the office of Dr. Veenod Chulani; and (6) my surgical consultations with D.H. and John Doe, which I performed virtually due to the coronavirus pandemic.

Discussion

Background on Gender Identity and Gender Dysphoria

19. Many transgender individuals experience gender dysphoria at some point in their lives. Gender dysphoria is defined as distress caused by a discrepancy between a person's gender identity and that person's primary and/or secondary sexual characteristics.

20. Gender dysphoria is a serious medical condition recognized by the International Classification of Diseases-10 (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) published by the American Psychiatric Association. Individuals diagnosed with gender dysphoria have an intense and persistent discomfort with the primary and/or secondary sex characteristics of the sex they were assigned at birth.

21. If untreated, gender dysphoria can lead to debilitating anxiety and depression, as well as serious incidents of self-harm, including self-mutilation, suicide attempts, and suicide.

22. Appropriate medical care, including mental health services, hormone therapy, and gender confirming surgeries, can help alleviate gender dysphoria. Gender confirming surgeries, which bring a person’s body into better alignment with their gender identity, have been shown to be an effective treatment for gender dysphoria.

Gender Confirming Surgeries are Standard, Medically Accepted Treatments for Gender Dysphoria and Are Medically Necessary for Many Transgender People

23. The World Professional Association for Transgender Health is a non-profit professional and educational organization devoted to transgender health. WPATH’s mission is “to promote evidence-based care, education, research, public policy, and respect in transgender health.” WPATH, Mission and Vision, <https://www.wpath.org/about/mission-and-vision>.

24. WPATH publishes *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The WPATH SOC are based on the best available scientific evidence and professional consensus of experts in the many disciplines involved in working with transgender patients.

25. WPATH published the first version of the standards of care in 1979. The guidelines have since been updated, the most current version being the seventh edition. These updates reflect the significant advances made in the understanding, management, and care of transgender individuals.

26. The WPATH SOC are widely recognized guidelines for the clinical management of transgender individuals with gender dysphoria and have been adopted by many major associations of healthcare professionals in the United States. Surgeons who

1 regularly treat individuals experiencing gender dysphoria, including myself, practice in
2 accordance with the WPATH SOC.

3 27. As indicated in the WPATH SOC, the only safe and effective treatment
4 options for gender dysphoria include psychotherapy, hormone therapy to feminize or
5 masculinize the body, and various surgical procedures to align a person's primary and/or
6 secondary sex characteristics with the person's gender identity. (SOC at 9-10).

7
8 28. Surgery is often the last and most considered of the treatment options.
9 Evidence shows that while some transgender individuals do not require surgery, "for many
10 others surgery is essential and medically necessary to alleviate their gender dysphoria. For
11 the latter group, relief from gender dysphoria cannot be achieved without modification of
12 their primary and/or secondary sex characteristics to establish greater congruence with
13 their gender identity." (SOC at 54-55).

14
15 29. Chest surgery to treat gender dysphoria is a medically necessary
16 reconstructive procedure. As discussed further below, some procedures to treat gender
17 dysphoria are similar to other reconstructive procedures performed for other diagnoses
18 (e.g., breast cancer). No particular surgery is inherently cosmetic or inherently
19 reconstructive; rather, the underlying diagnosis determines whether the procedure is
20 considered cosmetic or reconstructive. Because these medically necessary procedures
21 significantly alleviate gender dysphoria and ensure transgender individuals can live in a
22 manner more consistent with their gender identity, the professional medical consensus
23 recognizes that these are appropriately categorized as reconstructive procedures.
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1 30. The current version of the WPATH standards of care recognizes male chest
2 reconstruction surgery is medically necessary for many transgender young people under
3 eighteen. As with all medical care, the standards recommend that clinicians take a case-
4 by-case approach to evaluate whether and when the procedure is medically necessary for
5 a particular patient. (SOC at 21). Beyond those recommendations, the standards of care
6 have general criteria for initiation of surgical treatment. For individuals seeking male chest
7 reconstruction, the criteria are:
8

- 9
- 10 • The patient has the capacity to make fully informed decisions and to
11 consent for treatment;
 - 12 • If the patient has other significant medical or mental health concerns,
13 they are reasonably well-controlled prior to surgery; and
 - 14 • The patient has a referral from at least one mental health professional
15 documenting the patient’s necessity and preparedness for male chest
16 reconstruction surgery. (SOC at 59).
- 17

18

19 31. The Endocrine Society – the leading professional organization devoted to
20 research on hormones and the clinical practice of endocrinology – has also issued clinical
21 guidelines for the treatment of transgender individuals. Wylie C Hembree et al., *Endocrine*
22 *Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society*
23 *Clinical Practice Guideline*, 102 J. Clin. Endocrinology & Metabolism 3869 (2017). The
24 guidelines indicate that for many transgender individuals, gender confirming surgery is a
25 necessary and effective treatment. *Id.* The guidelines also specify that there is no specific
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1 age requirement for “breast surgery for transgender males,” but rather recommend that
2 clinicians “determine the timing of [such surgery] based upon the physical and mental
3 health status of the individual.” *Id.*

4
5 32. The broader medical community, including the American Medical
6 Association, American Academy of Pediatrics, and American College of Obstetricians
7 and Gynecologists, explicitly recognizes that gender confirming surgery is standard,
8 appropriate, and necessary treatment for many adolescents with gender dysphoria.
9

10 ***Chest Reconstruction Surgeries are Safe and Effective Treatment for Gender***
11 ***Dysphoria, Including for Many Adolescents and Young Adults***

12 33. The available peer-reviewed literature concludes that when performed in
13 accordance with the prevailing standards of care, male chest reconstruction surgery is safe
14 and effective in alleviating gender dysphoria, including in adolescents.
15

16 34. For example, a recent study in JAMA Pediatrics concluded that: “Chest
17 dysphoria was high among presurgical transmasculine youth, and surgical intervention
18 positively affected both minors and young adults.”² Another study found that transgender
19 men who received chest reconstruction experienced few clinical complications and were
20 overwhelmingly satisfied with their surgical outcomes; that study included patients ages
21 15 to 71.³ Yet another peer-reviewed study of transgender men ages 18 and older who
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25

26 ² Olson-Kennedy, J. et al., (2018). Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young
27 Adults, JAMA Pediatrics, 172(5), 431-436.

28 ³ Frederick, M. et al., (2017), Chest Surgery in Female to Male Transgender Individuals, Annals of Plastic Surgery,
78(3), 249-253.

1 received chest reconstruction found that the procedure improved psychosocial well-being
2 and physical well-being among participants.⁴

3 35. Prior to undergoing chest reconstruction, transgender men often use
4 constrictive materials to bind their chest. Binding can cause any number of health issues.
5 People may have difficulty maintaining a healthy body weight and body mass index when
6 they have a large amount of chest tissue. Binding may interfere with their breathing and,
7 as a result, their ability to exercise. Binding also stretches the skin and can cause rashes
8 and skin irritation. One of the many benefits of top surgery is that individuals no longer
9 need to engage in binding. Typically, the longer someone has been binding, the more
10 likely it is that male chest reconstruction surgery for that person will require longer
11 incisions and free nipple and areolar grafting techniques. This results in more visible
12 scarring and has a higher likelihood of permanent loss of nipple and areolar sensation.
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16 36. When performing gender confirming surgery, surgeons use many of the
17 same procedures that they use to treat other medical conditions. For example, surgeons
18 regularly perform mastectomies and chest/breast reconstruction to treat individuals with
19 cancer, or a genetic predisposition to cancer (BRCA 1, 2 genes in the case of prophylactic
20 mastectomy).
21
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24

25 ⁴ Agarwal, C. et al., (2018). Quality of life improvement after chest wall masculinization in female-to-male
26 transgender patients: A prospective study using the BREAST-Q and Body Uneasiness Test, 71, 651-657. *See also*
27 Van de Grift, T., et al., (2017). Surgical Indications and Outcomes of Mastectomy in Transmen: A Prospective
28 Study of Technical and Self-Reported Measures. *Plastic and Reconstructive Surgery*, 140(3), 415e-424e.
doi:10.1097/PRS.0000000000003607 (similar findings); Berry, M.G. et al., (2012). Female-to-male transgender
chest reconstruction: A large consecutive, single-surgeon experience. *Journal of Plastic, Reconstructive & Aesthetic*
Surgery 65, 711-719 (same).

1 37. When billing insurers for reimbursement, health care providers use Current
2 Procedural Terminology (CPT) codes, which are developed and maintained by the
3 American Medical Association. The same code or codes may apply to a particular
4 procedure regardless of whether the procedure is performed on a transgender patient or a
5 nontransgender patient. For example, a subcutaneous mastectomy may be performed for
6 a nontransgender woman to reduce her risk of breast cancer or for a transgender man with
7 gender dysphoria. The same CPT code is used for both procedures.
8
9

10 ***Clinical Evaluations of Plaintiffs D.H. and John Doe***

11 38. When a patient is referred to me for male chest reconstruction surgery, my
12 role is to assess whether the procedure will be safe and effective for the patient, review
13 the risk, benefits, and options, determine which surgical techniques are appropriate for the
14 patient based on their body habitus and goals/expectations, and obtain their informed
15 consent (or assent) for surgery. In accordance with the WPATH guidelines (and general
16 principles of surgical care), I discuss with the patient: the different surgical techniques
17 available; the advantages and disadvantages of each technique; the limitations of a
18 procedure to achieve “ideal” results; and the inherent risks and possible complications of
19 the various techniques. (SOC at 56).
20
21
22

23 39. My general practice is to conduct surgical consultations in my office.
24 However, due to the coronavirus pandemic, I performed virtual consultations with D.H.
25 and with John Doe. On April 1, 2020, I had an initial phone consultation with D.H. and
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28

1 his mother. On that same day, I had an initial phone consultation with John Doe and his
2 grandmother. At that time, my office was not equipped for video appointments.

3 40. Each phone consultation took approximately 45 minutes and proceeded as
4 follows: My medical assistant gathered basic in-take information. A physician assistant in
5 my office then obtained a detailed medical history. I reviewed the medical history with
6 the patients and their guardians and discussed the surgical options with the patient and
7 their guardian.
8

9
10 41. I later performed a second consultation with each of the Plaintiffs over
11 video. Those consultations each took approximately 15-30 minutes. On May 27, 2020, I
12 conducted a video consultation with D.H. and his mother. On June 1, 2020, I conducted a
13 video consultation with John Doe and his grandmother. The purpose of each consultation
14 was to examine the patient's chest to determine which precise surgical approach to
15 recommend.
16

17
18 42. After I met with D.H. and with John Doe, counsel for the Plaintiffs sent me
19 declarations provided by D.H.'s and John Doe's treating providers. With respect to D.H.,
20 I reviewed statements provided by Tamar Reed and Dr. Andrew Cronyn. With respect to
21 John Doe, I reviewed medical records from the office of Dr. Veenod Chulani and a
22 statement by Dr. Mischa Cohen Peck.
23

24 43. Based on my discussions with D.H. and his mother, my virtual examination
25 of his chest, and my review of the declarations provided by his treating providers, D.H.
26 appears to be a good candidate for male chest reconstruction surgery. I did not find any
27
28

1 evidence of mental health or medical conditions that would complicate the surgery or
2 D.H.'s recovery from the procedure. I am confident that D.H. is fully aware of the risks
3 and benefits associated with the procedure, and is prepared to take the steps necessary to
4 recover after surgery.
5

6 44. Based on my discussions with John Doe and his mother, my virtual
7 examination of his chest, and my review of the declarations provided by his treating
8 providers, John Doe appears to be a good candidate for male chest reconstruction surgery.
9 I did not find any evidence of mental health or medical conditions that would complicate
10 the surgery or John Doe's recovery from the procedure. I am confident that John Doe is
11 fully aware of the risks and benefits associated with the procedure, and is prepared to take
12 the steps necessary to recover after surgery.
13
14

15 45. To make a final assessment of D.H.'s and John Doe's suitability for surgery,
16 I would need to perform an in-person exam to rule out any pathology (*i.e.*, masses, lumps,
17 nipple retraction, all of which would be highly unusual for an adolescent) and to assess
18 skin elasticity. At that time, I would also confirm the specific operative approach with
19 D.H. and with John Doe, respectively. Currently, due to the pandemic, a negative COVID-
20 19 test is also required before surgery.
21
22

23 Conclusions

24 46. It is my professional opinion, consistent with the prevailing standards of
25 care, that male chest reconstruction surgery is safe, effective, and medically necessary for
26 many individuals with gender dysphoria, including adolescents.
27
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1 47. In my experience, the overwhelming number of individuals who undergo
2 gender confirming procedures, including male chest reconstruction surgery, describe a
3 reduction in or relief from their gender dysphoria and improvement in their quality of life
4 and overall functioning. Based on my experience and review of the literature, it is my
5 professional opinion that the denial of necessary medical care is likely to perpetuate
6 gender dysphoria and create or exacerbate other medical issues, such as depression and
7 anxiety, leading to an increased possibility of self-harm, negative health outcomes, and
8 even suicide.
9
10

11 48. In my professional opinion, the Arizona regulation prohibiting Medicaid
12 coverage of gender confirming surgery is not consistent with the prevailing standards of
13 care for treating transgender individuals diagnosed with gender dysphoria, nor is it
14 consistent with the peer-reviewed scientific and medical research demonstrating that male
15 chest reconstruction surgery is a safe, effective, and essential treatment for gender
16 dysphoria. To the extent the Arizona regulation is premised on the assumption that gender
17 confirming surgical care is never medically necessary, that assumption is wrong. The
18 standards of care confirm, based on clinical evidence, that gender confirmation surgeries
19 are medically necessary to help people alleviate an often lifelong struggle to find peace of
20 mind and lasting comfort with their bodies.
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24 49. Based on my clinical assessment of D.H. and John Doe, it is my professional
25 opinion that male chest reconstruction surgery is a safe, effective, and medically necessary
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1 treatment for each of them, assuming the absence of any pathology. I anticipate that male
2 chest reconstruction would alleviate both D.H.'s and John Doe's gender dysphoria.

3 I declare under penalty of perjury under the laws of the United States that the
4 foregoing is true and correct.
5

6 Executed this 3rd day of August, 2020 at Chicago, Illinois.

7
8
9 
Loren S. Schechter, M.D.

Exhibit A

Curriculum Vitae

NAME: LOREN SLONE SCHECHTER, MD, FACS

OFFICE: 9000 Waukegan Rd.
Suite 210
Morton Grove, IL 60053
Tel: 847.967.5122
Fax: 847.967.5125

E-MAIL: lss@univplastics.com

WEB SITE: www.univplastics.com
www.plasticsurgery.org/md/DRLOREN.htm

BIRTHDATE: August 14, 1968

BIRTHPLACE: Galveston, Texas

MARITAL STATUS: Married

SPOUSE: Rebecca Brown Schechter, MD

CHILDREN: Owen Slone Schechter

Miles Slone Schechter

CERTIFICATION: The American Board of Plastic Surgery 2001
Certificate Number 6271
Date Issued: September 2001
Maintenance of Certification: 2011

EDUCATION:

1986-1990	The University of Michigan	BS, 1990
1990-1994	The University of Chicago Pritzker School of Medicine	MD, 1994

POSTGRADUATE TRAINING:

Residency:	The University of Chicago Hospitals Coordinated Training Program in Plastic and Reconstructive Surgery	1994-1999
Chief Resident:	The University of Chicago Hospitals Section of Plastic and Reconstructive Surgery	1998-1999
Fellowship:	Reconstructive Microsurgery The University of Chicago Hospitals Section of Plastic and Reconstructive Surgery	1999-2000

TEACHING APPOINTMENT:

Clinical Professor of Surgery, The University of
Illinois at Chicago

Adjunct Assistant Professor, Dept. of Surgery,
Rush University Medical Center

Associate Professor, Physician Assistant Program,
College of Health Professionals, Rosalind
Franklin University

LICENSURE:

Illinois
Illinois Controlled Substance
DEA

STAFF APPOINTMENTS:

University of Illinois at Chicago Hospital
Rush University Medical Center
Advocate Lutheran General Hospital
Louis A. Weiss Memorial Hospital
Illinois Sports Medicine and Orthopedic Surgery Center

HONORS AND AWARDS:

2020	The University of Minnesota Program in Human Sexuality, recipient of 50 Distinguished Sexual and Gender Health Revolutionaries
2017-2020	Castle Connolly Top Doctor (Chicago)
2017	Chicago Consumer Checkbook Top Doctor
2015	University of Minnesota Program in Human Sexuality Leadership Council
2014-2015	Rosalind Franklin University of Medicine and Science Chicago Medical School Honors and recognizes for dedication and commitment to teaching
2014	National Center for Lesbian Rights honored guest
2013	Illinois State Bar Association Award for Community Leadership
2010	Advocate Lutheran General 2009 Physicians Philanthropy Leadership Committee-Outstanding Leadership
2009	Advocate Lutheran General Hospital Value Leader (received for compassion)
1994	Doctor of Medicine with Honors
1994	University of Chicago Department of Surgery Award for Outstanding Performance in the Field of Surgery
1994	Catherine Dobson Prize for the Best Oral Presentation Given at the 48 th Annual Senior Scientific Session in The Area of Clinical Investigation
1993	Alpha Omega Alpha
1991	University of Chicago National Institutes Of Health Summer Research Award
1990	Bachelor of Science with High Distinction

And Honors in Economics
 1990 James B. Angell Award for Academic Distinction
 1989 Omicron Delta Epsilon-National Economic Honor
 Society
 1988 College Honors Program Sophomore Honors Award
 For Academic Distinction
 1988 Class Honors (Dean's List)

MEMBERSHIPS:

2018- The American Association of Plastic Surgeons
 2016- The American Society for Gender Surgeons
 (founding member and president-elect)
 2010- World Society for Reconstructive Microsurgery
 2005- The University of Chicago Plastic Surgery Alumni
 Association
 2005- The Chicago Surgical Society
 2004- The American Society for Reconstructive
 Microsurgery
 2003- The American College of Surgeons
 2002- The American Society of Plastic Surgeons
 2001- Illinois Society of Plastic Surgeons (formerly,
 Chicago Society of Plastic Surgeons)
 2001- The American Society of Maxillofacial Surgeons
 2001- American Burn Association
 2001- Midwest Association of Plastic Surgeons
 2001- WPATH
 1994- The University of Chicago Surgical Society
 1994- The University of Chicago Alumni Association
 1992- American Medical Association
 1992- Illinois State Medical Society
 1992- Chicago Medical Society
 1990- The University of Michigan Alumni Association

CURRENT HOSPITAL COMMITTEES:

Director, Center for Gender Confirmation Surgery,
 Louis A. Weiss Memorial Hospital

PROFESSIONAL SOCIETY COMMITTEES:

American Society of Breast Surgeons Research
 Committee, ASPS representative

 American Board of Plastic Surgery, Guest Oral
 Board Examiner

 WPATH Ethics Committee

 American College of Radiology Committee on
 Appropriateness Criteria Transgender Breast
 Imaging Topic

American Society of Plastic Surgeons, Finance and Investment Committee

Board of Directors, at-large, The World Professional Association for Transgender Health

PlastyPac, Board of Governors

Medicare Carrier Advisory Committee

OTHER:

Guest Reviewer, Plastic and Aesthetic Research

Guest Reviewer, European Medical Journal

Guest Reviewer, Open Forum Infectious Diseases

Guest Reviewer, The Journal of The American College of Surgeons

Guest Book Reviewer, Plastic and Reconstructive Surgery

Editorial Board, Transgender Health

Editorial Board (Associate Editor), International Journal of Transgenderism

Fellow of the Maliniac Circle

Guest Reviewer, Journal of Reconstructive Microsurgery

Guest Reviewer, Journal of Plastic and Reconstructive Surgery

Guest Reviewer, Journal of Sexual Medicine

Guest Editor, Clinics in Plastic Surgery, Transgender Surgery (Elsevier Publishing)

Guest Reviewer, The Journal of Plastic and Reconstructive Surgery

PREVIOUS EDITORIAL ROLE:

Guest Reviewer, EPlasty, online Journal

Module Editor for Patient Safety, Plastic Surgery Hyperguide

Editorial Advisory Board, Plastic Surgery Practice

Guest Reviewer, International Journal of Transgenderism

Guest Reviewer, Pediatrics

PREVIOUS ACADEMIC APPOINTMENT:

Visiting Clinical Professor in Surgery, The University of Illinois at Chicago

Chief, Division of Plastic and Reconstructive Surgery, Chicago Medical School, Rosalind Franklin University of Medicine and Science

Associate Professor of Surgery, The College of Health Professionals, Rosalind Franklin University

Clinical Associate in Surgery, The University of Chicago

PREVIOUS HOSPITAL COMMITTEES:

Division Director, Plastic Surgery, Lutheran General Hospital

Division Director, Plastic Surgery, St. Francis Hospital

Medical Staff Executive Committee, Secretary, Advocate Lutheran General Hospital

Credentials Committee, Lutheran General Hospital

Pharmacy and Therapeutics Committee Lutheran General Hospital

Operating Room Committee, St. Francis Hospital

Cancer Committee, Lutheran General Hospital
-Director of Quality Control

Risk and Safety Assessment Committee, Lutheran General Hospital

Nominating Committee, Rush North Shore Medical Center

Surgical Advisory Committee, Rush North Shore Medical Center

Section Director, Plastic Surgery, Rush North Shore Medical Center

PREVIOUS SOCIETY COMMITTEES:

PlastyPac, Chair, Board of Governors

Chair of the Metro Chicago District #2 Committee on Applicants, American College of Surgeons

American Society of Plastic Surgery, Health Policy Committee

American Society of Plastic Surgery, Patient Safety Committee

American Society of Plastic Surgeons, Coding and Payment Policy Committee

American Society of Plastic Surgeons, Practice Management Education Committee

Board of Governors, Governor-at-large, The American College of Surgeons

American College of Surgeons, International Relations Committee

Chair, Government Affairs Committee, American Society of Plastic Surgeons

President, The Metropolitan Chicago Chapter of The American College of Surgeons

2012 Nominating Committee, American Society of Plastic Surgeons

Program Committee, The World Society for Reconstructive Microsurgery, 2013 Bi-Annual Meeting

President, Illinois Society of Plastic Surgeons

Vice-President, The Illinois Society of Plastic Surgeons (formerly the Chicago Society of Plastic Surgery)

Vice-President, The Metropolitan Chapter of the American College of Surgeons

American Society of Plastic Surgery, Chairman, Patient Safety Committee

2006-2007 Pathways to Leadership, The American Society of Plastic Surgery

2005 & 2006 President, The University of Chicago Plastic Surgery Alumni Association

2003 Leadership Tomorrow Program, The American Society of Plastic Surgery

Senior Residents Mentoring Program, The American Society of Plastic Surgery

American Society of Maxillofacial Surgery, Education Committee

Alternate Councilor, Chicago Medical Society

American Society of Aesthetic Plastic Surgery, Electronic Communications Committee

American Society of Aesthetic Plastic Surgery, Intranet Steering Committee

American Society of Aesthetic Plastic Surgery, International Committee

Membership Coordinator, The Chicago Society of Plastic Surgeons

The Illinois State Medical Society, Governmental Affairs Council

The Illinois State Medical Society, Council on Economics

Chicago Medical Society, Physician Review Committee

-Subcommittee on Fee Mediation

Chairman, Chicago Medical Society, Healthcare Economics Committee

Secretary/Treasurer, The Metropolitan Chicago Chapter of the American College of Surgeons

Scientific Committee, 2007 XX Biennial Symposium
WPATH

Local Organizing Committee 2007 WPATH

Secretary, The Chicago Society of Plastic
Surgeons

Treasurer, The Chicago Society of Plastic
Surgeons

Council Member, The Metropolitan Chicago Chapter
of the American College of Surgeons

INTERNATIONAL MEDICAL SERVICE:

Northwest Medical Teams

Manos de Ayuda (Oaxaca, Mexico)

Hospital de Los Ninos (San Juan, Puerto Rico)

COMMUNITY SERVICE:

The University of Minnesota Presidents Club
Chancellors Society

Board of Directors, Chicago Plastic Surgery
Research Foundation

National Center for Gender Spectrum Health
Advisory Council

PREVIOUS COMMUNITY SERVICE:

Board of Directors, Committee on Jewish Genetic
Diseases, Jewish United Fund, Chicago, Illinois

Governing Council, Lutheran General Hospital,
Park Ridge, Il

Lutheran General Hospital Development Council,
Park Ridge, Il

Lutheran General Hospital Men's Association, Park
Ridge, Il

Advisory Board, Committee on Jewish Genetic
Diseases, Cancer Genetics Subcommittee, Jewish
United Fund, Chicago, Illinois

Health Care Advisory Board, Congressman Mark
Kirk, 10th Congressional District, Illinois

Major Gifts Committee, Saint Francis Hospital
Development Council, Evanston, Il

Visiting Professor:

1. University of Utah, Division of Plastic Surgery, November 6-8, 2014.
2. Northwestern University, Division of Plastic Surgery, April 21-22, 2016.
3. The University of North Carolina, Division of Plastic Surgery, March 28-29, 2017
4. Georgetown University, Department of Plastic Surgery, May 17-18, 2017
5. The University of Basel, Basel, Switzerland, August 31-September 1, 2018
6. The Ochsner Health System, New Orleans, LA January 28-January 30, 2019
7. The University of Toronto, Toronto, Ontario, Canada, February 21-22, 2019
8. The University of Michigan, October 3-4, 2019, Ann Arbor, MI,

Invited Discussant:

1. Department of Defense, Military service by people who are transgender, Invitation from Terry Adirim, M.D., M.P.H. Deputy Assistant Secretary of Defense for Health Services Policy & Oversight, The Pentagon, November 9, 2017
2. Aesthetic Surgery Journal, Invited Discussant May 7, 2019, Journal Club. "What is "Nonbinary" and What Do I need to Know? A Primer for Surgeons Providing Chest Surgery for Transgender Patients."

Research Interests:

1. Role of Omental Stem Cells in Wound Healing (Grant: Tawani Foundation)
2. Robotic-Assisted Bilateral Prophylactic Nipple Sparing Mastectomy with Immediate Tissue Expander/Implant Reconstruction (Pending submission to the FDA for Investigational Device Exemption in association with Intuitive Surgical)

3. Transgender Health and Medicine Research Conference, National Institutes of Health, Bethesda, MD May 7-8, 2015

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3. Robert F. Lohman, **Loren S. Schechter**, Lawrence S. Zachary, Solomon Aronson: Evaluation of Changes in Skeletal Muscle Blood Flow in the Dog with Contrast Ultrasonography Revisited: Has the Technique Been Useful, and Where are We Headed Now? *The Journal of Plastic and Reconstructive Surgery* 111(4):1477-1480, 2003.
4. Alvin B. Cohn, Eric Odessey, Francis Casper, **Loren S. Schechter**: Hereditary Gingival Fibromatosis: Aggressive Two-Stage Surgical Resection in Lieu of Traditional Therapy, *The Annals of Plastic Surgery* Vol 57, Number 5, November 2006.
5. Eric Odessey, Al Cohn, Kenneth Beaman, and **Loren Schechter**: Mucormycosis of the Maxillary Sinus: Extensive Destruction with an Indolent Presentation, *Surgical Infections*, Vol. 9, Number 1, 2008
6. Iris A. Seitz, MD, David Tojo, MD, **Loren S. Schechter**, MD Anatomy of a Medication Error: Inadvertent Intranasal Injection of Neosynephrine During Nasal Surgery - A Case Report and Review of The Literature *Plast Reconstr Surg*. 2010 Mar;125(3):113e-4e. doi: 10.1097/PRS.0b013e3181cb68f9
7. Iris Seitz, MD Craig Williams, MD, Thomas Weidrich, MD, John Seiler, MD, Ginard Henry, MD, and **Loren S. Schechter, MD**: Omental Free Tissue Transfer for Coverage of Complex Upper Extremity Defects: The Forgotten Flap (N Y). 2009 Dec;4(4):397-405. doi: 10.1007/s11552-009-9187-6. Epub 2009 Mar 25.
8. Michael Salvino and **Loren S. Schechter**: Microvascular Reconstruction of Iatrogenic Femoral Artery Thrombus in an Infant: A Case Report and Review of the Literature *ePlasty* Volume 9 ISSN: 19357-5719, E-location ID: e20
9. Phillip C. Haeck, MD, Jennifer A. Swanson, BS, Med, Ronald E. Iverson, MD., **Loren S. Schechter, MD**, Robert Singer, MD, Bob Basu,

MD, MPH, Lynn A. Damitz, MD, Scott Bradley Bradley Glasberg, MD, Lawrence S. Glasman, MD, Michael F. McGuire, MD, and the ASPS Patient Safety Committee: Evidence-Based Patient Safety Advisory: Patient Selection and Procedures in Ambulatory Surgery, Supplement to Plastic and Reconstructive Surgery, Volume 124, Number 4s, October Supplement 2009.

10. Philip C. Haeck, MD, Jennifer A. Swanson, BS, Med, **Loren S. Schechter, MD**, Elizabeth J. Hall-Findlay, MD, Noel B. McDevitt, MD, Gary Smotrich, MD, Neal R. Reisman, MD, JD, Scot Bradley Glasberg, MD, and the ASPS Patient Safety Committee: Evidence-Based Patient Safety Advisory: Blood Dyscrasias, Patient Selection and Procedures in Ambulatory Surgery, Supplement to Plastic and Reconstructive Surgery, Volume 124, Number 4s, October Supplement 2009.

11. **Loren S. Schechter, MD**, The Surgeon's Relationship with The Physician Prescribing Hormones and the Mental Health Professional: Review for Version 7 of the World Professional Association of Transgender Health's Standards of Care *International Journal of Transgenderism* 11 (4), p.222-225 Oct-Dec 2009

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14. Iris A. Seitz, Sally Friedwald, MD; Jonathon Rimler, **Loren S. Schechter**, Breast MRI to Define The Blood Supply to The Nipple-Areolar Complex. *Plast Recon Surg Suppl* 126 (26) p. 27 Oct 2010

15. Kalliainen LK; ASPS Health Policy Committee Evidence-Based Clinical Practice Guidelines: Reduction Mammoplasty, The American Society of Plastic Surgeons *Plast Reconstr Surg*. 2012 Oct;130(4):785-9 **Loren S. Schechter** (member and contributor, ASPS Health Policy Committee)

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International Journal of Transgenderism, 13 (4) p. 165-232, August 2012.

17. Jonathan Bank, M.D., Lucio A. Pavone, M.D., Iris A. Seitz, M.D., Ph.D., Michelle C. Roughton M.D., **Loren S. Schechter M.D.** Case Report and Review of the Literature - Deep Inferior Epigastric Perforator Flap for Breast Reconstruction after Abdominal Recontouring, eplasty Ref.: Ms. No. EPLASTY-D-12-00050R1

18. Seitz IA, Siwinski P, Rioux-Forker D, Pavone L, **Schechter LS** Upper and Lower Limb Salvage with Omental Free Flaps: A Long-Term Functional Outcome Analysis, *Plast Reconstr Surg*. 2014; 134 (4 Suppl 1): 140. Doi:10.1097/01.prs.0000455514.83516.31. No abstract available. PMID: 25254872 [PubMed - in process]

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43. Ara A. Salibian, MD; **Loren S. Schechter, MD**, FACS; William M. Kuzon, MD; Mark-Bram Bouman, MD, PhD; Lee C. Zhao, MD; Rachel Bluebond-Langner, MD "Vaginal Canal Reconstruction in Penile Inversion Vaginoplasty with Flaps, Peritoneum or Skin Grafts: Where Is The Evidence," The Journal of Plastic and Reconstructive Surgery (submitted for publication)

44. Devin Coon, MD MSE, Rachel Bluebond-Langner, MD, Pierre Brassard, MD, William Kuzon, MD, Stan Monstrey, MD, **Loren S. Schechter, MD**, "The State of the Art in Vaginoplasty: A Comparison of Algorithms, Surgical Techniques and Management Practices Across Six High-Volume Centers," The Journal of Plastic and Reconstructive Surgery (in preparation)

45. Rayisa Hontscharuk, Brandon Alba, Devin Coon, Elyse Pine, Catherine Manno, Madeline Deutsch, **Loren Schechter**, Perioperative Transgender Hormone Management: Avoiding VTE and other

Complications, The Journal of Plastic and Reconstructive Surgery (in preparation)

46. **Loren S. Schechter** and Rayisa Hontscharuk, Invited Commentary, Phantom Penis: Extrapolating Neuroscience and Employing Imagination for Trans Male Embodiment, Studies in Gender and Sexuality (in preparation)

47. Omer Acar, Ervin Kocjancic, Susan Talamini, and **Loren Schechter**' Masculinizing Genital Gender Affirming Surgery: Metoidioplasty and Urethral Lengthening, Int J Impot Res. 2020 Mar 19. doi: 10.1038/s41443-020-0259-z. [Epub ahead of print] Review.PMID: 32203431

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51. Alireza Hamidian Jahromi, **Loren Schechter**, Commentary on: Telemedicine in Transgender Care: A Twenty First-Century Beckoning, accepted for publication, Journal of Plastic and Reconstructive Surgery

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3. **Schechter LS:** Mission Accomplished: Achieving a Successful Microsurgical Reconstruction of the Head and Neck. *Plastic Surgery Products*, March 2004
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5. **Loren S. Schechter, MD:** On Guard for DVT. *Plastic Surgery Products*, June 2007.
6. **Loren S. Schechter, MD** and Iris Seitz, MD, PhD: Mission: Possible Achieving a Successful Microsurgical Reconstruction of the Head and Neck, *Plastic Surgery Practice*, May 2009.
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8. Lucio A. Pavone, MD, Iris A. Seitz, MD, PhD, **Loren S. Schechter, MD:** Current Options in Autologous Breast Reconstruction, *Plastic Surgery Practice*, November, 2010.
9. Lucio A. Pavone, MD, Iris A. Seitz, MD, Michelle C. Roughton, MD, Daniel Z. Liu, **Loren S. Schechter, MD:** Options in Breast Reconstruction, *Chicago Medicine*, June 2013.

Textbooks and Book Chapters:

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2. **Loren S. Schechter,** Surgery for Gender Identity Disorder, *Plastic Surgery*, Fourth Edition, ed. Neligan, 2013, Elsevier, Vol. Four, Volume Editor (Submitted for publication): David H. Song
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4. **Loren S. Schechter,** Surgical Management of the Transgender Patient (Elsevier, 2016)
5. **Loren S. Schechter** and Rebecca B. Schechter, Pursuing Gender Transition Surgeries, *Adult Transgender Care An Interdisciplinary Approach for Training Mental Health Professionals*, First Edition, published 2018, Taylor and Francis, edited by Michael Kauth and Jillian Shipherd

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7. **Loren S. Schechter** (editor), Gender Confirmation Surgery-Principles and Techniques for an Emerging Field, Springer-Verlag, 2020
8. **Loren S. Schechter**, Bauback Safa, (editors), Gender Confirmation Surgery, Clinics in Plastic Surgery 45:3, Elsevier, July 2018
9. **Loren S. Schechter** and Paul Weiss, Transgender Breast Surgery, Cosmetic Breast Surgery, (In publication, Thieme)
10. **Loren S. Schechter**, Rebecca B. Schechteer, Surgical Effects of GnRHa Treatment, Pubertal Suppression in Transgender Youth, Elsevier, 2019
11. **Loren S. Schechter**, Surgical Anatomy: Phalloplasty, in Urological Care for the Transgender Patient: A Comprehensive guide (in preparation, Springer Nature)
12. **Loren S. Schechter** and Alexander Facque, Transgender Surgery-Feminization and Masculinization, Tips and Tricks in Plastic Surgery, edited by Seth R. Thaller and Zubin Panthaki, (Springer Nature, Submitted for publication)
13. **Loren S. Schechter** and Alexander Facque, Aesthetic Breast Surgery in Transgender Patients: Male to Female, Spear's Surgery of the Breast: Principles and Art, 4e by Allen Gabriel, Wolters Kluwer (in publication)
14. **Loren S. Schechter** and Alexander Facque, Navigating Problems with Transgender Top Surgery, Managing Common and Uncommon Complication of Aesthetic Breast Surgery, edited by Dr. John Y.S. Kim, Springer Nature
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ABSTRACTS:

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21. Iris A. Seitz, MD, PhD, Craig Williams, MD, Daniel Resnick, MD, Manoj Shah, MD, **Loren Schechter, MD, FACS**, Achieving Soft Tissue Coverage of Complex Upper and Lower Extremity Defects with Omental Free Tissue Transfer, Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, p. 28
22. Iris A. Seitz, MD, PhD, Craig Williams, MD, **Loren Schechter, MD, FACS**, Facilitating Harvest of the Serratus Fascial Flap with Ultrasonic Dissection, Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, p. 29
23. Michelle Roughton, MD, **Loren Schechter, MD, FACS**, Patient Safety: Abdominoplasty and Intra-Abdominal Procedures, Advocate Research Forum, Research and Case Report Presentation Abstracts, Advocate Lutheran General Hospital, May 5, 2010, p. 20
24. Iris A. Seitz, MD, PhD., Sarah M. Friedewald, MD, Jonathon Rimler, BS, **Loren S. Schechter, MD, FACS**, Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, Abstract, P. 44.
25. Loren S. Schechter, MD, FACS, Gender Confirmation Surgery in the Male-to-Female Individual: A Single Surgeon's Fourteen Year Experience, Annals of Plastic Surgery, Vol. 74, Suppl. 3, June 2015, p. s187.
26. 25th WPATH Symposium, Surgeons Only, November 1, 2018, Buenos Aires, Argentina, A Novel Approach for Neovagina Configuration During Vaginoplasty for Gender Confirmation Surgery
27. 25th WPATH Symposium, Surgeons Only, November 1, 2018, Buenos Aires, Argentina, IPP Implantation Post-Phalloplasty: The Chicago Experience
28. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, The Role of Pelvic Floor Physical Terhapy in Patients Undergoing Gender Confirming Vaginoplasty Procedures
29. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Establishing Guidelines for VTE Prophylaxis in Gender Confirmation Surgery
30. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Gender Surgeons Experience with Detransition and Regret

PRESENTATIONS:

1. Student Summer Research Poster Forum-The University of Chicago, Jan. 21, 1992: "A Comparison of Dynamic Energy Expenditure Versus Resting Energy Expenditure in Burn Patients Using The Doubly Labeled Water Method"
2. American Association for the Surgery of Trauma, Sept. 17-19, 1992, Louisville, KY: "Routine HIV Testing in A Burn Center: A Five Year Experience"
3. American Burn Association Poster Session, April 20-23, 1994, Orlando, Fl: "Calculated Versus Measured Energy Requirements in Adult Burn Patients"
4. 48th Annual Senior Scientific Session: The University of Chicago, May 19, 1994: "Calculated Versus Measured Energy Requirements in Adult Burn Patients"
5. Plastic Surgery Senior Residents Conference, April 20-25, 1999, Galveston, TX: "Plication of the Orbital Septum in Lower Eyelid Blepharoplasty"
6. The Chicago Society of Plastic Surgery, May 6, 1999, "Plication of the Orbital Septum in Lower Eyelid Blepharoplasty"
7. The American Society for Aesthetic Plastic Surgery, May 14-19, 1999, Dallas, TX: "Plication of the Orbital Septum in Lower Eyelid Blepharoplasty"
8. XIII Congress of the International Confederation for Plastic, Reconstructive, and Aesthetic Surgery, June 27-July 2, 1999, San Francisco, CA: "Craniofacial Osseo-Distraction: A Bridge to Eucephaly"
9. XIII Congress of the International Confederation for Plastic, Reconstructive, and Aesthetic Surgery, June 27-July 2, 1999 San Francisco, CA: "Ethnic Aesthetic Analysis and Surgery"
10. Inaugural Congress of the World Society for Reconstructive Microsurgery, October 31-November 3, 2001, Taipei, Taiwan: "Comparing Sural Neurocutaneous and Free Flaps for Reconstruction of Leg Wounds: Indications and Outcomes"
11. American Society for Reconstructive Microsurgery, January 12-15, 2002, Cancun, Mexico: "The Role to Free Tissue Transfer and Sural Neurocutaneous flaps for Reconstruction of Leg Wounds"
12. American Society of Plastic Surgery, 71st Annual Scientific Meeting, November 2-6, 2002, San Antonio, Texas: "Defining the Role

for Negative Pressure Therapy in the Treatment Algorithm of Extremity Wounds"

13. American Society of Reconstructive Microsurgery, Annual Scientific Meeting, January 11-15, 2003, Kauai, Hawaii: "Advances in Pediatric Liver Transplantation: Continuous Monitoring of Portal Venous and Hepatic Artery Flow With an Implantable Doppler Probe"

14. The 5th Annual Chicago Trauma Symposium, August 8-10, 2003, Chicago, Illinois: "Soft Tissue Salvage: Where Are We in 2003?"

15. The Midwestern Association of Plastic Surgeons, 42nd Annual Meeting, Chicago, Il May 1-2, 2004: "The Gastrocnemius-Achilles Tendon Myocutaneous Flap (GAT Flap) for Single Stage Reconstruction of Combined Soft Tissue and Extensor Mechanism Defects of the Knee: An Eighteen Year Experience"

16. The 6th Annual Chicago Trauma Symposium, August 12-15, 2004, Chicago, Il "Complex Wound Management"

17. The American Society of Plastic Surgery, October 9-13, 2004, Philadelphia, Pennsylvania: "The Gastrocnemius-Achilles Tendon Myocutaneous Flap (GAT Flap) for Single Stage Reconstruction of Combined Soft Tissue and Extensor Mechanism Defects of the Knee: An Eighteen Year Experience"

18. The American Society for Reconstructive Microsurgery, January 15-18, 2005, Fajardo, Puerto Rico: "Surviving as a Plastic Surgeon"

19. American Hernia Society, Poster Presentation, February 9-12, 2005, San Diego, California: "When Component Separation Isn't Enough"

20. The Midwestern Association of Plastic Surgeons, April 23-24, Chicago, Il: "Hereditary Gingival Fibromatosis in Monozygotic Twins: First Reported Case"

21. The Midwestern Association of Plastic Surgeons, April 23-24, Chicago, Il: "Modified Components Separation Technique for Two Massive Ventral Hernias"

22. The Midwestern Association of Plastic Surgeons, April 23-24, Chicago, Il: "Mucormycosis of the Head and Neck: A Fatal Disease?"

