Pl. Trial Ex. 075

NCTSN The National Child Traumatic Stress Network

# Gender-Affirming Care Is Trauma-Informed Care

Major medical associations recognize gender-affirming care as the standard of care for transgender, gender diverse, and intersex (TGI) youth. Gender-affirming care broadly refers to creating an environment that facilitates youth to move through the world safely as the gender they know themselves to be. This includes developmentally appropriate, evidence-based care provided by medical and mental health experts in partnership with youth, parents, and caregivers. It may include evidence-based interventions such as puberty blockers and gender-affirming hormones. Gender-affirming care also includes access to opportunities that all children should have, such as playing team sports, safely using bathrooms in their schools and other public places, and positive relationships with supportive adults.

Providing gender-affirming care is neither child maltreatment nor malpractice. The child welfare system in the US, charged with "improv(ing) the overall health and well-being of our nation's children and families,"[1] should not be used to deny care or separate families working to make the best decisions for their children's well-being. There is no scientifically sound research showing negative impacts from providing gender-affirming care. The decision for the child welfare system to become involved in the lives of families, potentially to the extent of removing children from their families and homes, should be wielded with the utmost care, grounded in evidence, and always prioritizing the well-being of children and preservation of families.

It has been well-documented that TGI youth experience trauma, discrimination, and health disparities at higher rates than their cisgender peers, including disproportionate rates of negative behavioral health outcomes and higher rates of attempted suicide.[2,3] Trauma exposure for TGI youth also includes the trauma of experiencing oppression when their identities are rejected by individuals in their lives, in their communities, or in the broader public. Alternatively, affirmation from families has been shown to be a protective factor against attempted suicide, depression, substance misuse, and other negative health outcomes.[4] Consistently using youth's chosen names and pronouns reduces suicidality and depression.[5] Gender-affirming medical care, particularly puberty blockers and gender-affirming hormones, reduces rates of depression, suicidal ideation, and other serious behavioral health outcomes.[6]

TGI youth can thrive when they are supported and affirmed in their identities and their identity development, when they have open and affirming school environments where they can talk about their experiences, and when their families are resourced to make the best evidence-based care decisions in collaboration with their providers. We have the tools to increase TGI youth's current social, emotional, and physical well-being and to support them to imagine and experience a future in which they can thrive and live full, happy lives. You can help keep TGI youth safe by expressing your support and acceptance and finding ways to partner with others to create affirming and supportive environments. Here are some practical suggestions for what you can do:

- **Take responsibility for your own knowledge and understanding of gender diversity** by staying up-to-date on evidence-based research and best practice, attending trainings, and reading work by transgender and gender diverse writers to understand more about the language and experiences of TGI youth. This will enable you to better establish safety, build trust, and provide better quality care. Recognize that despite what you've learned, you may not always be sure what something means, especially related to an individual's identities or experiences. It is okay to ask in a respectful and genuine manner.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

- **Believe and validate youth when they share their gender identities with you** by always using and validating the names, pronouns, and identities that youth share with you, even if those change while they are exploring their identities. Many children are aware of their own gender identity as early as 3-5 years old,[7,8] although it is also common for children to explore gender identity at later ages. Cisgender children are trusted to know and understand their gender, and social norms and customs validate their identities regularly. TGI youth deserve the same trust and validation. As parents, caregivers, and providers, you are responsible to communicate this validation by actively affirming their identities.

- **Avoid assumptions and misinformation by familiarizing yourself with how medical experts define the standard of care for transgender youth and what these treatments entail.** Seek reliable sources such as the World Professional Association for Transgender Health, American Academy for Child and Adolescent Psychiatry, and the American Academy of Pediatrics. Be prepared to share information, resources, and research with families as they decide how to achieve their care goals.

- **Proactively seek out and build relationships with local service providers who specialize in care for TGI youth in order to create a supportive network and provide reliable referrals to TGI youth and their families.** These services are not accessible in every community, and virtual/telehealth connections may be necessary to create a supportive network. Identify the nearest places to you where youth and their families can access this care, including resources to help address added travel burdens or reliable internet access limitations.

- **Prioritize using resources created by transgender and gender diverse experts** by identifying and connecting with transgender and gender diverse providers and organizations- nationally and in your community as partners and trainers. Make sure to compensate these experts for their resources equitably.