23. The 7th Annual Chicago Trauma Symposium, August 11-14, 2005, Chicago, Il "Management of Complex Injuries"

24. Current Concepts in Advanced Wound Healing: *A Practical Overview*, Rush North Shore Medical Center, Skokie, Il September 18, 2005 "From Flaps to Grafts"

25. Taizoon Baxamusa, M and Loren S. Schechter, MD, Abdominoplasty: Use in Reconstruction of the Mangled Upper Extremity, The American Association For Hand Surgery Annual Scientific Meeting, January 11-14, 2006, Tucson, Arizona.
26. The American Academy of Orthopedic Surgeons 2006 Annual Meeting, March 22-26, 2006, Chicago, IL "Methods of Patella-Femoral and Extensor Mechanism Reconstruction for Fracture and Disruption After Total Knee Arthroplasty"
27. Midwestern Association of Plastic Surgeons 44th Annual Meeting, April 29-30, 2006, Oak Brook, Illinois "Elective Abdominal Plastic Surgery Procedures Combined with Concomitant Intra-abdominal Operations: A Single Surgeon's Four Year Experience"
28. Midwestern Association of Plastic Surgeons 44th Annual Meeting, April 29-30, 2006, Oak Brook, Illinois "Hereditary Gingival Fibromatosis: Aggressive Two-Stage Surgical Resection Versus Traditional Therapy"
29. Midwestern Association of Plastic Surgeons 44th Annual Meeting, April 29-30, 2006, Oak Brook, Illinois "Abdominoplasty Graft & VAC Therapy: Two Useful Adjuncts in Full-Thickness Grafting of the Mangled Upper Extremity"
30. The American Association of Plastic Surgeons 85th Annual Meeting, May 6-9, 2006 Hilton Head, South Carolina "Excision of Giant Neurofibromas"
31. The 8th Annual Chicago Trauma Symposium, July 27-30, 2006, Chicago, IL "Management of Complex Injuries"
32. The American Society of Plastic Surgeons Annual Meeting, October 6-12, 2006, San Francisco, California "Excision of Giant Neurofibromas"
33. The American College of Surgeons Poster Presentation, October, 2006, Chicago, IL "Abdominoplasty: Use in Reconstruction of the Mangled Upper Extremity"
34. American Medical Association-RFS 3rd Annual Poster Symposium, November 10, Las Vegas, NV, 2006 "Abdominal Wall Reconstruction With Alloderm"
35. Advocate Injury Institute: "Trauma 2006: The Spectrum of Care", November 30-December 2, 2006, Lisle, IL, "Pit Bull Mauling: A Case Study"

36. The 9th Annual Chicago Trauma Symposium, August 10-12, 2007, Chicago, Il "Management of Complex Injuries"
37. The World Professional Association for Transgender Health (WPATH) 2007 XX Biennial Symposium, September 5-8, 2007, Chicago, Il Revision Vaginoplasty With Sigmoid Interposition: "A Reliable Solution for a Difficult Problem"
38. Metropolitan Chicago Chapter of the American College of Surgeons, 2008 Annual Meeting, March 15, 2008 "ER Call: Who's Job is it Anyway"
39. The 10th Annual Chicago Trauma Symposium, August 7-10, 2008, Chicago, Il "Management of Complex Injuries"
40. 23rd Annual Clinical Symposium on Advances in Skin & Wound Care: The Conference for Prevention and Healing October 26-30, 2008, Las Vegas, Nevada, poster presentation "Use of Dual Therapies Consisting of Negative Pressure Wound Therapy (NPWT) and Small Intestine Mucosa (SIS) on a Complex Degloving Injury With an Expose Achilles Tendon: A Case Report."
41. The American Society of Plastic Surgeons Annual Meeting, October 31-November 3, 2008, Chicago, Il "Panel: Fresh Faces, Real Cases"
42. The American Association for Hand Surgery Annual Meeting, January 7-13, 2009, Maui, Hawaii, poster session: "Omental Free Tissue Transfer for Coverage of Complex Upper Extremity and Hand Defects-The Forgotten Flap."
43. Plastic Surgery At The Red Sea Symposium, March 24-28, 2009 Eilat, Israel, "Omental Free Tissue Transfer for Coverage of Complex Upper Extremity and Hand Defects-The Forgotten Flap."
44. ASPS/IQUAM Transatlantic Innovations Meeting, April 4-7, 2009 Miason de la Chimie, Paris, France, "Advertising in Plastic Surgery?"
45. ASPS/IQUAM Transatlantic Innovations Meeting, April 4-7, 2009 Miason de la Chimie, Paris, France, "Cost-Effectiveness of Physician Extenders in Plastic Surgery"
46. Midwestern Association of Plastic Surgeons, 47th Annual Meeting, April 18-19, 2009, Chicago, Il, "Microvascular Reconstruction of Iatrogenic Femoral Artery Injury in a Neonate"
47. Midwestern Association of Plastic Surgeons, 47th Annual Meeting, April 18-19, 2009, Chicago, Il, "Two Birds, One Stone: Combining Abdominoplasty with Intra-Abdominal Procedures"

48. The 11th Annual Chicago Trauma Symposium, August 1, 2009, Chicago, IL "Management of Complex Injuries"
49. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Omental Free Tissue Transfer for Coverage of Complex Extremity Defects: The Forgotten Flap."
50. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Challenging Cases."
51. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, "President's Panel: The Future of the Solo Practice-Can We, Should We Survive?"
52. The 12th Annual Chicago Trauma Symposium, August 5-8, 2010, Chicago, IL "Management of Complex Injuries"
53. Breast MRI to Define The Blood Supply to the Nipple-Areolar Complex. German Society of Plastic, Reconstructive and Aesthetic Surgery (DGPAEC), Dresden, Germany, September 2010
54. Roundtable Discussion: Electronic Health Records-Implications for Plastic Surgeons, The American Society of Plastic Surgeons Annual Meeting, October 3, 2010, Toronto, CA
55. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, The American Society of Plastic Surgeons Annual Meeting, October 3, 2010, Toronto, CA.
56. ASPS/ASPSN Joint Patient Safety Panel: Patient Selection and Managing Patient Expectations, The American Society of Plastic Surgeons Annual Meeting, October 4, 2010, Toronto, CA
57. Lunch and Learn: Prevention of VTE in Plastic Surgery Patients, The American Society of Plastic Surgeons Annual Meeting, October 5, 2010, Toronto, CA
58. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, 16th Congress of The International Confederation for Plastic Reconstructive and Aesthetic Surgery, May 22-27, 2011, Vancouver, Canada
59. Breast MRI Helps Define the Blood Supply to the Nipple-Areolar Complex, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland

60. Applications of the Omentum for Limb Salvage: The Largest Reported Series, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland
61. Successful Tongue Replantation Following Auto-Amputation Using Supermicrosurgical Technique, Poster Session, The 6th Congress of The World Society for Reconstructive Microsurgery, WSRM 2011, 29 June-2 July, 2011, Helsinki, Finland
62. The 13th Annual Chicago Trauma Symposium, August 25-28, 2011, Chicago, IL "Soft Tissue Defects-Getting Coverage"
63. WPATH: Pre-conference Symposium, September 24, 2011, Atlanta, GA "Surgical Options and Decision-Making"
64. American Society of Plastic Surgeons Annual Meeting, September 27, 2011, Denver, CO Closing Session Lunch and Learn: Pathways to Prevention-Avoiding Adverse Events, Part I: Patient Selection and Preventing Adverse Events in the Ambulatory Surgical Setting
65. American Society of Plastic Surgeons Annual Meeting, September 27, 2011, Denver, CO Closing Session Lunch and Learn: Pathways to Prevention-Avoiding Adverse Events, Part III: Preventing VTE
66. XXIV Congresso Nazionale della Societa Italiana di Microchirurgia congiunto con la American Society for Reconstructive Microsurgery, October 20-22, 2011, Palermo, Sicily: 3 Step Approach to Lower Extremity Trauma
67. XXIV Congresso Nazionale della Societa Italiana Microchirurgia congiunto con la American Society for Reconstructive Microsurgery, October 20-22, 2011, Palermo, Sicily: Applications of the Omentum for Limb Salvage: The Largest Reported Series
68. American Society for Reconstructive Microsurgery, Poster Presentation, January 14-17, 2012, Las Vegas, NV: Neonatal Limb Salvage: When Conservative Management is Surgical Intervention
69. The 14th Annual Chicago Trauma Symposium, August 2-5, 2012, Chicago, IL "Soft Tissue Defects-Getting Coverage"
70. The Annual Meeting of The American Society of Plastic Surgeons, October 25th-30, 2012, New Orleans, LA "Reimbursement in Breast Reconstruction"
71. The Annual Meeting of The American Society of Plastic Surgeons, October 25th-30, 2012, New Orleans, LA "Thriving in a New Economic Reality: Business Relationships and Integration in the Marketplace"

72. The 15th Annual Chicago Trauma Symposium, August 2-5, 2013, Chicago, Il "Soft Tissue Defects-Getting Coverage"
73. 2014 WPATH Symposium, Transgender Health from Global Perspectives, February 14-18, 2014, "Short Scar Chest Surgery."
74. 2014 WPATH Symposium, Transgender Health from Global Perspectives, February 14-18, 2014, "Intestinal Vaginoplasty with Right and Left Colon."
75. 24th Annual Southern Comfort Conference, September 3-7, 2014, Atlanta, Georgia, "Gender Confirmation Surgery: State of the Art."
76. The 15th Annual Chicago Trauma Symposium, September 4-7, 2014, Chicago, Il "Soft Tissue Defects-Getting Coverage"
77. The Midwest Association of Plastic Surgeons, May 30, 2015, Chicago, Il "Gender Confirmation Surgery: A Single-Surgeon's Experience"
78. The Midwest Association of Plastic Surgeons, May 30, 2015, Chicago, Il, Moderator, Gender Reassignment.
79. the American Society of Plastic Surgeons 2015 Professional Liability Insurance and Patient Safety Committee Meeting, July 17, 2015, "Gender Confirmation Surgery."
80. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. From Fee-for-Service to Bundled Payments
81. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. Moderator, Transgender Surgery
82. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. Efficient Use of Physician Assistants in Plastic Surgery.
83. The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA. Patient Safety: Prevention of VTE
84. The World Professional Association for Transgender Health, Objective Quality Parameters for Gender Confirmation Surgery, June 18-22, 2016, Amsterdam, Netherlands
85. The World Professional Association for Transgender Health, Resident Education Curriculum for Gender Confirmation Surgery, June 18-22, 2016, Amsterdam, Netherlands
86. The World Professional Association for Transgender Health, Urologic Management of a Reconstructed Urethra(Poster session #195), June 18-22, 2016, Amsterdam, Netherlands

87. The World Professional Association for Transgender Health, Construction of a neovagina for male-to-female gender reassignment surgery using a modified intestinal vaginoplasty technique, poster session (Poster session #198), June 18-22, 2016, Amsterdam, Netherlands
88. Aesthetica Super Symposium, The American Society of Plastic Surgeons, Genital Aesthetics: What are we trying to achieve?, Washington, DC June 23-25, 2016
89. Aesthetica Super Symposium, The American Society of Plastic Surgeons, Female to Male Gender Reassignment, Washington, DC June 23-25, 2016
90. Aesthetica Super Symposium, The American Society of Plastic Surgeons, The journal of retractions, what I no longer do, Washington, DC June 23-25, 2016
91. Aesthetica Super Symposium, The American Society of Plastic Surgeons, The three minute drill, tips and tricks, Washington, DC June 23-25, 2016
92. Aesthetica Super Symposium, The American Society of Plastic Surgeons, Moderator, Mini master class: Male genital plastic surgery, Washington, DC June 23-25, 2016
93. The 16th Annual Chicago Trauma Symposium, August 18-21, 2016, Chicago, Il "Soft Tissue Defects-Getting Coverage"
94. USPATH Poster Session, Feb 2-5, 2017, Los Angeles, CA, Partial Flap Failure Five Weeks Following Radial Forearm Phalloplasty: Case Report and Review of the Literature
95. USPATH Poster Session, Feb 2-5, 2017, Los Angeles, CA, Urethroplasty for Stricture after Phalloplasty in Transmen Surgery for Urethral Stricture Disease after Radial Forearm Flap Phalloplasty-Management Options in Gender Confirmation Surgery
96. USPATH, Feb 2-5, 2017, Los Angeles, CA, Patient Evaluation and Chest Surgery in Transmen: A Pre-operative Classification
97. USPATH, Feb 2-5, 2017, Los Angeles, CA Single Stage Urethral Reconstruction in Flap Phalloplasty: Modification of Technique for Construction of Proximal Urethra
98. USPATH, Feb 2-5, 2017, Los Angeles, CA, Use of Bilayer Wound Matrix on Forearm Donor Site Following Phalloplasty
99. USPATH, Feb 2-5, 2017, Los Angeles, CA, Vaginoplasty: Surgical

Techniques

100. USPATH, Feb 2-5, 2017, Los Angeles, CA, Positioning of a Penile Prosthesis with an Acellular Dermal Matrix Wrap following Radial Forearm Phalloplasty
101. USPATH, Feb 2-5, 2017, Los Angeles, CA, Principles for a Gender Surgery Program
102. USPATH, Feb 2-5, 2017, Los Angeles, CA, Construction of a Neovagina Using a Modified Intestinal Vaginoplasty Technique
103. The 18th Annual Chicago Orthopedic Symposium, July 6-9, 2017, Chicago, Il "Soft Tissue Defects-Getting Coverage"
104. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, Moderator: Genital Surgery Trends for Women
105. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, Adding Transgender Surgery to Your Practice, Moderator and Speaker
106. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, Transbottom Surgery
107. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018 A Novel Approach to IPP Implantation Post Phalloplasty: The Chicago Experience
108. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018, A Novel Approach for Neovagina Configuration During Vaginoplasty for Gender Confirmation Surgery
109. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018 Developlment of a Pelvic Floor Physical Therapy Protocol for Patients Undergoing Vaginoplasty for Gender Confirmation
110. 14th Congress of The European Federation of Societies for Microsurgery, Belgrade, May 5-8, 2018 Establishing Guidelines for Gender Confirmation Surgery: The Perioperative Risk of Asymptomatic Deep Venous Thrombosis for Vaginoplasty
111. The 19th Annual Chicago Trauma Symposium, August 16-19, 2018, Chicago, Il "Soft Tissue Defects-Getting Coverage"
112. Midwest LGBTQ Health Symposium, September 14-15, 2018, Chicago, Il "Quality Parameters in Gender Confirmation Surgery"

113. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Poster Session, Proposed Guidelines for Medical Tattoo Following Phalloplasty; An Interdisciplinary Approach
114. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Establishment of the First Gender Confirmation Surgery Fellowship
115. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, ISSM Lecture, The Importance of Surgical Training
116. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Tracking Patient-Reported Outcomes in Gender Confirmation Surgery
117. "Theorizing the Phantom Penis," The Psychotherapy Center for Gender and Sexuality's 6th Biannual Conference, Transformations, March 29-March 30, 2019, NY, NY

INSTRUCTIONAL COURSES:

1. Emory University and WPATH: Contemporary Management of Transgender Patients: Surgical Options and Decision-Making, September 5, 2007 Chicago, IL
2. Craniomaxillofacial Trauma Surgery: An Interdisciplinary Approach, February 16-17, 2008, Burr Ridge, IL
3. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, Moderator: Free Papers, Lower Extremity
4. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, Moderator: ASPS/ASPSN Patient Panel: Effective Communication-A Key to Patient Safety and Prevention of Malpractice Claims
5. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, Instructional Course: Strategies to Identify and Prevent Errors and Near Misses in Your Practice
6. American Society of Plastic Surgeons Annual Meeting, October 23-27, 2009, Seattle, WA, Roundtable Discussion: Electronic Health Records-Implications for Plastic Surgeons
7. 10th Congress of The European Federation of Societies for Microsurgery, May 2-22, 2010, Genoa, Italy, "The Mangled Lower Extremities: An Algorithm for Soft Tissue Reconstruction."

8. Multispecialty Course for Operating Room Personnel- Craniomaxillofacial, Orthopaedics, and Spine, A Team Approach, AO North American, June 26-27, 2010, The Westin Lombard Yorktown Center.
9. Management of Emergency Cases in the Operating Room, The American Society of Plastic Surgeons Annual Meeting, October 4, 2010, Toronto, CA.
10. Surgical Approaches and Techniques in Craniomaxillofacial Trauma, November 6, 2010, Burr Ridge, IL.
11. The Business of Reconstructive Microsurgery: Maximizing Economic value (Chair) The American Society for Reconstructive Microsurgery, January 14-17, 2012, Las Vegas, Nevada.
12. Strategies to Identify and Prevent Errors and Near Misses in Your Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 25th-30th, 2012, New Orleans, LA
13. Strategies to Identify and Prevent Errors and Near Misses in Your Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 11th-15th, 2013, San Diego, CA
14. Mythbusters: Microsurgical Breast Reconstruction in Private Practice, The Annual Meeting of The American Society of Plastic Surgeons, October 11th-15th, 2013, San Diego, CA
15. Minimizing Complications in Perioperative Care, The American Society for Reconstructive Microsurgery, January 11-14, 2014, Kauai, Hawaii
16. Genitourinary and Perineal Reconstruction, The American Society for Reconstructive Microsurgery, January 11-14, 2014, Kauai, Hawaii
17. Transgender Breast Surgery, The American Society of Plastic Surgeons, October 16-20, 2015, Boston, MA
18. Gender Confirmation Surgery, The School of the Art Institute (recipient of American College Health Fund's Gallagher Koster Innovative Practices in College Health Award), October 27, 2015, Chicago, IL
19. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, IL Overview of Surgical Treatment Options
20. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015 Chicago, IL Surgical Procedures

21. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, IL Surgical Complications
22. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, IL Post-operative Care
23. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, November 5-7, 2015, Chicago, IL Case Discussions: The Multidisciplinary Team
24. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, January 20-23, 2016, Atlanta, GA Overview of Surgical Treatment Options
25. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, January 20-23, 2016, Atlanta, GA Surgical Treatment Options
26. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, March 30-April 1, 2016, Springfield, MO, Surgical Treatment Options.
27. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Certified Training Course, March 30-April 1, 2016, Springfield, MO, Multi-disciplinary Case Discussion.
28. Introduction to Transgender Surgery, ASPS Breast Surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
29. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course, September 28, 2016, Ft. Lauderdale, FL.
30. Cirugias de Confirmacion de Sexo Paso a Paso, XXXV Congreso Confederacion Americana de Urologia (CAU), Panama City, Panama, October 4-8, 2016.
31. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course, December 3, 2016, Arlington, VA.
32. PSEN (sponsored by ASPS and endorsed by WPATH), Transgender 101 for Surgeons, January 2017-March 2017
33. Surgical Anatomy and Surgical Approaches to M-to-F Genital Gender Affirming Surgery and the Management of the Patient Before, During and After Surgery: A Human Cadaver Based Course, Orange County, CA, Feb. 1, 2017

34. Gender Confirmation Surgery, ALAPP, 2 Congreso Internacional de la Asociacion Latinoamericana de Piso Pelvico, Sao Paulo, Brasil, 9-11 de marzo de 2017
35. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course, Overview of Surgical Treatment, March 31-April 2, 2017, Minneapolis Minnesota.
36. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course, The Multi-Disciplinary Team Case Discussions, March 31-April 2, 2017, Minneapolis Minnesota.
37. Transfeminine Cadaver Course, WPATH, May 19-20, 2017, Chicago, IL
38. Transgender/Penile Reconstruction-Penile Reconstruction: Radial Forearm Flap Vs. Anterolateral Thigh Flap, Moderator and Presenter, The World Society for Reconstructive Microsurgery, June 14-17, 2017, Seoul, Korea
39. Primer of Transgender Breast Surgery, ASPS Breast Surgery and Body Contouring Symposium, San Diego, CA, August 10-12, 2017
40. Confirmation Surgery in Gender Dysphoria: current state and future developments, International Continence Society, Florence, Italy, September 12-15, 2017
41. The American Society of Plastic Surgeons Annual meeting, October 6-10, 2017, Orlando, FL, ASPS/WPATH Joint Session, Session Planner and Moderator
42. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Foundations Training Course: Overview of Surgical Treatment, Columbus, OH, October 20-21, 2017
43. Transgender Health: Best Practices in Medical and Mental Health Care. A WPATH Global Education Initiative Advanced Training Course: Medical Care in the Perioperative Period, Aftercare: Identifying Potential Complications, Columbus, OH, October 20-21, 2017
44. Webinar: Gender Affirming Surgeries 101: Explore The Latest Topics in Gender Affirmation Surgery, PSEN, April 18, 2018
45. Course Director: MT. Sinai/WPATH Live Surgery Training Course for Gender Affirmation Procedures, April 26-28, 2018, New York, NY

46. Philadelphia Trans Wellness Conference, Perioperative Care of the Transgender Woman Undergoing Vaginoplasty (Workshop), Philadelphia, PA, August 3, 2018
47. Philadelphia Trans Wellness Conference, Gender Confirmation Surgery (Workshop), Philadelphia, PA, August 3, 2018
48. Gender Confirmation Surgery, 2018 Oral and Written Board Preparation Course, The American Society of Plastic Surgeons, August 16-18, 2018, Rosemont, IL
49. Confirmation Surgery in Gender Dysphoria: Current State and Future Developments, The International Continence Society, Philadelphia, PA August 28, 2018
50. WPATH Global Education Initiative, Foundations Training Course, "Overview of Surgical Treatment," Cincinnati, OH, September 14-15, 2018
51. WPATH Global Education Initiative, Foundations Training Course, "The Multi-Disciplinary Team: Case Discussions," Cincinnati, OH, September 14-15, 2018
52. WPATH Global Education Initiative, Advanced Training Course, "Medical Care in the Perioperative Period After Care: Identifying Potential Complications," Cincinnati, OH, September 14-15, 2018
53. 25th WPATH Symposium, Surgeons Conference, November 1, 2018, Buenos Aires, Argentina, Moderator
54. 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Global Education Initiative (GEI): Surgery and Ethics
55. WPATH GEI: Best Practices in Medical and Mental Health Care, Foundations in Surgery, New Orleans, March 22, 2019
56. WPATH GEI: Best Practices in Medical and Mental Health Care, Advanced Surgery, New Orleans, March 22, 2019
57. Program Chair: ASPS/WPATH GEI Inaugural Gender-Affirming Breast, Chest, and Body Master Class, Miami, FL, July 20, 2019
58. Overview of Surgical Management and The Standards of Care (WPATH, v. 7) ASPS/WPATH GEI Inaugural Gender-Affirming Breast, Chest, and Body Master Class, Miami, FL, July 20, 2019
59. Program Director, Gender Affirming Breast, Chest, and Body Master Class, The American Society of Plastic Surgeons, Miami, FL, July 20, 2019

60. Gender Confirmation Surgery, The American Society of Plastic Surgeons Oral and Written Board Preparation Course, August 15, 2019, Rosemont, Il
61. Upper Surgeries (chest surgery & breast augmentation), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
62. Preparing for Upper Surgeries-Case Based (chest surgery & breast augmentation), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
63. Preparing for Feminizing Lower Surgeries-Case Based (vaginoplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
64. Lower Surgeries-Masculinizing (phalloplasty & metoidioplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
65. Preparing for Masculinizing Lower Surgeries-Case Based (phalloplasty & metoidioplasty), WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
66. Panel Discussion about Ethics in Surgery and Interdisciplinary Care, WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
67. Discussion about Ethics and Tensions in Child and Adolescent Care, WPATH, Global Education Initiative, September 4-5, 2019, Washington, DC
68. Transgender Health: Best Practices in Medical and Mental Health Care Foundation Training Courses, Hanoi, Viet Nam, Jan 14-17, 2020 (Foundations in Surgery, Advanced Medical-surgery and complicated case studies), Planning & Documentation (upper surgeries-chest surgery and breast augmentation, preparing for upper surgeries-case based (chest surgery and breast augmentation), lower surgeries (feminizing-vaginoplasty), preparing for feminizing lower surgeries-case based, lower surgeries-masculinizing (phalloplasty and metoidioplasty), preparing for masculinizing lower surgeries-case-based (phalloplasty and metoidioplasty), Ethics-panel discussion about ethics in surgery and interdisciplinary care)
69. WPATH GEI Panel Cases Discussion, via Webinar, May 29, 30, 31, 2020

SYMPOSIA:

1. Program Director, 2011 Chicago Breast Symposium, October 15, 2011, The Chicago Plastic Surgery Research Foundation and The Chicago Medical School at Rosalind Franklin University, North Chicago, IL,
2. Fundamentals of Evidence-Based Medicine & How to Incorporate it Into Your Practice, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC
3. Understanding Outcome Measures in Breast & Body Contouring Surgery, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC
4. Benchmarking Complications: What We Know About Body Contouring Complication Rates from Established Databases, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC
5. Special Lecture: VTE Prophylaxis for Plastic Surgery in 2011, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC
6. Nipple Sparing Mastectomy: Unexpected Outcomes, Challenging Complications in Plastic Surgery: Successful Management Strategies, The American Society of Plastic Surgeons, July 13-14, 2012 Washington, DC
7. Program Director, 2011 Chicago Breast Symposium, October 13-14, 2012, The Chicago Plastic Surgery Research Foundation and The Chicago Medical School at Rosalind Franklin University, North Chicago, IL
8. Practice Strategies in a Changing Healthcare Environment, Moderator, Midwestern Association of Plastic Surgeons, April 27-28, 2013, Chicago, IL
9. Moderator: Breast Scientific Paper Session, The Annual Meeting of The American Society of Plastic Surgery, October 12, 2014, Chicago, IL.
10. Moderator: The World Professional Association for Transgender Health, Tuesday, June 21, Surgical Session (0945-1045), June 18-22, 2016, Amsterdam, Netherlands
11. Course Director: Transmale Genital Surgery: WPATH Gender Education Initiative, October 21-22, 2016 Chicago, IL

12. Co-Chair and Moderator: Surgeon's Only Session, USPATH, Los Angeles, CA, Feb. 2, 2017
13. Vascular Anastomosis: Options for Lengthening Vascular Pedicle, Surgeon's Only Session, USPATH, Los Angeles, CA, Feb. 2, 2017
14. Transgender Healthcare Mini-Symposium, Chicago Medical School of Rosalind Franklin University, North Chicago, Il March 10, 2017.
15. Moderator: Penile Transplant: Genito-urinary trauma/penile cancer, The European Association of Urologists, Meeting of the EAU Section of Genito-Urinary Reconstructive Surgeons (ESGURS), London, United Kingdom, March 23-26, 2017
- 16: 25th WPATH Symposium, November 2-6, 2018, Buenos Aires, Argentina, Mini-Symposium: A Comprehensive Approach to Gender Confirming Surgery
17. Program Director, 2nd Annual Live Surgery Conference for Gender Affirmation Procedures, Ichan School of Medicine at Mt. Sinai, NY, NY February 28, 2019-March 2, 2019.
18. Moderator, "Genital Reassignment for Adolescents: Considerations and Conundrums," Discussions on gender affirmation: surgery and beyond, Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
19. Moderator, "Reconstructive Urology and Genitourinary Options in Gender Affirming Surgery," Discussions on gender affirmation: surgery and beyond, Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
20. Moderator, "Complications in Masculinizing Genital Reconstruction Surgery," Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
21. Moderator, "Preparing for Surgery and Recovery," Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
22. Discussant, "WPATH Standards of Care Version 8 Preview," Dignity Health Saint Francis Memorial Hospital and WPATH GEI, San Francisco, CA, May 30-June 1, 2019
23. Program Coordinator, Surgeon's Only Course, USPATH, September 5, 2019, Washington, DC
24. Master Series in Transgender Surgery 2020: Vaginoplasty and Top Surgery, course co-director, Mayo Clinic, Rochester, MN, August 7-8, 2020

FACULTY SPONSORED RESEARCH:

1. Societa Italiana Di Microchirurgia, XXIII Congresso Nazionale della Societa Italiana di Microchirurgia, First Atlanto-Pacific Microsurgery Conference, Modena, Italy, October 1-3, 2009, "Free Tissue Transfer in the Treatment of Zygomycosis." Presented by Michelle Roughton, MD
2. Hines/North Chicago VA Research Day, Edward Hines, Jr., VA Hospital, Maywood, Il, April 29, 2010, "Breast MRI Helps to Define the Blood Supply to the Nipple-Areolar Complex." Presented by Iris A. Seitz, MD, PhD.
3. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Breast MRI Helps to Define the Blood Supply to the Nipple-Areolar Complex." Presented by Iris A. Seitz, MD, PhD.
4. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Achieving Soft Tissue Coverage of Complex Upper and Lower Extremity Defects with Omental Free Tissue Transfer." Presented by Iris A. Seitz, MD, PhD.
5. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Facilitating Harvest of the Serratus Fascial Flap with Ultrasonic Dissection." Presented by Iris A. Seitz, MD, PhD.
6. Advocate Research Forum, Advocate Lutheran General Hospital, May 5, 2010, "Patient Safety: Abdominoplasty and Intra-Abdominal Procedures." Presented by Michelle Roughton, MD
7. The Midwestern Association of Plastic Surgeons, 49th Annual Scientific Meeting, May 15th, 2010, "Breast MRI Helps Define The Blood Supply to the Nipple-Areolar Complex." Presented by Iris A. Seitz, MD, PhD.
8. Jonathan M. Hagedorn, BA, **Loren S. Schechter**, MD, FACS, Dr. Manoj R. Shah, MD, FACS, Matthew L. Jimenez, MD, Justine Lee, MD, PhD, Varun Shah. Re-examining the Indications for Limb Salvage, 2011 All School Research Consortium at Rosalind Franklin University. Chicago Medical School of Rosalind Franklin University, 3/16/11.
9. Jonathan Bank, MD, Lucio A. Pavone, MD, Iris A. Seitz, Michelle C. Roughton, MD, Loren S. Schechter, MD Deep Inferior Epigastric Perforator Flap for Breast Reconstruction after Abdominoplasty The Midwestern Association of Plastic Surgeons, 51st Annual Educational Meeting, April 21-22, 2012, Northwestern Memorial Hospital, Chicago, Illinois

10. Samuel Lake, Iris A. Seitz, MD, PhD, Loren S. Schechter, MD, Daniel Peterson, PhD Omentum and Subcutaneous Fat Derived Cell Populations Contain hMSCs Comparable to Bone Marrow-Derived hMSCs First Place, Rosalind Franklin University Summer Research Poster Session

11. J. Siwinski, MS II, Iris A. Seitz, MD PhD, Dana Rioux Forker, MD, Lucio A. Pavone, MD, Loren S Schechter, MD FACS. Upper and Lower Limb Salvage With Omental Free Flaps: A Long-Term Functional Outcome Analysis. Annual Dr. Kenneth A. Suarez Research Day, Midwestern University, Downers Grove, IL, May 2014

12. Whitehead DM, Kocjancic E, Iacovelli V, Morgantini LA, **Schechter LS**. A Case Report: Penile Prosthesis With an Alloderm Wrap Positioned After Radial Forearm Phalloplasty. Poster session presented at: American Society for Reconstructive Microsurgery Annual Meeting, 2018 Jan 13-16; Phoenix, AZ.

13. Whitehead DM, Kocjancic E, Iacovelli V, Morgantini LA, **Schechter LS**. An Innovative Technique: Single Stage Urethral Reconstruction in Female-to-Male Patients. Poster session presented at: American Society for Reconstructive Microsurgery Annual Meeting, 2018 Jan 13-16; Phoenix, AZ.

14. Whitehead, DM Inflatable Penile Prosthesis Implantation Post Phalloplasty: Surgical Technique, Challenges, and Outcomes, MAPS 2018 Annual Scientific Meeting, April 14, 2018, Chicago, IL

15. Whitehead, DM, Inverted Penile Skin With Scrotal Graft And Omission of Sacrospinal Fixation: Our Novel Vaginoplasty Technique MAPS 2018 Annual Scientific Meeting, April 14, 2018, Chicago, IL

Keynote Address:

1. University of Utah, Gender Confirmation Surgery, Transgender Provider Summit, November 8, 2014

INVITED LECTURES:

1. Management of Soft Tissue Injuries of the Face, Grand Rounds, Emergency Medicine, The University of Chicago, August, 1999

2. Case Report: Excision of a Giant Neurofibroma, Operating Room Staff Lecture Series, Continuing Education Series, St. Francis Hospital, Evanston, IL March 2000

3. Wounds, Lincolnwood Family Practice, Lincolnwood, IL April 2000

4. The Junior Attending, Grand Rounds, Plastic and Reconstructive Surgery, The University of Chicago, June 2000

5. Case Report: Excision of a Giant Neurofibroma, Department of Medicine Grand Rounds, St. Francis Hospital, Evanston, Il June 2000
6. Facial Trauma, Resurrection Medical Center Emergency Medicine Residency, September 2000
7. Plastic Surgery of the Breast and Abdomen, Grand Rounds, Dept. of Obstetrics and Gynecology, Evanston Hospital, September, 2000
8. Change of Face; Is Cosmetic Surgery for You?, Adult Education Series, Rush North Shore Medical Center, October, 2000
9. Reconstructive Surgery of the Breast, Professional Lecture Series on Breast Cancer, St. Francis Hospital, October, 2000
10. Plastic Surgery of the Breast and Abdomen, Grand Rounds, Dept. of Obstetrics and Gynecology, Lutheran General Hospital, December, 2000
11. Change of Face; Is Cosmetic Surgery for You?, Adult Education Series, Lutheran General Hospital and The Arlington Heights Public Library, December, 2000
12. Updates in Breast Reconstruction, The Breast Center, Lutheran General Hospital, January 2001
13. Abdominal Wall Reconstruction, Trauma Conference, Lutheran General Hospital, February 2001
14. Wound Care, Rush North Shore Medical Center, March 2001
15. Breast Reconstruction, Diagnosis and Treatment Updates on Breast Cancer, Lutheran General Hospital, April 2001
16. Wound Care and V.A.C. Therapy, Double Tree Hotel, Skokie, Il October 2001
17. The Role of the V.A.C. in Reconstructive Surgery, LaCrosse, WI November 2001
18. Dressing for Success: The Role of the V.A.C. in Reconstructive Surgery, Grand Rounds, The University of Minnesota Section of Plastic and Reconstructive, Minneapolis, MN January, 2002
19. The Vacuum Assisted Closure Device in the Management of Complex Soft Tissue Defects, Eau Claire, WI February, 2002
20. The Vacuum Assisted Closure Device in Acute & Traumatic Soft Tissue Injuries, Orland Park, Il March, 2002

21. Body Contouring After Weight Loss, The Gurnee Weight Loss Support Group, Gurnee, Il April, 2002
22. An Algorithm to Complex Soft Tissue Reconstruction With Negative Pressure Therapy, Owensboro Mercy Medical Center, Owensboro, Ky, April, 2002
23. Breast and Body Contouring, St. Francis Hospital Weight Loss Support Group, Evanston, Il April, 2002
24. The Wound Closure Ladder vs. The Reconstructive Elevator, Surgical Grand Rounds, Lutheran General Hospital, Park Ridge, Il, May, 2002.
25. An Algorithm for Complex Soft Tissue Reconstruction with the Vacuum Assisted Closure Device, The Field Museum, Chicago, Il, May, 2002
26. The Role of Negative Pressure Wound Therapy in Reconstructive Surgery, Kinetic Concepts, Inc. San Antonio, Texas, July 31, 2002
27. Management of Complex Soft Tissue Injuries of the Lower Extremity, Chicago Trauma Symposium, August 2-5, 2002, Chicago, Illinois:
28. Wound Bed Preparation, Smith Nephew, Oak Brook, Il, August 6, 2002
29. Getting Under Your Skin...Is Cosmetic Surgery for You?, Rush North Shore Adult Continuing Education Series, Skokie, Il August 28, 2002.
30. The Role of Negative Pressure Therapy in Complex Soft Tissue Wounds, Columbia/St. Mary's Wound, Ostomy, and Continence Nurse Program, Milwaukee, Wi, September 17, 2002
31. A Systematic Approach to Functional Restoration, Grand Rounds, Dept. of Physical Therapy and Rehabilitation Medicine, Lutheran General Hospital, September 19, 2002
32. The Role of Negative Pressure Wound Therapy in Reconstructive Surgery, Ann Arbor, Mi September 26, 2002
33. Dressing for Success: The Role of the Vacuum Assisted Closure Device in Plastic Surgery, Indianapolis, In November 11, 2002
34. The Wound Closure Ladder Versus the Reconstructive Elevator, Crystal Lake, Il November 21, 2002

35. A Systematic Approach to Functional Restoration, Grand Rounds, Dept. of Physical Therapy, Evanston Northwestern Healthcare, Evanston, Il February 13, 2003
36. Case Studies in Traumatic Wound Reconstruction, American Association of Critical Care Nurses, Northwest Chicago Area Chapter, Park Ridge, Il February 19, 2003
37. Reconstruction of Complex Soft Tissue Injuries of the Lower Extremity, Podiatry Lecture Series, Rush North Shore Medical Center, Skokie, Il March 5, 2003
38. The Use of Negative Pressure Wound Therapy in Reconstructive Surgery, Kalamazoo, Mi March 19, 2003
39. Updates in Breast Reconstruction, The Midwest Clinical Conference, The Chicago Medical Society, Chicago, Il March 21, 2003
40. Updates of Vacuum Assisted Closure, Grand Rounds, The Medical College of Wisconsin, Department of Plastic Surgery, Milwaukee, Wi March 26, 2003
41. Breast Reconstruction, Surgical Grand Rounds, Lutheran General Hospital, Park Ridge, Il March 27, 2003
42. Decision-Making in Breast Reconstruction: Plastic Surgeons as Members of a Multi-Disciplinary Team, 1st Annual Advocate Lutheran General Hospital Breast Cancer Symposium, Rosemont, Il, April 11, 2003
43. The Wound Closure Ladder Versus The Reconstructive Elevator, Duluth, Mn, April 24, 2003
44. Dressing For Successs: The Role of The Wound VAC in Reconstructive Surgery, Detroit, Mi, May 9, 2003
45. Plastic Surgery Pearls, Grand Rounds Orthopedic Surgery Physician Assistants Lutheran General Hospital and Finch University of Health Sciences, Park Ridge, Il, June 5, 2003
46. A Systematic Approach to Complex Reconstruction, 12th Annual Vendor Fair "Surgical Innovations," October 18, 2003, Lutheran General Hospital, Park Ridge, Il 2003
47. Dressing For Success: The Role of the Wound VAC in Reconstructive Surgery, American Society of Plastic Surgery, October 26, 2003, San Diego, CA

48. Beautiful You: From Botox to Weekend Surgeries, 21st Century Cosmetic Considerations, March 21, 2004 Hadassah Women's Health Symposium, Skokie, Il
49. Updates in Breast Reconstruction, The 2nd Annual Breast Cancer Symposium, Advocate Lutheran General, Hyatt Rosemont, April 2, 2004
50. Head and Neck Reconstruction, Grand Rounds, The University of Illinois Metropolitan Group Hospitals Residency in General Surgery, Advocate Lutheran General Hospital, May 6, 2004
51. Abdominal Wall Reconstruction, Surgeons Forum, LifeCell Corporation, May 15, 2004, Chicago, Il
52. 4th Annual Chicagoland Day of Sharing for Breast Cancer Awareness, Saturday, October 2, 2004, Hoffman Estates, Il
53. Abdominal Wall Reconstruction, University of Illinois Metropolitan Group Hospitals Residency in General Surgery, November 19, 2004, Skokie, Il
54. Advances in Wound Care, Wound and Skin Care Survival Skills, Advocate Good Samaritan Hospital, Tuesday, February 8, 2005, Downer's Grove, Il
55. Plastic Surgery: A Five Year Perspective in Practice, Grand Rounds, The University of Chicago, May 18, 2005, Chicago, Il
56. New Techniques in Breast Reconstruction, The Cancer Wellness Center, October 11, 2005 Northbrook, Il
57. Principles of Plastic Surgery; Soft Tissue Reconstruction of the Hand, Rehab Connections, Inc., Hand, Wrist, and Elbow Forum, October 28, 2005, Homer Glen, Il
58. Principles of Plastic Surgery, Lutheran General Hospital Quarterly Trauma Conference, November 9, 2005, Park Ridge, Il
59. Principles of Plastic Surgery, Continuing Medical Education, St. Francis Hospital, November 15, 2005, Evanston, Il
60. Dressing for Success: A Seven Year Experience with Negative Pressure Wound Therapy, Kinetic Concepts Inc, November 30, 2005, Glenview, Il.
61. Breast Reconstruction: The Next Generation, Breast Tumor Conference, Lutheran General Hospital, May 9, 2006.
62. Complex Wound Care: Skin Grafts, Flaps, and Reconstruction, The Elizabeth D. Wick Symposium on Wound Care, *Current Concepts in*

Advanced Healing: An Update, Rush North Shore Medical Center, November 4, 2006.

63. *An Approach to Maxillofacial Trauma: Grand Rounds*, Lutheran General Hospital/Univ. of Illinois Metropolitan Group Hospital Residency in General Surgery, November 9, 2006.

64. "From Paris to Park Ridge", Northern Trust and Advocate Lutheran General Hospital, Northern Trust Bank, June 7, 2007.

65. "Private Practice Plastic Surgery: A Seven Year Perspective," Grand Rounds, The University of Chicago, Section of Plastic Surgery.

66. "Meet the Experts on Breast Cancer," 7th Annual Chicagoland Day of Sharing, Sunday, April 13th, 2008

67. *Gender Confirmation Surgery: Surgical Options and Decision-Making*, The University of Minnesota, Division of Human Sexuality, May 10, 2008, Minneapolis, Minnesota.

68. "Private Practice Plastic Surgery: A Seven Year Perspective," Grand Rounds, Loyola University, 2008 Section of Plastic Surgery.

69. "Management of Lower Extremity Trauma," Grand Rounds, The University of Chicago, Section of Plastic Surgery, October, 8, 2008.

70. "Concepts in Plastic Surgery: A Multi-Disciplinary Approach," Frontline Surgical Advancements, Lutheran General Hospital, November 1, 2008

71. "Surgical Techniques-New Surgical Techniques/Plastic Surgery/Prosthetics," Caldwell Breast Center CME Series, Advocate Lutheran General Hospital, November 12, 2008

72. "Genetics: *A Family Affair*" Panel Discussion: Predictive Genetic Testing, 23rd Annual Illinois Department of Public Health Conference, Oak Brook Hills Marriott Resort, Oak Brook, Il, March 18, 2009

73. "Gender Confirmation Surgery" Minnesota TransHealth and Wellness Conference, May 15, 2009, Metropolitan State University, Saint Paul, MN.

74. "The Role of Plastic Surgery in Wound Care, " Practical Wound Care A Multidisciplinary Approach, Advocate Lutheran General Hospital, October 9-10, 2009, Park Ridge, Il.

75. "In The Family," Panel, General Session III, 2009 Illinois Women's Health Conference, Illinois Dept. of Health, Office of Women's Health October 28-29, 2009, Oak Brook, Il.

76. "Patient Safety in Plastic Surgery," The University of Chicago, Section of Plastic Surgery, Grand Rounds, November 18, 2009.
77. "Compartment Syndrome," 6th Annual Advocate Injury Institute Symposium, Trauma 2009: Yes We Can!, November 19-20, 2009.
78. "Maxillofacial Trauma," 6th Annual Advocate Injury Institute Symposium, Trauma 2009: Yes We Can!, November 19-20, 2009.
79. "Management of Complex Lower Extremity Injuries," Grand Rounds, The Section of Plastic Surgery, The University of Chicago, December 16, 2009, Chicago, Il.
80. "Gender-Confirming MTF Surgery: Indications and Techniques," Working Group on Gender, New York State Psychiatric Institute, March 12, 2010
81. "Gender-Confirmation Surgery," Minnesota Trans Health and Wellness Conference, Metropolitan State University, St. Paul Campus, May 14th, 2010
82. "Physical Injuries and Impairments," Heroes Welcome Home The Chicago Association of Realtors, Rosemont, Illinois, May 25th, 2010.
83. "Genetics and Your Health," Hadassah Heals: Healing Mind, Body, & Soul, Wellness Fair, 2010, August 29, 2010, Wilmette, Illinois.
84. "GCS," Southern Comfort Conference 2010, September 6-11, 2010, Atlanta, GA.
85. "Gender Confirming Surgery," The Center, The LGBT Community Center, October 22, 2010 New York, NY.
86. "Gender Confirming Surgery," the Center, The LGBT Community Center, May 20, 2011, New York, NY.
87. "Gender Confirming Surgery," Roosevelt-St. Lukes Hospital, May 20, 2011, New York, NY
88. "Principles of Plastic Surgery," Learn about Ortho, Lutheran General Hospital, May 25, 2011, Park Ridge, Il.
89. "Forging Multidisciplinary Relationships in Private Practice," Chicago Breast Reconstruction Symposium 2011, September 9, 2011, Chicago, Il

90. "Gender Confirming Surgery," Minnesota TransHealth and Wellness Conference, Diverse Families: Health Through Community, September 10, 2011, Minneapolis, Minnesota
91. "Gender Confirming Surgery," University of Chicago, Pritzker School of Medicine, Anatomy Class, September 16, 2011, Chicago, Il
92. "Facial Trauma," 8th Annual Advocate Injury Institute Symposium, Trauma 2011: 40 years in the Making, Wyndham Lisle-Chicago, November 9-10, 2011
93. "Establishing a Community-Based Microsurgical Practice," QMP Reconstructive Symposium, November 18-20, 2011, Chicago, Il
94. "Surgery for Gender Identity Disorder," Grand Rounds, Dept. of Obstetrics and Gynecology, Northshore University Health System, December 7, 2011
95. "Managing Facial Fractures," Trauma Grand Rounds, Lutheran General Hospital, Park Ridge, Il July 17, 2012
96. "Principles of Transgender Medicine," The University of Chicago Pritzker School of Medicine, Chicago, Il, September 7, 2012
97. "State of the art breast reconstruction," Advocate Health Care, 11th Breast Imaging Symposium, January 26, 2013, Park Ridge, Il.
98. "State of the art breast reconstruction," Grand Rounds, Dept. of Surgery, Mount Sinai Hospital, April 25, 2013, Chicago, Il.
99. "Getting under your skin: is cosmetic surgery right for you?" Lutheran General Hospital community lecture series, May 7, 2013, Park Ridge, Il.
100. "Gender Confirming Surgery," University of Chicago, Pritzker School of Medicine, Anatomy Class, September 27, 2013, Chicago, Il
101. "State of the Art Breast Reconstruction," Edward Cancer Center, Edward Hospital, October 22, 2013, Naperville, Il
102. "Transgender Medicine and Ministry," Pastoral Voice, Advocate Lutheran General Hospital, October 23, 2013, Park Ridge, Il
103. "Principles of Transgender Medicine and Surgery," The University of Illinois at Chicago College of Medicine, January 28, 2014, Chicago, Il
104. "Principles of Transgender Medicine and Surgery," Latest Surgical Innovations and Considerations, 22nd Annual Educational

Workshop, Advocate Lutheran General Hospital, March 1, 2014, Park Ridge, Il.

105. "Principles of Transgender Medicine: Gender Confirming Surgery," Loyola University Medical Center, March 12, 2014.

106. "Principles of Plastic Surgery," Grand Rounds, Dept. of Obstetrics and Gynecology, Lutheran General Hospital, September 12, 2014.

107. "Gender Confirmation Surgery," The University of Chicago, Pritzker School of Medicine, October 3, 2014

108. "Private Practice: Is There a Future?" The Annual Meeting of The American Society of Plastic Surgical Administrators/The American Society of Plastic Surgery Assistants, Chicago, Il, October 11, 2014.

109. "Private Practice: Is There a Future?" The Annual Meeting of The American Society of Plastic Surgery Nurses, Chicago, Il, October 12, 2014.

110. "Gender Confirmation Surgery" Grand Rounds, The University of Minnesota, Dept. of Plastic Surgery, Minneapolis, MN, October 29, 2014.

111. "Body Contour After Massive Weight Loss," The Bariatric Support Group, Advocate Lutheran General Hospital, February 5, 2015, Lutheran General Hospital, Park Ridge, Il.

112. "Gender Confirmation Surgery," The School of the Art Institute of Chicago, February 1, 2015, Chicago, Il.

113. "Gender Confirmation Surgery," The Community Kinship Life/Bronx Lebanon Department of Family Medicine, Bronx, NY, March 6, 2015

114. "Gender Confirmation Surgery," Educational Inservice, Lutheran General Hospital, Park Ridge, Il, April 20, 2015

115. "Principles of Plastic Surgery, " Surgical Trends, Lutheran General Hospital, Park Ridge, Il, May 16, 2015

116. "Updates on Gender Confirmation Surgery, " Surgical Trends, Lutheran General Hospital, Park Ridge, Il, May 16, 2015

117. "Gender Confirmation Surgery," Lurie Childrens' Hospital, Chicago, Il, May 18, 2015, Chicago, Il 2015.

118. "Gender Confirmation Surgery," TransClinical Care and Management Track Philadelphia Trans-Health Conference, June 5, 2015, Philadelphia, Pa.