- **Recognize your responsibility to actively ensure that your space accepts and affirms TGI youth, both as an organization and an individual provider.** This includes reviewing your practices, policies, and paperwork for bias, ensuring all staff are trained, and being proactive and consistent when communicating with youth and families about trust, confidentiality, and clients' rights.

- **Stay up-to-date with national and local policies and protections related to gender-affirming care to ensure youth and their families understand their rights.** Be aware of how public discourse and changing legislation may create or exacerbate confusion and mistrust about healthcare services, systems, and providers. Communicate with TGI youth and families about their rights and risks in their communities and the resources available to them.

- **Be mindful that young people are aware of the national conversations about access to gender-affirming care and the rights of LGBTQ+ youth**, and acknowledge that any feelings or fears that arise from witnessing prejudice towards LGBTQ+ youth are valid. Be prepared to offer a space for them to process, ask questions, and plan for their safety.

- **Create space for youth to explore the fullness of their gender and other cultural identities without fear of judgment or harm.** Recognize how intersecting marginalized identities—including race, ethnicity, religion, ability, socioeconomic status, and mental health status—can reduce access and amplify the impact of rejection and fear of consequences for accessing gender-affirming care.

- **Assist youth, parents, and caregivers with family safety planning by helping them create a "safe folder."** This folder can include letters from providers (e.g., medical, mental health) and community members (e.g., neighbors, spiritual leaders, school representatives) communicating that parents/ caregivers are not harming their child and that the child is benefitting from their care. Parents and caregivers can use this folder should they need to justify the affirming and supportive care they are providing for their child.

- **Communicate to TGI youth and families that many people are working hard to support them and make sure they have access to the care they need and deserve.** TGI youth need to know they are not alone and that there are supportive adults who care about them and are working hard to make sure their needs can be met.

- **Support and empower young people and their families to take action** by encouraging them to connect with culturally affirming peer communities for mutual support and to take part in local or national advocacy efforts. Advocacy, especially in community, can be a core aspect of healing from collective and oppression-based trauma.

- **Educate your community partners (e.g., child welfare, schools), policymakers, and the general public by sharing resources and information about gender-affirming care and offering or hosting trainings.** Research and share information about the positive, protective impacts of gender-affirming care for children and families. Share the benefits and savings to our healthcare and child welfare systems when we prevent negative health outcomes and preserve families.[9] Provide resources created by transgender and gender diverse experts, and offer opportunities to amplify their work by inviting them as trainers or speakers. As always, equitably compensate transgender and gender-diverse experts for their work.

- **Keep working to recognize and shift your own biases and assumptions** by continually asking yourself questions about the power and privilege you have based on your own gender identity, sexual orientation, race, provider status, and other aspects of your intersectional identities. Support and challenge your colleagues and collaborative partners to do the same, and build spaces to explore layers of seen and unseen privilege and oppression.

- **Be aware of the impact on you or your colleagues who are providing gender-affirming care and who themselves or whose loved ones hold transgender and gender diverse identities.** Acknowledge and honor the weight of witnessing and bearing the pain and anxiety experienced by the children and families served as well as the personal impact.

**Relevant NCTSN resources include:**

- Affirming Care for Transgender and Gender Expansive Youth (webinar)
- Identifying the Intersection of Trauma and Sexual Orientation and Gender Identity:
  - Part 1: Key Considerations
  - Part 2: The Screener
  - Webinar
- Engaging Families in Affirming Trauma-Informed Care for LGBTQ Children and Youth (webinar)

- Safe Places, Safe Spaces: Creating Welcoming and Inclusive Environments for Traumatized LGBTQ Youth
  - Resource Guide
  - Video
  - Webinar
- Assisting Parents/Caregivers in Coping with Collective Traumas
- Other NCTSN resources to support LGBTQ+ youth and provide affirming care can be accessed: https://www.nctsn.org/what-is-child-trauma/populations-at-risk/lgbtq-youth

**Additional Partner Resources**

- Statement by HHS Secretary Xavier Becerra Reaffirming HHS Support and Protection for LGBTQI+ Children and Youth
- American Academy of Child & Adolescent Psychiatry: Clinical Guidelines & Training for Pro viders, Professionals, and Trainees
- Trans Lifeline
- National SOGIE Center
- Family Acceptance Project
- A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children
- Gender Spectrum Education and Training
- Trans Student Educational Resources
- American Academy of Child & Adolescent Psychiatry Gender and Sexuality Resources
- Human Rights Campaign: All Children-All Families
- The Trevor Project

It is critically important that TGI youth know many adults are working hard to ensure their safety and access to gender-affirming care. In order to have hope for the future and to foster resilience, TGI youth need to experience an equally high level of support, empowerment, and affirmation in response to the disparaging and discriminatory public scrutiny they encounter in their communities and more widely in the public. Actively vocal and affirming adults can make a big difference to build a sense of safety and belonging, creating communities where TGI youth can thrive.