119. "Gender Confirmation Surgery: A Fifteen Year Experience," Grand Rounds, The University of Minnesota, Plastic and Reconstructive Surgery and the Program in Human Sexuality, July 30, 2015, Minneapolis, Mn
120. "Gender Confirmation Surgery," Grand Rounds, Tel Aviv Medical Center, Tel Aviv, Israel, August 13, 2015
121. "Gender Confirmation Surgery," Grand Rounds, University of Illinois, Dept of Family Medicine, September 2, 2015
122. "Principles of Plastic Surgery," Grand Rounds, St. Francis Hospital, Evanston, Il September 18, 2015
123. "Gender Confirmation Surgery," Midwest LGBTQ Health Symposium, Chicago, Il, October 2, 2015
124. "Gender Confirmation Surgery," Southern Comfort Conference, Weston, Fl, October 3, 2015
125. "Surgical Transitions for Transgender Patients," Transgender Health Training Institute, Rush University Medical Center, Chicago, Il, October 8, 2015
126. "Gender Confirmation Surgery," The Transgender Health Education Peach State Conference, Atlanta, GA, October 30, 2015
127. "Gender Confirmation Surgery," Weiss Memorial Medical Center, November 4, 2015, Chicago, Il
128. "Gender Confirmation Surgery," University of Illinois at Chicago, Operating Room Staff Inservice, November 18, 2015, Chicago, Il
129. "Gender Confirmation Surgery," University of Illinois at Chicago, Plastic Surgery and Urology Inservice, November 18, 2015, Chicago, Il
130. "Gender Confirmation Surgery," Weiss Memorial Medical Center, November 19, 2015, Chicago, Il
131. "Gender Confirmation Surgery," Section of Plastic Surgery, The University of Illinois at Chicago, January 13, 2016, Chicago, Il
132. "Gender Confirmation Surgery," Dept. of Medicine, Louis A. Weiss Memorial Hospital, February 18, 2016, Chicago, Il
133. "Gender Confirmation Surgery," BCBSIL Managed Care Roundtable March 2, 2016 Chicago, Il

134. "Gender Confirmation Surgery-MtF," Keystone Conference, March 10, 2016, Harrisburg, PA
135. "Gender Confirmation Surgery-FtM," Keystone Conference, March 10, 2016, Harrisburg, PA
136. "Gender Confirmation Surgery," Grand Rounds, Dept. of Ob-Gyn, March 25, 2016, Lutheran General Hospital, Park Ridge, Il 60068
137. "Surgical Management of the Transgender Patient," Spring Meeting, The New York Regional Society of Plastic Surgeons, April 16, 2016, New York, NY
138. "A Three Step Approach to Complex Lower Extremity Trauma," University of Illinois at Chicago, April 27, 2016, Chicago, Il.
139. "Gender Confirmation Surgery," Howard Brown Health Center, July 12, 2016, Chicago, Il
140. "Creating the Transgender Breast M-F; F-M", ASPS Breast surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
141. "Overview of Transgender Breast Surgery," ASPS Breast surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
142. "VTE Chemoprophylaxis in Cosmetic Breast and Body Surgery: Science or Myth", ASPS Breast surgery and Body Contouring Symposium, Santa Fe, NM, August 25-27, 2016
143. "Gender Confirmation Surgery," Gender Program, Lurie Childrens', Parent Group, September 20, 201, 467 W. Deming, Chicago, Il
144. "Gender Confirmation Surgery," The American Society of Plastic Surgeons Expo, September 24, 2016, Los Angeles, CA
145. Transgender Surgery, Management of the Transgender Patient, Female to Male Surgery, Overview and Phalloplasty, The American College of Surgeons, Clinical Congress 2016 October 16-20,2016 Washington, DC
146. "Gender Confirmation Surgery," The Department of Anesthesia, The University of Illinois at Chicago, November 9, 2016
147. "Gender Confirmation Surgery," The Division of Plastic Surgery, The University of Illinois at Chicago, December 14, 2016
148. "Gender Confirmation Surgery," Nursing Education, The University of Illinois at Chicago, January 10, 2017

149. "F2M-Radial Forearm Total Phalloplasty: Plastic Surgeon's Point of View," The European Association of Urologists, Meeting of the EAU Section of Genito-Urinary Reconstructive Surgeons (ESGURS), London, United Kingdom, March 23-26, 2017
150. "Gender Confirmation Surgery," Grand Rounds, The Department of Surgery, The University of North Carolina, March 29, 2017.
151. "Transgender Facial Surgery," *The Aesthetic Meeting 2017 - 50 Years of Aesthetics* - in San Diego, California April 27- May 2, 2017.
152. "Gender Confirmation Surgery: A New Surgical Frontier," 15th Annual Morristown Surgical Symposium Gender and Surgery, Morristown, NJ, May 5, 2017.
153. "Gender Confirmation Surgery: A New Surgical Frontier," Dept. of Obstetrics and Gynecology, The Medical College of Wisconsin, May 24, 2017
154. "Gender Confirmation Surgery: A New Surgical Frontier," Dept. of Obstetrics and Gynecology, Howard Brown Health Center, August 8, 2017
155. "Current State of the Art: Gynecomastia," ASPS Breast Surgery and Body Contouring Symposium, San Diego, CA, August 10-12, 2017
156. "Gender Confirmation Surgery-An Overview," ASPS Breast Surgery and Body Contouring Symposium, San Diego, CA, August 10-12, 2017
157. "Gender Confirmation Surgery," Grand Rounds, Dept. of Obstetrics and Gynecology, The University of Chicago, August 25, 2017
158. "Gender Confirmation Surgery," Wake Forest School of Medicine, Transgender Health Conference, Winston-Salem, NC, September 28-29, 2017
159. "Phalloplasty," Brazilian Professional Association for Transgender Health, Teatro Marcos Lindenberg, Universidade Federal de São Paulo (Unifesp), November 1-4, 2017
160. "Gender Confirmation Surgery," Brazilian Professional Association for Transgender Health/WPATH Session, Teatro Marcos Lindenberg, Universidade Federal de São Paulo (Unifesp), November 1-4, 2017
161. "Gender Confirmation Surgery," The Division of Plastic Surgery, The University of Illinois at Chicago, December 13, 2017, Chicago, Il

162. "Gender Confirmation Surgery," Gender and Sex Development Program, Ann and Robert H. Lurie Children's Hospital of Chicago, December 18, 2017, Chicago, IL
163. "Transgender Breast Augmentation," 34th Annual Atlanta Breast Surgery Symposium, January 19-21, 2018, Atlanta, GA
164. "Top Surgery: Transmasculine Chest Contouring," 34th Annual Atlanta Breast Surgery Symposium, January 19-21, 2018, Atlanta, GA
165. "Gender Confirmation Surgery," The 17th International Congress of Plastic and Reconstructive Surgery in Shanghai, March 18-25, 2018, Shanghai, China
166. "Gender Confirmation Surgery: Facial Feminization and Metoidioplasty," 97th Meeting of the American Association of Plastic Surgeons, Reconstructive Symposium, April 7-10, 2018, Seattle, WA
167. Moderator: "Gender Confirmation Surgery: Top Surgery", The Annual Meeting of The American Society of Aesthetic Plastic Surgery, April 26-May 1, 2018, New York, NY
168. "Gender Confirmation Surgery," Econsult monthly meeting, Dept. of Veterans' Affairs, May 24, 2018
169. "Gender Confirmation Surgery," Transgender Care Conference: Improving Care Across the Lifespan, Moses Cone Hospital, Greensboro, NC, June 8, 2018
170. "WPATH State of the Art," 1st Swiss Consensus Meeting on the Standardization of Sex Reassignment Surgery, The University of Basel, August 31, 2018-September 1, 2018
171. "Facial Feminization Surgery: The New Frontier?" 1st Swiss Consensus Meeting on the Standardization of Sex Reassignment Surgery, The University of Basel, August 31, 2018-September 1, 2018
172. "Current Techniques and Results in Mastectomies," 1st Swiss Consensus Meeting on the Standardization of Sex Reassignment Surgery, The University of Basel, August 31, 2018-September 1, 2018
173. "Gender Confirmation Surgery," The University of Chicago, Pritzker School of Medicine, September 7, 2018, Chicago, IL.
174. The Business End: Incorporating Gender Confirmation Surgery, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, September 29, 2018, Chicago, IL
175. Body Contouring in Men, Gynecomastia, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, September 30, 2018, Chicago, IL

176. Moderator: Breast Augmentation and Chest Surgery in Gender Diverse Individuals, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, October 1, 2018, Chicago, Il
177. Moderator: Aesthetic Surgery of The Male Genitalia, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, October 1, 2018, Chicago, Il
178. Moderator: Gender Confirmation Surgeries: The Standards of Care and Development of Gender Identity, Plastic Surgery The Meeting, Annual Meeting of The American Society of Plastic Surgeons, October 1, 2018, Chicago, Il
179. The Center for Gender Confirmation Surgery Lecture Series, "Introduction to Gender Confirmation Surgery," Weiss Memorial Hospital, October 17, 2018, Chicago, Il
180. Institute 3: Gender Dysphoria Across Development: Multidisciplinary Perspectives on the Evidence, Ethics, and Efficacy of Gender Transition, Gender Confirming Care in Adolescence: Evidence, Timing, Options, and Outcomes, The American Academy of Child and Adolescent Psychiatry, 65th Annual Meeting, October 22-27, 2018, Seattle, WA
181. Gender Confirmation Surgery, Combined Endocrine Grand Rounds, The University of Illinois at Chicago, Rush University, Cook County Hospital, January 8, 2019
182. Gender Confirmation Surgery: An Update, Division of Plastic Surgery, The University of Illinois at Chicago, January 23, 2019
183. Gender Confirmation Surgery from Top to Bottom: A 20 Year Experience, Grand Rounds, The Department of Surgery, Ochsner Health System, January 30, 2019, New Orleans, LA
184. Master Series of Microsurgery: Battle of the Masters One Reconstructive Problem - Two Masters with Two Different Approaches, Gender Affirmation, Male-to-Female Vaginoplasty: Intestinal Vaginoplasty, The American Society for Reconstructive Microsurgery, Palm Desert, California, February 2, 2019
185. Gender Confirmation Surgery: From Top to Bottom, The University of Toronto, Toronto, Canada, February 21, 2019
186. Gender Confirmation Surgery: Where are We, The University of Toronto, Toronto, Canada, February 21, 2019

187. Professors' Rounds: Gender Confirmation Surgery: A Twenty Year Experience, Princess Margaret Hospital, Toronto, Canada, February 22, 2019
188. A 3 Step Approach to Lower Extremity Trauma, Plastic Surgery at The Red Sea, Eilat, Israel, March 6-9, 2019.
189. Gender Surgery: Where are We Now?, Plastic Surgery at The Red Sea, Eilat, Israel, March 6-9, 2019.
190. Gender Confirmation Surgery, A Single Surgeon's 20 Year Experience, Plastic Surgery at The Red Sea, Eilat, Israel, March 6-9, 2019.
191. Gender Confirmation Surgery: Where We Have Been and Where We Are Going, Grand Rounds, The University of Chicago, Section of Plastic Surgery, March 13, 2019
192. Gender Confirmation Surgery: From Top To Bottom, Resident Core Curriculum Conference, The University of Chicago, Section of Plastic Surgery, March 13, 2019.
193. "Gender Confirmation Surgery," WPATH/AMSA Medical School Trans Health Elective, Webinar, March 13, 2019
194. Robotic Vaginoplasty: An Alternative to Penile Inversion Vaginoplasty in Cases of Insufficient Skin, Vaginal Stenosis, and Rectovaginal Fistula. The European Professional Association for Transgender Health, April 9-13, Rome, Italy
195. Current State of Gender-Affirming Surgery in the US and Beyond, Gender-affirming genital surgery presented by the American Urologic Association in collaboration with the Society for Genitourinary Reconstructive Surgeons (GURS), May 2, 2019, Chicago, Il
196. Surgical Training-How Can I get it, The Aesthetic Meeting 2019, New Orleans, LA, May 20, 2019
197. What is the Standard of Care in This New Frontier, The Aesthetic Meeting 2019, New Orleans, LA, May 20, 2019
198. The 20th Annual Chicago Orthopedic Symposium, August 15-18, 2019, Chicago, Il "Soft Tissue Defects-Getting Coverage"
199. Gender Confirmation Sugery, The Potocsnak Family Division of Adolescent and Young Adult Medicine, Ann & Robert H. Lurie Children's Hospital of Chicago, August 19, 2019

200. Anatomy, Embryology, and Surgery, The University of Chicago, First Year Medical Student Anatomy Lecture, September 9, 2019, The University of Chicago, Chicago, Il.
201. Gender Confirmation Surgery, Howard Brown Health Center Gender Affirming Learning Series, September 13, 2019, Chicago, Il.
202. Moderator, Patient Selection in Gender Affirming Survey Surgery, 88th Annual Meeting of The American Society of Plastic Surgeons, September 20-23, 2019, San Diego, CA
203. Breast Augmentation in Transwomen: Optimizing Aesthetics and Avoiding Revisions, 88th Annual Meeting of The American Society of Plastic Surgeons, September 20-23, 2019, San Diego, CA
204. Breast Reconstruction, State of the Art, NYU-Langone Health, NYU School of Medicine, Standards of Care and Insurance Coverage, Saturday, November 23, 2019, New York, NY.
205. ASRM Masters Series in Microsurgery: Think Big, Act Small: The Building Blocks for Success, "Building a Microsurgery Private Practice from the Ground Up", 2020 ASRM Annual Meeting, Ft. Lauderdale, Florida, January 10-14, 2020
206. ASPS/ASRM Combined Panel II: Gender Affirmation Surgery: Reconstruction Challenges of Function and Sensation, 2020 ASRM Annual Meeting, Ft. Lauderdale, Florida, January 10-14, 2020
207. Rush University Medical Center, Division of Urology, Grand Rounds, "Gender Confirmation Surgery: A Single Surgeon's Experience," January 22, 2020
208. Rush University Medical Center, Department of General Surgery, Grand Rounds, "Gender Confirmation Surgery: A Single Surgeon's Experience," February 5, 2020.
209. WPATH/AMSA (American Medical Association) Gender Scholar Course, Webinar, March 11, 2020
210. Rush University Medical Center, Division of Plastic Surgery, Weekly Presentation, Gender Confirmation Surgery: Can a Surgeon Provide Informed Consent?, April 29, 2020
211. Legal Issues Faced by the Transgender Community, ISBA Standing Committee on Women and The Law and the ISBA Standing Committee on Sexual Orientation and Gender Identity, Co-Sponsored by the National Association of Women Judges District 8, Live Webinar, May 28, 2020
212. Principles of Transgender Surgery, National Association of Women's Judges, District 8, Webinar, June 4, 2020

213. Gender-Affirming Surgery, National Association of Women's Judges, District 8, Webinar, July 8, 2020

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Counsel for Plaintiffs and the Class

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
Hennessy-Waller; and John Doe, by his
guardian and next friend, Susan Doe, on
behalf of themselves and all others
similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
Health Care Cost Containment System,
in her official capacity,

Defendant.

No.

**EXPERT DECLARATION OF
ARON JANSSEN, M.D. IN
SUPPORT OF PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

1 I, Aron Janssen, M.D., hereby declare as follows:

2 1. My name is Aron Janssen, M.D. I am a board-certified child and adolescent
3 psychiatrist. I specialize in the treatment of gender dysphoria in children and adolescents,
4 and I am an expert in this field.

5
6 2. I have been retained by counsel for Plaintiffs in the above-captioned lawsuit
7 to provide an expert opinion on the standards of care for treating individuals diagnosed
8 with gender dysphoria. In particular, I have been asked whether: (1) male chest
9 reconstruction surgery is medically necessary for the treatment of gender dysphoria in
10 adolescents and young adults; (2) delaying or denying male chest reconstruction surgery
11 has serious negative implications for a transgender person's health; and (3) a categorical
12 exclusion on Medicaid coverage for gender-confirming surgeries violates the prevailing
13 standards of care for treating transgender adolescents and young adults with gender
14 dysphoria.

15 3. I am over the age of eighteen and submit this expert declaration based on
16 my personal knowledge and experience.

17 4. If called to testify in this matter, I would testify truthfully and based on my
18 expert opinion. The opinions and conclusions I express herein are based on a reasonable
19 degree of scientific certainty.

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Background and Qualifications

5. The information provided regarding my professional background, experiences, publications, and presentations are detailed in my curriculum vitae. A true and correct copy of my CV is attached as Exhibit A.

6. I received my medical degree from the University of Colorado School of Medicine. I completed my residency in psychiatry and a fellowship in child and adolescent psychiatry at New York University Langone Medical Center.

7. In 2011, I founded the Gender and Sexuality Service at New York University, a clinical service dedicated to treating children and adolescents with gender dysphoria. In my last five years at NYU, that clinic served over 200 families, with 2-3 new referrals each week.

8. I am currently the Vice Chair of the Pritzker Department of Psychiatry and Behavioral Health and Chief Psychiatrist for the Gender Development Program at Ann and Robert H. Lurie Children's Hospital of Chicago. I am also a Clinical Associate Professor of Child and Adolescent Psychiatry at Northwestern University Feinberg School of Medicine. I maintain a clinical practice in Illinois where I treat patients from Illinois and the surrounding states.

9. I have been treating children and adolescents with gender dysphoria for over 10 years. I have treated over 300 children and adolescents with gender dysphoria during my medical career. Currently, approximately 90 percent of the patients in my clinical practice are transgender children and adolescents.

1 10. I am a contributing author to the Child and Adult Mental Health and Adult
2 Mental Health chapters of the Eighth Version (forthcoming) of the World Professional
3 Association for Transgender Health's (WPATH) *Standards of Care for the Health of*
4 *Transsexual, Transgender, and Gender-Nonconforming People* (hereafter, "WPATH
5 SOC").
6

7 11. The WPATH SOC provides clinical guidance for health professionals based
8 on the best available science and expert professional consensus. The purpose of the
9 WPATH SOC is to assist health providers in delivering necessary medical care to
10 transgender people, in order to maximize their patients' overall health, psychological well-
11 being, and self-fulfillment. The WPATH SOC has been recognized and adopted as the
12 prevailing standard of care by the major professional association medical and mental health
13 providers in the United States, including the American Medical Association, American
14 Academy of Pediatrics, American Psychiatric Association, American Psychological
15 Association, and Pediatric Endocrine Society, among others.
16

17 12. In addition, I have written a number of peer-reviewed journal articles and
18 chapters in professional textbooks about treatment of gender dysphoria in children and
19 adolescents. In 2018, I co-edited *Affirmative Mental Health Care for Transgender and*
20 *Gender Diverse Youth: A Clinical Casebook*, which is the first published clinical casebook
21 on mental health treatment for children and adolescents with gender dysphoria. A full and
22 complete list of my publications is included in my CV.
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1 13. I am an Associate Editor for the journal *Transgender Health*, and an Ad Hoc
2 Reviewer for the journal *LGBT Health*. Each of these publications is a peer-reviewed
3 medical journal.

4 14. I am actively involved in training other medical and mental health providers
5 in the treatment of children and adolescents with gender dysphoria. I have conducted
6 trainings for over 1,000 medical and mental health providers and have given dozens of
7 public addresses, seminars, and lectures on the treatment of gender dysphoria in children
8 and adolescents. I have also taught a number of courses through WPATH's Global
9 Education Initiative, which provides training courses toward a member certification
10 program in transgender health for practitioners around the world.

11 15. I am a member of the following professional organizations: American
12 Psychiatric Association, American Academy of Child and Adolescent Psychiatry
13 (AACAP), and World Professional Association for Transgender Health (WPATH). I am
14 also a member of the Sexual Orientation and Gender Identity Committee of AACAP, the
15 Gender Dysphoria Working Group of the American Psychiatric Association, and the
16 Transgender Health Committee of the Association of Gay and Lesbian Psychiatrists.

17 16. I am being compensated at an hourly rate of \$400/hour plus expenses for my
18 time spent preparing this declaration and providing local testimony (including deposition
19 or providing hearing testimony by telephone or video-teleconference). My compensation
20 does not depend on the outcome of this litigation, the opinions I express, or the testimony
21 I may provide.

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1 assigned sex, matches that person’s gender identity. For transgender people, their assigned
2 sex does not align with their gender identity.

3 21. Gender identity is a person’s inner sense of belonging to a particular gender,
4 such as male or female. It is core and universal component of human identity.

5
6 22. By the beginning of the twentieth century, scientific research had established
7 that external genitalia alone—the critical criterion for assigning sex at birth—are not
8 always an accurate proxy for a person’s sex. Instead, a person’s sex is comprised of a
9 number of components, including, among others, internal reproductive organs, external
10 genitalia, chromosomes, hormones, gender identity, and secondary-sex characteristics.
11 When there is a divergence between these factors, as there is for transgender and intersex
12 individuals, medical science recognizes that the person’s gender identity is the most
13 important and determinative factor. It is medically inappropriate and harmful to treat a
14 transgender person inconsistently with their gender identity.
15
16

17 23. Like nontransgender people, transgender people do not simply have a
18 “preference” to act or behave consistently with their gender identity. Every person has a
19 gender identity and it is not a personal decision, preference, or belief. A transgender boy
20 cannot simply turn off his gender identity like a switch, any more than a nontransgender
21 boy or anyone else could.
22

23 24. Living in a manner consistent with one’s gender identity is critical to the
24 health and well-being of any person, including transgender people.
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1 25. In other words, in terms of a person’s psychological makeup and core
2 identity, a transgender boy has always been a boy, regardless of the sex he was assigned at
3 birth. Likewise, a transgender girl has always been a girl, regardless of the sex she was
4 assigned at birth.

5
6 26. Current science recognizes that gender identity is innate and strongly
7 indicates that gender identity has a biological basis. For example, both post-mortem and
8 functional brain imaging studies in living people show that transgender men have areas of
9 the brain that are similar to the brains of other men who are not transgender, and
10 transgender women have areas of the brain that are similar to the brains of other women
11 who are not transgender. Additionally, research has found that the process of gender
12 identity development in transgender children is identical to that of nontransgender children
13 and that psychological measurements of the gender identities of children in each of the two
14 groups are indistinguishable from one another. That is, a transgender boy’s gender-related
15 development is the same as other boys who are not transgender, and a transgender girls’
16 gender-related development is the same as other girls who are not transgender.

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18
19 27. The evidence demonstrating that gender identity cannot be altered, either for
20 transgender or for nontransgender individuals, further underscores the innate and
21 immutable nature of gender identity. Past attempts to “cure” transgender individuals by
22 using talk therapy, and even aversive therapy, to change their gender identity to match their
23 birth-assigned sex were ineffective and caused extreme psychological damage. All major
24 associations of medical and mental health providers, such as the American Medical
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1 Association, the American Psychiatric Association, American Academy of Child and
2 Adolescent Psychiatry, the American Psychological Association, and WPATH's standards
3 of care, consider such efforts harmful and unethical.

4
5 28. Gender dysphoria is the medical diagnosis for the severe and unremitting
6 psychological distress resulting from the incongruity between a person's assigned sex and
7 their gender identity. It is a serious medical condition and is listed in both the DSM-5 and
8 the World Health Organization's International Classification of Diseases, the diagnostic
9 and coding compendia for mental health and medical professionals, respectively.
10

11 ***Standard of Care for Treatment of Gender Dysphoria in Youth***

12
13 29. Like all children, transgender children can thrive, grow into healthy adults
14 and have the same capacity for happiness, achievement, and contribution to society as
15 others. For this particular group of young people, that means supporting their need to live
16 in a manner consistent with their gender identity in all aspects of their lives.

17
18 30. Accordingly, treatment for gender dysphoria brings a transgender person's
19 life into closer alignment with their gender identity. The process of undergoing those
20 treatments is often referred to as transition. The steps that make up a transgender person's
21 transition will depend on that individual's medical and mental health needs. There is no
22 specific step, or series of steps, a transgender person must undertake to complete their
23 transition.
24

25
26 31. Transition does not make a transgender person more of a man or more of a
27 woman than they were before; rather, the person's gender identity already exists, just as it
28

1 does for nontransgender people. The purpose of transition is to allow a transgender person
2 to live congruently with their gender identity, including in many cases undergoing medical
3 treatments to align the person’s body with who they are.

4
5 32. Typically, transgender people start their transition with a series of steps that
6 are commonly referred to as a “social transition.” Those steps include changing their name,
7 using different pronouns, wearing clothing and adopting grooming habits typically
8 associated with their gender identity, and using the corresponding sex-specific facilities.
9 Making those changes enable a transgender person to begin living their life consistent with
10 their gender identity and helps ensure that they are treated as such by family, peers, and
11 others in the community.
12

13
14 33. At the onset of puberty, transgender young people may also start taking
15 puberty-delaying medication to prevent their bodies from being flooded with the incorrect
16 sex hormone and the attendant development of unwanted and psychologically distressing
17 secondary-sex characteristics that are in conflict with the person’s identity. For transgender
18 young people who need that medication, any delay will increase the experience of
19 debilitating psychological distress because their body and gender identity are diverging
20 even further each day, instead of coming into closer alignment. That psychological distress
21 is heightened by the reality that some of the physical changes associated with puberty may
22 be irreversible, permanently constricting a transgender young person’s future treatment
23 options and negatively affecting their quality of life.
24

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27 34. Hormone replacement therapy is medically necessary for most transgender
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1 young people regardless of whether they have taken puberty-delaying medication. That
2 treatment causes their bodies to develop the secondary-sex characteristics associated with
3 their gender identity, such as facial and body hair in boys and breasts in girls.

4
5 35. Surgical treatment is also medically necessary for some transgender youth in
6 order to alleviate their gender dysphoria. The most common surgical procedure that is
7 medically necessary for transgender young people is male chest reconstruction surgery,
8 which involves the removal of breast tissue and the creation of a male chest.

9
10 36. Delaying any of these treatments will not only exacerbate a transgender
11 young person's gender dysphoria, but also could lead to the development of other co-
12 occurring mental health conditions, including depression, anxiety, and disordered eating.
13 Those co-occurring mental health conditions may be accompanied by unhealthy coping
14 behaviors such as self-harm, substance misuse, and suicide attempts.

15
16 ***Transition is the only Safe and Effective Treatment for Gender Dysphoria***

17
18 37. Research and clinical experience repeatedly reaffirm that transition
19 significantly improves the mental and physical health of transgender young people.

20 38. This is true of each stage of a transgender young person's transition.
21 Transgender young people who underwent a social transition in childhood demonstrated
22 better mental health profile than prior studies of gender nonconforming children. *See* Lily
23 Durwood, et al., *Mental Health and Self-Worth in Socially Transitioned Transgender*
24 *Youth*, 56 J. Am. Acad. of Child & Adol. Psychiatry 116 (2017); Kristina Olson, et al.,
25 *Mental Health of Transgender Children who are Supported in Their Identities*, 137

1 Pediatrics 1 (2016). This same outcome has also been seen in a longitudinal study of
2 transgender young people who underwent each of the three stages of transition outlined
3 above. Annelou L.C. de Vries, et al., *Young Adult Psychological Outcome After Puberty*
4 *Suppression and Gender Reassignment*, 134 Pediatrics 696 (2014). In a study specifically
5 about male chest reconstruction surgery, post-operative transgender young people
6 demonstrated significant psychological and functional improvements, from a greater
7 willingness to plan for their future and to engage activities of daily living (e.g., bathing,
8 buying clothing). Johanna Olson-Kennedy, et al., *Chest Reconstruction and Chest*
9 *Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and*
10 *Postsurgical Cohorts*, 172 JAMA Pediatrics 431, 434 (2018)

11
12
13
14 39. Transition also can—and often does—alleviate co-occurring mental health
15 issues a transgender young person experienced prior to transition. Following transition,
16 transgender young people are often able to reduce dosage of psychiatric medications and
17 see significant improvements in functioning and quality of life. Treating their gender
18 dysphoria also increases a transgender young person’s capacity to develop and maintain
19 better coping strategies to manage any co-occurring conditions.
20

21
22 ***Medical Necessity of Male Chest Reconstruction Surgery for Transgender Males***

23 40. The presence—and prominence—of secondary-sex characteristics can
24 undermine the significant psychological relief associated with transition. Those physical
25 features serve as a constant reminder to a transgender young person of the dissonance
26 between their assigned sex and gender identity. This incongruity becomes even more stark
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1 as a transgender young person brings the other aspects of their appearance into closer
2 alignment with their gender identity. *See, e.g.,* Olson-Kennedy, *supra*, 172 JAMA
3 Pediatrics at 435 (“Chest dysphoria was higher for those who had been taking testosterone
4 longer, increasing by 0.33 points for each month taking testosterone.”).

5
6 41. Secondary-sex characteristics can also serve as markers that cause others to
7 incorrectly refer to a transgender person by their assigned sex or deny them access to sex-
8 separated spaces, which is already a source of anxiety for many transgender young people.
9 That anxiety is often compounded by fears that those incidents would force them to
10 disclose their transgender status and expose them to further mistreatment, or even violence.

11
12 42. The secondary-sex characteristic that commonly causes the most dysphoria
13 for transgender males is their chest. Transgender males will wear constrictive binders
14 designed to flatten their chest and give the appearance of male-chest contour. Binders offer
15 transgender males a critical method for self-treating the dysphoria they experience due to
16 the appearance of their chest. Without binders, many transgender males, including
17 adolescents and young adults, would experience debilitating gender dysphoria that would
18 significantly interfere with their daily functioning, let alone their overall mental health and
19 well-being.
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22
23 43. But the benefits of wearing a binder are limited and temporary. Although
24 binders can dampen a transgender male’s chest dysphoria during the day, they rarely
25 eliminate it. Even when wearing a binder, a transgender male’s chest dysphoria can still
26 impair their ability to function at school—academically, socially, and otherwise. And, they
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1 must remove the binder each night. Once removed, transgender males often experience a
2 significant increase in their gender dysphoria, a painful reminder that they are not yet able
3 to live fully as male. For that, and many other reasons, transgender males will regularly
4 wear their binder longer than recommended, jeopardizing their physical health.
5

6 44. Binders also becomes less effective over time at treating gender dysphoria.
7 Hormone replacement therapy—another critical element of transition—causes transgender
8 males to develop facial hair, prominent Adam’s apple, deeper voice, and other secondary-
9 sex characteristics associated with males. Those changes make the appearance of their
10 chest even more pronounced and discomfiting.
11

12 45. The restrictiveness of a binder also often causes physical discomfort and
13 limits the ability of transgender males to engage in physical activity, which can also
14 exacerbate gender dysphoria or other forms of psychological distress.
15

16 46. Male chest reconstruction surgery is the only effective treatment for the chest
17 dysphoria experienced by transgender males. The psychological relief that surgery
18 provides is palpable. The surgery removes the source of their psychological distress and
19 physical discomfort and significantly improves a transgender boy’s self-image and ability
20 to confidently move through the world as male.
21

22 47. Denying or delaying access to male chest reconstruction surgery can have
23 serious short- and long-term consequences for a young transgender male’s mental health.
24 At a minimum, the prolonged psychological distress associated with that delay can result
25 in a worsening of a transgender young person’s gender dysphoria, which can manifest in
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1 myriad ways from increased anxiety and depression to engaging in negative coping
2 behaviors such as self-harm (*i.e.* cutting, burning). The more severe the distress becomes,
3 the more likely that it will be harder to treat and have a longer-lasting effect on a
4 transgender young person's mental health and wellbeing. Untreated chest dysphoria in
5 transgender males can result in suicidal ideation and attempts.

7 **Conclusion**

8 48. Categorically excluding coverage for male chest reconstruction surgery to treat
9 gender dysphoria has no basis in the prevailing standards of care, peer-reviewed medical literature,
10 and clinical experience.

12 49. Male chest reconstruction surgery is medically necessary treatment for gender
13 dysphoria. That treatment is critical for the health, safety, and overall wellbeing of transgender
14 males, including adolescents and young adults. Any delay or denial of care will likely result in
15 serious psychological harm that could have lifelong implications.

18 I declare under penalty of perjury under the laws of the United States that the foregoing is
19 true and correct.

20 Executed this 3th day of August, 2020 at Chicago, Illinois.

22 
23 _____
24 Aron Janssen, M.D.

Exhibit A

Curriculum Vitae

Aron Janssen, M.D.

312-227-7783

aron.janssen@nyumc.org

Personal Data

Born Papillion, Nebraska
Citizenship USA

Academic Appointments

2011-2017 Clinical Assistant Professor of Child and Adolescent Psychiatry
2011-2019 Founder & Clinical Director, NYU Gender and Sexuality Service
Director, LGBT Mental Health Elective, NYULMC
2015-2019 Co-Director, NYU Pediatric Consultation Liaison Service
New York University Department of Child and Adolescent Psychiatry
2017-present Clinical Associate Professor of Child and Adolescent Psychiatry
2019-present Vice Chair, Pritzker Department of Psychiatry and Behavioral Health
Ann and Robert H. Lurie Children's Hospital of Chicago

Education

Year	Degree	Field	Institution
6/97	Diploma		Liberty High School
5/01	B.A.	Biochemistry	University of Colorado
5/06	M.D.	Medicine	University of Colorado

Postdoctoral Training

2006-2009 Psychiatry Residency Ze'ev Levin, M.D. NYU Department of Psychiatry
2009-2011 Child and Adolescent Psychiatry Fellowship – Fellow and Clinical Instructor
Jess Shatkin, M.D. NYU Dept of Child/Adolescent Psychiatry

Licensure and Certification

2007-present New York State Medical License
2011-present Certification in Adult Psychiatry, American Board of Psychiatry and Neurology
2013-present Certification in Child and Adolescent Psychiatry, ABPN

Academic Appointments

2009-2011 Clinical Instructor, NYU Department of Child and Adolescent Psychiatry
2011-present Clinical Asst Professor, NYU Dept of Child and Adolescent Psychiatry
2011-present Clinical Director, NYU Gender and Sexuality Service
2015-present Co-Director, NYU Pediatric Consultation-Liaison Service

Awards and Honors

2006 Adler Scholarship
2001 Dean Van Ek Award
2001 Phi Beta Kappa

Major Committee Assignments

National and Regional

2015-present	Department of Child Psychiatry Diversity Ambassador
2013-present	Sexual Orientation and Gender Identity Committee Member, AACAP
2012-present	Founder and Director, Gender Variant Youth and Family Network
2012-present	Association of Gay and Lesbian Psychiatrists, Transgender Health Committee
2012-2019	NYULMC, Chair LGBTQ Advisory Council
2012-2019	NYULMC, Child Abuse and Protection Committee
2013-2015	NYULMC, Pediatric Palliative Care Team
2003-2004	American Association of Medical Colleges (AAMC), Medical Education Delegate
2004-2006	AAMC, Western Regional Chair

Psychiatry Residency

2006-2009	Resident Member, Education Committee
2007-2008	Resident Member, Veterans Affairs (VA) Committee

Medical School

2002-2006	Chair, Diversity Curriculum Development Committee
2002-2006	AAMC, Student Representative
2003-2004	American Medical Student Assoc. (AMSA) World AIDS Day Coordinator
2003-2004	AMSA, Primary Care Week Coordinator
2004-2006	Chair, Humanism in Medicine Committee

Memberships, Offices, and Committee Assignments In Professional Societies

2006-present	American Psychiatric Association (APA)
2009-present	American Academy of Child and Adolescent Psychiatry (AACAP)
2011-present	World Professional Association for Transgender Health (WPATH)
2011-present	Director, Gender Variant Youth and Family Network, NYC
2013-present	Chair, NYU Langone Medical Center LGBTQ Council
2015-present	Clinical Associate Editor, <i>Transgender Health</i>

Editorial Positions

2016-present	Clinical Assistant Editor, <i>Transgender Health</i>
2014-present	Ad Hoc Reviewer, <i>LGBT Health</i>
2018-present	Associate Editor, <i>Transgender Health</i>

Principal Clinical and Hospital Service Responsibilities

2011-2019	Staff Psychiatrist, Pediatric Consultation Liaison Service
2011-2019	Faculty Physician, NYU Child Study Center
2011-2019	Founder and Clinical Director, NYU Gender & Sexuality Service
2015-2019	Co-Director, Pediatric Consultation Liaison Service
2019-present	Vice Chair, Pritzker Dept of Psychiatry and Behavioral Health
2019-present	Chief Psychiatrist, Gender Development Program

Program Development

- Gender and Sexuality Service
 - founded by Aron Janssen in 2011, who continues to direct the service
 - first mental health service dedicated to transgender youth in NYC
 - served over 200 families in consultation, with 2-3 referrals to the gender clinic

- per week
- trained over 500 mental health practitioners in transgender mental health – 1 or 2 full day trainings in partnership with the Ackerman Institute’s Gender and Family Project (GFP) and with WPATH Global Educational Initiative (GEI)
- New hires in Adolescent Medicine, Psychology, Plastic Surgery, Urology, Gynecology, Endocrinology, Social Work, Department of Population Health with focus on transgender care has led to expansion of available services for transgender youth at NYULMC in partnership with the Gender and Sexuality Service
- development of partnerships with Ackerman Institute, Callen-Lorde Health Center – both institutions have been granted access to our IRB and have agreed to develop shared research and clinical priorities with the Gender and Sexuality Service. Two active projects are already underway
- multiple IRB research projects underway, including in partnership with national and international clinics
- model has been internationally recognized

NYU Consultation-Liaison Service

- 3-fold increase in number of consults since becoming co-director
- expansion into outpatient pediatrics
- oversaw hiring of 5 new clinicians
- initiated and expanded research/QI projects within service
 - RCT for novel model of CBT for IBD (in process, currently in recruitment for a study to test a novel 4-session CBT-based treatment)
 - RCT for treatment of delirium (in process, finalizing IRB submission)
 - QI project on stress/resilience for families in the PICU – over 90% of patients screened each week with stress thermometer with standardized response protocol.
- Development of Pediatric and Family Behavioral Emergency Response Team

Clinical Specialties/Interests

Gender and Sexual Identity Development
 Pediatric Consultation/Liaison Psychiatry
 Psychotherapy

- Gender Affirmative Therapy, Supportive Psychotherapy, CBT

Teaching Experience

- 2002-2006 Course Developer and Instructor, LGBT Health (University of Colorado School of Medicine)
- 2011-present Instructor, Cultural Competency in Child Psychiatry (NYU Department of Child and Adolescent Psychiatry) – 4 hours per year
- 2011-present Course Director, Instructor “Sex Matters: Identity, Behavior and Development” – 100 hours per year
- 2011-present Course Director, LGBT Mental Health Elective (NYU Department of Psychiatry) - 50 hours of direct supervision/instruction per year
- 2011-present Course Director, Transgender Mental Health (NYU Department of Child and Adolescent Psychiatry – course to begin in Spring 2018.
- 2015-present Instructor, Gender & Health Selective (NYU School of Medicine) – 4 hours per year.

Academic Assignments/Course Development

New York University Department of Child and Adolescent Mental Health Studies

-Teacher and Course Director: “Sex Matters: Identity, Behavior and Development.”

A full semester 4 credit course, taught to approximately 50 student per year since 2011, with several students now in graduate school studying sexual and gender identity development as a result of my mentorship.

NYU Department of Child and Adolescent Psychiatry

-Instructor: Cultural Competency in Child and Adolescent Psychiatry

-Director: LGBTQ Mental Health Elective

World Professional Association of Transgender Health

-Official Trainer: Global Education Initiative – one of two child psychiatrists charged with training providers in care of transgender youth and adults.

Peer Reviewed Publications

1. Janssen, A., Erickson-Schroth, L., “A New Generation of Gender: Learning Patience from our Gender Non-Conforming Patients,” Journal of the American Academy of Child and Adolescent Psychiatry, Volume 52, Issue 10, pp. 995-997, October, 2013.
2. Janssen, A., et. al. “Theory of Mind and the Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning Autism Spectrum
3. Janssen A, Huang H, and Duncan C., Transgender Health. February 2016, “Gender Variance Among Youth with Autism: A Retrospective Chart Review.” 1(1): 63-68. doi:10.1089/trgh.2015.0007.
4. Goedel WC, Reisner SL, Janssen AC, Poteat TC, Regan SD, Kreski NT, Confident G, Duncan DT. (2017). Acceptability and Feasibility of Using a Novel Geospatial Method to Measure Neighborhood Contexts and Mobility Among Transgender Women in New York City. Transgender Health. July 2017, 2(1): 96-106.
5. Janssen A., et. al., “Gender Variance Among Youth with ADHD: A Retrospective Chart Review,” in review
6. Janssen A., et. al., “Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents,” Journal of Child & Adolescent Psychology, 105-115, January 2018.
7. Janssen A., et. al., “A Review of Evidence Based Treatments for Transgender Youth Diagnosed with Social Anxiety Disorder,” Transgender Health, 3:1, 27–33, DOI: 10.1089/ trgh.2017.0037.
8. Janssen A., et. al., “The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study,” Archives of Sexual Behavior, 2019. # 3563492
9. Kimberly LL, Folkers KM, Friesen P, Sultan D, Quinn GP, Bateman-House A, Parent B, Konnoth C, Janssen A, Shah LD, Bluebond-Langner R, Salas-Humara C., “Ethical Issues in Gender-Affirming Care for Youth,” Pediatrics, 2018 Dec;142(6).
10. Strang JF, Janssen A, Tishelman A, Leibowitz SF, Kenworthy L, McGuire JK, Edwards-Leeper L, Mazefsky CA, Rofey D, Bascom J, Caplan R, Gomez-Lobo V, Berg D, Zaks Z, Wallace GL, Wimms H, Pine-Twaddell E, Shumer D, Register-Brown K, Sadikova E, Anthony LG., “Revisiting the Link: Evidence of the Rates of Autism in Studies of Gender Diverse Individuals,” Journal of the American Academy of Child and Adolescent Psychiatry, 2018 Nov;57(11):885-887.
11. Goedel William C, Regan Seann D, Chaix Basile, Radix Asa, Reisner Sari L, Janssen Aron C, Duncan Dustin T, “Using global positioning system methods to explore

- mobility patterns and exposure to high HIV prevalence neighbourhoods among transgender women in New York City,” *Geospatial Health*, 2019 Jan; 14(2): 351-356.
12. Madora, M., Janssen, A., Junewicz, A., “Seizure-like episodes, but is it really epilepsy?” *Current Psychiatry*. 2019 Aug; 18(8): 42-47.
 13. Janssen, A., Busa, S., Wernick, J., “The Complexities of Treatment Planning for Transgender Youth with Co-Occurring Severe Mental Illness: A Literature Review and Case Study,” *Archives of Sexual Behavior*. 2019 Oct; 48(7): 2003-2009.
 14. Wernick Jeremy A, Busa Samantha, Matouk Kareen, Nicholson Joey, Janssen Aron, “A Systematic Review of the Psychological Benefits of Gender-Affirming Surgery,” *Urol Clin North Am*. 2019 Nov; 46(4): 475-486.
 15. Strang, J.F., Knauss, M., van der Miesen, A.I.R., McGuire, J., Kenworthy, L., Caplan, R., Freeman, A.J., Sadikova, E., Zacks, Z., Pervez, N., Balleur, A., Rowlands, D.W., Sibarium, E., McCool, M.A., Ehrbar, R.D., Wyss, S.E., Wimms, H., Tobing, J., Thomas, J., Austen, J., Pine, E., Willing, L., Griffin, A.D., Janssen, A., Gomez-Lobo, A., Brandt, A., Morgan, C., Meagher, H., Gohari, D., Kirby, L., Russell, L., Powers, M., & Anthony, L.G., (in press 2020). A clinical program for transgender and gender-diverse autistic/neurodiverse adolescents developed through community-based participatory design. *Journal of Clinical Child and Adolescent Psychology*. DOI 10.1080/15374416.2020.1731817
 16. Coyne, C. A., Poquiz, J. L., Janssen, A., & Chen, D. (In press 2020). Evidence-based psychological practice for transgender and non-binary youth: Defining the need, framework for treatment adaptation, and future directions. *Evidence-based Practice in Child and Adolescent Mental Health*.
 17. Janssen, A., Voss, R. (In press 2020). Policies sanctioning discrimination against transgender patients flout scientific evidence and threaten health and safety. *Transgender Health*.

Published Abstracts

1. Thrun, M., Janssen A., et. al. “Frequency of Patronage and Choice of Sexual Partners may Impact Likelihood of HIV Transmission in Bathhouses,” original research poster presented at the 2007 Conference on Retroviruses and Opportunistic Infections, February, 2007.
2. Janssen, A., “Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations.” Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting, October 2012.
3. Janssen, A., “Gender Variance in Childhood and Adolescents: Training the Next Generation of Psychiatrists,” 23rd Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, February 2014.
4. Janssen, A., “When Gender and Psychiatric Acuity/Comorbidities Overlap: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth,” AACAP Annual Meeting, October 2014.
5. Janssen, A., “Patient Experiences as Drivers of Change: A unique model for reducing transgender health disparities as an academic medical center,” Philadelphia Transgender Health Conference, June 2016.
6. Janssen, A., “How much is too much? Assessments & the Affirmative Approach to TGNC Youth,” 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.

7. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
8. Janssen, A., "Gender Variance Among Youth with Autism: A Retrospective Chart Review," Research Poster, 24th Symposium of the World Professional Association for Transgender Health, Amsterdam, The Netherlands, June 2016.
9. Janssen, A., "Gender Fluidity and Gender Identity Development," Center for Disease Control – STD Prevention Conference, September 2016.
10. Janssen, A., "Transgender Identities Emerging During Adolescents' Struggles With Mental Health Problems," AACAP Annual Conference, October 2016.
11. Janssen, A., "How Much is Too Much? Assessments and the Affirmative Approach to Transgender and Gender Diverse Youth," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
12. Janssen, A., "Trauma, Complex Cases and the Role of Psychotherapy," US Professional Association for Transgender Health Inaugural Conference, Los Angeles, February 2017.
13. Sutter ME, Bowman-Curci M, Nahata L, Tishelman AC, Janssen AC, Salas-Humara C, Quinn GP. Sexual and reproductive health among transgender and gender-expansive AYA: Implications for quality of life and cancer prevention. Oral presentation at the Oncofertility Consortium Conference, Chicago, IL. November 14, 2017.
14. Janssen, A., Sidhu, S., Gwynette, M., Turban, J., Myint, M., Petersen, D., "It's Complicated: Tackling Gender Dysphoria in Youth with Autism Spectrum Disorders from the Bible Belt to New York City," AACAP Annual Conference, October 2017.
15. May 2018: "A Primer in Working with Parents of Transgender Youth," APA Annual Meeting.
16. October 2018: "Gender Dysphoria Across Development" – Institute for AACAP Annual Conference.
17. November 2018: "Gender Variance Among Youth with Autism," World Professional Association for Transgender Health Biannual Conference.
18. March 2019: "Gender Trajectories in Child and Adolescent Development and Identity," Austin Riggs Grand Rounds.
19. Janssen, A., et. al., "Ethical Principles in Gender Affirming Care," AACAP Annual Conference, October 2019.
20. Janssen, A., "Gender Diversity and Gender Dysphoria in Youth," EPATH Conference, April 2019
21. Englander, E., Janssen A., et. al., "The Good, The Bad, and The Risky: Sexual Behaviors Online," AACAP Annual Conference, October 2020

Books

1. Janssen, A., Leibowitz, S (editors), *Affirmative Mental Health Care for Transgender and Gender Diverse Youth: A Clinical Casebook*, Springer Publishing, 2018.

Book Chapters

1. Janssen, A., Shatkin, J., "Atypical and Adjunctive Agents," *Pharmacotherapy for Child and Adolescent Psychiatric Disorders*, 3rd Edition, Marcel Dekker, Inc, New York, 2012.

2. Janssen, A; Liaw, K: “Not by Convention: Working with People on the Sexual & Gender Continuum,” book chapter in The Massachusetts General Hospital Textbook on Cultural Sensitivity and Diversity in Mental Health. Humana Press, New York, Editor R. Parekh, January 2014.
3. Janssen, A; Glaeser, E., Liaw, K: “Paving their own paths: What kids & teens can teach us about sexual and gender identity,” book chapter in Cultural Sensitivity in Child and Adolescent Mental Health, MGH Psychiatry Academy Press, Editor R. Parekh, 2016
4. Janssen A., “Gender Identity,” Textbook of Mental and Behavioral Disorders in Adolescence, February 2018.
5. Busa S., Wernick, J., & Janssen, A. (In Review) Gender Dysphoria in Childhood. Encyclopedia of Child and Adolescent Development. Wiley, 2018.
6. Janssen A., Busa S., “Gender Dysphoria in Childhood and Adolescence,” Complex Disorders in Pediatric Psychiatry: A Clinician’s Guide, Elsevier, Editors Driver D., Thomas, S., 2018.
7. Wernick J.A., Busa S.M., Janssen A., Liaw K.R.L. “Not by Convention: Working with People on the Sexual and Gender Continuum.” Book chapter in The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health, editors Parekh R., Trinh NH. August, 2019.
8. Weis, R., Janssen, A., & Wernick, J. The implications of trauma for sexual and reproductive health in adolescence. In *Not Just a nightmare: Thinking beyond PTSD to help teens exposed to trauma*. 2019
9. Connors J., Irastorza, I., Janssen A., Kelly, B., “Child and Adolescent Medicine,” The Equal Curriculum: The Student and Educator Guide to LGBTQ Health, editors Lehman J., et al. November 2019.
10. Janssen, A., et. al., “Gender and Sexual Diversity in Childhood and Adolescence,” Dulcan’s Textbook of Child and Adolescent Psychiatry, 3rd edition, editor Dulcan, M., (in press)

Invited Academic Seminars/Lectures

1. April 2006: “How to Talk to a Gay Medical Student” – presented at the National AAMC Meeting.
2. March 2011: “Kindling Inspiration: Two Model Curricula for Expanding the Role of Residents as Educators” – workshop presented at National AADPRT Meeting.
3. May 2011: Janssen, A., Shuster, A., “Sex Matters: Identity, Behavior and Development,” Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
4. March 2012: Janssen, A., Lothringer, L., “Gender Variance in Children and Adolescents,” Grand Rounds Presentation, NYU Department of Child and Adolescent Psychiatry.
5. June 2012: Janssen, A., “Gender Variance in Childhood and Adolescence,” Grand Rounds Presentation, Woodhull Department of Psychiatry
6. October 2012: “Advocating for the mental health of Lesbian, Gay, Bisexual and Transgender (LGBT) population: The Role of Psychiatric Organizations.” Workshop for the American Psychiatric Association Institute of Psychiatric Services Annual Meeting.
7. March 2013: “Gender Variance in Childhood and Adolescence,” Sexual Health Across the Lifespan: Practical Applications, Denver, CO.

8. October 18th, 2013: “Gender Variance in Childhood and Adolescence,” Grand Rounds Presentation, NYU Department of Endocrinology.
9. October, 2014: GLMA Annual Conference: “Theory of Mind and Intolerance of Ambiguity: Two Case Studies of Transgender Individuals with High-Functioning ASD,” Invited Presentation
10. October 2014: New York Transgender Health Conference: “Mental Health Assessment in Gender Variant Children,” Invited Presentation.
11. November, 2014: Gender Spectrum East: “Affirmative Clinical Work with Gender-Expansive Children and Youth: Complex Situations.”
12. October 2015: “Gender Dysphoria and Complex Psychiatric Co-Morbidity,” LGBT Health Conference, Invited Speaker
13. October 2015: “Transgender Health Disparities: Challenges and Opportunities,” Grand Rounds, Illinois Masonic Department of Medicine
14. November 2015: “Autism and Gender Variance,” Gender Conference East, Invited Speaker
15. February 2016: “Working with Gender Variant Youth,” New York State Office of Mental Health State Wide Grand Rounds, Invited Speaker
16. March, 2016: “Working with Gender Variant Youth,” National Council for Behavioral Health Annual Meeting, Invited Speaker
17. March 2016: “Gender Variance Among Youth with Autism: A Retrospective Chart Review and Case Presentation,” Working Group on Gender, Columbia University, Invited Speaker.
18. September, 2016: “Best Practices in Transgender Mental Health: Addressing Complex Issues for Gender Dysphoric and Non-Conforming Youth,” DeWitt Wallace Institute for the History of Psychiatry, Weill Cornell.
19. October, 2016: “LGBTQ Youth Psychiatric Care,” Midwest LGBTQ Health Symposim
20. October, 2016: “Gender Fluidity and Gender Identity Development,” NYU Health Disparities Conference.
21. February, 2017: “Best Practices in Transgender Mental Health,” Maimonides Grand Rounds
22. March, 2017: “Transgender Health: Challenges and Opportunities,” Invited speaker, Center for Disease Control STD Prevention Science Series.
23. September 2017: “Autism and Gender Dysphoria,” Grand Rounds, NYU Department of Neurology.
24. November 2017: “Consent and Assent in Transgender Adolescents,” Gender Conference East.
25. November 2017: “Transgender Mental Health: Challenges and Opportunities,” Grand Rounds, Lenox Hill Hospital.
26. April 2018: “Gender Trajectories in Childhood and Adolescent Development and Identity,” Sex, Sexuality and Gender Conference, Harvard Medical School.
27. September 2019: “Social and Psychological Challenges of Gender Diverse Youth,” Affirmative Mental Health Care for Gender Diverse Youth, University of Haifa.
28. October 2019: “Best Practices in Transgender Mental Health,” Grand Rounds, Rush Department of Psychiatry.
29. February 2020: “The Overlap of Autism and Gender Dysphoria,” Grand Rounds, Northwestern University Feinberg School of Medicine Department of Psychiatry
30. February 2020: “Gender Dysphoria and Autism,” Grand Rounds, University of Illinois at Chicago Department of Psychiatry

Selected Invited Community Seminars/Lectures

1. April 2012: “Gender and Sexuality in Childhood and Adolescence,” Commission on Race, Gender and Ethnicity, NYU Steinhardt Speakers Series.
2. February 2013: “Supporting Transgender Students in School,” NYC Independent School LGBT Educators Panel, New York, NY.
3. June 2013: “LGBT Health,” Presentation for Neuropsychology Department
4. August 2013: “Chronic Fatigue Syndrome: Etiology, Diagnosis and Management,” invited presentation.
5. September 2013: Panelist, “LGBTQ Inclusive Sex Education.”
6. April 2015: Transgender Children, BBC News, BBCTwo, invited expert
7. January 2016: Gender Dysphoria and Autism – Ackerman Podcast - <http://ackerman.podbean.com/e/the-ackerman-podcast-22-gender-dysphoria-autism-with-aron-janssen-md/>
8. February 2016: “Best Practices in Transgender Mental Health,” APA District Branch Meeting, Invited Speaker.
9. May 2016: “Best Practices in Transgender Mental Health,” Washington D.C., District Branch, APA, Invited Speaker
10. July 2016: “Transgender Youth,” Union Square West
11. November 2017: “Understanding Gender: Raising Open, Accepting and Diverse Children,” Heard in Rye, Conversations in Parenting.
12. January 2018: “The Emotional Life of Boys,” Saint David’s School Panel, Invited Speaker
13. June 2018: “Supporting Youth Engaged in Gender Affirming Care,” NYU Child Study Center Workshop.
14. October 2018: “Medicine in Transition: Advances in Transgender Mental Health,” NYCPS HIV Psychiatry and LGBT Committee Meeting.
15. October 2018: “Understanding Gender Fluidity in Kids,” NYU Slope Pediatrics.

Selected Mentoring of Graduate Students, Residents, Post-Doctoral Fellows

2013-2014	Rebecca Hopkinson, Adult Psychiatry Resident, Provided clinical supervision for one year and training in transgender mental health. Dr. Hopkinson works as at Attending Child Psychiatrist at Seattle Children’s and works with transgender youth
2013-2014	Sara Weekly, Chief Child and Adolescent Psychiatry Resident. Provided clinical supervision. Dr. Weekly is now an attending physician at Bay Area Children’s Association in Oakland, California.
2013-present	Elizabeth Glaeser, Undergraduate Student. Provided research and administrative supervision. Elizabeth is now a PhD candidate in Psychology at Columbia and the director of research at the Gender and Family Project
2014-2015	Laura Erickson Schroth, Adult Psychiatry Resident. Provided clinical supervision for one year and training in transgender mental health. Dr. Erickson Schroth is the editor of Trans Bodies, Trans Selves, and Attending Psychiatrist at the Hetrick Martin Institute
2015-2016	Brandon Ito, Child Psychiatry Fellow, Provided Clinical Supervision. Dr. Ito is now an Attending Child and Adolescent Psychiatrist at UCLA.

2015-2017	Howard Huang, Undergraduate Student. Provided research supervision. Howard is now a PhD candidate in psychology at Boston College, pursuing work in gender and sexuality with published peer-reviewed literature.
2016-2019	Samantha Busa, PsyD, Post-Doctoral Fellow. Provide clinical supervision in transgender health. Dr. Busa joined the NYU Gender and Sexuality Service as faculty in 2017.
2016-2019	Lara Brodsinzy, PhD, Attending Psychologist. Provide clinical supervision in transgender health. Dr. Brodsinzy is an Attending Psychologist on the NYU Pediatric Consultation Liaison Service.
2016-2019	Jeremy Wernick, MSW. Provide clinical and administrative supervision.
2017-2019	Serena Chang, Child Psychiatry Fellow; provide clinical and research supervision.

Major Research Interests

Gender and Sexual Identity Development
 Member, AGIR: Adolescent Gender Identity Research Group
 Member, Research Consortium for Gender Identity Development
 Delirium: Assessment, Treatment and Management

Research Studies

<u>Study Title</u>	<u>IRB Study#</u>	<u>Dates</u>
Adolescent Gender Identity Research Study (principal investigator) - unfunded	s15-00431	4/15-5/19
Co-Occurrence of Autism Spectrum Disorders and Gender Variance: Retrospective Chart Review (principal investigator) - unfunded	s14-01930	10/14-5/19
Expert Consensus on Social Transitioning Among Prepubertal Children Presenting with Transgender Identity and/or Gender Variance: A Delphi Procedure Study (principal investigator) - unfunded	s13-00576	3/16-5/19
Co-Occurrence of ADHD/Gender Dysphoria (principal investigator) - unfunded	s16-00001	1/16-5/19
PICU Early Mobility- unfunded	s16-02261	12/16-5/19
Metformin for Overweight and Obese Children and Adolescents with Bipolar Spectrum Disorders Treated with Second-Generation Antipsychotics – Funded by PCORI	s16-01571	8/16-present

Other

Direct income for the department generated by teaching Sex Matters: Identity, Behavior and Development for the Child and Adolescent Mental Health Studies (CAMS) undergraduate program at NYU:

<u>Time Frame</u>	<u>Income</u>
2011 - 2016	\$1,968,950

Selected Media Appearances:

Guest Expert on Gender Identity on Anderson, “When Your Husband Becomes Your Wife,” Air
Date February 8th, 2012
Guest Host, NYU About Our Kids on Sirius XM, 2011
NYU Doctor Radio: LGBT Health, September 2013
NYU Doctor Radio: LGBT Kids, November 2013
NYU Doctor Radio: LGBT Health, July 2014
NYU Doctor Radio: Gender Variance in Childhood, December 2014
BBC Two: Transgender Youth, April 2015
NYU Doctor Radio: Transgender Youth, June 2015
Fox-5 News: Trump’s proposed military ban and Transgender Youth, July, 2017
Healthline.com: Mental Health Experts Call President’s Tweets ‘Devastating’ for Trans Teens,
July, 2017
Huffington Post: What the Military Ban Says to Our Transgender Youth: August, 2017
Metro: How to talk to your transgender kid about Trump, August 2017
NYU Doctor Radio: Transgender Youth, August 2017

Brent P. Ray (*pro hac vice* forthcoming)
 Andrew J. Chinsky (*pro hac vice* forthcoming)
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Counsel for Plaintiffs and the Class

UNITED STATES DISTRICT COURT
 DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No.

**DECLARATION OF DR.
 ANDREW CRONYN IN
 SUPPORT OF PLAINTIFFS'
 MOTION FOR PRELIMINARY
 INJUNCTION**

1 I, Dr. Andrew Cronyn, hereby declare as follows:

- 2 1. I am a pediatrician based in Tucson, Arizona.
- 3 2. I am licensed to practice medicine in Arizona.
- 4 3. I specialize in providing health care to transgender and LGBTQ youth.
- 5 4. As detailed herein, I provide this declaration in support of Plaintiff D.H.'s request
- 6 that AHCCCS cover D.H.'s male chest reconstruction surgery as a medically necessary
- 7 procedure to treat his gender dysphoria.

8 5. My professional opinion of D.H. is based on my in-person assessments of his health

9 as well as a review of prior medical records, including notes from his previous primary care

10 doctor, Dr. Arianna Foster, who had been seeing him since 2016, and his pediatric

11 endocrinologist, Dr. Cindy Chin, who had been seeing him since 2017.

12 Education and Experience

13 6. I have a medical degree from the Albert Einstein College of Medicine.

14 7. I completed my residency in pediatric medicine at Montefiore Medical Center in

15 Bronx, New York in 2000.

16 8. Since completing my residency, I have worked as a pediatrician in Missouri and

17 Arizona.

18 9. In November 2014, after practicing in Missouri for several years, I returned to work

19 at El Rio Health Center in Tucson, Arizona. Shortly after my return, I started treating my first

20 transgender patient, a child whose pediatrician refused to continue seeing him because he is

21 transgender. I reached out to nationally recognized experts in the field to learn everything I could

22 about providing care to transgender youth. The number of transgender patients I saw grew

23 exponentially from there.

24 10. Around February 2015, I became co-leader of transgender health care within El

25 Rio. Over the past five years, the number of transgender patients at El Rio has grown significantly

26 and now treats approximately 250 transgender youth per year ranging in age from four to twenty-

27 one. Of those patients, more than forty of those patients are transgender boys who receive their

28

1 health insurance coverage through AHCCCS and need male chest reconstruction surgery. El Rio
2 has a team of pediatricians, including myself, nurses, behavioral health professionals, and
3 pharmacists who treat transgender patients.

4 11. I personally treat approximately 120 transgender youth per year. I provide general
5 pediatric care in an affirming clinical setting and—when medically indicated—prescribe
6 treatments to alleviate their gender dysphoria. The treatments I prescribe for a patient are based
7 on my assessment of the patient and their unique needs and medical history, in consultation with
8 the prevailing standards of care, and cover the range of clinically indicated treatments for this
9 population. For patients who have not yet started puberty, I have prescribed and supported them
10 through social transition, including drafting letters to assist them in correcting their identity
11 documents. For those who have started puberty, I have prescribed puberty-delaying medications
12 and hormone-replacement therapy and monitored their progress on those treatments. Finally,
13 when medically necessary, I have also referred patients for gender-confirming surgeries, such as
14 male chest reconstruction surgery.

15 12. I have given lectures on health care for transgender youth on several occasions,
16 including a talk on “Creating a Primary Care Medical Home for Transgender Youth,” which I’ve
17 been invited to give at multiple conferences.

18 Assessment of D.H.

19 13. I began treating D.H. for gender dysphoria in January 2020. D.H. was assigned
20 female at birth but has identified as male for many years. When I first started treating D.H., he
21 was already living as male and had been prescribed hormone-replacement therapy (*i.e.*
22 testosterone).

23 14. I provide D.H. both primary care and specialty care. D.H.’s primary care needs
24 include general well-child care as well as ongoing care for his existing asthma. The specialty care
25 I provide D.H. is focused on treating his gender dysphoria and includes management of his social
26 transition and hormone-replacement therapy.

1 15. D.H. reports using a binder to minimize the contour of his chest since around
2 twelve-years old.

3 16. I am concerned about the consequences of his continued binding on his physical
4 health. D.H. started developing asthma in October 2019 after a bout of bronchitis. Prior to that
5 he had never had respiratory issues. This is quite uncommon at his age.

6 17. In order to be effective, a binder must sufficiently constrict the wearer's rib cage to
7 flatten the contour of their chest. That makes it difficult for the wearer to get full, deep breaths.
8 For D.H., his prolonged and extensive use of a binder contributed to his developing asthma, a
9 chronic lung condition. The deterioration of his lung capacity has resulted in him feeling short
10 of breath when he wakes up in the morning and requires him to use an inhaler when engaging in
11 increased physical activity.

12 18. Physical activity, however, is an important part of a child's development. Children
13 who don't exercise have higher rates of obesity and all the concomitant health problems. Lack of
14 exercise also contributes to mental health conditions such as depression and anxiety, conditions
15 that are already negatively affecting D.H.'s mental health.

16 19. D.H. also reports issues with back pain as a result of extended use of a binder. This
17 is a very common complaint among my patients who wear binders regularly. Although I have
18 many patients who complain about back pain, the pain caused by extended binder use is distinct
19 and located in the mid-back region. D.H. currently does stretches to relieve the pain, engages in
20 limited exercise and, when necessary, decreases binder wearing, but these steps are not sufficient
21 to alleviate the pain and other symptoms he experiences as result of wearing the binder.

22 20. Not wearing the binder, however, is not an effective solution as that will have
23 multiple negative effects on D.H.'s health. D.H. indicated that he doesn't leave his home when
24 he is not wearing his binder. The few times he recalls attempting to go outside without a binder,
25 his gender dysphoria causes severe anxiety, such that he must return home to get the binder and
26 put it on before he can leave again.

1 21. Although D.H. binds less when at home to avoid wearing the binder longer than
2 the recommended eight hours per day, he reports slouching to minimize the appearance of his
3 chest contour.

4 22. His mother has also informed me that when D.H. isn't binding, he is much moodier
5 and angrier than usual. This dates back as far as middle school, when he would miss school
6 rather than not bind. This is consistent with the experience of other patients I treat for gender
7 dysphoria.

8 23. It is my opinion that it is medically necessary for D.H. to receive chest
9 reconstructive surgery to treat his dysphoria. D.H.'s physical health will continue to decline if he
10 is not able to obtain this surgery immediately. For example, D.H.'s continued use of a binder
11 will exacerbate the symptoms of his asthma, especially if D.H. gets bronchitis or a respiratory
12 infection such as pneumonia, all of which could result in further chronic damage to his lungs.

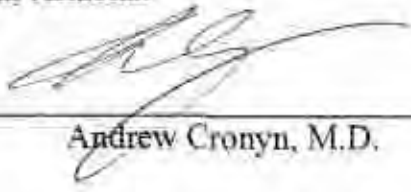
13 24. In addition, without chest reconstruction surgery, his back pain will very likely
14 worsen. D.H. currently avoids taking any medication for the pain, but that might end up changing
15 in the future if his back pain continues to increase. Approximately fifty percent of the transgender
16 boys treated at El Rio report back pain as a result of persistent binder wearing that is significant
17 enough to warrant referrals to a physical therapist or an orthopedic surgeon. I am concerned that
18 D.H. will join that group of patients if does not undergo male chest reconstruction surgery soon.

19 25. Although he has not yet reported skin irritation with wearing the binder, that is
20 common complication in the transgender boys seen at El Rio, especially with extended, years-
21 long binder use. Most skin complications associated with extended binder use are treatable,
22 however, those conditions can have significant effects on a patient's daily life. For transgender
23 boys, skin conditions are both physically uncomfortable and exacerbate their gender dysphoria,
24 which can have many cascading effects, including poorer mental health, inability to focus in
25 school, among others. Given D.H.'s binder use, especially when wearing his binder for days at
26 time, it is highly likely that he will develop skin conditions, if he does not receive chest
27 reconstruction surgery.

1 26. In my opinion, D.H. requires male chest reconstruction surgery to treat his gender
2 dysphoria and prevent the numerous physical health consequences outlined above that will result
3 from his continued use of a binder. Given that D.H. has been wearing a binder for about five
4 years, which is much longer than I would recommend any patient continue binding, and it is not
5 sufficiently alleviating his gender dysphoria, his need for male chest reconstruction surgery is
6 urgent.

7 I declare under penalty of perjury pursuant to the laws of the State of Arizona that the
8 foregoing is true and correct.

9 Executed this 3rd day of August, 2020 at Tucson, Arizona.

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12 _____
13 Andrew Cronyn, M.D.
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11 *Counsel for Plaintiffs and the Class*

12 UNITED STATES DISTRICT COURT
 13 DISTRICT OF ARIZONA

14 D.H., by and through his mother, Janice
 15 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 16 behalf of themselves and all others
 similarly situated,

17 Plaintiffs,

18 vs.

19 Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 20 in her official capacity,

21 Defendant.

No.

**DECLARATION OF TAMAR
 REED IN SUPPORT OF
 PLAINTIFFS' MOTION FOR
 PRELIMINARY INJUNCTION**

1 I, Tamar Reed, hereby declare as follows:

2 1. I am a child and family therapist at Casa de los Niños in Tucson, Arizona, and am
3 currently treating D.H., a plaintiff in the above-titled action.

4 2. I make this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

5 Education and Experience

6 3. I received a master's degree of Science in Counseling and Clinical Mental Health
7 Counseling from Prescott College.

8 4. I am a Licensed Professional Counselor. I work exclusively with preteens, teens,
9 and young adults. I specialize in working with LGBT young people as well as clients
10 experiencing suicidal ideation, self-harming behaviors, and complex trauma.

11 Assessment of D.H.

12 5. I started seeing D.H. in October 2016. He was referred to me by another
13 practitioner because of my expertise in working with transgender young people.

14 6. At the time I started seeing D.H. he had pervasive anxiety, chronic suicidal
15 ideations and attempts, and related self-harm issues (including cutting, burning and hair-pulling).
16 I also understood that he had recently come out as transgender.

17 7. My initial impressions of D.H. was that he was very dysregulated, highly anxious
18 and defiant with his mother. I understood that he was refusing to go to school, and that he had
19 also been hospitalized in the past. D.H. was diagnosed with gender dysphoria by his treating
20 pediatrician, a diagnosis that I confirmed.

21 8. My treatment of D.H. focused on gender dysphoria, anxiety, trauma and
22 oppositional disorder. I treated his gender dysphoria with behavioral therapy, identity and values
23 regulation and attempting to improve his relationship with his mother. I met with D.H. every
24 week for numerous months. Over that time, D.H. began his transition and his mental health
25 improved significantly. The mental-health benefits of D.H.'s transition gave him the emotional
26 energy to develop the tools he needed to continue working on improving his mental health.
27

1 9. When D.H. started hormone treatment in November 2017, I saw a dramatic shift in
2 his well-being. His chronic behaviors subsided significantly, but certain behaviors persisted.
3 When his urges came back to engage in self-harm, they were specifically triggered by the sight
4 of his chest. For example, when he was in the shower, and had no opportunity to cover himself.

5 10. The topic of surgery came up early in my conversations with D.H. Although the
6 determination of whether surgery is medically necessary to treat a patient's gender dysphoria is
7 made by a medical professional, I am consulted in this process that treatment has a distinct mental
8 health component. Based on my professional experience working with transgender young people
9 and my assessment of D.H., he met the criteria for a referral for male chest reconstruction surgery
10 under WPATH standards as early as April 2019. He is fully adjusted to living as male and exhibits
11 the psychological maturity and thoughtfulness necessary to provide independent and informed
12 consent to the procedure.

13 11. After a break of several months in mid-2019, D.H. self-referred himself back to me
14 for further treatment in October 2019, ready to tackle other issues related to his gender dysphoria.
15 Since then, I have seen D.H. weekly. Our appointments became less frequent at the beginning of
16 the COVID-19 pandemic, but soon thereafter D.H. requested to return to our regular weekly
17 appointment, which I have conduct via telehealth.

18 12. Not being able to undergo male chest reconstruction surgery would be a huge
19 setback for D.H., who has a lot of potential. D.H.'s chest would continue to be a persistent
20 obstacle to him being comfortable in his own body. It would prevent him from developing
21 healthy levels of self-esteem and confidence, which can have far-reaching implications for his
22 social and academic functioning as well as keeping him from participating in dance, an activity
23 that had a significant positive effect in his life.

24 13. Without male chest reconstruction surgery, D.H.'s significant dysphoria will also
25 exacerbate his anxiety and psychological distress caused by prior trauma. The longer his
26 dysphoria and psychological distress persist, the more difficult it will be to treat those underlying
27 mental health conditions and trauma.

1 14. Equally concerning is that as D.H.'s psychological distress becomes more
2 emotionally taxing, his coping mechanism are likely to start failing him, diminishing his ability
3 to resist returning to negative coping behaviors such as self-harm. D.H.'s prior hospitalizations
4 further increase the likelihood that his mental health could significantly deteriorate if he is unable
5 to get male chest reconstruction surgery. Any decline in D.H.'s mental health is particularly
6 concerning given his history of suicidal ideation. This makes D.H.'s need for surgery immediate.
7

8 I declare under penalty of perjury pursuant to the laws of the State of Arizona that the
9 foregoing is true and correct.

10 Executed this 4th day of August, 2020 at Tucson, Arizona.

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12 
13 Tamar Reed

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DECLARATION OF TAMAR REED IN SUPPORT OF PLAINTIFFS'
MOTION FOR PRELIMINARY INJUNCTION

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Counsel for Plaintiffs and the Class

UNITED STATES DISTRICT COURT
 DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No.

**DECLARATION OF JANICE
 HENNESSY-WALLER IN
 SUPPORT OF PLAINTIFFS'
 MOTION FOR PRELIMINARY
 INJUNCTION**

1 I, Janice Hennessy-Waller, hereby declare as follows:

2 1. I am the mother of plaintiff D.H.

3 2. I am an Arizona resident. I live in Pima County.

4 3. I am enrolled in Arizona's Medicaid program.

5 4. My son was diagnosed with gender dysphoria. He was identified as female at birth
6 but is male and lives as male in every aspect his life.

7 5. As a child, D.H. was often frustrated and angry and I had no idea why. I tried
8 everything I could to figure out what was causing him so much distress and never suspected it
9 was because he is transgender. I continued to treat him like the girl I thought he was.
10 Unfortunately, that did not help his distress and D.H. developed significant psychological distress
11 at an early age, including severe anxiety and suicidal ideation. Over the years, I had to hospitalize
12 D.H., including in intensive psychiatric care, four times due to these issues, beginning at age
13 eleven in 2014.

14 6. When D.H. was eleven, I suggested that he get involved in dance; it was an activity
15 he liked as a little kid and I hoped it would help him cope with his anxiety and distress. He took
16 to dance immediately. It seemed to be working; he was making friends and exercising—both of
17 which helped him feel good about himself—and he finally appeared to have a handle on his
18 mental health. Once he started puberty, however, dance became another source of distress
19 because of the physical changes his body was undergoing, especially his breast development.

20 7. Soon thereafter, I noticed that D.H. started wanting to appear more masculine, such
21 as wearing boys' clothing and hairstyle. Within six months, around September 2016, he told me
22 that he was transgender. I was definitely surprised when he told me, but I wanted to support him,
23 especially if it was going improve his mental health and wellbeing.

24 8. Seeing that D.H. was still struggling with anxiety, I arranged for him to see a
25 therapist who recommended that D.H. see Tamar Reed, a mental health provider with experience
26 working with transgender youth. With the recommendation and support of Ms. Reed, D.H. began
27 to transition to live in accordance with his gender identity and to treat his gender dysphoria.
28

1 9. Because dance was such an important part of his life, D.H. continued to participate
2 in dance after starting his transition. But that eventually became too difficult for him. On the ride
3 home from one of his dance competitions in January 2017—where he did well—D.H.’s mental
4 health started to deteriorate, which led me to bring him in a second time for in-patient psychiatric
5 treatment.

6 10. After a year of working with his therapist, Ms. Reed and Dr. Chin, D.H.’s then-
7 treating medical provider for his gender dysphoria, recommended that he start taking
8 testosterone. This was a very big deal for D.H. He has always been very afraid of needles, but
9 knowing how important this was for his health, D.H. overcame his fear. D.H. started taking
10 testosterone in November 2017 and has given himself the weekly testosterone shot since then.

11 11. With each prior stage of his transition, I noticed a significant change in D.H.’s
12 overall wellbeing. Still, I was not prepared for the tremendous benefit that came with him starting
13 testosterone. D.H. became happier, more confident, and calm, which I had never really seen in
14 him before that. It was certainly a welcomed change.

15 12. Even with ongoing mental health treatment and medications, D.H. still experiences
16 significant distress regarding his body and specifically his chest. In September 2018, I had to
17 hospitalize D.H. again due to chest dysphoria and suicidal ideations. Then, less than a year later
18 in April 2019, he had to enter a 30-day assessment and intervention center due to the same
19 symptoms.

20 13. As it was clear that hormone treatment was not effective in completely treating
21 D.H.’s dysphoria, his treating physician and therapist recommended that he obtain male chest
22 reconstruction surgery to further align his body with his gender identity and alleviate his gender
23 dysphoria to an extent that his current treatments cannot achieve. D.H. was over the moon when
24 he received this recommendation.

25 14. In May 2019, after completing his 30-day treatment program, D.H. consulted with
26 Dr. Ethan Larson, a surgeon who regularly performs male chest reconstruction surgery. The
27 surgeon evaluated him and determined that he was a good candidate for the surgery.
28

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Counsel for Plaintiffs and the Class

UNITED STATES DISTRICT COURT
 DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
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 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No.

**DECLARATION OF D.H. IN
 SUPPORT OF PLAINTIFFS'
 MOTION FOR PRELIMINARY
 INJUNCTION**

1 I, D.H., hereby declare as follows:

2 1. I am a seventeen-year-old transgender Arizona resident. I live in Pima County.

3 2. I am enrolled in Arizona's Medicaid program.

4 3. I have been diagnosed with gender dysphoria. I was identified as female at birth,
5 but I am male and live as male in every aspect my life.

6 4. I first became aware of my male gender identity around the age of four. I became
7 frustrated and angry at my inability to explain that I was transgender to my mother, Janice. I
8 developed significant psychological distress at an early age, including severe anxiety and suicidal
9 ideation. My stress related to my gender identity—combined with the other stressors I was trying
10 to navigate—was so overwhelming that I started losing my hair. My mother placed me in
11 intensive psychiatric care when I was eleven and thirteen.

12 5. In sixth grade, shortly after my first in-patient psychiatric treatment, I started to get
13 involved in dance. The movements were like therapy to me. Dance also became a social outlet; I
14 made friends and felt a sense of belonging. It was the only thing in my life that could make me
15 feel better. By the seventh grade, I was enrolled in three different dance classes: ballet, modern,
16 and jazz.

17 6. Once puberty began, however, I hated my body and everything that came with it.
18 My thoughts and fears about experiencing a female puberty—with its associated physical
19 changes that would take my body even further away from my gender identity—became all-
20 consuming and significantly affected my ability to function. I hid my changing body under baggy
21 clothes and hated being perceived as a girl at school.

22 7. Around that time, I also started to explore ways to make my appearance more
23 masculine. I began using a variety of methods to flatten my chest from multiple sports bras and
24 Ace bandages to duct tape. Those initial attempts were extremely uncomfortable and irritated my
25 skin. Needing a better and safer solution, I secretly bought my first binder to attempt to give the
26 appearance of a flat chest. Putting on the binder gave me a sense of relief that no amount of
27 therapy or medication had ever given me.
28

1 8. Over the next six months, I developed the confidence to tell my mother that I was
2 transgender. After I shared that information with my mother, she arranged for me to see a mental
3 health provider with experience working with transgender youth. Thereafter, with the
4 recommendation and support of my healthcare providers, I began to transition, including medical
5 treatments, to live in accordance with my gender identity and to treat my gender dysphoria.

6 9. Wearing a binder, however, significantly interferes with my daily life. Keeping
7 the binder on for long periods of time is uncomfortable and painful. The pain and discomfort
8 caused by wearing the binder prevents me from focusing on school and homework.

9 10. The binder is also very restrictive and prevents me from engaging in physical
10 activity, especially dance which had previously been a source of relief for me. The compression
11 from the binder prevents me from breathing too deeply. I get winded too easily to dance with a
12 binder, but the dysphoria is too great for me to dance without one. I eventually had to stop
13 dancing. I tried joining theater in its place, but my binder made it difficult to sing and my mental
14 health prevented me from regularly participating in rehearsals.

15 11. I regularly wear my binder for ten hours a day. At least twice per week I will wear
16 it for longer than ten hours. On occasion, I've worn my binder for three consecutive days. I
17 sometimes struggle to take the binder off even at home, a place I feel the most comfortable being
18 myself and know that I will be treated as male.

19 12. Even with the binder, my dysphoria about my chest has become overwhelming at
20 times and contributed to my need for in-patient psychiatric treatment.

21 13. After a year of working with my therapist, at the recommendation of my mental
22 health and medical providers, I started taking testosterone. Over the last two years, my voice
23 deepened, I started growing facial hair, and developed a more masculine musculature. The
24 testosterone, however, cannot reverse the physical changes that already occurred prior to my
25 transition.

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11 *Counsel for Plaintiffs and the Class*

12 UNITED STATES DISTRICT COURT
 13 DISTRICT OF ARIZONA

14 D.H., by and through his mother, Janice
 15 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 16 behalf of themselves and all others
 similarly situated,

17 Plaintiffs,

18 vs.

19 Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 20 in her official capacity,

21 Defendant.

No.

**DECLARATION OF MISCHA
 COHEN PECK, PHD IN
 SUPPORT OF PLAINTIFFS'
 MOTION FOR PRELIMINARY
 INJUNCTION AND JOHN
 DOE'S MOTION TO PROCEED
 UNDER A PSEUDONYM**

1 I, Dr. Mischa Cohen Peck, hereby declare as follows:

2 1. I am a licensed clinical social worker and psychotherapist based in Phoenix,
3 Arizona, and am currently treating John Doe, a plaintiff in the above-titled action.

4 2. I make this declaration in support of Plaintiffs' Motion for Preliminary Injunction.

5 Education and Experience

6 3. I have more than 25 years of experience teaching and practicing as a clinical
7 therapist.

8 4. I received a Master of Social Work from the University of Southern California, Los
9 Angeles, in 1993, and obtained a PhD in Social Welfare from the University of Washington,
10 Seattle, in 2003.

11 5. Since that time, I have served in several academic positions including as an
12 Assistant Professor in the School of Social Work at San José State University in California, and
13 as a Lecturer and Visiting Professor at the School of Social Work at Arizona State University. I
14 currently serve as an Adjunct Assistant Professor for the Smith College for Social Work in
15 Northampton, MA.

16 6. However, I am primarily a licensed clinical therapist. For the past 11 of my 25
17 years of practice, I have specialized in work with individuals on issues regarding sexuality, sexual
18 orientation, and gender identity. This includes work with transgender people dealing with gender
19 dysphoria; I provide mental health support through their transition, which is the process of
20 bringing their lives into closer alignment with their gender identity. I treat transgender patients
21 who range in age from 9 years to approximately 75 years of age. Roughly a third of my
22 transgender patients are less than 18 years of age.

23 7. I also have been a member of the World Professional Association of Transgender
24 Health (WPATH) since 2015.

25 Assessment of John Doe

26 8. The assessment and opinions presented herein are based on my work with John
27 Doe as a patient. I first saw John on March 14, 2020, and, since then, have seen John
28

1 approximately every other week. During this time, my clinical work and John's progress have
2 been extensive and significant.

3 9. I understand that John is asking the Court to use this pseudonym to protect his
4 identity and private health information from the public. I fully recommend and support John's
5 request to proceed using a pseudonym. During our sessions, John expressed a desire to keep both
6 his transgender identity and the details of his transition private. John is concerned that being
7 publicly identified with this lawsuit places his physical safety in school and around his
8 community at risk because of the negative attitudes towards transgender people of his classmates
9 and others.

10 10. The potential of unwanted exposure would also heighten his anxiety, fear, and
11 shame. This could lead to an increase in depressive symptoms, an increased risk of self-harm,
12 and other negative consequences. Given John's history of depression and self-harm, John is
13 particularly vulnerable to psychological harm if his identity is revealed to the public. John's
14 concerns for his physical and mental well-being are justified and reasonable.

15 11. John started seeing me to help him address the increasing psychological distress he
16 has experienced because of his gender dysphoria. John was diagnosed with gender dysphoria
17 prior to starting treatment with me. I have confirmed that diagnosis and, also, diagnosed him
18 with chronic post-traumatic stress disorder stemming from early-life attachment trauma. Those
19 co-occurring conditions exacerbate one another, making his mental health particularly fragile.

20 12. Regarding John's gender dysphoria, he reports a long history of feeling distress
21 related to his body, and that distress increased significantly with puberty, specifically when he
22 began developing feminine-appearing breasts. This distress became so intense that during the
23 6th grade he recalls many times crying himself to sleep due to gender-related distress. He
24 describes the experience of puberty as being detached from his body, as if his body was betraying
25 him while developing feminine-appearing secondary sex characteristics.

26 13. Those feelings of distress, and those of shame, transformed into self-harming
27 behaviors, including cutting, burning, and food restriction. John also describes himself as having
28

1 difficulty sleeping, low motivation, anxiety, and fear. His distress, including periodic desire for
2 self-harm, and his risk of depression, remains present today. He still cries himself to sleep 2-3
3 times a week. He finds it impossible to ignore his chest and to feel comfortable with his chest.
4 John also continues to experience suicidal ideation but denies any current plan and intent. These
5 are all very common manifestations of gender dysphoria in transgender males.

6 14. Approximately three years ago, John began his transition and living consistent with
7 his gender identity. For John, that has included using a male name—which is now his legal
8 name—and corresponding pronouns, as well as starting a regimen of hormone-replacement
9 therapy to further masculinize his appearance, including growing facial hair and deepening his
10 voice. Like most transgender males, John started binding his chest, typically using compressive
11 fabric, to flatten the appearance of his chest. In addition to binding, John wears baggy clothing
12 and curves his shoulders forward to further hide the contour of his chest.

13 15. Such changes helped to reduce some symptoms of John's gender dysphoria,
14 making it more manageable, but dysphoria continues to affect his ability to function in significant
15 ways. For example, binding provides important, but limited, relief from his chest dysphoria,
16 while also impeding physical movement and causing potential physical discomfort and irritation.
17 Wearing the binder makes it possible for him to leave the house, but John continues to experience
18 chronic distress at school and in social situations because of the fear that those around him will
19 see or notice the binder under his clothing. At night, when he removes the binder, the benefits
20 that John experiences from using a binder disappear as he, once again, must confront the
21 appearance of his chest, thereby aggravating his hatred of his body.

22 16. John has achieved the maximum mental health benefit from hormone-replacement
23 therapy and binding. Without further treatment for his gender dysphoria—specifically surgical
24 treatment—he will not be able to progress further in his mental health treatment.

25 17. Based on my professional experience working with transgender young people and
26 my assessment of John, he meets the criteria for a referral for male chest reconstruction surgery
27 under WPATH standards. He is fully adjusted to living as male and exhibits the psychological
28

1 maturity and thoughtfulness necessary to provide independent and informed consent to the
2 procedure.

3 18. The mental health benefits of male chest reconstruction surgery are transformative.
4 Prior to the surgery, my transgender male patients experience shame, self-hate, and self-doubt—
5 the same emotions John struggles with. Those emotions significantly decrease—and for some
6 patients entirely disappear—within days of the surgery.

7 19. Male chest reconstruction surgery will remove the major source of John’s gender
8 dysphoria, alleviating the shame, dysphoria, and other negative emotions associated with his
9 chest. The reduction or elimination of those negative emotions will also create emotional space
10 for positive emotions, including pride and self-acceptance, and give him greater capacity to
11 develop healthy coping mechanisms.

12 20. Male chest reconstruction surgery is also likely to have a positive impact on John’s
13 PTSD. The confidence he will gain from the surgery will help him develop the close friendships
14 and intimate relationships that his early-attachment trauma hindered. Without the distress caused
15 by the gender dysphoria, John also will have greater emotional capacity to progress in his
16 treatment of the trauma underlying his PTSD.

17 21. John’s need for surgery is immediate. If John is unable to get male chest
18 reconstruction surgery, or even experiences any significant delay in getting the surgery, he will
19 be at significant risk of physical and emotional harm. John’s prolonged anxiety, depression, and
20 self-hate will continue, making his gender dysphoria and PTSD more intractable and harder to
21 treat. It will also be increasingly harder for John to resist the perceived psychological rewards of
22 self-harm, which can quickly become very dangerous when coupled with his suicidal ideation.

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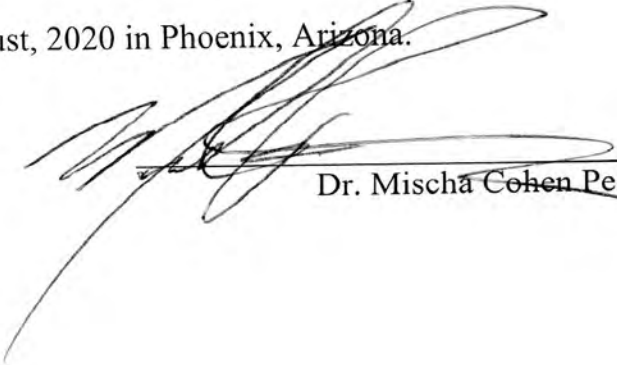
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1 I declare under penalty of perjury pursuant to the laws of the State of Arizona that the
2 foregoing is true and correct.

3 Executed this 4 th day of August, 2020 in Phoenix, Arizona.

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6 Dr. Mischa Cohen Peck
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Counsel for Plaintiffs and the Class

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
Hennessy-Waller; and John Doe, by his
guardian and next friend, Susan Doe, on
behalf of themselves and all others
similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
Health Care Cost Containment System,
in her official capacity,

Defendant.

No.

**DECLARATION OF SUSAN
DOE IN SUPPORT OF
PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION
AND JOHN DOE'S MOTION TO
PROCEED UNDER A
PSEUDONYM**

1 I, Susan Doe, hereby declare as follows:

2 1. I am a party to this action and the grandmother, caregiver and next friend of John
3 Doe, co-plaintiff in the above-titled action.

4 2. I am an Arizona resident. I live in Maricopa County.

5 3. My grandson John is enrolled in Arizona's Medicaid program.

6 4. John has been diagnosed with gender dysphoria. He was identified as female at
7 birth but is male, and for the past three-plus years, has lived as male in every aspect of his life.

8 5. I have been John's primary caregiver ever since he was two-years old, because
9 John's biological parents have been unable to care for him and provide him with a stable home
10 environment.

11 6. Growing up as a child, John had always been more comfortable around other boys,
12 and dressed and acted more like how boys were "supposed" to act. At the time, I initially thought
13 John was just a tomboy, or going through a phase. John was generally very confident and
14 outgoing as a child, but I eventually started noticing signs that John would struggle at times.

15 7. John's struggles intensified significantly when he started puberty around twelve-
16 years old. John became very stressed and unhappy. The confidence he had at an earlier age
17 disappeared and he stopped being social. I checked in with him often and John would always
18 assure me that he was okay. Knowing that puberty—and adolescence, in general—can be
19 difficult, I decided to hold off on taking John to therapy.

20 8. It wasn't until the end of John's 6th grade year that he told me he is transgender
21 and started letting me in on what had been causing him so much distress.

22 9. It was initially difficult for me to understand and accept what John was telling me.
23 At the time, I still believed John was just going through a phase. But it soon became apparent to
24 me that John's mental health was not getting better. He asked that I call him by a male name and
25 use male pronouns when referring to him. Wanting him to know that I love and accept him, I
26 worked hard to consistently honor his request. I know other members of the family tried as well,
27 but I could see how much it bothered him when we made mistakes.
28

1 10. As John progressed through puberty, he started hiding his body more, wearing
2 baggy or bulky clothing, like hooded sweatshirts, even in the summer. He also used sports bras
3 and other tight undergarments to flatten his chest. And, around his period, John's level of distress
4 would increase dramatically.

5 11. John also struggled socially after coming out as transgender. I could tell he was
6 uncomfortable in social situations. Like with his family, John's peers at school did not always
7 refer to him by his male name or use male pronouns, which made John's 7th grade year very
8 stressful. But John was uneasy around people who did not know he was transgender too.

9 12. Throughout John's 7th grade year, we had many conversations to help me better
10 understand what John was going through and how I could support him. Those conversations were
11 very helpful, but I also made sure to do my own research as well, including talking with John's
12 pediatrician.

13 13. During John's annual checkup in 2018, his pediatrician recommended that I take
14 John to the Gender Support Program at Phoenix Children's Hospital. Given all of the
15 psychological distress John had exhibited throughout the prior year, she felt it was appropriate to
16 seek specialized healthcare to address John's unique needs. After seeing John continue to
17 struggle with anxiety and depression, I was eager to get him the help he needed.

18 14. In November 2018, John had his first appointment at the Gender Support Program.
19 Dr. Chulani, his doctor at the Program, referred John to a mental health provider to talk about the
20 distress he was experiencing. Dr. Chulani also prescribed medications that stopped John from
21 getting his period every month, which helped alleviate John's anxiety and depression.

22 15. Then, in June 2019, after about six months of weekly sessions with a therapist, Dr.
23 Chulani and John's mental health provider recommended that John start hormone-replacement
24 therapy with testosterone. Even more so than the prior medication, testosterone had a big positive
25 effect on John's mental health. As his voice dropped and his body changed in response to the
26 testosterone, the burden he had been carrying looked like it was finally lifting. It was nice to
27 finally see John feeling like himself again.

1 16. Even with all that progress, I could see John was still struggling with significant
2 depression and anxiety, particularly regarding the appearance of his chest. In December 2019,
3 John bought his first binder, a compressive fabric specifically designed to flatten the chest. But
4 that was not enough to stem John's mounting psychological distress, which became
5 overwhelming earlier this year. John asked to start seeing a therapist again. John's current
6 therapist, Dr. Mischa Peck, confirmed his diagnosis of gender dysphoria, and also diagnosed
7 John with post-traumatic stress disorder.

8 17. Through his therapy and consultation with Dr. Chulani, it became clear that
9 hormone-replacement therapy did not completely treat John's gender dysphoria. Both Drs.
10 Chulani and Peck recommended that John undergo male chest reconstruction surgery to further
11 align his body with his gender identity. On July 2, 2020, Dr. Peck gave John a referral letter for
12 that surgery.

13 18. Having watched John struggle all these years, I have no doubt that male chest
14 reconstruction surgery will have a tremendous impact on John's self-esteem, outlook on life, and
15 overall mental health. For that reason, it was difficult telling John that he couldn't get the
16 treatment he so desperately needs because AHCCCS won't cover the surgery. While John
17 understands I cannot afford the cost of the surgery, John was incredibly frustrated and defeated.

18 19. If John cannot get this surgery soon, I believe his health and mental well-being will
19 be put into significant risk. Just six months ago, John's gender dysphoria caused his mental
20 health to deteriorate to the point of needing therapy. I worry that his feeling defeated will turn
21 into hopelessness because he will have no way of getting the only effective treatment for his
22 condition. That is particularly concerning given John's history of self-harm and suicidal ideation.

23 20. I am equally concerned about John's mental health if he is not permitted to use a
24 pseudonym to challenge AHCCCS's exclusion for surgical treatment for gender dysphoria.
25 Disclosing his identity to the public will significantly aggravate his social anxiety, causing him
26 to be constantly worried about whether people know that he is transgender. I also share John's
27 concern for his safety given the negative attitudes towards transgender people that are regularly
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1 expressed in our community. This concern is particularly heightened because this lawsuit seeks
2 AHCCCS to pay for treatments it refuses to cover, which is already a sensitive topic in general.
3 Because of the private details shared as part of this case, it is critical that I am allowed to proceed
4 under a pseudonym. Otherwise, community members will likely be able to figure out John's
5 identity. I worry that increased likelihood alone will cause John's anxiety to spike.

6
7 I declare under penalty of perjury pursuant to the laws of the State of Arizona that the
8 foregoing is true and correct.

9 Executed this 5 th day of August, 2020 in Maricopa County, Arizona.

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11 Susan Doe

12 Susan Doe
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DECLARATION OF SUSAN DOE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION
AND JOHN DOE'S MOTION TO PROCEED UNDER A PSEUDONYM

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Counsel for Plaintiffs and the Class

UNITED STATES DISTRICT COURT
 DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No.

**DECLARATION OF JOHN DOE
 IN SUPPORT OF PLAINTIFFS'
 MOTION FOR PRELIMINARY
 INJUNCTION AND JOHN
 DOE'S MOTION TO PROCEED
 UNDER A PSEUDONYM**

DECLARATION OF JOHN DOE

I, John Doe, hereby declare as follows:

1. I am a fifteen-year-old transgender boy. I live in Maricopa County, Arizona.
2. I am enrolled in AHCCCS, Arizona's Medicaid program.
3. Although I was assigned female at birth, I am male and have lived as male in every aspect my life for over three years.
4. Nothing about being treated as a girl ever felt right. I was always uncomfortable wearing clothes meant for girls—especially dresses—and never wanted to play with typical girl toys. People tried help me fit into being a girl and referred to as a “tomboy.” That term never fit either. It was not until I was older that I was finally able to articulate why: I am male, it was not just that I “acted like a boy” or “liked boy things.”
5. When I started puberty, the disconnect between my body and my gender identity became increasingly wider. Once my chest began to develop, my psychological distress spiked. I began to hate my body to such an extent that it began to consume me, interfering with every aspect of my life. I quickly fell into a serious depression, suffered from extreme anxiety, distanced myself from friends and family, and lost interest in activities I used to love. Physically, I lost a significant amount of weight in a very short period of time because I was limiting my food intake and began to cut and burn myself in an attempt to cope with how I was feeling. At my lowest points, I contemplated suicide.
6. Stigma and fear of rejection initially kept me from sharing my gender identity with friends and family, even those closest to me. I was unable to speak even to my grandmother, Susan, who I live with and has cared for me since I was two-years old. That fear kept me isolated, exacerbating my emotional and physical distress and prevented me from seeking or receiving the specialized care that I needed.
7. When I was around twelve-years old I could not keep the fact that I am transgender to myself; I needed to get help from health care providers who have experience working with young people like me. Without that care I was worried that my mental health would continue to

1 deteriorate. I finally talked to my grandmother about everything I had been experiencing since I
2 was a child.

3 8. Over the next year, my grandmother and I had many conversations about my being
4 transgender. During that time, she was gathering information about how best to help and support
5 me, including talking to my pediatrician, who recommended that I see the providers at the Gender
6 Support Program at Phoenix Children's Hospital.

7 9. I had my first appointment at the Gender Support Program recommended in
8 November 2018. I was relieved to be seeing a healthcare provider with experience working with
9 transgender young people. My doctor, Dr. Veenod Chulani, referred me to a mental health
10 provider. He also prescribed medication that stopped me from getting my period to reduce my
11 gender dysphoria while I was waiting to start hormone-replacement therapy. In June 2019, I
12 began hormone replacement therapy to masculinize my appearance, bringing my body into closer
13 alignment with my gender identity. Testosterone has made changes to my body and voice that
14 have provided me significant relief.

15 10. Although the testosterone has helped reduce my gender dysphoria, I still experience
16 significant dysphoria because of my chest. I use multiple methods of hiding and flattening my
17 chest just to function. I constantly wear multiple layers of loose clothing, even wearing a hooded
18 sweatshirt both indoors and outdoors nearly every day, including during the summer.

19 11. Under those many layers, I also wear a binder, a constrictive fabric that flattens my
20 chest and gives me a more masculine form. I started binding when I was about 13 years old. On
21 a typical day, I put the binder on when I wake up and leave it on until I go to bed, even wearing
22 it while I am at home.

23 12. Wearing a binder for that long is uncomfortable, both physically and emotionally.
24 In order to function properly, the binder must be tight. Sometimes, the binder is so tight that it
25 restricts my breathing and makes it hard for me to keep up with my friends in dance class or when
26 practicing, which is made even worse by the fact that I have asthma. Because I wear so many
27 layers in addition to the binder, my chest often gets sweaty, increasing my discomfort and the
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1 possibility of getting skin sores. And, going to the pool to cool off like many of my friends comes
2 with its own challenges. Even at the pool, I wear my binder under a t-shirt, which leads to
3 uncomfortable questions, especially from people who notice the binder under my clothing, which
4 leads to me having to explain what the binder is and why I wear one.

5 13. I have been told not to wear the binder for longer than 8 hours a day, but I regularly
6 wear it for well-past that amount of time. However, it is worth it to me to wear the binder as
7 much as I do, because being without the binder causes me a great deal of stress and anxiety.
8 Putting on the binder and hiding my chest from myself and from others gives me a sense of relief
9 that I cannot get through any other means.

10 14. It is to the point that without the binder, I am unable to function because I am so
11 upset about my chest. Without the binder, it is difficult for me to even move around because I
12 hate the feeling of clothing without the binder covering my chest. I cannot bear to even look at
13 myself in the mirror without the binder on. Even having the binder off while I go to bed is
14 difficult at times. At least once a week, I will wake up in the middle of the night in tears, unable
15 to go back to sleep, because of an intense feeling of disgust over my chest. These panic attacks
16 will sometimes last hours at a time. Putting my binder back on is the only way I can lull myself
17 back to sleep.

18 15. Binding is, and always has been limited and temporary relief. Even with the binder,
19 there are social situations in which I remain conscious of the binder which causes me social
20 anxiety, and even with the binder my dysphoria sometimes forces me to excuse myself so that I
21 can regain my composure. And, the second I take the binder off each night, my gender dysphoria
22 returns all at once, and it takes a long time for me reduce my distress enough that I can sleep.

23 16. After discussing the extent of my chest dysphoria with my providers, they
24 recommended that I pursue male chest reconstruction surgery to further align my body with my
25 gender identity and alleviate my gender dysphoria in a way that is not possible with the
26 testosterone, binder, or any other treatment. When my doctors made this recommendation in late
27 2019, I learned that Arizona Medicaid does not cover the procedure to treat gender dysphoria,
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1 and I might not be able to get the surgery because my family cannot afford to pay for it if
2 Medicaid does not cover it.

3 17. Having surgery to conform my chest to match my gender identity would be life
4 changing. Just being able to look at my own upper body in the mirror without it being covered
5 by a binder would provide me a sense of relief I have not felt since my gender dysphoria began.
6 Just based on the relief I know I feel from wearing the binder, having this surgery would allow
7 me to be more myself out in public and more freely express myself to others without worrying
8 about being regularly mistaken for female. Now knowing that relief from my dysphoria is
9 possible through medical treatment, it would be devastating for my mental health and overall
10 well-being if I were unable to get the procedure done.

11 18. Given the serious consequences of any further delay in getting male chest
12 reconstruction surgery, I couldn't pass up the opportunity to join this lawsuit. It is my only hope
13 of getting this critical treatment for my gender dysphoria. Yet, without a pseudonym, sharing the
14 private intimate details about my life and medical treatment to pursue this case will cause several
15 significant harms. I will no longer have control over very private information about my
16 transgender status, my medical history, and treatment. Although I have told some people in my
17 life that I am transgender, that is not information I want shared publicly and greatly value my
18 ability to decide with whom to share that very private information. I already experience a lot of
19 anxiety about people discovering that I am transgender. Having my identity connected with this
20 case will amplify that anxiety, further impairing my mental health and ability to function.

21 19. Being identified in this case would also expose me to harassment, discrimination,
22 and other forms of mistreatment. At school, it is not uncommon for me to overhear another
23 student saying harmful things to or about a transgender person. I have been fortunate to have
24 experienced little direct harassment, but that is likely to change if my identity was made public
25 as part of this lawsuit.

1 I declare under penalty of perjury pursuant to the laws of the State of Arizona that the
2 foregoing is true and correct.

3 Executed this 5 th day of August, 2020 at Maricopa County, Arizona.

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John Doe

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DECLARATION OF JOHN DOE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND
JOHN DOE'S MOTION TO PROCEED UNDER A PSEUDONYM

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
Hennessy-Waller; and John Doe, by and
through his guardian and next friend,
Susan Doe, on behalf of themselves and
all others similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
Health Care Cost Containment System,
in her official capacity,

Defendant.

No.

**ORDER GRANTING
PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION**

The Court, having considered Plaintiffs' Motion for Preliminary Injunction and the declarations attached thereto, and having found good cause in support thereof, IT IS ORDERED that Plaintiffs' Motion for Preliminary Injunction is GRANTED.

IT IS FURTHER ORDERED THAT:

(1) Defendants shall be immediately enjoined from further enforcement of Ariz. Admin. Code R9-22-205(B)(4)(A), on the grounds that it violates the Medicaid Act's EPSDT and Comparability Requirements, Section 1557 of the Affordable Care Act, and the Equal Protection Clause of the United States Constitution .

(2) Arizona Healthcare Cost Containment System shall provide coverage for Plaintiffs' male chest reconstruction surgeries, consistent with all other requirements of federal law.

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(Additional Counsel on Signature Page)

UNITED STATES DISTRICT COURT
DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
Hennessy-Waller; and John Doe, by his
guardian and next friend, Susan Doe, on
behalf of themselves and all others
similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
Health Care Cost Containment System,
in her official capacity,

Defendant.

No.

**PLAINTIFFS D.H. AND JOHN
DOE'S NOTICE OF MOTION AND
MOTION FOR PRELIMINARY
INJUNCTION**

***ORAL ARGUMENT
REQUESTED***

I. INTRODUCTION

Plaintiffs D.H and John Doe¹ are transgender teenagers who urgently need male chest reconstruction surgery to alleviate their gender dysphoria. There is broad consensus within the medical community that the surgery is a safe, effective, and medically necessary treatment for many individuals with gender dysphoria, including adolescents. Plaintiffs' treating providers determined that they require the surgery as soon as possible.

If not treated properly, gender dysphoria can seriously jeopardize a transgender individual's physical and mental health. Both D.H. and John experience suicidal ideation as a result of being denied medically needed care for their gender dysphoria. D.H. was admitted to psychiatric facilities on account of his distress over being denied care for gender dysphoria on multiple occasions. Both teenagers are forced to self-treat their gender dysphoria by wearing restrictive bindings to reduce the profile of their chests. Plaintiffs' treating providers are very concerned about the many negative health consequences of those binders.

Despite these ongoing harms, Arizona Medicaid refuses to cover this critical surgical procedure. Instead, it cites a categorical exclusion for surgical treatment for gender dysphoria, including male chest reconstruction surgery. Ariz. Admin. Code R9-22-205(B)(4)(A). There is no legitimate basis for this exclusion. It is contrary to the prevailing standards of care and violates the Medicaid Act, the Affordable Care Act, and the Equal Protection Clause.

Due to the significant harm this exclusion causes D.H. and John, and the irreparable damage the continued denial of coverage will have on their physical and mental health, Plaintiffs move to preliminarily enjoin Defendants from further enforcement of the regulation and order AHCCCS to cover male chest reconstruction surgery for D.H. and John.

II. FACTUAL BACKGROUND

A. **Male Chest Reconstruction Surgery as Treatment for Gender Dysphoria**

Gender dysphoria—the clinically significant distress associated with the incongruence between a transgender person's gender identity and assigned sex—is a serious medical condition

¹ John Doe concurrently filed a separate motion seeking leave to proceed under a pseudonym.

1 often requiring medical interventions. Declaration of Dr. Aron Janssen (“Janssen Decl.”) ¶¶ 28-
2 30, 33-35; Declaration of Loren Schechter (“Schechter Decl.”) ¶¶ 20-22.

3 Because a person’s gender identity is a core component of human identity, treatments for
4 gender dysphoria enable a transgender person to live consistently with his or her gender identity.
5 Janssen Decl. ¶¶ 22-28. The process of undergoing these treatments is called “gender transition”
6 and is guided by well-established, internationally recognized standards of care developed by the
7 World Professional Association for Transgender Health (WPATH). *Id.* ¶¶ 30-36; Schechter Decl.
8 ¶¶ 23-27. Major professional associations of healthcare providers in the United States adopted
9 the WPATH standards, including the American Medical Association, American Psychological
10 Association, the American Academy of Pediatrics, and the Endocrine Society. Janssen Decl., ¶
11 11; Schechter Decl. ¶¶ 31-32.

12 Under the prevailing standards of care, treatments for gender dysphoria in adolescents
13 who have entered puberty generally include mental health services and hormone therapy. Janssen
14 Decl. ¶¶ 33-34; Schechter Decl. ¶ 22. For transgender males, they frequently also include male
15 chest reconstruction surgery. Schechter Decl., ¶¶ 30-34; Janssen Decl. ¶ 35. The first step to
16 getting approved for male chest reconstruction surgery is obtaining a letter from a qualified
17 mental health professional referring the transgender young person for surgery. Schechter Decl.,
18 ¶ 30. The letter details the young person’s psychological functioning, the clinical bases for the
19 surgical referral, and their ability to consent to the procedure. *Id.* Then, they must consult with a
20 surgeon to determine whether they are a good candidate for male chest reconstruction surgery.

21 The surgery is not cosmetic; it is functional. Schechter Decl. ¶ 29. By converting the chest
22 from a female- to a male-appearing chest contour, the surgery alleviates the severe distress
23 experienced by transgender men with female-appearing breasts. *Id.*; Janssen Decl. ¶ 35. As a
24 result of the surgery, a transgender male’s body matches the person’s internal identity, thereby
25 providing enormous psychological relief, and enables them to interact with others and to function
26 in a male identity much more effectively and confidently. Janssen Decl. ¶ 31.

27 The surgery also eliminates the need for a chest binder along with the discomfort and pain
28 associated with it. Janssen Decl. ¶¶ 42-46; Schechter Decl. ¶ 35. This is not an insignificant issue.

1 A binder is a compressive garment that flattens the chest. Janssen Decl. ¶ 42; Schechter Decl.
2 ¶ 35. Many transgender men without access to male chest reconstruction surgery, in an effort to
3 self-treat, wear a binder for long durations of time. Janssen Decl., ¶ 43. Extended use of a binder
4 causes difficulty breathing and exacerbates preexisting pulmonary conditions like asthma.
5 Schechter Decl. ¶ 35; Declaration of Dr. Andrew Cronyn (“Cronyn Decl.”) ¶ 17. The constant
6 compression causes rashes and stretches the skin and can result in more serious skin conditions
7 such as vitiligo. Schechter Decl. ¶ 35. Wearing a binder over a long period of time also affects
8 surgical outcomes for male chest reconstruction surgery by (i) requiring a larger incision, (ii)
9 necessitating more difficult surgical techniques, and (iii) causing more scarring. *Id.*

10 Finally, excessive binding can result in a vicious Catch-22. Specifically, skin conditions
11 on or around the chest exacerbate a transgender person’s gender dysphoria because they require
12 them to devote attention to and seek medical care for the very part of their body causing them
13 significant psychological distress. Cronyn Decl. ¶ 25.

14 **B. D.H.’s and John’s history of Gender Dysphoria**

15 D.H. and John are seventeen- and fifteen-year-old transgender males on Medicaid.
16 Declaration of D.H. (“D.H. Decl.”) ¶¶ 1-2; Declaration of John Doe (“John Decl.”) ¶¶ 1-2. Both
17 experienced significant psychological distress as they first came to understand that they were
18 male, despite being assigned female at birth. D.H. Decl. ¶¶ 3-4; John Decl. ¶¶ 3-5. This distress
19 intensified at the onset of puberty. D.H. Decl. ¶ 6; John Decl. ¶ 5.

20 Starting at age four, D.H. struggled to express to his mother, Janice, that he is male. D.H.
21 Decl. ¶ 4. Not recognizing the message D.H. was trying to convey, Janice continued treating him
22 as female, which caused D.H. to decompensate psychologically. *Id.* ¶ 4; Declaration of Janice
23 Hennessy-Waller (“Hennessy-Waller Decl.”) ¶ 5. D.H. fervently tried mask or cope with the pain
24 he felt due to the disconnect between his body and his gender identity. D.H. Decl. ¶¶ 6-7. Nothing
25 could contain those emotions for long. At ages eleven, thirteen, fifteen, and sixteen, he required
26 intensive in-patient psychiatric treatment as a result of his distress at being treated as female. *Id.*
27 ¶ 4; Hennessy-Waller Decl. ¶¶ 5, 9, 12.

For John, everyone referred to him as a “tomboy,” but the term never really fit. John Decl. ¶ 4. He was not mimicking a boy; he was already a boy. *Id.* At the onset of puberty, as John’s body looked less like that of his male peers, he became unmoored and slipped into a serious depression. *Id.* ¶ 5. During that time, he distanced himself from friends, no longer found joy in the activities he used to love, lost a significant amount of weight, and contemplated suicide as a result of trying to hide and suppress his male identity and his intense discomfort as a result of developing breasts and other female secondary-sex characteristics. *Id.* Fear of rejection kept him from sharing his male identity with those closest to him, especially his grandmother and caretaker, Susan. *Id.* ¶ 6. That delay also prevented John from getting the specialized treatment he desperately needed as his chest continued to develop and his psychological distress intensified. *Id.* ¶ 6-7.

At their own times, D.H. and John found the words and courage to disclose that they are transgender to their families. D.H. Decl. ¶ 8; John Decl. ¶ 7. Janice and Susan responded to this news very similarly. They started gathering information and learning about how best to support their child’s health and wellbeing. Hennessy-Waller Decl. ¶ 7; Declaration of Susan Doe (“Susan Decl.”) ¶ 12. This was not a fast or easy process for either Janice or Susan, but they sought and relied on the advice of medical experts to help guide them in making the decisions in D.H.’s and John’s best interests. Hennessy-Waller Decl. ¶ 6; Susan Decl. ¶ 12.

After being evaluated by medical and mental health professionals, D.H. and John were diagnosed with gender dysphoria. Reed Decl. ¶ 7; Peck Decl. ¶ 11. At the recommendation of their healthcare providers, D.H. and John started the first, and critical, step of their transitions: “social transition.” Reed Decl. ¶ 8; Peck Decl. ¶ 14. During this stage, individuals change their name, pronouns, clothing, hair, and mannerisms to correspond with those typically associated with their gender identity. Janssen Decl. ¶ 32. Those changes help ensure that a transgender young person is treated consistent with their gender identity throughout their daily life, which is often accompanied by significant improvement in mental health. *Id.*

Eventually, D.H. and John also began hormone treatment. Cronyn Decl. ¶ 14; Peck Decl. ¶ 14. D.H. and John have been taking testosterone for more than a year. D.H. Decl. ¶ 13; John

Decl. ¶ 9. This treatment helped masculinize their appearance in the same way that it masculinizes the appearance of other boys their age. *See* Janssen Decl. ¶ 34; D.H. Decl. ¶ 13; John Decl. ¶ 9. Both D.H. and John experienced a decrease in their gender dysphoria since starting testosterone treatment. Hennessy-Waller Decl. ¶ 11; Reed Decl. ¶ 9; John Decl. ¶ 9; Peck Decl. ¶ 16. The more masculine appearance of their face and deeper voice also helps ensure that others—including strangers—treat D.H. and John as male. *See* Janssen Decl. ¶¶ 30, 34.

C. D.H. and John continue to experience significant emotional distress

Each step of their respective transitions helped reduce D.H.’s and John’s gender dysphoria and improve their daily lives. But their treatment is not complete because having breasts—a female-appearing chest—is exacerbating their gender dysphoria. D.H. Decl., ¶¶ 13-14; John Decl., ¶ 10. And self-treating their dysphoria by wearing a binder is no longer effective. D.H. Decl., ¶¶ 9-10, 13-15; John Decl., ¶ 15.

Like many transgender males, D.H. and John regularly wear their binders for far longer than the maximum daily time—eight hours—recommended by health care providers. D.H. Decl., ¶ 11; John Decl., ¶ 13. But the binders provide psychological relief that is essential to their ability to function. D.H. Decl., ¶¶ 7, 11; John Decl., ¶ 14; Cronyn Decl., ¶ 20; Peck Decl. ¶ 15. Removing the binder causes their psychological distress to come flooding back. D.H. Decl. ¶ 11; John Decl., ¶¶ 14, 15; Cronyn Decl., ¶ 20; Peck Decl. ¶ 15; Janssen Decl. ¶ 43.

On occasions when his gender dysphoria is particularly intense, D.H. has worn his binder for several consecutive days without taking it off. D.H. Decl., ¶ 11. But excessive use of the binder is dangerous and restrictive. D.H. Decl., ¶ 9-10; Cronyn Decl., ¶¶ 16-19, 24-25; Janssen Decl. ¶ 43. The binder prevents D.H. from dancing—formerly a major source of psychological relief—because the binder keeps him from breathing in too deeply, making it difficult to engage in any type of physical activity. D.H. Decl., ¶ 10. In fact, D.H.’s primary care provider noted that D.H. is starting to develop asthma as a result of his use of the binder. Cronyn Decl., ¶ 16.

Even when worn safely, the binder causes significant psychological distress for both D.H. and John. D.H. Decl., ¶¶ 12, 14; John Decl., ¶ 14-15. The contour of their chest—even with the binder—undermines every other aspect of who they are. At fifteen-years-old, D.H. became

1 consumed with distress again; the appearance of his chest being a major contributing factor.
2 Hennessy-Waller Decl., ¶ 12. D.H. was placed in an intensive psychiatric treatment program for
3 a third time. *Id.* D.H. recovered, but still finds himself in an impossible position: his chest is both
4 the major source of his ongoing psychological distress and the barrier to his return to dance,
5 D.H.'s outlet for relieving that distress. D.H. Decl. ¶ 10.

6 John too experiences significant distress regarding his chest. John cannot look at himself
7 in the mirror or in photographs. John Decl., ¶ 14. He needs layers of clothing to feel comfortable
8 enough to leave his home. *Id.* ¶ 10. John's binder causes debilitating anxiety during regular social
9 interactions among teenage friends. *Id.* ¶ 12. He cannot engage in physical activity in the same
10 way as his peers because the binder restricts his breathing. *Id.* Before going into the pool with
11 friends, he must steel himself for the inevitable questions about why he wears a shirt in the pool
12 and why he can't just take it off and be bare chested like his male peers. *Id.* And, at least once a
13 week, John is kept awake at night by the dysphoria associated with his chest; putting his binder
14 back on is the only way to calm that distress. *Id.* ¶ 14. As a result of his increasing distress, earlier
15 this year John asked Susan if he could start seeing a therapist regularly. Susan Decl., ¶ 16.

16 **D. D.H. and John also experience significant physical discomfort and pain**

17 John is constantly uncomfortable with the appearance of his chest and wears layers of
18 clothing to obscure the contour of his chest. John Decl. ¶ 10. This includes a hooded sweatshirt,
19 which he wears every day, even in the blistering heat of the Arizona summers. *Id.* Those layers
20 of additional clothing make John hot, sweaty, and uncomfortable for large portions of his day.
21 John also has asthma, which in combination with the binder, prevents him from keeping up in
22 his dance classes, an activity he loves. *Id.* at ¶ 12.

23 For D.H., his binder is constrictive and painful. D.H. Decl. at ¶¶ 9-10. That pain and
24 discomfort interferes with D.H.'s ability to fully engage in his schoolwork, particularly
25 homework because the pain is the most intense towards the end of the day. *Id.* D.H.'s treating
26 physician is concerned that this back pain will become severe enough to warrant medication or
27 referrals to additional healthcare services, such as physical therapy or even orthopedic surgery.
28 Cronyn Decl. at ¶ 24.

E. D.H. and John require male chest reconstruction surgery

In May 2019, following D.H.’s fourth hospitalization, D.H. was evaluated by Dr. Ethan Larson, a surgeon who regularly performs male chest reconstruction surgery on transgender patients. Hennessy-Waller Decl. ¶ 14. Dr. Larson concluded that D.H. was a good candidate for male chest reconstruction surgery and recommended that he proceed with the surgery. *Id.* In light of D.H.’s urgent need for the surgery, Janice decided to seek pre-authorization from AHCCCS for the procedure because privately paying for the procedure was not an option given her income. *See id.* ¶¶ 13, 16.

D.H.’s request for pre-authorization for male chest reconstruction surgery was denied. Hennessy-Waller Decl. ¶ 15. Janice appealed, but the denial was upheld on July 5, 2019. *Id.* The denial of coverage for D.H.’s male chest reconstruction surgery relied upon AHCCCS’s explicit exclusion for surgical treatments for gender dysphoria. *Id.*

Although John has the referral letter from his mental health provider, Susan is unable to schedule a surgical consult because she cannot afford the surgery and AHCCCS will not cover it. Susan Decl. ¶ 18.

D.H.’s and John’s treating health care providers are all in agreement: without male chest reconstruction surgery, D.H. and John are at substantial risk of short- and long-term harm to their health and well-being. Reed Decl. ¶¶ 12-14; Cronyn Decl. ¶ 26; Peck Decl. ¶ 19-21.

III. ARGUMENT

The Court should issue a preliminary injunction when plaintiffs establish that (a) they are “likely to succeed on the merits,” (b) they are “likely to suffer irreparable harm in the absence of preliminary relief,” (c) “the balance of equities tips in [their] favor,” and (d) “an injunction is in the public interest.” *Alliance for the Wild Rockies v. Cottrell*, 632 F. 3d 1127, 1135 (9th Cir. 2011); *United Food and Commercial Workers Local 99 v. Brewer*, 817 F. Supp. 2d 1118, 1123 (D. Ariz. 2011). These elements are “balanced” using a “‘sliding scale’ approach,” so that “a stronger showing of one element may offset a weaker showing of another.” *United Food*, 817 F. Supp. 2d at 1118 (quoting *Wild Rockies*, at 1127). For example, when “the moving party demonstrate[s] a very high likelihood of injury . . . , the likelihood of success on the merits may

1 be relaxed” and “an injunction may be granted when ‘serious questions going to the merits were
2 raised’” but “the balance of hardships tips sharply in the plaintiff’s favor.” *Id.* (quoting *Wild
3 Rockies*, at 1135).

4 D.H. and John’s claims satisfy each of these elements.

5 **A. Plaintiffs are Likely to Succeed on the Merits of Their Claims**

6 *1. Excluding surgical care for transgender young people violates Medicaid’s*
7 *EPSDT requirements*

8 The fundamental purpose of the Early and Periodic Screening, Diagnostic and Treatment
9 (EPSDT) requirements is to “[a]ssure that health problems are diagnosed and treated early, before
10 they become more complex and their treatment more costly.” Ctrs. for Medicare & Medicaid
11 Servs., State Medicaid Manual § 5010.B. The EPSDT provisions accomplish that objective by
12 ensuring that Medicaid recipients under age 21 receive the “health care they need when they need
13 it.” Ctrs. for Medicare & Medicaid Servs., *EPSDT – A Guide for States* (2014),
14 https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf. Specifically,
15 the EPSDT provisions require state Medicaid agencies to cover any service that is allowable
16 under § 1396d(a) if “necessary . . . to correct or ameliorate” illnesses or conditions regardless of
17 whether the service is covered for adults. 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(10)(A),
18 1396d(a)(4)(B).

19 “The EPSDT obligation is thus extremely broad.” *Katie A., ex rel. Ludin v. L.A. County*,
20 481 F. 3d 1150, 1154 (9th Cir. 2007). And, “there is a very strong inference to be inclusive rather
21 than exclusive” when determining the meaning of “correct or ameliorate.” *Ekloff v. Rodgers*, 443
22 F.Supp.2d 1173, 1180 (D. Ariz. 2006). Further, states must take the proactive step of ensuring
23 that services determined to be medically necessary for a particular beneficiary are actually
24 provided. 42 U.S.C. § 1396a(a)(43)(C); *Katie A.*, 481 F. 3d at 1158-59.

25 Here, the EPSDT provisions require AHCCSS to cover male chest reconstruction surgery
26 for D.H. and John. The procedure is included within the categories of services that must be
27 covered under the Medicaid Act. *See* 42 U.S.C. § 1396d(a)(2)(A) (outpatient hospital services),
28

1 (5)(A) (services furnished by a physician). It is also necessary to “correct or ameliorate”
2 Plaintiffs’ gender dysphoria. *Id.* § 1396d(r)(5).

3 There is broad consensus within the medical community that male chest reconstruction
4 surgery is a safe and effective treatment for gender dysphoria. Schechter Decl. ¶¶ 27-30; Janssen
5 Decl. ¶ 46. Plaintiffs’ treating health care providers determined that the Plaintiffs need the
6 surgery to alleviate their dysphoria. Reed Decl. ¶¶ 12-14; Cronyn Decl. ¶ 26; Peck Decl. ¶¶ 19-
7 21; *see also* Schechter Decl. ¶¶ 43-44, 49. That surgery will significantly improve D.H.’s and
8 John’s ability to function in every aspect of their lives. Reed Decl. ¶¶ 12; Cronyn Decl. ¶¶ 24-
9 26; Peck Decl. ¶¶ 18-20. By alleviating their gender dysphoria, D.H. and John will be better able
10 to address the anxiety, depression, and co-occurring mental health issues that have accompanied
11 their gender dysphoria. Reed Decl. ¶ 13; Peck Decl. ¶ 20. Further, the surgery will relieve D.H.
12 and John of the pain associated with prolonged use of a binder. D.H. Decl. ¶ 17; John Decl. ¶ 17;
13 Cronyn Decl. ¶¶ 24-26. It will also prevent the binder from causing any additional health
14 complications such as skin rashes, irritations, or stretching, or vitiligo or exacerbating existing
15 conditions, such as asthma. Cronyn Decl. ¶ 23; Schechter Decl. ¶ 35; *see Ekloff*, 443 F.Supp.2d
16 at 1180 (holding that AHCCCS’s refusal to cover incontinence briefs when necessary to prevent
17 skin breakdown and “the needless pain of skin sores” violated the EPSDT requirements).

18 2. *Excluding surgical care for transgender people violates Medicaid’s*
19 *comparability requirement*

20 The Medicaid Act also requires AHCCCS to ensure that the “medical assistance made
21 available to any [categorically needy] individual . . . shall not be less in amount, duration, or
22 scope than the medical assistance made available to any other such individual.” 42 U.S.C. §
23 1396a(a)(10)(B); 42 C.F.R. § 440.240. Federal regulations make clear that states “may not
24 arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise
25 eligible beneficiary solely because of the diagnosis, type of illness, or condition.” 42 C.F.R. §
26 440.230(c).

27 Courts repeatedly hold that the comparability requirement “prohibits discrimination
28 among individuals with the same medical needs stemming from different medical conditions.”

1 *Davis v. Shah*, 821 F.3d 231, 258 (2d Cir. 2016) (finding state policy covering prescription
2 orthopedic footwear and compression stockings for beneficiaries with certain listed conditions,
3 but not for those with equal need for service due to other conditions, violated comparability
4 requirement); *see also White v. Beal*, 555 F.2d 1146, 1148 (3d Cir. 1977); *Cota v. Maxwell-Jolly*,
5 688 F. Supp. 2d 980, 993 (N.D. Cal. 2010).

6 With the Challenged Exclusion, however, AHCCCS is doing just that. Male chest
7 reconstruction surgery is medically necessary for many individuals with gender dysphoria,
8 including D.H. and John. Reed Decl. ¶¶ 12-14; Cronyn Decl. ¶ 26; Peck Decl. ¶¶ 19-21;
9 Schechter Decl. ¶¶ 27-30; Janssen Decl. ¶ 46. While AHCCCS refuses to cover the surgery when
10 necessary to treat gender dysphoria, AHCCCS covers the same services when necessary to treat
11 other conditions. *See, e.g., Arizona Administrative Code R9-22-2004(A)(4)*; AHCCCS Medical
12 Policy Manual, § 310-C Breast Reconstruction After Mastectomy (2018),
13 <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310C.pdf>. The
14 Western District of Wisconsin recently held that a nearly identical coverage policy violates the
15 comparability requirement. *Flack v. Wis. Dep't of Health Servs.*, 395 F. Supp. 3d 1001, 1019
16 (W.D. Wis. 2019) (finding the categorical exclusion of coverage for “transsexual surgery”
17 impermissible because it “discriminates on the basis of diagnosis” and permanently enjoining the
18 State from enforcing the exclusion).

19 The circumstances here are no different. By failing to provide “comparable services for
20 individuals with comparable needs,” AHCCSS is plainly violating the Medicaid Act. *Cota*, 688
21 F. Supp. 2d at 993.

22 3. *Excluding surgical care for transgender people violates Section 1557 of*
23 *the Affordable Care Act*

24 The nondiscrimination provision of the Affordable Care Act prohibits any health program
25 that receives federal funds from discriminating on the basis on sex, among other protected
26 characteristics. 42 U.S.C. § 18116(a). Drawing from the statutory language, there are three
27 elements to a claim under Section 1557: (1) the program is federally funded; (2) the plaintiff was
28 denied benefits of or otherwise discriminated against by the program based on a protected

1 characteristic—in this case sex; (3) the discrimination was a but-for cause of the plaintiff’s injury.

2 *See id.*

3 As a health program that receives federal funds, AHCCCS must comply with Section 1557
4 of the Affordable Care Act.

5 Discrimination because a person is transgender is discrimination because of sex. *Bostock*
6 *v. Clayton Cnty., Ga.*, --- S. Ct. ---, 2020 WL 3146686 at *7 (Jun. 15, 2020); *see, also, Toomey*
7 *v. Arizona*, Case No. CV-19-00035-TUC-RM, 2019 WL 7172144, at *5 (D. Ariz. Dec. 23, 2019).
8 As the Supreme Court has explained, “it is impossible to discriminate against a person for
9 being . . . transgender without discriminating against that individual based on sex.” *Bostock*,
10 2020 WL 3146686 at *7.

11 The Supreme Court’s analysis in *Bostock* applies to the Affordable Care Act as well.
12 Because the statutory language—and thus, the original public meaning—of Section 1557 is
13 indistinguishable from Title VII, courts rely on the interpretation of Title VII, and other federal
14 sex-discrimination laws, to analyze claims under Section 1557. *See, e.g., Prescott v. Rady*
15 *Children’s Hosp.-San Diego*, 265 F. Supp. 3d 1090, 1098–99 (S.D. Cal. 2017). In particular,
16 courts have recognized that discrimination against transgender people by excluding coverage of
17 transition-related care violates Section 1557. *See, e.g., Flack v. Wis. Dept. of Health Svcs.*, 395
18 F.Supp.3d 1001 (W.D. Wis. 2019); *Boyden v. Conlin*, 341 F.Supp.3d 979 (W.D. Wis. 2018).

19 By enforcing a categorical exclusion for “gender reassignment surgeries,” AHCCCS
20 discriminates against transgender Medicaid beneficiaries based on sex. That conclusion is plain
21 from the sex-based language of the exclusion, which expressly prohibits surgeries undertaken for
22 the purpose of “gender reassignment.”² The sex-based character of the exclusion is apparent on
23 its face.

24
25
26
27 ² The exclusion’s use of the word “gender” instead of “sex” is legally insignificant. Courts
28 have used those terms interchangeably to determine whether a defendant’s conduct violated
federal sex-discrimination laws. *Glenn v. Brumby*, 663 F.3d 1312, 1317 (11th Cir. 2011)

1 The exclusion also discriminates based on sex because it applies only to transgender
2 people, who are the only beneficiaries who require gender-reassignment surgeries. The fact that
3 AHCCCS would have provided coverage had D.H. or John needed this surgery for other
4 medically necessary reasons, such as to treat cancer or traumatic injury, but refuses to do so for
5 the treatment of gender dysphoria, demonstrates that the exclusion on its face discriminates based
6 on transgender status and thus on sex.

7 The harm caused to D.H. and John by AHCCCS's refusal to cover their medically
8 necessary male chest reconstruction surgery is equally plain. Unable to afford this medically
9 necessary surgery themselves, D.H. and John have no choice but to delay. Hennessy-Waller Decl.
10 ¶ 16; Susan Decl. ¶ 18. In the meantime, they are exposed to the daily emotional pain of having
11 a body that is inconsistent with who they are, exacerbated by physical pain of wearing a binder
12 to flatten the appearance of their chest. D.H. Decl. ¶¶ 9-12, 14-15; John Decl. ¶¶ 10-15. And,
13 despite their efforts to ensure their appearance accurately presents their male gender identity,
14 both are regularly mistaken for female due to their female-appearing breasts, a particularly
15 painful indignity. D.H. Decl. ¶ 15; John Decl. ¶ 17.

16 For D.H., that psychological distress intensified to the point that he required in-patient
17 intensive psychiatric care due to suicidal ideations. D.H. Decl. ¶ 12. John cannot look at himself
18 in the mirror due to the shame he feels about his body, goes to great lengths to obscure the
19 appearance of chest, even wearing hooded sweatshirts in the summer, and avoids social
20 interaction with peers due to anxiety, and has sought mental health treatment for these symptoms.
21 John Decl. ¶¶ 10, 14.

22 All these significant harms could be avoided if AHCCCS covered this critical, medically
23 necessary care.

24 4. *The Challenged Exclusion Violates the Equal Protection Clause*

25 AHCCCS's categorical exclusion for "gender reassignment surgery" impermissibly
26 discriminates against transgender Medicaid recipients based on sex. That exclusion explicitly
27 disregards the medical necessity of surgical care for transgender people. Governmental action
28 that discriminates based on transgender status is subject to heightened scrutiny. Because

1 discrimination against transgender people is a form of sex discrimination, *Bostock*, 2020 WL
2 3146686 at *7, courts have applied heightened scrutiny to equal-protection claims brought by
3 transgender people. *See, e.g., F.V.*, 286 F. Supp. 3d at 1144; *Norsworthy*, 87 F. Supp. 3d at 1119;
4 *see also Whitaker v. Kenosha Unified Sch. Dist. No. 1*, 858 F. 3d 1034, 1051 (7th Cir. 2017);
5 *Glenn v. Brumby*, 663 F.3d 1312, 1320 (11th Cir. 2011); *Smith v. City of Salem*, 378 F.3d 566,
6 572 (6th Cir. 2004).

7 Under heightened scrutiny, the government must have an “exceedingly persuasive
8 justification” for its discrimination. *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 723-24
9 (1982) (internal citation omitted). This requires that “the [challenged] classification serve[]
10 important government objectives and that the discriminatory means employed are substantially
11 related to the achievement of those objectives.” *Id.* at 723-24 (citations and internal quotation
12 marks omitted). The justification must also be “genuine, not hypothesized or invented post hoc
13 in response to litigation.” *United States v. Virginia*, 518 U.S. 515, 533 (1996). But, AHCCCS’s
14 categorical exclusion for “gender reassignment surgeries” cannot survive any level of
15 constitutional scrutiny because the exclusion is no more than “a bare desire to harm a politically
16 unpopular group.” *Romer v. Evans*, 517 U.S. 620, 634 (1996).

17 By excluding “gender reassignment surgeries,” AHCCCS categorically denies coverage
18 for medically necessary surgical care required by transgender people, while providing the same
19 surgical care when necessary to treat other medical conditions not associated with transgender
20 people. Pre-authorizations for surgical care required to treat other conditions follow a well-
21 established procedure: assessing the medical necessity of the procedure based on the prevailing
22 standards of care and evidence of need provided by treating healthcare providers. In contrast,
23 AHCCCS does not consider any standards of care or even review documentation of a
24 beneficiary’s medical need for surgical care; coverage is automatically denied because it is being
25 requested for a condition that affects transgender people. This categorical denial even overrides
26 the requirement that AHCCCS cover treatments “necessary . . . to correct or ameliorate” illnesses
27 or conditions for Medicaid beneficiaries under 21, regardless of whether the treatment is covered
28 for adults. 42 U.S.C. § 1396d(r)(5).

1 There is no legitimate—or even rational—basis for that distinction. Indeed, this Court in
2 *Toomey* denied Arizona’s motion to dismiss finding that a similar exclusion in Arizona’s health
3 plan for state employees was so devoid of purpose that, “even were the Court to apply rational
4 basis review to Plaintiff’s Equal Protection claim . . . it is not certain that Plaintiff’s claim would
5 fail that test.” *Toomey v. Arizona*, 2019 WL 7172144, *8 (D. Ariz. 2019). As a result, D.H. and
6 John have a strong likelihood of success on their equal protection claim.

7 **B. Plaintiffs will be irreparably harmed in the absence of an injunction**

8 *1. Irreparable harm is presumed for violations of constitutional rights*

9 “It is well established that the deprivation of constitutional rights ‘unquestionably
10 constitutes irreparable injury.’” *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012). There
11 is a presumption of irreparable injury upon a showing of likelihood of success on a constitutional
12 claim, as “constitutional violations cannot be adequately remedied through damages.” *Am.*
13 *Trucking Ass’ns, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1059 (9th Cir. 2009) (quotations
14 omitted). Courts apply this principle to equal-protection claims brought by transgender plaintiffs.
15 See, e.g., *Edmo v. Corizon, Inc.*, 935 F.3d 757, 798 (9th Cir. 2019) (citing *Nelson v. NASA*, 530
16 F.3d 865, 882 (9th Cir. 2008)).

17 Thus, the continued enforcement of the Challenged Exclusion in violation of the Equal
18 Protection Clause—in and of itself—would be sufficient to presume irreparable harm to justify
19 a preliminary injunction. As detailed above, however, D.H. and John have and will continue to
20 experience significant harm to their short- and long-term health and well-being.

21 *2. AHCCCS’ continued denial of care causes irreparable physical and*
22 *emotional harm*

23 Delayed access to medically necessary healthcare services is sufficient to establish
24 irreparable harm. *Bowen v. City of New York*, 476 U.S. 467, 483-84 (1986) (finding denial of
25 benefits caused irreparable injury by exposing plaintiffs to “severe medical setbacks or
26 hospitalization”); *Edmo v. Corizon, Inc.*, 935 F.3d 757, 797 (9th Cir. 2019). In *Edmo*, the Ninth
27 Circuit held that the continued denial of gender-confirming surgery, and the accompanying
28 psychological distress and risk to Edmo’s physical health due to prior suicidal ideation,

1 constituted irreparable harm. 935 F.3d at 957. Courts repeatedly hold that serious psychological
2 distress, deterioration of health, and risk of self-harm or suicide are irreparable harms—even
3 when unconnected to a denial of medically necessary care. *Thomas v. Cnty. of Los Angeles*, 978
4 F.2d 504, 512 (9th Cir. 1992); *Chalk v. U.S. Dist. Ct. Cent. Dist. of California*, 840 F.2d 701, 709
5 (9th Cir. 1988); *see also Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d
6 1034, 1045 (7th Cir. 2017).

7 Here, further delay of this medically necessary surgery will cause D.H. and John
8 irreparable harm to their physical health, which could have long-lasting implications. Reed Decl.
9 ¶¶ 12-14; Cronyn Decl. ¶¶ 23-24, 26; Peck ¶¶ 19-21. D.H. and John treat their symptoms of
10 gender dysphoria by wearing a binder, which causes pain and discomfort. D.H. Decl. ¶¶ 7, 9-12;
11 John Decl. ¶¶ 11-15. The binder also impairs their ability to engage in physical activity and is
12 exacerbating John's and D.H.'s asthma, which could limit D.H.'s chances of being able to fully
13 return to dancing—an activity that previously brought him significant psychological relief. D.H.
14 Decl. ¶ 10; Cronyn Decl. ¶¶ 17-18, 23; John Decl. ¶ 12. Further, prolonged use of the binder,
15 without which neither D.H. or John would be able to function, can cause significant damage to
16 the skin and tissue on their chest, potentially requiring a larger incision to complete the male
17 chest reconstruction surgery, which would also result in more scarring. Schechter Decl. ¶ 35.

18 The emotional harms D.H. and John will experience absent immediate relief are also
19 irreparable. D.H.'s and John's gender dysphoria will become increasingly debilitating. Reed
20 Decl. ¶¶ 13-14; Cronyn Decl. ¶¶ 23-24; Peck Decl. ¶ 21. To date, there have been very serious
21 consequences for D.H., who required intensive psychiatric treatment on multiple occasions due
22 to suicidal ideation associated with being unable to access medically necessary care for gender
23 dysphoria. D.H. Decl. ¶¶ 4, 12; Hennessy-Waller, ¶¶ 5, 9, 12. John also experienced suicidal
24 ideation when his gender dysphoria spiked at the onset of puberty. John. Decl. ¶ 5. John is already
25 exhibiting the signs of increased psychological distress as a result of not being able to undergo
26 male chest reconstruction surgery. Susan Decl. ¶ 16; Peck Decl. ¶ 21. He also continues to
27 experience significant anxiety in social situations out of fear that the appearance of his chest will
28 cause others to treat him differently and not as male. John Decl. ¶ 15; Susan Decl. ¶ 20. Each of

1 those harms is sufficiently irreparable, but when combined demonstrate the critical importance
2 of injunctive relief for D.H. and John.

3 **C. The balance of equities tips sharply in Plaintiffs' favor**

4 The balance of equities heavily favors D.H. and John's requested relief. When considering
5 a request for preliminary injunction, the "court must balance the competing claims of injury and
6 must consider the effect on each party of the granting or withholding of the requested relief." *Arc*
7 *of Cal. v. Douglas*, 757 F.3d 975, 991 (9th Cir. 2014) (quoting *Amoco Prod. Co. v. Vill. of*
8 *Gambell*, 480 U.S. 531, 542 (1987)). The balance of equities and public interest factors "merge
9 when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 435 (2009).

10 D.H. and John provided detailed declarations from their treating providers and medical
11 experts outlining the serious physical and emotional injuries a further delay of this medically
12 necessary surgery would cause. Indeed, both individuals have already suffered greatly due to the
13 denial of medically necessary care caused by AHCCCS's categorical exclusion.

14 On the other hand, AHCCCS cannot show that it will be harmed at all, let alone irreparably
15 so. The government "cannot reasonably assert that it is harmed in any legally cognizable sense"
16 when a court enjoins it from violating the constitution. *Zepeda v. I.N.S.*, 753 F.2d 719, 727 (9th
17 Cir. 1983); *see also Ariz. Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1069 (9th Cir. 2014);
18 *Melendres*, 695 F.3d at 1002. Requiring AHCCCS to cover medically necessary care, as required
19 by the Medicaid Act, and in a nondiscriminatory manner, as required by the Affordable Care Act
20 and the Equal Protection Clause, does not harm Arizona.

21 Nor does the cost of complying with the injunction cause the balance of equities to shift
22 in favor of AHCCCS. The Ninth Circuit repeatedly holds that access to medically necessary care
23 for Medicaid recipients and people with disabilities outweighs budgetary concerns. *See, e.g.,*
24 *M.R. v. Dreyfus*, 697 F.3d 706, 737-38 (9th Cir. 2012); *Beltran v. Myers*, 677 F.2d 1317, 1322
25 (9th Cir. 1982); *see also Newton-Nations v. Rogers*, 316 F.Supp.2d 883, 888 (D. Ariz. 2004).

26 In fact, given the experiences of other states who cover male chest reconstruction surgery
27 and other gender-confirming care, it is likely that the cost savings to Arizona from the reduced
28 need for treatment of symptoms and co-occurring conditions associated with gender dysphoria

1 will far exceed the costs of covering surgery itself. *See, e.g.,* Am. Medical Ass’n & Gay and
2 Lesbian Medical Ass’n, *Issue Brief: Health insurance coverage for gender-affirming care of*
3 *transgender patients* 3 (2019), available at, [https://www.ama-assn.org/system/files/2019-](https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf)
4 [03/transgender-coverage-issue-brief.pdf](https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf); *see also* *Boyden v. Conlin*, 341 F. Supp. 3d 979, 990
5 (W.D. Wis. 2018) (defense expert estimating per member cost of removing gender-confirming
6 care exclusion between \$0.04-\$0.10 per month); *Flack*, 395 F. Supp. 3d at 1008 (“For purposes
7 of this lawsuit, defendants estimate that removing the Challenged Exclusion and covering
8 gender-confirming surgeries would cost between \$300,000 and \$1.2 million annually. There is
9 no dispute that these amounts are actuarially immaterial as they are equal to approximately
10 0.008% to 0.03% of the State’s \$3.9 billion share of Wisconsin Medicaid’s \$9.7 billion annual
11 budget”).

12 The cost to AHCCCS of covering the medically necessary care D.H. and John seek will
13 be insignificant, but for D.H. and John, it will relieve them of the significant physical and
14 emotional harms they experience on a daily basis; it will be life-changing and further AHCCCS’s
15 mission to “provide comprehensive, quality health care to those in need.”

16 **IV. THE COURT SHOULD NOT REQUIRE PLAINTIFF TO POST A BOND**

17 The District Court has discretion not to require the moving party to post a bond before
18 granting a preliminary injunction. *Diaz v. Brewer*, 656 F. 3d 1008, 1015 (9th Cir. 2011) (citing
19 *Johnson v. Couturier*, 572 F.3d 1067, 1089 (9th Cir. 2009). The Court should exercise that
20 discretion here. D.H., John, and their families are low-income, and they are seeking to enjoin an
21 unlawful policy that prevents them from obtaining medically necessary treatments they cannot
22 otherwise afford. In these circumstances, a waiver of the security bond requirement is
23 appropriate. *See, e.g., Save Our Sonoran, Inc. v. Flowers*, 408 F.3d 1113, 1126 (9th Cir. 2005)
24 (“district court has discretion to dispense with the security requirement . . . where requiring
25 security would effectively deny access to judicial review” due to financial hardship).

26 **V. CONCLUSION**

27 The Court should grant the requested injunction.
28

Respectfully submitted,

DATED: AUGUST 6, 2020

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UNITED STATES DISTRICT COURT
 DISTRICT OF ARIZONA

D.H., by and through his mother, Janice
 Hennessy-Waller; and John Doe, by his
 guardian and next friend, Susan Doe, on
 behalf of themselves and all others
 similarly situated,

Plaintiffs,

vs.

Jami Snyder, Director of the Arizona
 Health Care Cost Containment System,
 in her official capacity,

Defendant.

No.

**COMPLAINT FOR
 DECLARATORY AND
 INJUNCTIVE RELIEF**

Plaintiffs D.H. and John Doe respectfully state and allege as follows

PRELIMINARY STATEMENT

1. D.H. is a seventeen-year-old transgender Arizona resident enrolled in Arizona's Medicaid program, known as the Arizona Health Care Cost Containment System ("AHCCCS"). John Doe is a fifteen-year-old transgender Arizona resident enrolled in AHCCCS. D.H. and John bring this lawsuit on behalf of themselves and

1 similarly situated individuals to challenge Arizona’s categorical prohibition of coverage
2 of medically necessary treatments for gender dysphoria, specifically, male chest
3 reconstruction surgery.

4 2. Gender dysphoria refers to the distress that can result from the incongruence
5 between a person’s gender identity and their assigned sex at birth. Gender dysphoria is a
6 serious medical condition that, if left untreated, can cause anxiety, depression, and even
7 self-harm or suicidal ideation.

8 3. Gender-confirming medical treatments—including male chest
9 reconstruction surgery—are safe, effective, and medically necessary to treat gender
10 dysphoria in many transgender individuals, including adolescents.

11 4. A longstanding Arizona regulation, promulgated in 1982 and enforced by
12 AHCCCS, expressly prohibits Medicaid coverage for “gender reassignment surgeries.”
13 Ariz. Admin. Code R9-22-205-B.4(a) (“Challenged Exclusion”). Because of the
14 Challenged Exclusion, D.H., John, and similarly situated individuals have been denied or
15 prevented from obtaining Medicaid coverage for medically necessary male chest
16 reconstruction surgery.

17 5. Both D.H. and John have been diagnosed with gender dysphoria. Although
18 identified as female at birth, D.H. and John are male and live as male in every aspect of
19 their lives.

20 6. D.H. first became aware of his male gender identity around the age of four.
21 Frustrated and angry at his inability to communicate that he was transgender to his mother,
22 D.H. developed significant psychological distress at an early age, including severe anxiety
23 and suicidal ideation. Concerned for his safety and well-being, D.H.’s mother, Janice,
24 placed him in a psychiatric treatment facility on several occasions.

25 7. At thirteen, D.H. developed the confidence to tell Janice that he is
26 transgender. Janice then arranged for D.H. to see a mental health provider with experience
27 working with transgender youth. With the recommendation and support of his health care
28 providers, D.H. began to transition to live in accordance with his gender identity. As part

1 of the treatment for his gender dysphoria, D.H. started taking testosterone to masculinize
2 his body

3 8. Just before turning thirteen, D.H. started wearing a binder to flatten his
4 chest, which alleviates his gender dysphoria, but significantly impairs his ability to
5 function. The pain and discomfort caused by wearing the binder interferes with D.H.'s
6 ability to focus on school and homework. The binder also prevents him from engaging in
7 prolonged or intense physical activity, especially dance, which had previously been a
8 source of relief for D.H.

9 9. Last year, D.H.'s pediatrician and his therapist recommended that he obtain
10 male chest reconstruction surgery to further alleviate his gender dysphoria. However, prior
11 authorization for this surgery was denied due to the Challenged Exclusion.

12 10. John started becoming aware of his male gender identity when he was about
13 eleven years old and his body began showing the first signs of puberty. Worried that his
14 family would reject him for being transgender, John kept everything he was going through
15 to himself and began to experience depression and suicidal ideation.

16 11. After about six months, John recognized that he needed help and reached
17 out to his sister, and then eventually told his grandmother, Susan, both of whom were
18 supportive. John started using a male name and pronouns, which helped to alleviate his
19 gender dysphoria to some degree.

20 12. In November 2018, John began seeing a specialist at the Gender Support
21 Program at Phoenix Children's Hospital.

22 13. Like D.H., John also wears a binder, which is very tight and restrictive. Even
23 with the binder, John feels uncomfortable being outside without layers of clothing. He
24 wears a hooded sweatshirt nearly every day, including in the summer. John's chest also
25 hinders his social interactions. For example, John wears his binder and a t-shirt when at
26 the pool, often having to answer uncomfortable questions about why he insists on wearing
27 a t-shirt in the water.
28

1 14. Around February 2020, John’s health care providers recommended that he
2 pursue male chest reconstruction surgery to further alleviate his gender dysphoria.
3 However, due to the Challenged Exclusion, John cannot receive the surgery.

4 15. The Challenged Exclusion unlawfully denies medically necessary surgical
5 care to transgender beneficiaries on AHCCCS. Arizona disregards the transition-related
6 health care needs of Medicaid’s transgender beneficiaries. In doing so, Arizona exposes
7 transgender people to significant and avoidable harms to their health and well-being, in
8 violation of the U.S. Constitution and federal law.

9 16. The Challenged Exclusion violates Plaintiffs’ civil rights under Section
10 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116 (“Section
11 1557”); the Early and Periodic Screening, Diagnostic and Treatment requirements of the
12 federal Medicaid Act, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B),
13 1396d(r); the comparability requirement of the Medicaid Act, *id.* § 1396a(a)(10)(B); and
14 the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution.

15 17. D.H. and John further seek immediate declaratory and injunctive relief to
16 enjoin Arizona from continuing to deny them medically necessary treatment in violation
17 of federal law. Without the injunctive relief sought in this lawsuit, the Challenged
18 Exclusion will prevent effective treatment of D.H.’s and John’s gender dysphoria, causing
19 them irreparable physical and psychological harm.

20 **JURISDICTION AND VENUE**

21 18. The Court has jurisdiction over the claims asserted herein pursuant to 28
22 U.S.C. §§ 1331, 1343(a)(3)-(4).

23 19. Plaintiffs’ claims for declaratory and injunctive relief are authorized by 28
24 U.S.C. §§ 2201, 2202 and 42 U.S.C. § 1983.

25 20. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(b) because
26 Plaintiffs reside within this judicial district and D.H. resides within the Tucson division,
27 the events giving rise to this action occurred in this judicial district, and the Defendant is
28 subject to personal jurisdiction in this judicial district.

1 **THE PARTIES**

2 21. Plaintiff D.H. is a seventeen-year-old boy who has been diagnosed with
3 gender dysphoria. D.H. resides in Pima County, Arizona and brings this action through his
4 mother, Janice Hennessy-Waller. Due to his family's limited income, D.H. is eligible for
5 Arizona's Medicaid program. D.H. has been enrolled in Arizona's Medicaid program at
6 all relevant times.

7 22. Plaintiff John Doe is a fifteen-year-old boy who has been diagnosed with
8 gender dysphoria. John resides in Maricopa County, Arizona and brings this action through
9 his grandmother and legal guardian, Susan Doe. Due to his family's limited income, John
10 is eligible for Arizona's Medicaid program. John has been enrolled in Arizona's Medicaid
11 program at all relevant times.

12 23. Defendant Jami Snyder is the Director of AHCCCS, the single-state agency
13 that administers Arizona's Medicaid program. As such, she has a duty to ensure that the
14 AHCCCS program is administered in accordance with federal Medicaid law. Defendant
15 Snyder is sued in her official capacity.

16 **STATEMENT OF FACTS**

17 ***Gender Identity and Gender Dysphoria***

18 24. Gender identity is an innate, internal sense of one's sex—*i.e.*, being male or
19 female—and is a core, hard-wired aspect of a person's identity. Everyone has a gender
20 identity. Most people's gender identity is consistent with the sex they were assigned at
21 birth ("assigned sex"). Transgender people, however, have a gender identity that differs
22 from their assigned sex. A transgender man is a man who was assigned female at birth but
23 has a male gender identity. A transgender woman is a woman who was assigned male at
24 birth but has a female gender identity.

25 25. Gender identity and transgender status are inextricably linked to one's sex
26 and are sex-related characteristics.

27 26. Around the onset of puberty, many transgender youth experience a level of
28 psychological distress that significantly interferes with their overall wellbeing and ability

1 to function. For some transgender youth, that distress becomes debilitating and can lead
2 to a severe decline in mental health.

3 27. That distress stems, in part, from the visible physical changes that
4 accompany puberty. Those physical changes undermine a transgender young person's
5 ability to live in a manner consistent with their gender identity, exacerbating their
6 psychological distress. Even basic daily tasks, such as bathing and getting dressed, can
7 become emotionally paralyzing because those tasks are painful reminders of the
8 disconnect between a transgender young person's body and their gender identity. In
9 addition, a transgender boy who has begun to develop breasts is more likely to be mistaken
10 for female, a probability that serves as a constant source of anxiety. The psychological
11 distress transgender youth experience is further heightened by the reality that some of
12 those physical changes may be irreversible, permanently constricting their future
13 treatment options and negatively affecting their quality of life. Consequently, timely
14 treatment is critical.

15 28. This significant increase in distress causes many transgender youth who had
16 previously delayed disclosing that they are transgender to set aside their fears of rejection
17 and ask for help from family. With the permission of their parents or legal guardians, a
18 transgender young person can begin accessing the health care services needed to alleviate
19 their psychological distress. That distress is commonly referred to as gender dysphoria.

20 29. Gender dysphoria is a serious medical condition recognized by the
21 American Psychiatric Association. Am. Psychiatric Ass'n, *Diagnostic and Statistical*
22 *Manual of Mental Disorders* (5th ed. 2013) ("DSM-5").¹ Gender dysphoria refers to the

23
24 ¹ Earlier editions of the DSM included a diagnosis referred to as "Gender Identity
25 Disorder." The DSM-5 noted that Gender Dysphoria "is more descriptive than the
26 previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical
27 problem, not identity *per se*." Being diagnosed with gender dysphoria "implies no
28 impairment in judgment, stability, reliability, or general social or vocational capabilities." Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender & Gender Variant Individuals* (2012), at <https://goo.gl/iXBM0S>.

1 distress that can result from the incongruence between a person’s gender identity and their
2 assigned sex. If left untreated, gender dysphoria can cause anxiety, depression, and even
3 self-harm or suicidal ideation. Gender dysphoria is often heightened “when physical
4 interventions by means of hormones and/or surgery are not available.” *Id.* at 451. Access
5 to appropriate, individualized medical care can mitigate and often prevent all of those
6 symptoms.

7 30. Gender dysphoria is highly treatable. As with other medical conditions,
8 health care providers follow a well-established standard of care when working with
9 patients with gender dysphoria. The World Professional Association for Transgender
10 Health (“WPATH”), and its predecessors, has set those standards for over four decades.

11 31. WPATH is an international, multidisciplinary, professional association of
12 medical providers, mental health providers, researchers, and others, with a mission of
13 promoting evidence-based care and research for transgender health, including the
14 treatment of gender dysphoria. WPATH published the seventh and most recent edition of
15 the Standards of Care in 2011.

16 32. Building on those standards and incorporating the most current research and
17 clinical experience, the Endocrine Society released the Endocrine Treatment of Gender-
18 Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice
19 Guideline in September 2017. Those guidelines reaffirm the WPATH Standards of Care
20 and offer medical providers practical guidance on providing transition-related care to
21 patients with gender dysphoria, including young people.

22 33. The WPATH and the Endocrine Society standards have been adopted by
23 many major associations of healthcare professionals, including the American Medical
24 Association, American Psychiatric Association, and American Psychological Association,
25 as well as associations of healthcare professionals focused on youth and adolescents, such
26 as the American Academy of Pediatrics, American Association of Child and Adolescent
27 Psychiatrists, and the Pediatric Endocrine Society. Federal courts across the country have
28

1 also recognized the standards of these medical societies as setting the prevailing standard
2 of care for the treatment of gender dysphoria.

3 34. A key component of treating gender dysphoria is a “social transition,” in
4 which the individual lives in accordance with their gender identity in all aspects of life.
5 Though specific to each person, a social transition typically includes adopting a new first
6 name, using and asking others to use pronouns reflecting the individual’s true gender,
7 wearing clothing typically associated with that gender, and using sex-specific facilities
8 corresponding to that gender.

9 35. Studies and anecdotal evidence demonstrate the tremendous mental health
10 benefits transgender youth experience following a social transition. One study found that
11 the mental health profile of transgender children who underwent a social transition was
12 nearly identical to that of their nontransgender peers. Kristina Olson et al., *Mental Health*
13 *of Transgender Children Who Are Supported in Their Identities*, 137 *Pediatrics* 1 (2016).
14 Another study found that transgender young people who were referred to by the correct
15 name and pronoun throughout their daily lives demonstrated a seventy-seven percent
16 decrease in severe depressive symptoms. Stephen Russell et al., *Chosen Name Use is*
17 *Linked to Reduced Depressive Symptoms, Suicidal Ideation and Behavior among*
18 *Transgender Youth*, 63 *J. of Adolescent Health* 503 (2018). The success of a social
19 transition hinges on parents, extended family, peers, and others in the community treating
20 the individual consistently with their gender identity.

21 36. Consistent with the standard of care, many transgender individuals also need
22 health care services that alter their physical characteristics to bring their outer appearance
23 into alignment with their gender identity. The purpose of the services is to enable a
24 transgender person to live consistently with their gender identity in every aspect of their
25 life. This alleviates a transgender individual’s gender dysphoria by reducing the
26 incongruence between their assigned sex and gender identity. Those treatments also ensure
27 that they are seen by others in a way that reflects their true gender, addressing a significant
28 source of distress.

37. For transgender youth who have entered puberty, these health care services may include hormone-replacement therapy and surgery. Hormone-replacement therapy ensures that transgender people develop physical sex characteristics typical of their gender identity—not their assigned sex—such as facial and body hair in boys and breasts in girls.

38. The prevailing standards of care for the treatment of gender dysphoria recognize that transgender males may need male chest reconstruction surgery before turning eighteen. A prerequisite for male chest reconstruction surgery is a referral letter from the young person’s treating mental health provider. That letter provides the surgeon with a psychological assessment of the patient and the clinical rationale(s) for the referral and confirms that the patient is capable of consenting to the procedure.

39. The purpose of the surgery is functional. Following the surgery, a transgender male is more readily seen as male, improving the effectiveness of their social transition because they are less likely to be mistaken for female, which can significantly reduce the anxiety and dysphoria they experience. The surgery also improves their self-image because they no longer have to see or wear a binder to hide a part of their body that causes so much physical pain and psychological distress. As a result, transgender males who have had male chest reconstruction surgery experience fewer barriers to engaging in physical activity, among other physical and mental health benefits.

40. As with other treatments for gender dysphoria, both scientific research and clinical evidence highlight the importance of male chest reconstruction surgery in the treatment of gender dysphoria in transgender males.

The Federal Medicaid Act

41. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396w-5, creates the Medicaid program—a cooperative federal-state program that provides health care services to specified categories of individuals meeting income and other criteria. The objective of Medicaid is to enable states to “furnish [] medical assistance” to individuals “whose income and resources are insufficient to meet the cost of necessary medical

1 services” and to provide “rehabilitation and other services to help such families and
2 individuals attain or retain capability for independence or self-care.” 42 U.S.C. § 1396-1.

3 42. States are not required to participate in the Medicaid program. States that
4 choose to participate must comply with the federal Medicaid Act and its implementing
5 regulations.

6 43. In return, the federal government reimburses each participating state for a
7 substantial portion of the cost of providing medical assistance. *See id.* §§ 1396b(a),
8 1396d(b), 1396(c).

9 44. The Medicaid Act requires each participating state to establish or designate
10 a single state agency that is responsible for administering or supervising the administration
11 of the state’s Medicaid program. *Id.* § 1396a(a)(5); 42 C.F.R. § 431.10.

12 45. In addition, each participating state must maintain a comprehensive plan for
13 medical assistance approved by the Secretary of the U.S. Department of Health and
14 Human Services. *Id.* § 1396a. The plan must describe the state’s program and affirm its
15 commitment to comply with the Medicaid Act and its implementing regulations.

16 46. While a state is entitled to delegate certain of its responsibilities to other
17 entities, such as local agencies or Medicaid managed care plans, the single state agency is
18 ultimately responsible for ensuring compliance with all aspects of federal Medicaid law.
19 *See, e.g.,* 42 C.F.R. §§ 438.100(a)(2), 438.100(d).

20 47. Under the Medicaid Act, a participating state must provide medical
21 assistance to certain eligibility groups. *Id.* § 1396a(a)(10)(A)(i). One mandatory eligibility
22 category is children and adolescents under age 18 whose household income is below 133%
23 of the federal poverty level. *Id.* §§ 1396a(a)(10)(A)(i)(VI)-(VII), 1396a(l).

24 ***The Medicaid Early and Periodic Screening, Diagnostic and Treatment***
25 ***Requirements***

26 48. The Medicaid Act requires states to cover certain services and gives them
27 the option to cover other services. *Id.* §§ 1396a(a)(10)(A), 1396d.

1 49. Each participating state must cover Early and Periodic Screening,
2 Diagnostic and Treatment (“EPSDT”) for individuals under age 21. *Id.* §§
3 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

4 50. EPSDT’s fundamental purpose is to “[a]ssure that health problems are
5 diagnosed and treated early, before they become more complex and their treatment more
6 costly.” Ctrs. for Medicare & Medicaid Servs., *State Medicaid Manual* § 5010.B.

7 51. As part of providing EPSDT, states must:

- 8 a. Inform all persons in the state who are under the age of 21 and who
9 are eligible for Medicaid of the availability of EPSDT as described
10 in 42 U.S.C. § 1396d(r);
11 b. Provide or arrange for screening services in all cases where they are
12 requested as required by § 1396d(r)(5); and
13 c. Arrange for (directly or through referral) corrective treatment for any
14 conditions identified by the screening services as required by
15 § 1396a(a)(43)(C).

16 52. Pursuant to the EPSDT requirements, states must cover four specific,
17 separate categories of screening services: medical, vision, dental, and hearing. 42 U.S.C.
18 § 1396d(r)(1)-(4).

19 53. States also must cover “[s]uch other necessary health care, diagnostic
20 services, treatment, and other measures described in [§ 1396d(a)] to correct or ameliorate
21 defects and physical and mental illnesses and conditions discovered by the screening
22 services, whether or not such services are covered under the State plan.” *Id.* § 1396d(r)(5).
23 In other words, the EPSDT mandate requires states to cover all necessary Medicaid
24 services for individuals under age 21.

25 54. EPSDT services must be initiated in a timely manner, as the individual needs
26 of the child require, and must be consistent with accepted medical standards, no later than
27 six months from the date of request. 42 C.F.R. § 441.56(e).

55. Surgery to treat gender dysphoria, including male chest reconstruction surgery, is an EPSDT service under § 1396d(r)(5).

The Medicaid Comparability Requirement

56. Under the Medicaid Act, “the medical assistance made available to any individual . . . shall not be less in amount, duration or scope than the medical assistance made available to any other such individual.” *Id.* § 1396a(a)(10)(B)(i). *See also* 42 C.F.R. § 440.240(b).

57. A state “Medicaid agency may not arbitrarily deny or reduce the amount or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.” 42 C.F.R. § 440.230(c).

58. States must also ensure that “[e]ach service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.” 42 C.F.R. § 440.230(b).

The Arizona Medicaid Program

59. Arizona participates in Medicaid, calling its program the Arizona Health Care Cost Containment System (“AHCCCS”). Ariz. Rev. Stat. §§ 36-2901 to 2972.

60. AHCCCS is also the name of the single-state Medicaid agency that is responsible for administering and implementing Arizona’s Medicaid program consistent with the requirements of federal law. *See* 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10.

61. AHCCCS contracts with private managed care plans to provide health care services to Medicaid enrollees. *See* AHCCCS, Available Health Plans, <https://www.azahcccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.html> (listing the eight Medicaid managed care plans operating in the State).

62. The federal government reimburses Arizona for approximately seventy percent of its expenditures on health care services. U.S. Dep’t of Health & Human Servs., Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children’s Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2020 Through September 30, 2021, 84 Fed. Reg. 66204, 66204 (Dec. 3, 2019).

1 ***Arizona’s Exclusion on Surgical Care for Transgender Medicaid Beneficiaries***

2 63. Since 1982, an Arizona regulation (the “Challenged Exclusion”) has
3 prohibited AHCCCS coverage for “gender reassignment surgeries.” Ariz. Admin. Code
4 R9-22-205-B.4(a). The Challenged Exclusion has been applied since that time to deny
5 coverage to transgender AHCCCS beneficiaries seeking male chest reconstruction
6 surgery.

7 64. Arizona has singled out transition-related surgical care for an express
8 exclusion even though AHCCCS covers the same surgical services to treat other health
9 conditions. *See, e.g.*, Ariz. Admin. Code R9-22-2004(A)(4), AHCCCS Medical Policy
10 Manual, § 310-C Breast Reconstruction After Mastectomy (2018),
11 <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310C.pdf>.

12 65. The Challenged Exclusion has no medical or scientific basis. To the
13 contrary, for many transgender people, including adolescents, surgical care is medically
14 necessary to treat gender dysphoria.

15 66. Contrary to the prevailing standard of care for the treatment of gender
16 dysphoria, Defendant continues to enforce the Challenged Exclusion against transgender
17 Medicaid recipients, even those covered under EPSDT, including D.H. and John.

18 67. On information and belief, many transgender AHCCCS recipients have
19 been deterred from seeking prior authorization for transition-related surgeries because of
20 their knowledge, or the knowledge of their medical providers, that the Challenged
21 Exclusion would make such requests futile.

22 ***D.H.’s Gender Dysphoria and Need for Surgical Treatment***

23 68. D.H. was identified as female at birth but has known that he is male since
24 age four.

25 69. As a young child, D.H. struggled to express to his mother that he is male.
26 Nothing he said or did got the result he had hoped for; Janice, D.H.’s mother, continued
27 to treat him as a girl. As a result, D.H. began exhibiting signs of significant psychological
28

1 distress including depression, prolonged crying episodes, anxiety, and insomnia. The
2 severity of D.H.'s distress led his mother to seek the advice of mental health professionals.

3 70. When he was about eleven years old, the stress related to his gender
4 identity—combined with the other stressors D.H. was trying to navigate—was so
5 overwhelming that D.H. started losing his hair. He was eventually hospitalized for
6 intensive psychiatric treatment.

7 71. Following his hospitalization, Janice enrolled D.H. in dance class, hoping it
8 would provide D.H. a healthy way to cope with his distress. The movements were like
9 therapy to him. Dance also became a social outlet; he made friends and felt a sense of
10 belonging. It was the only thing in his life that could make him feel better. By the
11 following year, D.H. was enrolled in three different dance classes: ballet, modern, and
12 jazz.

13 72. That euphoria ended later that year once puberty began. Because of D.H.'s
14 increasing chest size, dance no longer provided the same psychological release it once
15 had. D.H. hated his body and everything that came with it. His thoughts and fears about
16 experiencing puberty—with its associated physical changes that would take his body even
17 further out of alignment with his gender identity—became all-consuming and significantly
18 affected his ability to function. D.H. hid his changing body under baggy clothes and hated
19 being perceived as a girl at school.

20 73. D.H. began using a variety of methods to flatten his chest, from multiple
21 sports bras and Ace bandages to duct tape, so that his appearance better aligned with his
22 gender identity. Those initial attempts were extremely uncomfortable and irritated his
23 skin. Needing a better and safer solution, D.H. secretly bought his first binder, an article
24 of clothing that compresses a person's chest, giving the appearance of a flat chest. Putting
25 on the binder gave D.H. a sense of relief that no amount of therapy or medication had ever
26 given him. It also eventually helped him gain the confidence to tell his mother what he
27 struggled to express as a child: "I am a boy."
28

1 74. Janice was supportive but sought out the advice of health care providers with
2 experience working with transgender youth before making any decisions regarding next
3 steps.

4 75. Soon after disclosing to his mother that he is transgender at age thirteen,
5 D.H. started seeing Tamar Reed, a therapist who specializes in treating gender dysphoria
6 in children and adolescents. After carefully assessing D.H.'s mental health, Ms. Reed
7 recommended that D.H. begin to transition to living as male. D.H. started using a male
8 name and asked that others refer to him using that name and masculine pronouns. He also
9 changed his hairstyle and started wearing boys' clothing.

10 76. D.H.'s social transition provided him with much-needed psychological
11 relief. He was regularly being referred to by a male name and pronouns and treated as
12 male by those around him.

13 77. Nevertheless, D.H.'s distress continued to build.

14 78. A few months before his fourteenth birthday, the depression and suicidal
15 ideation became overwhelming. Janice noticed a change in D.H.'s personality and that he
16 had started distancing himself from his peers and activities that had previously brought
17 him joy. Then, following a dance competition in January 2017, D.H.'s mental health
18 decompensated significantly. Out of concern for his safety and wellbeing, D.H. was
19 admitted to a ten-day intensive psychiatric treatment program.

20 79. Following that treatment program, his health care providers recommended
21 that he start hormone-replacement therapy to further his social transition—that treatment
22 would both halt the effects of estrogen and make his appearance more typically masculine.
23 D.H.'s pediatrician referred him to a pediatric endocrinologist for this treatment and
24 related specialty care. D.H. received his first shot of testosterone in November 2017.

25 80. The testosterone has caused D.H.'s voice to deepen, he has grown facial
26 hair, and he has developed a more masculine musculature. The testosterone, however,
27 cannot reverse the physical changes that had already occurred prior to D.H.'s transition,
28 particularly chest development.

1 81. Because of the prominent appearance of his chest, D.H.'s binder continues
2 to be one of his most important pieces of clothing. Although binders are not supposed to
3 be worn for more than seven to eight hours a day, D.H. regularly wears his binder for ten
4 hours a day, and at least twice per week D.H. wears it for longer than ten hours. On
5 occasion, D.H. has worn his binder for multiple consecutive days. He even struggles to
6 take the binder off at home, where feels the most comfortable being himself.

7 82. Keeping the binder on that long is uncomfortable and painful. The effort it
8 takes to ignore the pain interferes with D.H.'s ability to focus on school, particularly
9 homework, as D.H.'s discomfort compounds throughout the day. The compression from
10 the binder also prevents him from breathing too deeply. In fact, D.H.'s current
11 pediatrician, Dr. Andrew Cronyn, remarked that D.H.'s binder contributed to him
12 developing asthma in adolescence and needing an inhaler to engage in extended physical
13 activity.

14 83. While taking testosterone and using the binder have improved D.H.'s mental
15 health, D.H. continues to experience significant gender dysphoria because of his chest.
16 The benefits of using a binder were—and continue to be—temporary and imperfect. The
17 binder dampens the distress D.H. feels during the day, but once he removes the binder at
18 night, D.H.'s distress intensifies. And, even with the binder, D.H. continues to be mistaken
19 for female, exacerbating his anxiety around interacting with unfamiliar people.

20 84. D.H.'s distress began compounding again and, in September 2018, D.H. was
21 placed in an intensive psychiatric treatment program for a third time due to suicidal
22 ideation. D.H. was fifteen-years old at that time.

23 85. The mental health treatment D.H. received following that hospitalization
24 helped him develop more effective strategies for coping with the distress caused by gender
25 dysphoria and the appearance of his chest. Even with those strategies, D.H.'s distress still
26 has a significant effect on his mental health, daily life, and ability to function. D.H. still
27 struggles with an ever-present anxiety that the appearance of his chest will cause others to
28 treat him as female. This prevents him from participating in social activities with his

1 friends and caused him to quit dance over a year ago because he gets winded too easily to
2 dance with a binder, but the dysphoria is too great for him to dance without one. His
3 dysphoria also makes him extremely uncomfortable revealing his body even when he is
4 by himself or in a doctor's office.

5 86. In 2019, D.H.'s pediatrician referred D.H. to a surgeon, Dr. Ethan Larson,
6 who could perform male chest reconstruction surgery. D.H.'s health care providers
7 determined that the surgery was medically necessary to alleviate D.H.'s gender dysphoria.
8 Dr. Larson evaluated D.H. and agreed he would be a good candidate for the surgery.

9 87. Dr. Larson requested prior authorization for the surgery from
10 UnitedHealthcare, D.H.'s Medicaid managed care plan. UnitedHealthcare denied prior
11 authorization for the surgery. D.H. appealed the denial of the surgery, and on July 5, 2019,
12 UnitedHealthcare upheld its denial of coverage pursuant to the Challenged Exclusion.

13 88. Due to her income, Janice cannot afford to pay for John to undergo male
14 chest reconstruction surgery without AHCCCS covering the procedure.

15 ***John's Gender Dysphoria and Need for Surgical Treatment***

16 89. John was identified as female at birth. His grandmother, Susan, has cared
17 for him since he was two years old and continues to be his legal guardian.

18 90. As a child, John did not like dresses or typical girl toys, but was never able
19 to pinpoint a reason.

20 91. Approximately three years ago, just before John turned twelve, he started
21 experiencing the first signs of puberty. Those signs were coupled with an almost
22 immediate and significant decline in his mental health. He experienced symptoms of
23 severe depression, such as a constant and overwhelming sadness, distancing himself from
24 his friends, and suicidal ideation. Unable to describe his feelings and uncertain about how
25 Susan would respond even if he could, John kept those emotions bottled up.

26 92. Worried about how Susan and others in his family might react, especially
27 given their strong religious faith, John waited nearly six months before telling his older
28 sister that he is transgender. He eventually told Susan as well.

1 93. Over the course of the following year, John’s 7th grade year, Susan and John
2 had many extensive conversations to help her better understand what he was experiencing
3 and how she could help him.

4 94. John continued to experience significant gender dysphoria throughout his
5 7th grade year. Although John continued to wear the boys’ clothes he always had and
6 started using a male name, his peers, teachers, and family did not consistently refer to him
7 by that name and male pronouns. Not being consistently treated as male caused John to
8 be stressed the entire school year.

9 95. Wanting to prevent a repeat of the prior year, in the summer prior to starting
10 8th grade, John e-mailed each of his teachers to inform them that he is transgender and
11 ask that they refer to him as John and by male pronouns. This helped set the tone; in 8th
12 grade, John was more regularly referred to by the correct name and pronouns—both in
13 school and out.

14 96. Around that same time, at thirteen years old, John’s pediatrician referred
15 him to the Gender Support Program at Phoenix Children’s Hospital, a clinic specializing
16 in healthcare services for transgender young people.

17 97. John had his first appointment at Phoenix Children’s Hospital in November
18 2018, where he began to see Dr. Veenod Chulani, an adolescent-medicine specialist. Dr.
19 Chulani referred John to a mental health provider, who formally diagnosed John with
20 gender dysphoria. Soon thereafter John started taking medication to stop his menstrual
21 cycle, which helped relieve some of the gender dysphoria he was experiencing at the time.
22 In May 2019, Dr. Chulani and John’s therapist determined that it was medically necessary
23 for him to start taking testosterone, which he started the following month. John is pleased
24 with how the testosterone therapy has changed his voice and other aspects of his body.
25 Transitioning has also boosted his confidence, and now far fewer people mistake him for
26 female.

27 98. His transition and testosterone treatment, however, have not lessened the
28 intense dysphoria he experiences regarding the appearance of his chest. Starting in 2018,

1 John began binding his chest using a variety of methods, such as multiple sports bras and
2 constrictive undergarments. He bought his first binder in December 2019.

3 99. Every morning, the first thing John does is to put on a binder, which he often
4 wears for longer than the recommended eight-hour maximum. Even with the binder, John
5 still feels uncomfortable being outside without multiple layers of clothing, including a
6 hooded sweatshirt that he wears nearly every day. The binder constricts his breathing,
7 which in combination with his asthma, requires him to take far more breaks than his peers
8 when engaging in physical activity.

9 100. Although the binder sometimes allows him to forget about his chest—a
10 sense of relief he treasures—the hardest part of John’s daily routine is removing his binder.
11 The dysphoria John experiences regarding his chest comes flooding back, a difficult
12 reminder that his body still does not match who he is. John’s chest-related dysphoria keeps
13 him awake at night at least once a week; putting on his binder temporarily is the only way
14 he can calm his distress, a task he often tries to do without opening his eyes or turning on
15 the lights so that he does not have to see his bare chest.

16 101. Having top surgery would have a significant positive impact on John’s life.
17 John would finally be able to look at himself in the mirror and be in public without having
18 to wear so many layers of clothing on top of his binder, which would benefit both his
19 mental and physical health. John would gain confidence that will help improve his social
20 functioning and broaden his horizons, challenging himself to try to new things.

21 102. Around February 2020, Dr. Chulani recommended that John undergo male
22 chest reconstruction surgery to alleviate the dysphoria caused by the shape and appearance
23 of his chest. At that time, Dr. Chulani also referred John to another mental health provider
24 to assist John with the increased psychological distress he was experiencing and to
25 evaluate John for male chest reconstruction surgery as required by the prevailing standards
26 of care.

27 103. On July 2, 2020, John received a referral letter from his mental health
28 provider for the surgery, as required by the standards of care.

1 104. Due to her income, Susan cannot afford to pay for John to undergo male
2 chest reconstruction surgery without AHCCCS covering the procedure.

3 **CLASS ACTION ALLEGATIONS**

4 105. Plaintiffs, on behalf of themselves and all similarly situated individuals,
5 bring their claims for declaratory and injunctive relief as a class action under Fed. R. Civ.
6 P. 23(a) and 23(b)(2).

7 106. Plaintiffs request that the Court certify the following class (“Class”) under
8 Fed. R. Civ. P. 23(b)(2):

9 All transgender individuals under age 21 who are or will be enrolled
10 in AHCCCS, have or will have a diagnosis of gender dysphoria, and
11 are seeking or will seek coverage for male chest reconstruction
12 surgery following a determination by their respective health care
13 providers that the procedure is necessary to treat their gender
14 dysphoria.

15 107. Plaintiffs are adequate representatives of the Class. Plaintiffs are
16 transgender individuals under age 21 who are enrolled in AHCCCS, have been diagnosed
17 with gender dysphoria, and are seeking coverage for male chest reconstruction surgery to
18 treat their gender dysphoria.

19 108. The Class satisfies the requirements of Fed. R. Civ. P. 23(a)(1) because the
20 class is so numerous that joinder of all members is impracticable. There are at least one
21 hundred transgender males under age 21 who are enrolled in AHCCCS and who require
22 male chest reconstruction surgery to treat their gender dysphoria. In addition, because of
23 the transient nature of the AHCCCS population, in part because individuals’ income may
24 make them eligible or ineligible for Medicaid at various points in their lives, it is
25 impractical to join all transgender individuals under age 21 (who may live in various parts
26 of Arizona) with gender dysphoria who may be denied AHCCCS coverage by the
27 Challenged Exclusion at some point.

28 109. The Class satisfies the commonality requirements of Fed. R. Civ. P. 23(a)(2)
because there are questions of law and fact common to the Class. Pursuant to the
Challenged Exclusion, Defendant has acted or refused to act on grounds generally

1 applicable to the Class. This action raises questions of law common to all members of the
2 Class, including: (a) whether the Challenged Exclusion, facially and as applied to
3 members of the Class, violates the EPSDT and comparability provisions of the federal
4 Medicaid Act; (b) whether the Challenged Exclusion, facially and as applied to members
5 of the Class, violates the prohibition on sex discrimination under Section 1557 of the
6 Patient Protection and Affordable Care Act; and (c) whether the Challenged Exclusion,
7 facially and as applied to members of the Class, violates the Equal Protection Clause of
8 the Fourteenth Amendment to the U.S. Constitution. All members of the Class share a
9 common question of fact: Would their male chest reconstruction surgery be covered by
10 AHCCCS but for Defendant's continuing enforcement of the Challenged Exclusion?

11 110. The Class satisfies the typicality requirements of Fed. R. Civ. P. 23(a)(3)
12 because the named Plaintiffs' claims are typical of the claims of the Class. Plaintiffs are
13 members of the Class, are individuals who have been unable and will be unable to obtain
14 AHCCCS coverage for medically necessary male chest reconstruction surgery because of
15 the Challenged Exclusion, and as a result, have faced or will face delayed or denied access
16 to these medically necessary treatments. Plaintiffs and members of the Class share the
17 same legal claims under Section 1557, the Medicaid Act, and the Equal Protection Clause
18 of the Fourteenth Amendment to the U.S. Constitution.

19 111. The Class satisfies the adequacy requirements of Fed. R. Civ. P. 23(a)(4)
20 because the class representatives will fairly and adequately represent the interests of the
21 Class. The named Plaintiffs seek the same declaratory and injunctive relief as the other
22 members of the Class: a declaratory judgment that the Challenged Exclusion violates the
23 Medicaid Act, Section 1557, and the Equal Protection Clause, and preliminary and
24 permanent injunctions enjoining Defendant from enforcing the Challenged Exclusion. The
25 named Plaintiffs seek this relief to benefit themselves and to protect other low-income
26 transgender Arizona residents who are or will be enrolled in AHCCCS. In asserting their
27 own rights, the named Plaintiffs will vindicate the rights of all members of the Class fairly
28

1 and adequately. The class representatives have no interests that are antagonistic to the
2 interests of other members of the Class.

3 112. The Class further satisfies the requirements of Fed. R. Civ. P. 23(a)(4)
4 because counsel for the Class will fairly and adequately represent the interests of the Class.
5 The Class is represented by counsel from King & Spalding LLP and Perkins Coie LLP,
6 two of the largest law firms in the country; the National Center for Lesbian Rights
7 (“NCLR”), a legal organization dedicated to advancing the civil and human rights of the
8 LGBTQ community; and the National Health Law Program (“NHeLP”), a non-profit law
9 firm dedicated to protecting and advancing the health rights of low-income and
10 underserved individuals and families. Collectively, counsel has significant experience
11 litigating civil rights cases, including transgender rights cases, Medicaid EPSDT cases,
12 and complex class actions in federal court.

13 113. The Class also satisfies the requirements of Fed. R. Civ. P. 23(b)(2) because
14 Defendant has acted or refused to act on grounds that apply generally to the Class, so that
15 final injunctive or corresponding declaratory relief is appropriate respecting the class as a
16 whole. The Class exhibits sufficient cohesiveness because its members have suffered
17 group, as opposed to individual, injuries, namely, the Challenged Exclusion’s categorical
18 denial of male chest reconstruction surgery. Members of the Class are bound together by
19 the significant common traits that they are all transgender, they have gender dysphoria,
20 and they need male chest reconstruction surgery to treat their gender dysphoria.

21 114. Further, by definition, members of the Class are low-income individuals
22 who would otherwise have difficulty affording counsel to individually challenge the
23 Challenged Exclusion. Therefore, a class action is the ideal—and the only—method by
24 which the Class may vindicate the denial of their civil rights.

COUNT I

**(Violation of the Medicaid Act's EPSDT Requirements,
42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(A)-(C), 1396d(a)(4)(B), and 1396d(r)(5))**

115. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

116. The Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), and Defendant's refusal, based on the Challenged Exclusion, to provide coverage for surgical treatments and services for gender dysphoria to Plaintiffs and members of the Class, violate the Medicaid Act's EPSDT requirements, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43)(A)-(C), 1396d(a)(4)(B), and 1396d(r)(5), which are enforceable by Plaintiffs under 42 U.S.C. § 1983.

COUNT II

**(Violation of the Medicaid Act's Comparability Requirement,
42 U.S.C. § 1396a(a)(10)(B))**

117. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

118. The Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), and Defendant's refusal, based on the Challenged Exclusion, to provide coverage for surgical treatments and services for gender dysphoria to Plaintiffs and members of the Class, while covering the same services for other AHCCCS beneficiaries with different diagnoses, violate the Medicaid Act's comparability requirement, 42 U.S.C. § 1396a(a)(10)(B), which is enforceable by Plaintiffs under 42 U.S.C. § 1983.

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COUNT III

**(Unlawful Discrimination on the Basis of Sex in Violation of
Section 1557 of the Patient Protection and Affordable Care Act,
42 U.S.C. § 18116)**

119. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

120. Under Section 1557 of the Affordable Care Act, “an individual shall not . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)” on the basis of sex. 42 U.S.C. § 18116.

121. Section 1557’s prohibitions on sex discrimination are enforceable by Plaintiffs in a judicial action under 20 U.S.C. § 1683, which Section 1557 incorporates by reference. 42 U.S.C. § 18116(a). The Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), on its face and as applied to Plaintiffs and members of the Class, violates Section 1557’s prohibition against discrimination on the basis of sex in a health program or activity receiving federal financial assistance.

122. Plaintiffs and the Class have been and are continuing to be injured by Defendants’ application of the Challenged Exclusion to deny them AHCCCS coverage for surgical treatments for gender dysphoria.

COUNT IV

**(Violation of the Equal Protection Clause of the
Fourteenth Amendment of the United States Constitution)**

123. Plaintiffs reallege and incorporate by reference paragraphs 1 to 114 of this Complaint.

124. First, the Challenged Exclusion, Arizona Administrative Code R9-22-205-B.4(a), on its face and as applied to Plaintiffs and members of the Class, impermissibly discriminates against Plaintiffs and members of the Class on the basis of sex and violates

1 their right to equal protection of the laws under the Equal Protection Clause of the
2 Fourteenth Amendment to the United States Constitution.

3 125. Second, the Challenged Exclusion, Arizona Administrative Code R9-22-
4 205-B.4(a), on its face and as applied to Plaintiffs, impermissibly discriminates against
5 Plaintiffs and members of the Class for being transgender and violates their right to equal
6 protection of the laws under the Fourteenth Amendment to the United States Constitution.

7 126. Defendant's promulgation and continued enforcement of the Challenged
8 Exclusion did not, and does not, serve any rational, legitimate, important, or compelling
9 state interest. Rather, the Challenged Exclusion serves only to prevent Plaintiffs and
10 members of the Class from obtaining medically necessary surgical care and services to
11 treat their gender dysphoria, complete their gender transitions, and live as their authentic
12 selves.

13 **PRAYER FOR RELIEF**

14 WHEREFORE, Plaintiffs respectfully request that this Court:

15 A. Certify a Class consisting of: All transgender individuals under age 21 who
16 are or will be enrolled in AHCCCS, have or will have a diagnosis of gender dysphoria,
17 and are seeking or will seek male chest reconstruction surgery following a determination
18 by their respective health care providers that the procedure is necessary to treat their
19 gender dysphoria.

20 B. Name D.H. and John as representatives of the Class, and appoint Plaintiffs'
21 counsel as King & Spalding LLP, Perkins Coie LLP, the NCLR, and NHeLP;

22 C. On behalf of Plaintiffs and all similarly situated individuals, issue
23 preliminary and permanent injunctions prohibiting Defendant from any further
24 enforcement or application of the Challenged Exclusion, Arizona Administrative Code
25 R9-22-205-B.4(a), and directing Defendant and their agents to provide Medicaid coverage
26 for medically necessary male chest reconstruction surgery;

27 D. On behalf of Plaintiffs and all similarly situated individuals, enter a
28 declaratory judgment that the denial of coverage for male chest reconstruction surgery:

- 1 1. Violates the Medicaid Act's EPSDT requirements, 42 U.S.C. §§
- 2 1396a(a)(10)(A), 1396a(a)(43)(A), (C), 1396d(a)(4)(B), and 1396d(r)(5);
- 3 2. Violates the Medicaid Act's comparability requirement, 42 U.S.C. §
- 4 1396a(a)(10)(B);
- 5 3. Violates Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116,
- 6 by discriminating against Plaintiffs and all similarly situated individuals on
- 7 the basis of sex; and
- 8 4. Violates the Equal Protection Clause of the Fourteenth Amendment
- 9 to the U.S. Constitution by discriminating against Plaintiffs and all similarly
- 10 situated individuals on the basis of sex (including sex stereotyping, gender
- 11 identity, being transgender, and undergoing a gender transition), and for
- 12 being transgender;

13 E. Waive the requirement for the posting of a bond of security for the entry of

14 temporary and preliminary relief;

15 F. Award Plaintiffs their reasonable attorneys' fees, costs, and expenses under

16 42 U.S.C. § 1988 or other applicable statutes; and

17 G. Award such other and further relief as the Court may deem just and proper.

18 Respectfully submitted,

19 DATED: AUGUST 6, 2020 **PERKINS COIE LLP**

20 /s/ Daniel C. Barr

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28

1 IN THE UNITED STATES DISTRICT COURT

2 DISTRICT OF ARIZONA

3 D.H., by and through his mother, Janice CV-20-335-TUC-SHR
4 Hennessy-Waller; and John Doe, by and
5 through his guardian and next friend, Susan
6 Doe, on behalf of themselves and all others
7 similarly situated,

8 Plaintiffs,

9 vs.

10 Jami Snyder, Director of the Arizona Health
11 Care Cost Containment System, in her
12 official capacity,

13 Defendant.

February 5, 2021
10:06 a.m.
Tucson, Arizona

14 REPORTER'S OFFICIAL TRANSCRIPT OF PROCEEDINGS

15 ORAL ARGUMENT

16 BEFORE THE HONORABLE SCOTT H. RASH
17 UNITED STATES DISTRICT JUDGE

18
19
20
21 Court Reporter: Erica R. McQuillen, RDR, CRR
22 Official Court Reporter
23 405 W. Congress Street
24 Tucson, Arizona 85701
25 (520) 205-4267

Proceedings Reported by Stenographic Court Reporter
Transcript Prepared by Computer-Aided Transcription

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P R O C E E D I N G S

THE CLERK: In Civil Matter 20-335, Hennessy-Waller, et al., v. Snyder, on for oral argument.

Counsel -- would arguing counsel please state your appearances.

MR. ORR: Good morning, Your Honor. Asaf Orr, attorney for plaintiffs D.H. and John Doe.

THE COURT: Okay. Counsel, I'm going to ask you to restate that. I'm getting too much feedback on the phone right now to really understand you clearly, so I'm going to try to figure out how I'm going to reduce that feedback a little bit.

So if you can restate your name, and then I may have you do it again if I still can't understand. Go ahead.

MR. ORR: Sorry. No problem, Your Honor. Good morning, Your Honor. Asaf Orr, attorney for plaintiffs D.H. and John Doe.

THE COURT: No, neither me nor the court reporter are getting you down, so hang on a second. I gotta figure out a way to tone this thing so that I can hear you more clearly.

Counsel, could you just say something again so we can get a test on this again?

MR. ORR: Sure. Good morning, Your Honor. Can you hear me now?

THE COURT: Okay. I can hear. That's a little

1 better. Turn that down just a little bit more. See if that
2 kind of ends that feedback.

3 All right. Counsel, let's try one more time.

4 MR. ORR: Sure. Good morning, Your Honor. Asaf
5 Orr, attorney for plaintiffs D.H. and John Doe.

6 THE COURT: All right. Thank you.

7 MR. BARTON: Good morning, Your Honor. David
8 Barton, attorney for the defendant.

9 THE COURT: Okay. And do we have anybody else on
10 the phone?

11 (Indiscernible simultaneous speaking from counsel.)

12 THE COURT: Okay. All right. Let's start with the
13 plaintiffs' side. Anybody else additional on the phone?

14 MS. HENNESSY-WALLER: Good morning, Your Honor.
15 Janice Hennessy-Waller, mother of D.H.

16 MR. RAY: Good morning, Your Honor. Brent Ray of
17 King & Spalding for the plaintiffs.

18 THE COURT: All right.

19 MR. CHINSKY: Good morning, Your Honor. Andrew
20 Chinsky, also King & Spalding, for the plaintiffs.

21 THE COURT: All right.

22 MR. BARR: And good morning -- and good morning,
23 Your Honor. Dan Barr also -- from Perkins Coie, also with the
24 plaintiffs.

25 THE COURT: All right.

1 MS. McKEE: Good morning. This is Catherine McKee
2 from the National Health Law Program, also for the plaintiffs.

3 THE COURT: All right.

4 MS. COURSOLLE: And Abigail Coursolle --

5 MS. HOWE: And good morning --

6 MS. COURSOLLE: -- also with the National Health Law
7 Program for the plaintiffs. Thank you.

8 THE COURT: Okay. Hang on. Can the last person who
9 announced repeat that? There was a little overlap.

10 MS. COURSOLLE: Certainly, Your Honor. This is
11 Abigail Coursolle, also with the National Health Law Program
12 for the plaintiff.

13 THE COURT: All right. Anybody else for the
14 plaintiffs?

15 MS. HOWE: Yes, Your Honor. This is Janet Howe with
16 Perkins Coie for the plaintiffs.

17 THE COURT: Okay. Okay. That sounds like it
18 finishes the plaintiffs. Anybody else there for the
19 defendants?

20 MS. KING: Good morning, Your Honor --

21 MR. JOHNSTON: Logan Johnston -- sorry. Please go
22 ahead.

23 MS. KING: I apologize. Good morning, Your Honor.
24 This is Kathryn King with Burns Barton for defendant Jami
25 Snyder.

1 MR. JOHNSTON: And also, Your Honor, Logan Johnston
2 for the defendant Snyder.

3 THE COURT: Okay. Anybody else from the defendants?

4 MR. JOHNSTON: No, Your Honor.

5 THE COURT: All right. Welcome, everybody.

6 Let me first apologize for having to reschedule this
7 a couple of times. One was because the COVID virus even
8 visits judge's households, and I was dealing with that, and
9 after I dealt with that and tried to reschedule it, we have a
10 very tight schedule here in terms of what courtrooms we can
11 use and what phone lines and VTCs we can use, because we only
12 have so much bandwidth and availability. So apparently I had
13 scheduled on another judge's time and whatnot, and I needed to
14 reset it. So the Court apologizes for having to reschedule
15 this a couple of times.

16 With that, since we are on the phone and not in
17 person, you folks can't see what's going on in the courtroom,
18 I can't see what's going on on your end. As I've indicated,
19 the phones here, usually they're pretty good, but sometimes I
20 get this feedback, and I have a difficult time hearing, so I
21 may have to interrupt counsel, and I don't mean to, but I may
22 have to if I just can't hear you and your words are getting
23 garbled. I want to make sure I'm hearing you clearly, so I
24 may stop you and ask you to repeat something.

25 The other thing is, I do have some questions for

1 both sides. If I can get them in, fine. If I can't, I won't
2 ask them, but they may follow nicely into something that
3 you're arguing, so I may try to catch you. So you may pause
4 periodically. Maybe I can get in one of my questions. With
5 that, I'm going to give each side about 30 minutes to present
6 and argue, and we will go from there.

7 All right. Mr. Orr, since it's your motion, you get
8 to proceed.

9 MR. ORR: Thank you, Your Honor. May it please the
10 Court, I'd like to reserve five minutes for rebuttal.

11 THE COURT: Certainly.

12 MR. ORR: D.H. and John Doe urgently need male chest
13 reconstruction surgery. The psychological distress that D.H.
14 and John Doe are experiencing is debilitating, and it's
15 affecting every aspect of their lives. As Tamar Reed, D.H.'s
16 mental health provider, predicted back in August, the delay in
17 getting male chest reconstruction surgery is starting to
18 affect D.H.'s ability to cope with the psychological distress
19 he's experiencing. And as we informed the Court, back in
20 November of 2020, D.H. experienced such a severe panic attack
21 due to being treated as female at work that he required
22 emergency medical care and a visit to the hospital.

23 D.H. -- excuse me. John Doe's mental health is also
24 in significant distress. He experiences regular anxiety
25 attacks at night that keep him up for hours at a time. He has

1 a history of self-harm, and both his mental health provider
2 and grandmother, who's his caretaker and guardian, are
3 concerned that any further delay in his ability to get this
4 medically necessary surgery will further harm his mental
5 health.

6 But both D.H. and John need the surgery for more
7 than just their mental health. For example, D.H. experiences
8 significant physical pain from wearing the binder for long
9 periods of time. This also impacts his ability to focus in
10 school and has prevented him from participating in dance,
11 which was an activity that was both good for his physical
12 health, as well as providing him significant emotional relief.

13 As for John, he has to wear multiple layers of
14 clothing, even in the hot Arizona summers, which is
15 extraordinarily uncomfortable. He also has significant social
16 anxiety out of fear that one of his peers will treat him as
17 female because of the appearance of his body.

18 Denying or delaying this care further will have
19 devastating short- and long-term consequences on their
20 physical and mental health, for example, worsening --
21 continuing worsening of their mental health and gender
22 dysphoria and other conditions.

23 Each of these harms are sufficient to be irreparable
24 on their own, let alone in combination with one another, and
25 plaintiffs are here today, Your Honor, seeking an opportunity

1 to demonstrate the medical necessity of male chest
2 reconstruction surgery and are asking the Court to enjoin
3 enforcement of that exclusion as to D.H. and John Doe so they
4 can demonstrate to the managed care organizations that this
5 procedure is, in fact, medically necessary for them.

6 As outlined in our -- as outlined in our briefs and
7 the accompanying declarations, plaintiffs meet each of the
8 four factors for obtaining a preliminary injunction. Before
9 getting to those four factors, however, Your Honor, I'd like
10 to first address what is the appropriate standard for this
11 Court's analysis of our motion for preliminary injunction.

12 This is a classic example of a prohibitory
13 injunction. Plaintiffs ask for an order prohibiting a
14 Government agency from continuing its unlawful and
15 discriminatory conduct. As the Ninth Circuit has made clear
16 in multiple cases, it doesn't matter if the prohibitory
17 injunction ultimately resulted in defendant paying money. For
18 example, in *M.R. v. Dreyfus*, the Ninth Circuit upheld the
19 injunction which required the Washington State Medicaid agency
20 to pay more in benefits.

21 It also doesn't matter whether the policy is about
22 to be implemented or long-standing, which was the case, for
23 example, in *Melendres v. Arpaio*, where the Ninth Circuit
24 upheld an injunction of a long-standing practice.

25 The cases cited by defendant don't warrant imposing

1 the mandatory injunction standard. Those cases involve
2 private parties along equal footing when they permitted what
3 was then the status quo --

4 THE COURT REPORTER: I'm sorry. Can you slow down?
5 I can't understand you.

6 THE CLERK: Mr. Orr? Mr. Orr?

7 MR. ORR: Yes.

8 THE CLERK: We're going to need you to slow down and
9 back up a bit since you're -- I think you're reading. The
10 court reporter's having a hard time taking it down.

11 MR. ORR: I'm sorry. I'm not reading, but I'll make
12 sure to slow down just a little bit.

13 So I think I'll go back to discussing defendant's
14 cases. As I indicated, the cases cited by defendant don't
15 warrant imposing the mandatory injunction standard here.
16 Those cases involve private parties who are on equal footing
17 when they created the status quo. They also involve cases of
18 employment discrimination, cases which are -- where injunctive
19 relief is rare because of the lack of irreparable harm. In
20 those cases, Courts can order back pay and front pay as well
21 as backdate promotion such that they can make the plaintiff
22 whole.

23 Finding otherwise, finding that the mandatory
24 injunction standard would apply, would place a thumb on the
25 scales against plaintiffs who are challenging an

1 unconstitutional governmental practice because those
2 plaintiffs don't have an opportunity to participate in the
3 creation of the status quo. And again, the Ninth Circuit has
4 been clear even in cases involving the -- involving AHCCCS
5 that the prohibitory injunction standard would need to be
6 applied. But even if the Court finds that it needs to apply
7 the mandatory injunction standard, plaintiffs meet that
8 standard as well.

9 This is not a doubtful case. As discussed in our
10 briefs and as I'll discuss later in this argument, plaintiffs
11 have demonstrated a likelihood of success on each of the four
12 claims that are brought forth as part of this preliminary
13 injunction, as well as the very serious nature of the harms to
14 plaintiffs.

15 In fact, one of the cases cited by defendants, Dahl
16 v. HEM Pharmaceuticals, in that case, the Ninth Circuit upheld
17 the mandatory injunction on behalf of the plaintiffs, who were
18 entitled to receive a medication as a result of participating
19 in a drug trial, and the Court found that the harm caused by
20 denying them that medication was irreparable and warranted a
21 mandatory injunction.

22 Lastly, I'll note on the preliminary injunction
23 standard that, regardless of the elements that the Court
24 applies, the elements are a balance using a sliding scale
25 approach.

1 Before getting to the likelihood of success on the
2 merits of each claim, however, I did also want to discuss the
3 standard of care, because that -- for the treatment of gender
4 dysphoria, because that applies to each of the four claims
5 that plaintiffs bring here.

6 Male chest reconstruction surgery is the
7 well-established consensus standard of care. There is medical
8 literature and clinical expertise that's been demonstrated
9 that this procedure is safe and effective for the treatment of
10 gender dysphoria in adolescents and young adults, as well as
11 adults.

12 The standards of care were developed through a
13 consensus of experts in the field and have been adopted by
14 many professional associations of medical and mental health
15 providers. Those associations include the American Medical
16 Association, the American Psychological Association, the
17 American Academy of Pediatrics and the Endocrine Society.

18 Male chest reconstruction surgery is not
19 experimental even under AHCCCS's own regulatory definition of
20 that term. The treatment is generally and widely accepted and
21 is safe and effective for the treatment of gender dysphoria,
22 as demonstrated by the wide support that the standard of care
23 has gotten by the major medical and mental health associations
24 in the United States. It is also supported by substantial
25 literature in the peer-reviewed journals in the United States.

1 And the opinions of Drs. Laidlaw and Levine don't
2 change the analysis. As with any standards of care --

3 THE CLERK: Mr. Orr, could you repeat the names of
4 the doctors, please?

5 MR. ORR: Sure. Drs. Laidlaw and Levine. Would it
6 be helpful for the court if I spelled them?

7 THE CLERK: Yes.

8 MR. ORR: Okay. Laidlaw is spelled L as in Larry, A
9 as in apple, I as in ice cream, D as in David, L as in Larry,
10 A as in apple, W as in William. And Levine is L as in Larry,
11 E as in extra, V as in Victor, I as in ice cream, N as in
12 Nancy, E as in extra.

13 THE COURT: Mr. Orr, before you go on, as I read it,
14 the DSM-5 says the majority of adolescent cases of gender
15 dysphoria resolve on their own without surgical intervention.
16 If that's the case, then granted, there's doctors that feel
17 otherwise, and they're well-qualified, but doesn't that then
18 create some kind of disjunction between the argument you're
19 making and the argument the defendants are making such that
20 the Court probably needs to hear from the experts before I can
21 really make a ruling on this?

22 MR. ORR: No, Your Honor. Those studies that I've
23 cited in the DSM-5 as well as in the declarations and briefs
24 filed by the defendant deal with gender dysphoria in
25 childhood, where here, what we have here, both D.H. and John

1 Doe are adolescents, and there is consensus among providers,
2 including the authors of those studies, around sort of
3 continuation of gender dysphoria that, in adolescents, it is
4 critical for adolescents to be able to access medically
5 necessary treatment, including medications as well as surgery.

6 THE COURT: All right. And hearken back, then, for
7 a minute to your mandatory versus prohibitory injunction. It
8 seems to me we're just kind of playing semantics here because,
9 while you may call it a prohibitory injunction, if I issue it,
10 that means that the adolescents would get the surgery;
11 correct?

12 MR. ORR: No, Your Honor. What would then occur is
13 that D.H. and John Doe would submit prior authorizations to
14 the managed care organizations that would then apply the
15 standard medical necessity analysis and determine whether or
16 not, again, it's medically necessary for them. What we are
17 asking the Court to do is just enjoin AHCCCS from using that
18 exclusion as a basis for denying coverage for these two
19 plaintiffs.

20 THE COURT: Well, that sounds to me like there's
21 administrative remedies. Now I'm really confused, Mr. Orr.
22 You're going to have to help me out here. Are you telling me
23 that it hasn't even been established whether it's medically
24 necessary for these two juveniles or adolescents to have the
25 surgery because, if I grant the injunction, that just then

1 starts the process as to whether they can actually be reviewed
2 or certified in whether it's medically necessary?

3 Help me out here.

4 MR. ORR: Sure, Your Honor.

5 No. Our clients have been evaluated by their mental
6 health providers, by their medical providers, and they've also
7 been evaluated by Dr. Schechter, and each of those providers
8 have stated that male chest reconstruction surgery is
9 medically necessary for them. All that we're saying, Your
10 Honor, is that, in order to go through the process and get
11 coverage approved, is that our clients would have to file the
12 request for prior authorization, and once that that would be
13 approved, then they would be able to get the surgery.

14 You know, as defendant indicated in the denial of
15 D.H.'s prior authorization, the only impediment is this
16 exclusion, so we fully expect that, given that both D.H. and
17 John Doe have the support of their medical and mental health
18 providers, that the managed care organizations will find that
19 it's medically necessary for our clients to undergo male chest
20 reconstruction surgery, but we want it to be clear, Your
21 Honor, that what we're asking for in terms of this Court's
22 order is to enjoin enforcement of the exclusion as to both
23 D.H. and John Doe.

24 THE COURT: Well, if I grant -- all right. If I
25 grant the injunction, you're saying that your clients still

1 have to go through a process to be determined as to whether
2 Medicaid would cover the surgery as to whether it's medically
3 necessary. That sounds to me like there's administrative
4 appeals, and there should be some kind of an administrative
5 process that hasn't occurred yet, and then I'm curious as to
6 why we're here, because if they've still got a process by
7 which they can appeal or seek coverage, which is what you're
8 telling me, then I'm just not clear as to why we're here then.

9 MR. ORR: Your Honor, we're here because D.H. did in
10 fact seek prior authorization and was told that they would not
11 authorize the surgery because it is not covered because of the
12 exclusion; and therefore, we're here challenging the exclusion
13 because it violates both the Medicaid Act as well as Section
14 1557 and the Equal Protection Clause, and we're seeking an
15 order essentially requiring AHCCCS to consider the prior
16 authorization request without taking into account the
17 exclusion.

18 We believe, given, again, that their mental health
19 providers and medical providers are universal in this in that
20 male chest reconstruction surgery is medically necessary for
21 them, that that would then be approved.

22 THE COURT: Well, when you say the word "universal,"
23 that's pretty all-encompassing, and I gotta tell you, although
24 I haven't had a chance to read it, but I heard about it, the
25 defendants filed a case from Britain that kind of questions

1 that. There is other literature out there that questions it.
2 And I know your experts simply just, you know, wrote that off
3 in their supplemental rebuttal that was filed with your reply.

4 It seems a little disingenuous. I mean, clearly
5 there's some other avenues of thought out there that, you
6 know, this male chest reconstruction surgery is not all the
7 cure that it's claimed to be by others.

8 And then your other argument, and again, maybe I'll
9 let you just get back to it, because you'll answer my
10 questions, but is it permissible for AHCCCS to cover a
11 treatment, whether medication, surgery, et cetera, for one
12 diagnosis but deny it for the other? I mean, isn't this
13 really about whether AHCCCS can discriminate on the basis of a
14 diagnosis instead of on, quote, the basis of sex?

15 Let me just give you an example. If AHCCCS covers a
16 surgery for women with breast cancer and for men with breast
17 cancer, does that also mean they have to cover it for purposes
18 of treating something else?

19 MR. ORR: Thank you, Your Honor, and just to
20 clarify, when I used the word "universal," I meant that both
21 of their mental health providers and their medical providers
22 believe that it is medically necessary for their patients.

23 You know, in responding quickly to the Court's
24 reference to Dahl v. Tavistock, you know, although we intend
25 to review it more thoroughly and provide our thoughts on that

1 case in particular, I actually think that that case is not
2 relevant to a legal analysis here. It discusses a treatment
3 that is not at issue here. It is -- you know, it involved
4 those -- if I remember correctly --

5 THE COURT: Well, Mr. Orr I haven't read the case.
6 I haven't read the case, so I'm not too concerned about it at
7 this time. It was just that you mentioned that this is
8 universal, and it just -- from everything I've seen, it
9 doesn't seem like it's that universal.

10 And let me see if I can kind of clarify my question
11 a little bit, and let's take it out of this context, because
12 this context may be a little heated in terms of the political
13 and social rhetoric. Let's just take, do you believe that
14 AHCCCS can deny treatment for fertility treatments?

15 MR. ORR: Your Honor, I know that AHCCCS does have
16 an exclusion for fertility treatments. What I can say, I
17 think hopefully this will address your question, is that if
18 AHCCCS provides fertility treatments to treat for certain
19 conditions and denies it to others, it must have a rational
20 basis for distinguishing between those two groups of Medicaid
21 recipients, and you know, a Medicaid recipient who is
22 currently being denied infertility services does not need to
23 demonstrate that they have an identical need for those same
24 services as the preapproved Medicaid recipients for whom that
25 is currently covered, and the Courts have recognized that the

1 need between two groups of people is rarely going to be
2 identical, but they need to be able to demonstrate that it's
3 comparable and that there's a comparability argument, Your
4 Honor.

5 THE COURT: Yeah, and I gotta tell you, I'm trying
6 to wrap my head around that comparability argument as well.
7 I've read the briefs and whatnot. I just gotta tell you, it's
8 not an issue I'm overly familiar with. And I guess, taking my
9 example a little bit further, here's what my thinking was, and
10 maybe my thinking's wrong, and you can correct me if you think
11 so. It's that, if a woman wants some fertility treatments,
12 they're denied by AHCCCS, and she goes to AHCCCS and says, I
13 want fertility treatments, I need them because my mental
14 health is suffering because I want to have children and I
15 can't do it, and AHCCCS says, no, there's a clear denial, you
16 know, it's not covered, and so she goes out, and she gets her
17 doctor and her therapist to say, you know, I'm suffering from
18 intense distress and depression because I'm unable to have
19 children, that it's medically necessary for me to have these
20 fertility treatments, you know, just because those doctors and
21 therapists say that it's medically necessary, and she makes a
22 strong case that she needs fertility treatments, can AHCCCS
23 still deny that, or under your argument, does AHCCCS have to
24 say, no, you know, that's a discriminatory provision, and
25 we're going to have to I guess now go through that process

1 that you talked about, whether -- which we go further down the
2 road? That's where I'm kind of -- I'm unclear.

3 MR. ORR: And Your Honor, I think those two -- well,
4 that scenario I think differs significantly from what we have
5 here. In that case, of a woman who is seeking treatment for
6 infertility, you know, and is suffering some level of
7 psychological distress, whether that's anxiety or depression,
8 what I can say, you know, off the cuff, is that my
9 understanding is that treatment for infertility does not treat
10 depression, does not treat anxiety, whereas what we have here
11 is male chest reconstruction surgery. It is a treatment that
12 is designed to treat gender dysphoria, and it's the standard
13 of care and is recognized as safe and effective for the
14 treatment of gender dysphoria.

15 And I think that is the critical difference, is that
16 we have on the one hand a person who's seeking coverage for
17 fertility services and is experiencing psychological distress
18 because of her inability to conceive whereas -- and so there's
19 a disconnect between what is the standard of care for the
20 treatment of the psychological distress she's experiencing
21 versus here, the surgery is recognized, is well established as
22 a safe and effective treatment for gender dysphoria.

23 THE COURT: Well, aren't fertility treatments also
24 considered safe and effective?

25 MR. ORR: Your Honor, I can't disagree with that. I

1 don't know that -- but that is not the -- there may be other
2 reasons that allow Medicaid to exclude fertility services, but
3 both between the comparability requirement as well as the
4 obligation under EPSDT, certainly the Medicaid Act would
5 require AHCCCS and other Medicaid agencies to allow Medicaid
6 recipients to demonstrate medical necessity for procedures
7 like male chest reconstruction surgery.

8 THE COURT: All right. Let me go back, then, to
9 more your universal claim. Who gets to decide what is safe
10 and effective treatment, or medically necessary, for that
11 matter? I mean, I practiced for a lot of years. I talked to
12 a lot of experts. I can find experts just about on most
13 issues on either side of the coin. And as a judge, I get to
14 have the benefit of having the experts both in my courtroom
15 and getting to ask them questions so I can figure out how
16 things work in a lot of respects.

17 But I guess I'm a little curious as to why your
18 experts are so adamant about their position and unwilling to
19 consider another expert's opinion. Even though the
20 qualifications may be different, they seem equally qualified.

21 MR. ORR: Well, I think, Your Honor, the standards
22 of care and the standards that were discussed in the
23 declarations of Drs. Janssen and Dr. Schechter track the
24 consensus standards of care which have been adopted by many
25 major mental and medical health associations in the United

1 States and around the world.

2 And on the other side, Drs. Laidlaw and Levine are
3 providers for whom their regular practice does not include
4 treatment of adolescents with gender dysphoria and that they
5 simply disagree with that consensus, you know, and there are
6 many situations where there is a consensus standard of care
7 and there are providers that are kind of on the margins, some
8 providers that believe the standards of care went too far and
9 others that didn't, feel that it didn't go far enough. The
10 existence of those opinions doesn't negate the fact that they
11 are still the prevailing standards of care.

12 And, you know, as we detailed further in our -- in
13 the reply declarations as well as our reply brief, we feel
14 that there are a number of other reasons why the opinions of
15 Drs. Laidlaw and Levine are not reliable, and in fact, Federal
16 Courts have repeatedly declined to rely on several opinions,
17 including those of Dr. Levine, and also Federal Courts
18 consistently recognize the standard of care that has been
19 adopted by the AMA and AAP and other organizations as the
20 prevailing standard of care.

21 So I hope that answers your question, Your Honor.

22 THE COURT: It's helpful. Thank you, Mr. Orr.
23 Please continue.

24 MR. ORR: Sure.

25 With that, I'd like to move into a discussion of

1 likelihood of success on the merits, starting with our EPSDT
2 claim. Courts interpret EPSDT to be broad and exclusive
3 rather than exclusive. EPSDT was designed to provide critical
4 coverage to Medicaid recipients under age 21. The
5 congressional intent behind EPSDT is clear: We want to
6 provide coverage, greater coverage, to young people before
7 their health conditions become more complex and difficult and,
8 frankly, more expensive to treat as adults, and that is why
9 EPSDT requires Medicaid agencies to provide coverage for
10 services that quote/unquote correct and ameliorate a condition
11 regardless of whether or not that treatment is covered for
12 adults.

13 This Court's decision in *Ekloff v. Rodgers* is
14 particularly instructive here. In that case, children with
15 developmental disabilities were denied coverage for diapers to
16 treat incontinence. This Court found that the diapers were
17 necessary to correct or ameliorate a condition, specifically,
18 that those diapers prevented the children from developing skin
19 sores, which then ultimately allowed them to avoid unnecessary
20 medical treatment to treat that condition, as well as the pain
21 associated with those skin conditions. It also increased the
22 plaintiff's ability to engage in their daily life, which
23 included classes that helped build their social skills and
24 other skills they needed to live.

25 Just as in *Ekloff*, EPSDT requires coverage in male

1 chest reconstruction surgery. A declaration provided by
2 plaintiffs, both by plaintiffs themselves, their treating
3 providers, as well as the experts, Drs. Janssen and Schechter,
4 prove that male chest reconstruction surgery will correct or
5 ameliorate gender dysphoria. It will alleviate the gender
6 dysphoria as well as reduce the functional limitations that
7 D.H. and John Doe experience, for example, limitations on the
8 ability to focus in school, to participate in physical
9 activities, to engage in social activities with friends. It
10 will eliminate physical pain that D.H. in particular
11 experiences as a result of the binder. It will increase both
12 of their capacities to address the current medical health
13 issues that they're experiencing, something that Dr. Peck
14 specifically spoke about in her declaration, that, you know,
15 John Doe has come far in his mental health treatment, but his
16 not having access to male chest reconstruction surgery is
17 preventing him from progressing any further.

18 It will also prevent D.H. and John Doe from
19 developing the skin conditions that are often associated with
20 long-term binder use. It also reduces the complexity of the
21 surgical procedure for male chest reconstruction surgery and,
22 relatedly, the amount of scarring.

23 It's also important to point out that there's also
24 cost savings here, that providing the surgery will then result
25 in AHCCCS not having to provide coverage, for example, the

1 emergency medical services that D.H. required back in
2 November. And so, you know, it is entirely consistent with
3 the purpose of EPSDT to provide this coverage from a
4 cost-saving perspective as well.

5 The cases cited by defendant don't diminish the
6 strength of plaintiffs' EPSDT claim. For example, the
7 defendant's cite a case from the Fifth Circuit from 1980, Rush
8 v. Parham. In that case, the Fifth Circuit simply remanded
9 back to the District Court in order for the District Court to
10 consider or to allow the Medicaid agency to present evidence
11 that the surgical treatment that the plaintiff in that case
12 requested was experimental. It made no conclusions about
13 whether or not the procedure itself was, in fact,
14 experimental.

15 But it's also important to note that that case was
16 decided approximately 40 years ago, and in that time, the
17 standards of care and our understanding of the necessary
18 treatments for gender dysphoria have developed significantly,
19 and there's significant support for, again, the safety and
20 efficacy of male chest reconstruction surgery in adolescents
21 and young adults.

22 THE COURT: Well, 40 years ago, Mr. Orr, I don't
23 think gender dysphoria was even something that was even on the
24 radar, was it?

25 MR. ORR: Your Honor, it was in the DSM -- I think

1 III at the time, and it was referred to as gender identity
2 disorder. In this most recent iteration of the DSM, DSM-5,
3 the American Psychiatric Association changed it to gender
4 dysphoria to show that it's not that there's something
5 inherently psychologically problematic with being transgender
6 and really focusing on the dysphoria caused by not being able
7 to be affirmed and live consistent with your gender identity
8 in all aspects of your life.

9 THE COURT: Right. The older one, 40 years ago,
10 they still looked at it as some kind of a -- well, more of a
11 mental problem or something of that effect. I mean, I agree
12 with you, times have definitely changed in 40 years, and I'm
13 not sure that that case was particularly, at this point
14 anyways, in terms of standard of care, has any real
15 significance.

16 MR. ORR: Agreed.

17 If the Court doesn't have any further questions
18 about the EPSDT claim, I'd like to move on to the
19 comparability claim, and hopefully that will sort of provide
20 further color to our discussion earlier about that claim.

21 THE COURT: All right. I would like to hear about
22 the comparability, so I'm going to let you go there, and
23 you've got about three minutes, reserving five minutes for
24 your rebuttal.

25 MR. ORR: Okay. Thank you, Your Honor.

1 The comparability requirement really operates as an
2 equality principle, and it is about prohibiting Medicaid
3 agencies from arbitrarily denying a required service solely
4 because of the diagnosis, type of illness, or condition. And
5 AHCCCS provides chest reconstructive surgery to other Medicaid
6 recipients to treat a variety of short- and long-term physical
7 and mental health needs, and, you know, the needs that male
8 chest reconstruction surgery will address for gender dysphoria
9 is comparable, again, if not identical. The exclusion itself
10 is expressly prohibited by federal regulations even though
11 there's no legitimate reason for enforcing that exclusion. As
12 I indicated before --

13 THE COURT REPORTER: I'm sorry. I can't hear him.

14 THE CLERK: Mr. Orr? Mr. Orr?

15 THE COURT: Mr. Orr, Mr. Orr, I'm sorry. My court
16 reporter here is telling me she isn't able to keep up with you
17 again, so if you could slow down just a little bit.

18 Thank you.

19 MR. ORR: I'm sorry. Sure, sure.

20 So as I was saying, Your Honor, AHCCCS also provides
21 chest reconstructive surgery to other Medicaid recipients to
22 treatment a variety of short- and long-term physical and
23 mental health needs, and those needs are similar to the ones
24 that would be addressed by male chest reconstruction surgery
25 here. The surgery for D.H. and John would address D.H.'s

1 physical pain and would improve their overall functioning in
2 every aspect of their lives.

3 Given the amount of time I have left, I do want to
4 quickly address the discrimination claims. Discrimination
5 against transgender people is a form of sex discrimination.
6 That has been clear even before Bostock but certainly since,
7 and Courts have treated it that way.

8 THE COURT: Well, hang on. You mentioned --
9 Mr. Orr, you mentioned Bostock, but Bostock by its own terms
10 only applies to employment discrimination. How could this
11 Court expand that beyond employment discrimination when the
12 case itself explicitly says it's only addressing employment
13 discrimination?

14 MR. ORR: Your Honor, Federal Courts have
15 interpreted sex discrimination laws as a consistent whole, and
16 there is a vast number of cases where Courts have interpreted
17 Title IX as including -- as including protections for
18 transgender people, as well as Section 1557 itself, and as the
19 Court is familiar, Section 1557 prohibits sex discrimination
20 by inclusion of or reference to Title IX, so these are a
21 consistent whole.

22 THE COURT: Okay.

23 MR. ORR: And the text of the exclusion itself,
24 "gender reassignment surgery," creates a sex-based
25 distinction. The Court -- sorry. Medicaid can't apply that

1 exclusion without considering sex. The fact that AHCCCS
2 covers other treatments for gender dysphoria is irrelevant.
3 That exclusion is still sex-based, and the regulations that
4 defendant points to are unavailable because they've been
5 enjoined for violating the Administrative Procedures Act.

6 And lastly, Your Honor, if I have a few moments, I'd
7 like to quickly talk about the equal protection claim, which
8 is that equal protection -- discrimination based on gender
9 identity is entitled to intermediate scrutiny. The cases
10 cited by defendants to the contrary have been overruled by
11 Bostock. The exclusion, again, just like in the context of
12 Section 1557, is sex-based.

13 The difference here is that now the State bears the
14 burden of proof demonstrating it has an extremely persuasive
15 justification, and here the Medicaid agency, AHCCCS, only
16 proffers post hoc rationalizations, which are not permitted.
17 Plaintiff propounded multiple RFPs and interrogatories to ask
18 about the origins of the exclusion and were repeatedly told
19 that no records existed.

20 And their claims that this is based on an idea that
21 the surgery was experimental are belied by the regulation
22 itself, which just appears in a litany of other excluded
23 procedures, including hysterectomies and abortion care.

24 THE COURT: All right. All right. Mr. Orr, I'm
25 going to have to come back to you. I need to hear from

1 Mr. Barton a little bit. I let you run over a little bit
2 because I'm interested in what you had to say on that, but
3 maybe you can revisit it in your rebuttal real briefly. Okay?

4 MR. ORR: Yes. Thank you, Your Honor. I appreciate
5 it.

6 THE COURT: All right. Mr. Barton?

7 MR. BARTON: Thank you, Your Honor. I'm going to
8 try and speak slowly, but if I get blustering, please just
9 stop me.

10 THE COURT: All right.

11 MR. BARTON: I want to begin with the notion of what
12 type of injunction is sought here. This is not very
13 difficult. A mandatory injunction by definition, quote,
14 requires a party to take action, and the Court need look no
15 farther than the Docket 3-1, which is the order, proposed
16 order, on the injunction. Item Number 2, the plaintiffs ask
17 the Court to require the Arizona Health Care Cost Containment
18 System shall provide coverage for plaintiffs' male
19 reconstruction surgery consistent with all the requirements of
20 federal law.

21 No doubt they are requiring us to take action. They
22 ask this Court to require us to provide coverage for their
23 surgery. That is a mandatory injunction that the Courts have
24 said are particularly disfavored and not issued in doubtful
25 cases.

1 So let's talk about why this case is doubtful.
2 First of all, the plaintiffs claim that D.H. and John meet the
3 eligibility requirements for male chest reconstruction surgery
4 and the prevailing standards of care. That's in their reply
5 at page 2. That is critical to their claim. They have to
6 prove that their plaintiffs meet the eligibility requirement
7 and that chest reconstruction surgery is the prevailing
8 standard of care for gender dysphoria. Both of those items
9 are seriously in doubt, and let me explain.

10 First, we know almost nothing of consequence
11 regarding D.H. and John. Despite repeated requests, the
12 plaintiffs have refused to turn over their medical records,
13 including with their initial disclosure, did not include any
14 medical records from the plaintiffs. All we have is the
15 carefully selected facts their lawyers have decided to share
16 with the Court in declarations that they have provided. We
17 would submit the decisions about the health care of Arizona's
18 children should not be made based upon one-sided,
19 one-dimensional declarations prepared by attorneys.

20 And let's talk a little bit about those declarations
21 for just a second when we consider the claim by the plaintiffs
22 that this treatment is medically necessary for D.H. and John
23 Doe. D.H.'s claim is supported by just one actual doctor,
24 Dr. Cronyn. He's D.H.'s pediatrician.

25 As far as his psychological care is concerned, he

1 submitted only a declaration from Tamar Reed. Ms. Reed has a
2 master's in counseling, and she is a licensed professional
3 counselor. Under Arizona law, a licensed professional
4 counselor can't even prescribe medication, but the plaintiffs
5 would have you believe that her recommendation is sufficient
6 to warrant this incredibly invasive and irreversible surgery
7 for D.H.

8 John Doe doesn't even have any kind of a medical
9 provider supporting his application. His application is
10 supported only by the declaration of Mischa Cohen Peck, a
11 licensed clinical social worker and therapist. She has a
12 master's in social work and a Ph.D. in social welfare but no
13 medical degree. She too cannot even prescribe medication, and
14 yet she is the only medical person who provides any support
15 for John Doe's claim that he's medically entitled to these
16 surgeries.

17 They next provide two declarations from experts who
18 are both WPATH members, one of whom is on the WPATH board of
19 directors. Dr. Janssen bases his opinions related to John Doe
20 and D.H. entirely upon a declaration he was supplied by legal
21 counsel. That's found in his declaration at paragraph 19.
22 Dr. Schechter, who is on the board of directors of WPATH, is a
23 surgeon, but he's never met D.H. and John Doe. He had one
24 video conference with them. That's at paragraph 18 of his
25 declaration.

1 This is the medical evidence that these plaintiffs
2 claim support their contention that this treatment is
3 medically necessary for them and is consistent with the
4 prevailing standards of care. I would suggest, Your Honor,
5 that that is a huge claim to make given the limited medical
6 information we have here.

7 Next, the plaintiffs posit the -- they promote, they
8 suggest, that the only standard of care is the standard of
9 care championed by WPATH, an organization that they admit is
10 an advocacy organization, and its mission is to promote only
11 one possible treatment for individuals suffering from gender
12 dysphoria, and that is affirmation. The culmination of
13 affirmation is gender reassignment surgery, which is what the
14 plaintiffs seek here.

15 We would point out and we have pointed out that
16 there are other treatments available for gender dysphoria, and
17 to the Court's earlier question, is the State or AHCCCS
18 required to provide all available treatments for this
19 condition, no. The State can select between various
20 treatments, and the State provides treatments for gender
21 dysphoria, and if it decides in its logic and its analysis
22 that a treatment is not medically necessary or is not safe and
23 effective, it's well within its rights to decide that that
24 treatment is not going to be provided, and that's all we have
25 happening here.

1 As our experts have pointed out, the affirmation
2 approach to the care and treatment of gender dysphoria has not
3 been proven safe and effective in long-term studies, and it
4 could be downright dangerous in many cases.

5 Before being required to abandon the rule that has
6 been in place since 1982, AHCCCS is entitled to a fair hearing
7 to determine whether reassignment surgery is the prevailing
8 standard of care for children and young adults suffering from
9 gender dysphoria. That hearing can only happen after
10 discovery, including discovery into the class issues we've
11 raised and the merits of plaintiffs' claims.

12 THE COURT: And Mr. Barton --

13 MR. BARTON: Plaintiffs' argument --

14 THE COURT: Mr. Barton, I want to jump in here
15 because you're touching on that issue that I raised with
16 Mr. Orr in that, is there some type of administrative process
17 that still needs to take place here, I mean, before this case
18 even comes here? Because you're kind of saying, at least what
19 I hear you saying, is you're entitled to a hearing as to
20 whether -- is that hearing an administrative hearing as to
21 whether this is safe and effective, medically necessary, or is
22 it like Mr. Orr says, that, no, Judge, if you just prohibit
23 them from enforcing this clause under the regulation, then we
24 have this hearing to determine whether it's medically
25 necessary for my clients?

1 MR. BARTON: Great point, Your Honor. There, in
2 fact, is a medical -- a process before AHCCCS, an
3 administrative process, that could be utilized to determine
4 whether John Doe and D.H. qualify for this surgery, and in
5 fact, what we have so far, at least what we know, is that D.H.
6 applied for benefits and was denied, but he did not appeal
7 that determination. He did not invoke the administrative
8 machinery to determine whether, in his particular case and in
9 his unique circumstances, there were reasons why he should get
10 this surgery. So it has not been determined that surgery is
11 medically necessary for him even though it could have been
12 through the AHCCCS process, the appeal, administrative appeal
13 process.

14 John Doe hasn't even applied for this benefit. He's
15 not even sought the benefit. So he hasn't been denied. He
16 hasn't appealed. He hasn't tried to prove that his
17 circumstances warrant the medical benefits he seeks.

18 THE COURT: Okay. Well, that --

19 MR. BARTON: Does that answer your question?

20 THE COURT: Well, it does in some degree. I guess
21 it seems to me, then, is this lawsuit a bit premature? I
22 guess I'm trying to figure out, is that discussion that we're
23 going to have, whether it's medically necessary and safe and
24 effective for these particular plaintiffs, something that the
25 Court's going to do, or that's really something that it sounds

1 to me like AHCCCS should rule on first, and then you come to
2 the Courts and you say, hey, Judge, we disagree with their
3 findings and how they did it or whatever conclusion you may
4 come to, if indeed you come to a conclusion that's contrary to
5 their position?

6 MR. BARTON: We agree, Your Honor. We believe they
7 should be given -- AHCCCS should be given the opportunity to
8 consider these unique cases and make a determination before a
9 Court compels AHCCCS to provide the relief they want.

10 THE COURT: Isn't under the APA or even under AHCCCS
11 itself, isn't there a requirement that you exhaust your
12 administrative remedies before you file the lawsuit?

13 MR. BARTON: It is.

14 THE COURT: Okay. I'm going to let you continue on,
15 but Mr. Orr, that's something I really want you to address in
16 your rebuttal.

17 Go ahead, Mr. Barton.

18 MR. BARTON: So next, plaintiffs, you know, as
19 you've heard the plaintiffs argue with our experts. They
20 criticize their opinions and credentials. It's the same sort
21 of political attacks that are leveled against anyone who dares
22 to question the path promoted by WPATH.

23 But if you review the reports our experts supplied,
24 you will see in the footnotes that the opinions expressed by
25 our experts are based on sound scientific studies. Gender

1 reassignment surgery is not the panacea WPATH makes it out to
2 be. Indeed, the only long-term studies that have been
3 conducted show that individuals who have gender reassignment
4 surgery have a 19 percent higher rate of successful suicide
5 after 10 years than the general public. At a minimum, this
6 Court needs to hear the evidence and examine the underlying
7 scientific reports before it strikes down the AHCCCS rule.

8 Now, in reply, the plaintiffs' specific criticisms
9 leveled against Dr. Levine are addressed by Dr. Janssen, and
10 he points to a number of studies that debate the studies
11 relied on by Dr. Laidlaw and Dr. Levine, but here are some key
12 points to take away from the Dr. Janssen reply and the reply
13 by Dr. Schechter.

14 Number one, both Dr. Schechter and Dr. Janssen admit
15 that male chest reconstruction surgery is not medically
16 appropriate until at least adolescence. That's important
17 because the proposed class here is anybody under the age of
18 21. Two, neither Dr. Janssen nor Dr. Schechter can point to
19 any long-term study showing that gender reassignment surgery
20 is safe and effective for adolescents.

21 Number three, nothing in the replies by Dr. Janssen
22 or Dr. Schechter rebuts the studies and evidence relied upon
23 by Dr. Levine and Dr. Laidlaw to show that gender dysphoria
24 will not persist into adulthood in 80 to 95 percent of
25 children if the condition is simply left untreated.

1 As the Court pointed out, even the DSM-5 points out
2 that persistence is rare. The DSM-5 -- I want to quote it
3 exactly. The DSM-5 says that, in natal males, persistence of
4 gender dysphoria has ranged from 2.2 percent to 30 percent.
5 In natal females, persistence has ranged from 12 percent to 50
6 percent.

7 I heard the plaintiffs today trying to argue even
8 with the DSM-5 that there can be no doubt that the scientific
9 evidence suggests that there is reason to do nothing with
10 gender dysphoric children, the group of people here at issue,
11 because the experts certainly disagree about whether it's
12 better to provide treatment or just let it play out and see
13 what happens.

14 Now, Dr. Janssen points to three studies, and I want
15 the Court to look at those studies carefully because they're
16 very interesting. The first is the Bränström study that was
17 conducted in 2020. This is a peer-reviewed study, and when
18 the peer-review happened on this study, the American Journal
19 of Psychiatry just this year had to issue a correction saying
20 that the study, quote, did not support a finding of improved
21 mental health post surgery. That's critical. This year the
22 Journal of American Psychiatry has already changed its view
23 with regard to the Bränström study.

24 The second one is the Olson-Kennedy study from 2018.
25 Take a look at the details of that study, Your Honor. The

1 survey involved only 136 participants, all of whom identified
2 as transgender. 68 had chest reconstruction surgery; 68 did
3 not. As Dr. Laidlaw points out, the study used a survey tool
4 that had not been scientifically validated, and it included
5 children as young as 13 and 14 years of age. For these
6 reasons, Dr. Laidlaw called the survey flawed and unethical.

7 I would add that the survey was not a long-term
8 study. The vast majority of respondents, 59 out of 68 of
9 them, were less than two years post surgery. Only one was
10 five years post surgery.

11 They also point to the de Vries study, which is a
12 Dutch study from 2014. It examined just 55 patients based on
13 the conclusion of the SRS patients one year after surgery.
14 Importantly, the mean age of the participants in that survey
15 was only -- was 20.7 years of age, which means that the study
16 has almost nothing to say about the class of adolescents and
17 children proposed here.

18 The bottom line is, the evidence -- the claim that
19 the plaintiffs make that this surgery is proven to be safe and
20 effective simply does not have the scientific support they
21 would like. Take a look at Dr. Schechter's reply at paragraph
22 20. He makes this bold statement under the heading,
23 "Peer-reviewed research indicates that male chest
24 reconstruction is safe and effective." He then goes on to
25 say, "Here the existing literature indicates that male chest

1 reconstruction surgery is safe and effective treatment for
2 individuals with gender dysphoria, including adolescents." I
3 was looking really hard for a footnote there. There is none.
4 There's not a single citation to any study to back up that
5 bold claim by Dr. Schechter.

6 Now, on the other hand, we point to two studies,
7 long-term studies. Our experts point to two of them. They're
8 in the Laidlaw Declaration, page 35. The Dhejne study, a
9 long-term follow-up with transsexual persons undergoing sex
10 reassignment surgery. This study examined data from 324
11 patients who underwent gender reassignment surgery. It
12 carefully compared the group with matching individuals in the
13 general population. It found that, when followed out beyond
14 10 years, the gender reassignment group had 19 times the
15 complete suicide rate and nearly three times the rate of
16 all-cause mortalities than the general population. A similar
17 study by Simonsen in 2016 out of Denmark reached similar
18 results.

19 Perhaps it's for this reason that the Centers for
20 Medicare & Medicare Services, which is the federal agency that
21 makes determinations about Medicaid eligibility, says there is
22 inconclusive evidence to support a coverage determination
23 based upon the efficacy of gender reassignment surgery.

24 Your Honor, the bottom line is that these plaintiffs
25 simply cannot prove that gender reassignment surgery is safe

1 and effective for children and adolescents.

2 Finally, I would point out that the plaintiffs bring
3 this claim under two federal statutes and the Constitution.
4 Neither the Constitution nor the statute cited say anything
5 about gender reassignment surgery. Plaintiffs are asking this
6 Court to interpret those statutes and the Constitution in a
7 way that would require the surgery, but the plain language of
8 those documents is silent.

9 And perhaps more importantly, not one of the cases
10 cited by the plaintiffs have provided the relief requested
11 here. You can -- I've looked up every one of their cases in
12 their briefs, Your Honor, and I can say quite confidently that
13 no Court has interpreted the Medicaid Act, the Affordable Care
14 Act, or the Constitution to require a state agency to pay for
15 gender reassignment surgery for children and adolescents. If
16 this Court were to do so, it would be the first.

17 Thank you.

18 THE COURT: All right. Thank you.

19 And Mr. Barton, just -- I want to follow up on --
20 that was -- you talked about the Bränström study, that there
21 was a -- you said just the last year there was a change in
22 that or they --

23 MR. BARTON: Yes, that's the Bränström,
24 B-r-a-n-s-t-r-o-m, study cited at page 28 of the Janssen
25 reply, or paragraph 28.

1 THE COURT: And you said there was -- just the last
2 year that there was some kind of amendment or clarification on
3 that study?

4 MR. BARTON: Correct. Professor or Dr. Laidlaw
5 talks about this in his declaration in paragraph 38, that this
6 is a study that was released initially, suggested that, you
7 know, transgender health was improved through surgery, but
8 after it was released, the American Journal of Psychiatry
9 issued a correction in August of 2020 saying that the study
10 did not, in fact, support an improved mental health post
11 surgery.

12 THE COURT: Okay. And Mr. Barton, when we had our
13 first kind of hearing in this particular matter, and I kind of
14 discussed with the parties about whether the Court thought it
15 might be necessary to have an evidentiary hearing before I
16 actually ruled on the preliminary injunction motion, you
17 indicated that you didn't think it was necessary, but what I
18 hear you saying and what I hear Mr. Orr saying is that, you
19 know, we each have experts that --

20 (Noise interruption.)

21 THE COURT: Whoa. I don't know what that was, but
22 thank you for getting it under control.

23 It sounds to me like I've got a battle of the
24 experts to some degree, and then, based upon your comment,
25 that AHCCCS does have a process where it could look at these

1 particular individuals and say, okay, in this unique
2 situation, maybe male chest reconstruction surgery is
3 medically necessary or safe and effective because of these
4 unique circumstances. Have I kind of got that right? Is that
5 what -- I mean, would you disagree with that?

6 MR. BARTON: Your Honor, I'm sorry. You cut out
7 there for just a second. Let me try and understand by trying
8 to restate your question.

9 I think the first question was, do we believe that
10 there is a need for discovery and a full evidentiary hearing?
11 The answer to that is yes.

12 THE COURT: Well, then why, when I kind of -- before
13 you go on, then why when I raised that issue when we first had
14 our first hearing and I asked the parties, you know, I said,
15 you know, the Court may believe that I need an evidentiary
16 hearing before I can rule on the preliminary injunction, the
17 plaintiff said, no, Judge, you don't, but you also said, no, I
18 don't. And so I thought, well, then I'm going to dig into
19 this a little deeper. Maybe it's not necessary.

20 But as both of you, Mr. Orr and yourself, sit here
21 and argue, it sounds like I've got a battle of the experts.
22 You've got experts that say one thing; he's got experts that
23 say another. I've got to judge the credibility of those
24 experts and their studies and what they rely on before I can
25 really make an informed decision on this.

1 MR. BARTON: I guess my thought was on that, Your
2 Honor, that I don't think they can meet the standard. The
3 standard requires them to prove, in essence, beyond a doubt
4 that, for these particular plaintiffs, this is medically
5 necessary, and for the reasons I described today, I don't
6 think they can do that or the evidence they presented does
7 that.

8 When we get to the broader question -- and so I
9 don't think they're entitled to a preliminary injunction. I
10 think you can decide that as, you know, basically based on the
11 evidence presented, but when it comes to the broader question
12 about the second requested relief which they have, which
13 should be -- which is, should the Arizona Health Care Cost
14 Containment System be required to abandon its exclusion, that
15 certainly is going to require much more evidence and much more
16 evaluation of the evidence --

17 THE COURT: All right. Well, then --

18 MR. BARTON: -- including the battle of the experts.

19 THE COURT: All right. And then that gets me back
20 to the other thing that you kind of brought up, which there is
21 a process that AHCCCS has in place that these particular
22 plaintiffs, given their unique situation, could apply to have
23 male chest reconstruction surgery because it might be
24 medically necessary and/or safe and effective for them.

25 Did I understand that correctly?

1 MR. BARTON: That is correct.

2 THE COURT: Okay.

3 MR. BARTON: And I will volunteer this, Your Honor,
4 although I will not disclose this completely because we
5 haven't yet reviewed the data, we're still in the process of
6 gathering the data, but in response to plaintiffs' discovery
7 request, we did some searches to find out, you know, what's
8 happened with regard to transgender youth who have sought
9 chest reconstruction surgery. It appears, based on a
10 preliminary finding, and I need to verify this, we've had at
11 least two cases where they have been approved through AHCCCS.

12 THE COURT: Okay. Any further thoughts, Mr. Barton,
13 before I switch back to Mr. Orr?

14 MR. BARTON: No, Your Honor.

15 THE COURT: All right. Mr. Orr, I may give you a
16 couple extra minutes because, again, you can tell by my
17 comments, I'm concerned about this exhaustion of
18 administrative remedies. I understand that there is some
19 dispute. I mean, you may disagree with that, but there is
20 some dispute about -- between experts about whether this
21 procedure is generally necessary and/or safe and effective,
22 but it may be necessary or safe and effective for your
23 particular plaintiffs, in which case there is a process
24 already established within AHCCCS to basically have that
25 evidentiary hearing, to have the experts testify, to, you

1 know, submit all the studies and everything else, before this
2 Court should have to hear all that, and I'd really like your
3 thoughts on that.

4 MR. ORR: Thank you, Your Honor.

5 There's no administrative exhaustion requirement for
6 the claims that plaintiffs bring here. What plaintiffs are
7 requesting here, Your Honor, is an order that the exclusion
8 itself violates federal law, both statutory and constitutional
9 law. So it's not specific to the medical necessity of this
10 procedure for D.H. or John Doe.

11 And you know, as I indicated in my urging earlier,
12 our understanding is that, if the Court were to agree and
13 issue the preliminary injunction enjoining AHCCCS from
14 considering the exclusion, that then that would open up the
15 process for plaintiffs to submit a prior authorization
16 request. The process --

17 THE COURT: Why would that open up the process,
18 Mr. Orr? I guess that's where I'm losing you. I understand
19 the process is already in place. Why do I need to make a
20 ruling to get that process in place? According to Mr. Barton,
21 that process is in place, and I don't need to make a ruling
22 for you to pursue those avenues of remedy for your particular
23 plaintiffs.

24 MR. ORR: Thank you, Your Honor.

25 Pursuing those remedies, Your Honor, would be

1 futile. There is an exclusion that would always prevent our
2 clients from getting coverage. Their denial of the prior
3 authorization for D.H. said explicitly that we are denying
4 this because of the exclusion. It doesn't matter if it's
5 medically necessary or not, this is excluded under our state
6 plan and, therefore, we don't cover it. There was no
7 determination of medical necessity anywhere in that
8 assessment, and Courts have consistently made clear that
9 plaintiffs have the right under Section 1983, through the
10 Medicaid Act, and other legal remedies to challenge a Medicaid
11 agency's determination of what is or is not excluded for
12 coverage, and so there is no need to go through that
13 administrative process simply to challenge the legality of the
14 exclusion here.

15 THE COURT: Well, I understand your argument, but it
16 sounds to me that what you really want me to do is argue on
17 this kind of higher plain, if you will, kind of almost
18 ignoring your particular defendants, or plaintiffs, excuse me.
19 I mean, they're just kind of there because they happen to be a
20 useful purpose to get to this larger argument that you wish to
21 bring regarding the, you know, whether the exclusion itself
22 violates federal law.

23 I guess I'm more interested in your particular
24 plaintiffs, and if they've got a remedy and an avenue and a
25 possibility that, without going through this whole big lawsuit

1 and everything else, they could apply to AHCCCS and
2 potentially get coverage, you know, why should I make a
3 decision about the federal viability of the exclusion itself?

4 MR. ORR: Well, Your Honor, D.H. has tried that
5 process and was outright denied, and John Doe couldn't go
6 through that process because of the exclusion. There were no
7 competent providers from which he could seek an assessment,
8 providers covered by AHCCCS where he could seek an assessment
9 to seek that prior authorization.

10 So the difficulty, Your Honor, is that our clients
11 don't even really have access. Sure, they can -- you know,
12 maybe they can find -- their pediatrician can submit a prior
13 authorization or somebody else can submit a prior
14 authorization, but they still don't have -- there's no way for
15 that authorization to be approved because of the exclusion.
16 The exclusion says, regardless of whether or not it's
17 medically necessary, that doesn't matter, we just don't cover
18 these surgeries, and they don't cover these surgeries because
19 they're transgender, and they're there to treat a condition
20 associated with being transgender.

21 THE COURT: Okay.

22 MR. ORR: And so the administrative process is not
23 really available to them, and that's why we came to Federal
24 Court seeking an order instructing AHCCCS to not consider that
25 exclusion when they're evaluating the medical necessity,

1 essentially requiring them to look at the actual medical
2 necessity and not just dismiss it outright because of the
3 exclusion.

4 THE COURT: All right. What else did you want to
5 address, sir?

6 MR. ORR: Sure. I have a number of points, Your
7 Honor.

8 First, and I'll try and take them sort of
9 chronologically through Mr. Barton's argument, regarding the
10 mandatory injunction, as I noted in my argument, in M.R. v.
11 Dreyfus, the Ninth Circuit upheld an order and injunction that
12 required Washington Medicaid to pay for services it did not
13 believe it should be required to pay for, and so I don't think
14 that that necessitates that this is a mandatory injunction,
15 and in fact, in M.R., the Ninth Circuit applied the
16 prohibitory injunction standard.

17 THE COURT: Okay.

18 MR. ORR: With regards to their refusal of medical
19 records, you know, this injunction is really about the legal
20 arguments, and in fact, you know, Drs. Laidlaw and Levine made
21 clear that the facts are irrelevant to them. They do not
22 believe that any of these treatments for the treatment of
23 gender dysphoria is ever appropriate, and Dr. Laidlaw
24 specifically said as much in his declaration.

25 With regard to Mr. Barton's claim that this is

1 just -- these are just therapists who are not allowed to
2 prescribe anything, you know, this process is consistent with
3 the standard of care. The standard of care requires that a
4 young person for whom medically -- who male chest
5 reconstruction surgery may be medically necessary to have to
6 first obtain a letter from their mental health provider
7 demonstrating that they are -- that they've met the
8 requirements, the underlying requirements, and then they have
9 to be evaluated by a medical provider, which, you know, could
10 not happen in this case, again, because of the exclusion.

11 With regards to WPATH, that is an organization of
12 medical and mental health and other professionals that treat
13 and work with transgender patients. It's not an advocacy
14 organization, you know, and as Dr. Janssen noted in his
15 declaration, that he's had patients who presented to him with
16 some of the symptoms or sort of precursors of gender
17 dysphoria, but ultimately, because they didn't have gender
18 dysphoria, he recommended treatments other than transition or
19 transition-related care for them. So this idea that it's sort
20 of like a factory, everyone comes in, gets a gender dysphoria
21 diagnosis, and then automatically gets treatment, that is not,
22 in fact, accurate.

23 And there are long-term studies. The de Vries study
24 is a long-term cohort study involving transgender young people
25 that they followed from the beginning of puberty, through

1 surgery, and found that the mental health outcomes in that
2 cohort of people was identical to the general population, with
3 the exception that they were more likely to seek advanced
4 educational degrees. So again, I would challenge
5 Dr. Barton or Mr. Barton's discussion on that.

6 With regard to the Dhejne study and the mortality
7 rates, you know, Drs. Laidlaw and Levine consistently cited
8 this study, but in fact, the study itself says that the higher
9 mortality rates -- there is no causal connection between
10 either the treatment for gender dysphoria and the higher
11 mortality rates. The study was not designed to look at that
12 and, therefore, cannot support such conclusion.

13 Similar to the Bränström study, it is true that the
14 initial study indicated there was a causal relationship, but
15 the current study, the republished version, says that there's
16 still a positive correlation between undergoing treatments for
17 gender dysphoria and improvements in mental health.

18 THE COURT: Well, and isn't one of your clients,
19 they were receiving -- AHCCCS was covering hormone therapy,
20 and they were doing better, the hormone therapy really helped,
21 they improved their mental health, and they were better? But
22 I mean, your position is, is that it wasn't enough; right?

23 MR. ORR: Well, Your Honor, and this was explained a
24 little bit further in Dr. Janssen's declaration, but what's
25 something that often happens is that the testosterone helps

1 address a portion of the gender dysphoria, but the changes
2 that are caused by the testosterone, namely facial hair and
3 the dropping voice, that in some respects also increased the
4 disconnect between their presentation, because here you have a
5 transgender guy who's got a deep voice and facial hair but
6 also has a female-appearing chest.

7 And so it's very common for testosterone treatment
8 to improve gender dysphoria significantly, but given that in
9 this case both D.H. and John started undergoing puberty
10 significantly before starting testosterone, that it's not
11 surprising that, given their -- the way that they present to
12 the world, that they still have gender dysphoria, and no
13 amount of therapy or testosterone is going to address that
14 because, ultimately, the chest is still the same, and that is
15 what is causing the persistent dysphoria.

16 With regards to Mr. Barton's reference to the Center
17 for Medicare and Medicaid Services, in fact, CMS used to have
18 an exclusion that's nearly identical to the one that AHCCCS is
19 defending here, and an internal appeals within the U.S.
20 Department of Health and Human Services found that that
21 exclusion is not reasonable and ultimately eliminated that
22 exclusion from Medicare services.

23 And so Medicare does, in fact, cover
24 transition-related surgeries, and it does so on a case-by-case
25 basis, which is exactly what our clients are seeking here, is

1 an opportunity to demonstrate that it is medically necessary
2 for them, which they cannot do because of the exclusion.

3 THE COURT: And Mr. -- and Mr. Orr, Mr. Orr, we seem
4 to be going circular again, because you're saying, because of
5 the exclusion, they can't do the administrative remedies.

6 Is it your position that AHCCCS has no internal
7 administrative procedure for reviewing denial of coverage
8 decisions for generally excluded treatment under Arizona
9 Administrative Code R9-22-205(B)(4)?

10 That's a very specific question, and I'd like you to
11 answer it, please.

12 MR. ORR: Sure.

13 Your Honor, my understanding is that, once a
14 Medicaid recipient files or seeks prior authorization, that
15 they will get back a response either -- or in this case a
16 denial because of the exclusion, and at that point, if they
17 choose, they can go to a state fair hearing, but that
18 exhaustion requirement, that is not an administrative remedy
19 that plaintiffs are required to exhaust prior to filing a
20 complaint in Federal Court, certainly in a case such as this,
21 when it's claiming that the exclusion itself violates federal
22 law.

23 THE COURT: All right. Thank you.

24 Mr. Orr, I gave you more time because I was
25 interested in your responses to the various issues that

1 Mr. Barton raised, but I think at this time I need to
2 conclude, in all fairness to both sides.

3 I'm going to take the matter under advisement. I
4 will get you out a decision as soon as possible.

5 Thank you, folks.

6 MR. BARTON: Thank you, Your Honor.

7 MR. ORR: Thank you, Your Honor.

8 THE COURT: We stand at recess.

9 (Proceedings conclude at 11:24 a.m.)
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C E R T I F I C A T E

I, Erica R. McQuillen, Federal Official Realtime Reporter, in and for the United States District Court for the District of Arizona, do hereby certify that, pursuant to Section 753, Title 28, United States Code, the foregoing is a true and correct transcript of the stenographically reported proceedings held in the above-entitled matter and that the transcript page format is in conformance with the regulations of the Judicial Conference of the United States.

Dated this 9th day of February, 2021.

s/Erica R. McQuillen
Erica R. McQuillen, RDR, CRR
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13
14 **UNITED STATES DISTRICT COURT**
15 **FOR THE DISTRICT OF ARIZONA**

16 D.H., by and through his mother, Janice
17 Hennessy-Waller; and John Doe, by his
18 guardian and next friend, Susan Doe, on
19 behalf of themselves and all others
20 similarly situated,

19 Plaintiffs,

20 vs.

21 Jami Snyder, Director of the Arizona
22 Health Care Cost Containment System,
23 in her official capacity,

23 Defendant.

No. 4:20-cv-335-SHR

**NOTICE OF PRELIMINARY
INJUNCTION APPEAL**

1 Notice is hereby given that D.H. and John Doe, plaintiffs in the above-captioned
2 case, hereby appeal to the United States Court of Appeals for the Ninth Circuit from the
3 Order denying Plaintiffs' Motion for Preliminary Injunction, Doc. 66, dated March 30,
4 2021.

5
6 Respectfully submitted,

7 DATED: APRIL 16, 2021

PERKINS COIE LLP

8 /s/ Daniel C. Barr

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CERTIFICATE OF SERVICE

I hereby certify that on April 16, 2021, I electronically transmitted the attached documents to the Clerk's Office using the CM/ECF System for filing and transmittal of a Notice of Electronic Filing to the following CM/ECF registrants:

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138410-0001/152169327.1

APPEAL,STD

**U.S. District Court
DISTRICT OF ARIZONA (Tucson Division)
CIVIL DOCKET FOR CASE #: 4:20-cv-00335-SHR**

Hennessy-Waller et al v. Snyder
Assigned to: Judge Scott H Rash
Case in other court: 9th CCA, 21-15668
Cause: 42:1983 Civil Rights Act

Date Filed: 08/06/2020
Jury Demand: None
Nature of Suit: 440 Civil Rights: Other
Jurisdiction: Federal Question

Plaintiff

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*on behalf of themselves and all others
similarly situated
on behalf of
D.H.*

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ER579

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Plaintiff

Susan Doe
on behalf of themselves and all others
similarly situated
next friend of
John Doe

represented by **Abigail K Coursolle**
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V.

Defendant

Jami Snyder
*Director of the Arizona Health Care Cost
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Date Filed	#	Docket Text
08/06/2020	<u>1</u>	COMPLAINT. Filing fee received: \$ 400.00, receipt number 0970-18545419 filed by Susan Doe, Janice Hennessy-Waller. (Barr, Daniel) (Attachments: # <u>1</u> Civil Cover Sheet)

ER581

		(SCA) (Entered: 08/06/2020)
08/06/2020	2	MOTION to Proceed Under a Pseudonym by Susan Doe, Janice Hennessy-Waller.(Barr, Daniel) (Attachments: # 1 Text of Proposed Order)(SCA) (Entered: 08/06/2020)
08/06/2020	3	MOTION for Preliminary Injunction by Susan Doe, Janice Hennessy-Waller. (Barr, Daniel) (Attachments: # 1 Text of Proposed Order)(SCA) (Entered: 08/06/2020)
08/06/2020	4	DECLARATION of John Doe, Susan Doe, and Mischa Cohen Peck, PHD. in Support of Plaintiffs' 3 Motion for Preliminary Injunction and 2 John's Motion to Proceed Under a Pseudonym. (Barr, Daniel) (Attachments: # 1 Declaration of Susan Doe, # 2 Declaration of Mischa Cohen Peck, PHD)(SCA) (Entered: 08/06/2020)
08/06/2020	5	Declaration of D.H., Janice Hennessey-Walker, Tamar Reed, and Dr. Andrew Cronyn, Aron Janssen, M.D., Loren S. Schechter, M.D. in Support of Plaintiffs' 3 Motion for Preliminary Injunction. (Barr, Daniel) (Attachments: # 1 Declaration of Janice Hennessey-Walker, # 2 Declaration of Tamar Reed, # 3 Declaration of Dr. Andrew Cronyn, # 4 Declaration of Aron Janssen, M.D., # 5 Declaration of Loren S. Schechter, M.D.)(SCA) (Entered: 08/06/2020)
08/06/2020	6	SUMMONS Submitted by Susan Doe, Janice Hennessy-Waller.(Barr, Daniel) (SCA) (Entered: 08/06/2020)
08/06/2020	7	Filing fee paid, receipt number 0970-18545419. This case has been assigned to the Honorable Scott H Rash. All future pleadings or documents should bear the correct case number: CV-20-00335-TUC-SHR. Notice of Availability of Magistrate Judge to Exercise Jurisdiction form attached. (SCA) (Entered: 08/06/2020)
08/06/2020	8	Summons Issued as to Jami Snyder. (SCA). *** IMPORTANT: When printing the summons, select "Document and stamps" or "Document and comments" for the seal to appear on the document. (Entered: 08/06/2020)
08/11/2020	9	SERVICE EXECUTED filed by Susan Doe, Janice Hennessy-Waller: Proof of Service re: Summons, Complaint, Civil Cover Sheet, Motion to Proceed Under a Pseudonym (order), Motion for Preliminary Injunction (order), Notice of Availability of Magistrate Judge, Declarations of John Doe, Susan Doe, Mischa Cohen Peck, Phd, D.H., Janice Hennessy-Waller, Tamar Reed, Dr. Andrew Cronyn, Aron Janssen, MD, Loren S. Schechter, MD upon Jami Snyder, Director of the Arizona Health Care Cost Containment System on August 7, 2020. (Barr, Daniel) (Entered: 08/11/2020)
08/11/2020	10	MOTION to Transfer Related Case by Susan Doe, Janice Hennessy-Waller. (Attachments: # 1 Text of Proposed Order) (Associated Cases: CV-20-00335-TUC-SHR,CV-19-0035-TUC-RM(LAB)) (Barr, Daniel) (Entered: 08/11/2020)
08/23/2020	11	*First MOTION for Extension of Time To Respond to Complaint re: Doc. 1 and Motion for Extension of Time to File Response to Motion for Preliminary Injunction re: Doc. 3 by Jami Snyder. (Attachments: # 1 Text of Proposed Order)(Johnston, Logan). *Modified to add motion type and add reference to related documents on 8/24/2020 (MYE). (Entered: 08/23/2020)
08/25/2020	12	ORDERED that Defendant's Motion 11 is granted, and Defendant may have until September 28, 2020 to respond to Plaintiffs' Complaint (Doc. 1) and Motion for Preliminary Injunction (Doc. 3) herein. Signed by Judge Scott H Rash on 8/25/20. (MYE) (Entered: 08/25/2020)
08/25/2020	13	RESPONSE to Motion re: 10 MOTION to Transfer Related Case filed by Jami Snyder. (King, Kathryn) (Entered: 08/25/2020)
08/26/2020	14	NOTICE of Appearance by Kathryn H King on behalf of Jami Snyder. (King, Kathryn) (Entered: 08/26/2020)

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		(Entered: 08/26/2020)
08/26/2020	15	NOTICE re: No Opposition by Jami Snyder re: 2 MOTION to Proceed Under a Pseudonym . (King, Kathryn) (Entered: 08/26/2020)
08/26/2020	16	REPLY to Response to Motion re: 10 MOTION to Transfer Related Case to Judge Rosemary Marquez filed by Susan Doe, Janice Hennessy-Waller. (Barr, Daniel) (Entered: 08/26/2020)
09/28/2020	17	ANSWER to 1 Complaint for Declaratory and Injunctive Relief by Jami Snyder.(King, Kathryn) (Entered: 09/28/2020)
09/28/2020	18	RESPONSE in Opposition re: 3 MOTION for Preliminary Injunction filed by Jami Snyder. (Attachments: # 1 Exhibit Exhibit A, # 2 Exhibit Exhibit B)(Barton, David) (Entered: 09/28/2020)
09/28/2020	19	NOTICE TO FILER OF DEFICIENCY re: 18 Response in Opposition to Motion filed by Jami Snyder. Document not in compliance with LRCiv 5.5(g) - Documents signed by an attorney shall be filed using that attorney's ECF log-in and password and shall not be filed using a log-in and password belonging to another attorney. Document(s) signed by attorney Kathryn Hackett King but submitted using the log-in and password belonging to attorney David Barton. <i>No further action is required.</i> This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry. (MYE) (Entered: 09/29/2020)
09/30/2020	20	MOTION for Extension of Time to File Response/Reply as to 3 MOTION for Preliminary Injunction (<i>Unopposed</i>) by Susan Doe, Janice Hennessy-Waller. (Attachments: # 1 Text of Proposed Order)(Barr, Daniel) (Entered: 09/30/2020)
09/30/2020	21	ORDERED that Plaintiffs' Motion for Extension of Time to File Reply in Support of Motion for Preliminary Injunction 20 is GRANTED and Plaintiffs shall file their reply in support of their pending Motion for Preliminary Injunction (Doc. 3) on or before Monday, October 26, 2020. Signed by Judge Scott H Rash on 9/30/20. (MYE) (Entered: 09/30/2020)
09/30/2020	22	RESPONSE to Motion re: 20 Plaintiff's Unopposed Motion for Extension of Time to File Reply in Support of Motion for Preliminary Injunction by Defendant Jami Snyder. (King, Kathryn) *Modified to correct reference to related document on 10/1/2020 (MYE). (Entered: 09/30/2020)
10/21/2020	23	ORDERED that the motion to transfer filed on August 11, 2020 pursuant to LRCiv42.1 is DENIED. (Doc. 113); (CV 20-0335-TUC-SHR, Doc. 10). Signed by Magistrate Judge Leslie A Bowman on 10/19/20. (MYE) (Entered: 10/21/2020)
10/23/2020	24	ORDERED Plaintiff John Doe's Motion to Proceed Under a Pseudonym (Doc. 2) is GRANTED. Signed by Judge Scott H Rash on 10/22/20. (MYE) (Entered: 10/23/2020)
10/26/2020	25	REPLY to Response to Motion re: 3 MOTION for Preliminary Injunction (<i>Plaintiffs D.H. and John Doe</i>) filed by Susan Doe, Janice Hennessy-Waller. (Attachments: # 1 Reply Expert Declaration of Aron Janssen, M.D. in Support of Plaintiffs' Motion for Preliminary Injunction, # 2 Reply Expert Declaration of Loren S. Schechter, M.D. in Support of Plaintiffs' Motion for Preliminary Injunction)(Barr, Daniel) (Entered: 10/26/2020)
11/20/2020	26	MOTION for Leave to File Plaintiff D.H.'s Motion for Leave to File Supplemental Declaration of Andrew Cronyn, MD, in Support of D.H. and John Doe's Motion for Preliminary Injunction by Susan Doe, Janice Hennessy-Waller. (Attachments: # 1 Text of Proposed Order)(Barr, Daniel) (Entered: 11/20/2020)
11/20/2020	27	LODGED Proposed Supplemental Declaration of Andrew Cronyn, MD, in Support of D.H. and John Doe's Motion for Preliminary Injunction re: 26 MOTION for Leave to File

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		Plaintiff D.H.'s Motion for Leave to File Supplemental Declaration of Andrew Cronyn, MD, in Support of D.H. and John Doe's Motion for Preliminary Injunction . Document to be filed by Clerk if Motion or Stipulation for Leave to File or Amend is granted. Filed by Susan Doe, Janice Hennessy-Waller. (Barr, Daniel) (Entered: 11/20/2020)
11/23/2020	28	NOTICE of Service of Discovery filed by Susan Doe, Janice Hennessy-Waller. (Barr, Daniel) (Entered: 11/23/2020)
11/23/2020	29	NOTICE of Service of Discovery filed by Jami Snyder. (Johnston, Logan) (Entered: 11/23/2020)
11/24/2020	30	ORDER: A thirty-minute status conference is set for Friday, December 11, 2020 at 11:00 A.M., before the Honorable Scott H. Rash. The parties shall appear telephonically and shall call 888-363-4735 at the EXACT time of the hearing. The access code is 2872694. Signed by Judge Scott H Rash on 11/23/20. (MYE) (Entered: 11/24/2020)
11/24/2020	31	ORDERED Plaintiff's Motion (Doc. 26) is GRANTED and the Supplemental Declaration of Andrew Cronyn, MD, in Support of D.H. and John Does' Motion for Preliminary Injunction (Doc. 27) is accepted. Signed by Judge Scott H Rash on 11/24/20. (MYE) (Entered: 11/24/2020)
11/24/2020	32	SUPPLEMENTAL Declaration of Andrew Cronyn, MD, In Support of D.H. and John Doe's re: 3 MOTION for Preliminary Injunction. (Barr, Daniel) (MYE) (Entered: 11/24/2020)
12/02/2020	33	REPORT of Rule 26(f) Planning Meeting by Susan Doe, Janice Hennessy-Waller. (Attachments: # 1 Text of Proposed Order)(Barr, Daniel) (Entered: 12/02/2020)
12/03/2020	34	STIPULATION <i>Joint for Entry of Stipulated Protective Order</i> by Susan Doe, Janice Hennessy-Waller. (Attachments: # 1 Exhibit A, # 2 Text of Proposed Order)(Barr, Daniel) (Entered: 12/03/2020)
12/08/2020	35	RESPONSE re: 32 Supplement by Defendant Jami Snyder. (Attachments: # 1 Exhibit) (King, Kathryn) (Entered: 12/08/2020)
12/10/2020	36	NOTICE of Service of Discovery filed by Susan Doe, Janice Hennessy-Waller. (Barr, Daniel) (Entered: 12/10/2020)
12/11/2020	38	MINUTE ENTRY for proceedings held before Judge Scott H Rash: Status Conference held on 12/11/2020. The Court tentatively sets telephonic Oral Argument on the Motion for Preliminary Injunction for 1/13/2021 at 10:00 am. The Court will provide notice to the parties if it determines an Evidentiary Hearing is necessary. The parties agree to the Court entering the Protective Order. Plaintiff has 30 days to request class certification. APPEARANCES: Telephonic appearance by Asaf Orr with Brent Ray for Plaintiff. Telephonic appearance by Kathryn King with Logan Johnson and David Barton for Defendant. (Court Reporter Erica McQuillen.) Hearing held 11:02 am to 11:29 am. This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry. (SMJ) (Entered: 12/17/2020)
12/15/2020	37	ORDER Adopting Stipulated Protective Order: The Protective Order (Doc. 34) submitted to this Court shall be entered as an order of this Court. Signed by Judge Scott H Rash on 12/14/20. (MYE) (Entered: 12/15/2020)
01/06/2021	39	ORDER Resetting Oral Argument on Plaintiffs' Motion for Preliminary Injunction: IT IS ORDERED the telephonic oral argument on Plaintiffs' 3 Motion for Preliminary Injunction, presently set for Wednesday, January 13, 2021 at 10:00 A.M. is VACATED and RESET. The telephonic oral argument will be reset for Wednesday, January 27, 2021 at 11:00 A.M. before the Honorable Scott. H. Rash. The parties shall appear telephonically

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		and shall call 888-363-4735 at the EXACT time of the hearing. The access code is 2872694. Signed by Judge Scott H Rash on 1/6/21. (MYE) (Entered: 01/06/2021)
01/11/2021	40	MOTION to Certify Class by Susan Doe, Janice Hennessy-Waller. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Text of Proposed Order)(Barr, Daniel) (Entered: 01/11/2021)
01/19/2021	41	NOTICE of Service of Discovery filed by Jami Snyder. (King, Kathryn) (Entered: 01/19/2021)
01/20/2021	42	NOTICE of Service of Discovery filed by Jami Snyder. (King, Kathryn) (Entered: 01/20/2021)
01/22/2021	43	Due to a conflict in the Court's calendar, IT IS ORDERED the telephonic oral argument for 3 Motion for Preliminary Injunction filed by Janice Hennessy-Waller, Susan Doe presently set for 01/27/21 at 11:00 AM, is VACATED and RESET. Oral argument set for 2/5/2021 at 10:00AM before Judge Scott H Rash. Ordered by Judge Scott H Rash. (SHR, zk)(This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry.) (Entered: 01/22/2021)
01/25/2021	44	NOTICE of Service of Discovery filed by Jami Snyder. (King, Kathryn) (Entered: 01/25/2021)
01/25/2021	45	*MOTION for Extension of Time to Conduct Class Discovery and Respond to Plaintiff's Motion for Class Certification re: 40 Motion to Certify Class by Jami Snyder. (Attachments: # 1 Exhibit, # 2 Text of Proposed Order)(King, Kathryn) . *Modified to correct motion type, add motion type, and to correct reference to related document on 1/26/2021.(MFR) (Entered: 01/25/2021)
02/01/2021	46	REPLY to Response to Motion re: 40 MOTION to Certify Class , 45 MOTION for Extension of Time to Complete Discovery MOTION for Extension of Time to File Response/Reply filed by Susan Doe, Janice Hennessy-Waller. (Howe, Janet) (Entered: 02/01/2021)
02/04/2021	47	NOTICE re: Supplemental Authority by Jami Snyder . (Attachments: # 1 Exhibit)(King, Kathryn) (Entered: 02/04/2021)
02/05/2021	48	MINUTE ENTRY for proceedings held before Judge Scott H Rash: Preliminary Injunction Hearing held on 2/5/2021. After argument, IT IS ORDERED taking under advisement 3 Motion for Preliminary Injunction. APPEARANCES: Telephonic appearance by Asaf Off with Plaintiff Janice Hennessy-Waller and co-counsel Brent Ray, Andrew Chinsky, Daniel Barr, Catherine McKee, Abigail Coursolle, and Janet How for Plaintiffs. Telephonic appearance by Daniel Barton with co-counsel Kathryn King and Logan Johnston for Defendant. (Court Reporter Erica McQuillen.) Hearing held 10:05 am to 11:23 am. This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry. (SMJ) (Entered: 02/05/2021)
02/08/2021	49	TRANSCRIPT REQUEST by Jami Snyder for proceedings held on 02/05/2021, Judge Scott H Rash hearing judge(s). (King, Kathryn) (Entered: 02/08/2021)
02/08/2021	50	AMENDED DOCUMENT by Jami Snyder. Amendment to 49 Transcript Request . (King, Kathryn) (Entered: 02/08/2021)
02/08/2021	51	TRANSCRIPT REQUEST by Susan Doe, Janice Hennessy-Waller for proceedings held on February 5, 2021, Judge Scott H. Rash hearing judge(s). (Howe, Janet) (Entered: 02/08/2021)
02/08/2021	52	NOTICE TO FILER OF DEFICIENCY re: 50 Amended Document (NOT Motion/Complaint) filed by Jami Snyder. Incorrect event selected: AMENDED

ER585

		DOCUMENT found in the OTHER FILINGS category. Correct event: TRANSCRIPT REQUEST found in the OTHER FILINGS category. FOLLOW-UP ACTION REQUIRED: Please refile amended document in correct event. This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry. (NEC) (Entered: 02/08/2021)
02/08/2021	53	NOTICE TO FILER OF DEFICIENCY re: AO 435 51 Transcript Request filed by Janice Hennessy-Waller, Susan Doe. Item 17 - TRANSCRIPT REQUESTED: No dates of proceedings specified. FOLLOW-UP ACTION REQUIRED: Please refile with dates of proceedings in Item 17. This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry. (NEC) (Entered: 02/08/2021)
02/08/2021	54	AMENDED TRANSCRIPT REQUEST pursuant to 52 Notice of Deficiency by Jami Snyder for proceedings held on 2/5/2021, Judge Scott H Rash hearing judge(s). (King, Kathryn) (Entered: 02/08/2021)
02/08/2021	55	AMENDED TRANSCRIPT REQUEST pursuant to 53 Notice of Deficiency by Susan Doe, Janice Hennessy-Waller for proceedings held on 2/5/2021, Judge Scott H. Rash hearing judge(s). (Howe, Janet) (Entered: 02/08/2021)
02/08/2021	56	*REPLY to Response to Motion re: 45 MOTION for Extension of Time to Complete Discovery MOTION for Extension of Time to File Response/Reply filed by Jami Snyder. (Attachments: # 1 Exhibit Exhibits 1-2)(King, Kathryn) *Modified to correct event type and correct related document on 2/9/2021 (MYE). (Entered: 02/08/2021)
02/09/2021	57	NOTICE re: Supplemental Briefing by Jami Snyder . (King, Kathryn) (Entered: 02/09/2021)
02/09/2021	71	TRANSCRIPT of ORAL ARGUMENT held on 02/05/2021, before Judge Scott H. Rash. Court Reporter Erica R. McQuillen. The ordering party will have electronic access to the transcript immediately. All others may view the transcript at the court public terminal or it may be purchased through the Court Reporter by filing a Transcript Order Form on the docket before the deadline for Release of Transcript Restriction. After that date it may be obtained through PACER. Redaction Request due 3/2/2021. Redacted Transcript Deadline set for 3/12/2021. Release of Transcript Restriction set for 5/10/2021. (NEC) (Entered: 04/21/2021)
02/10/2021	58	MOTION for Leave to File Supplemental Brief <i>in Support of Motion for Preliminary Injunction on Administrative Appeals and Exhaustion of Remedies</i> by Susan Doe, Janice Hennessy-Waller. (Attachments: # 1 Exhibit A, # 2 Text of Proposed Order)(Barr, Daniel) (Entered: 02/10/2021)
02/10/2021	59	*FILED at Doc. 62 - LODGED Proposed Supplemental Brief in Support of Motion for Preliminary Injunction re: 58 MOTION for Leave to File Supplemental Brief <i>in Support of Motion for Preliminary Injunction on Administrative Appeals and Exhaustion of Remedies</i> . Document to be filed by Clerk if Motion or Stipulation for Leave to File or Amend is granted. Filed by Susan Doe, Janice Hennessy-Waller. (Barr, Daniel) Modified on 2/18/2021 (MYE). (Entered: 02/10/2021)
02/17/2021	60	NOTICE re: Defendant's Second Notice of Supplemental Briefing by Jami Snyder . (Barton, David) (Entered: 02/17/2021)
02/18/2021	61	ORDERED Plaintiffs' motion (Doc. 58) is GRANTED and their lodged Supplemental Brief in Support of Motion for Preliminary Injunction (Doc. 59) is accepted. IT IS FURTHER ORDERED that Defendant Jami Snyder shall file her response to Plaintiff's Supplemental Brief on or before Thursday, March 4, 2021. No reply will be permitted. Signed by Judge Scott H Rash on 2/18/21. (MYE) (Entered: 02/18/2021)
02/18/2021	62	SUPPLEMENTAL Brief in Support of Motion for Preliminary Injunction re: 3 MOTION

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		for Preliminary Injunction by Plaintiffs Susan Doe, Janice Hennessy-Waller. (Barr, Daniel) (MYE) (Entered: 02/18/2021)
03/01/2021	63	NOTICE of Service of Discovery filed by Jami Snyder. (King, Kathryn) (Entered: 03/01/2021)
03/04/2021	64	RESPONSE re: 62 Supplement (<i>Plaintiff's</i>) <i>Brief in Support of Motion for Preliminary Injunction</i> by Defendant Jami Snyder. (Attachments: # 1 Exhibit)(Barton, David) (Entered: 03/04/2021)
03/29/2021	65	NOTICE of Service of Discovery filed by Jami Snyder. (King, Kathryn) (Entered: 03/29/2021)
03/30/2021	66	ORDERED Plaintiff's Motion for Preliminary Injunction (Doc. 3) is DENIED. Signed by Judge Scott H Rash on 3/30/21. (MYE) (Entered: 03/30/2021)
04/15/2021	67	NOTICE re: Preliminary Injunction Appeal by Susan Doe, Janice Hennessy-Waller . (Attachments: # 1 Exhibit 9th Circuit Representation Form)(Barr, Daniel) (Entered: 04/15/2021)
04/16/2021	68	NOTICE OF INTERLOCUTORY APPEAL to 9th Circuit Court of Appeals re: 66 Order on Motion for Preliminary Injunction by Susan Doe, Janice Hennessy-Waller. Filing fee received: \$ 505.00, receipt number 0970-19369149. (Attachments: # 1 Exhibit Form 6 Representation Statement)(Barr, Daniel) (Entered: 04/16/2021)
04/19/2021	69	USCA Case Number re: 68 Notice of Interlocutory Appeal. Case number 21-15668, 9th CCA. (KAH) (Entered: 04/19/2021)
04/19/2021	70	*MOTION for Hearing re: Joint Request for Status Conference by Plaintiffs Susan Doe, Janice Hennessy-Waller. (Howe, Janet) *Modified to add motion type on 4/20/2021 (MYE). (Entered: 04/19/2021)
04/27/2021	72	ORDER granting the parties' 70 Joint Request for Status Conference. IT IS ORDERED a thirty-minute status conference is set for Tuesday, May 4, 2021 at 10:30 A.M. before the Honorable Scott H. Rash. The parties shall appear telephonically and shall call 888-363-4735 at the EXACT time of the hearing. The access code is 2872694. Signed by Judge Scott H Rash on 4/27/21. (MYE) (Entered: 04/27/2021)
05/04/2021	73	NOTICE of Service of Discovery filed by Jami Snyder. (Attachments: # 1 Exhibit)(King, Kathryn) (Entered: 05/04/2021)
05/04/2021	76	MINUTE ENTRY for proceedings held before Judge Scott H Rash: Status Conference held on 5/4/2021. Order to issue. APPEARANCES: Telephonic appearance by Brent Ray with Andrew Chinsky for Plaintiffs. Telephonic appearance by Kathryn King with Logan Johnston for Defendant. (Court Reporter Anni Bryan.) Hearing held 10:32 am to 11:18 am. This is a TEXT ENTRY ONLY. There is no PDF document associated with this entry. (SMJ) (Entered: 05/06/2021)
05/05/2021	74	ORDERED Defendant's Motion for Time to Conduct Class Discovery and Respond to Plaintiffs' Motion for Class Certification (Doc. 45) is GRANTED in-part, to the extent this Order requires the parties to focus first on discovery related to class certification and therefore provides Defendant with additional time to respond to Plaintiffs' Motion for Class Certification, and is DENIED in all other respects. IT IS FURTHER ORDERED a thirty-minute telephonic status conference is set for Monday, August 9, 2021 at 11:00 A.M. before the Honorable Scott H. Rash. The parties shall appear telephonically and shall call 888-363-4735 at the EXACT time of the hearing. The access code is 2872694. IT IS

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		FURTHER ORDERED the parties shall file a joint status report on or before Monday, August 2, 2021. Signed by Judge Scott H Rash on 5/4/21. (MYE) (Entered: 05/05/2021)
05/06/2021	75	NOTICE of Service of Discovery filed by Jami Snyder. (Attachments: # 1 Exhibit)(King, Kathryn) (Entered: 05/06/2021)
05/07/2021	77	NOTICE of Service of Discovery filed by Jami Snyder. (King, Kathryn) (Entered: 05/07/2021)

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