**Suggested Citation:** Clarke, M., Farnan, A., Barba, A., Giovanni, K., Brymer, M. & Julian, J., (2022). *Gender-Affirming Care Is Trauma-Informed Care.* Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

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# End Notes


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AUTHENTICATED U.S. GOVERNMENT INFORMATION GPO

Federal Register / Vol. 87, No. 63 / Friday, April 1, 2022 / Presidential Documents 19349

# Presidential Documents

Pl. Trial Ex. 076

**Proclamation 10355 of March 30, 2022**

## Transgender Day of Visibility, 2022

**By the President of the United States of America**

**A Proclamation**

To everyone celebrating Transgender Day of Visibility, I want you to know that your President sees you. The First Lady, the Vice President, the Second Gentleman, and my entire Administration see you for who you are—made in the image of God and deserving of dignity, respect, and support. On this day and every day, we recognize the resilience, strength, and joy of transgender, nonbinary, and gender nonconforming people. We celebrate the activism and determination that have fueled the fight for transgender equality. We acknowledge the adversity and discrimination that the transgender community continues to face across our Nation and around the world.

Visibility matters, and so many transgender, nonbinary, and gender nonconforming Americans are thriving. Like never before, they are sharing their stories in books and magazines; breaking glass ceilings of representation on television and movie screens; enlisting—once again—to serve proudly and openly in our military; getting elected and making policy at every level of government; and running businesses, curing diseases, and serving our communities in countless other ways.

Despite this progress, transgender Americans continue to face discrimination, harassment, and barriers to opportunity. Transgender women and girls—especially transgender women and girls of color—continue to face epidemic levels of violence, and 2021 marked the deadliest year on record for transgender Americans. Each of these lives lost was precious. Each of them deserved freedom, justice, and joy. We must honor their lives with action by advancing equity and civil rights for all transgender people.

In the past year, hundreds of anti-transgender bills in States were proposed across America, most of them targeting transgender kids. The onslaught has continued this year. These bills are wrong. Efforts to criminalize supportive medical care for transgender kids, to ban transgender children from playing sports, and to outlaw discussing LGBTQI+ people in schools undermine their humanity and corrode our Nation's values. Studies have shown that these political attacks are damaging to the mental health and well-being of transgender youth, putting children and their families at greater risk of bullying and discrimination.

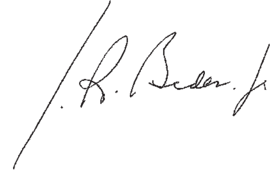
My entire Administration is committed to ensuring that transgender people enjoy the freedom and equality that are promised to everyone in America. That is why I signed an Executive Order Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation. We are expanding Federal non-discrimination protections; promoting strategies to address violence against the transgender community and advance gender equity and equality; and disseminating new resources to enhance inclusion, opportunity, and safety for transgender people. Additionally, Americans will soon be able to select more inclusive gender markers on their passports. I continue to call on the Congress to swiftly pass the bipartisan Equality Act, which will ensure that LGBTQI+ individuals and families cannot be denied housing, employment, education, credit, and more because of who they are or who

they love. We will continue to work to help transgender people around the world live free from discrimination and violence.

On this Transgender Day of Visibility, we honor transgender people who are fighting for freedom, equality, dignity, and respect. We also celebrate the parents, teachers, coaches, doctors, and other allies who affirm the identities of their transgender children and help these young people reach their potential. Transgender people are some of the bravest Americans I know, and our Nation and the world are stronger, more vibrant, and more prosperous because of them. To transgender Americans of all ages, I want you to know that you are so brave. You belong. I have your back.

NOW, THEREFORE, I, JOSEPH R. BIDEN JR., President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim March 31, 2022, as Transgender Day of Visibility. I call upon all Americans to join us in lifting up the lives and voices of transgender people throughout our Nation and to work toward eliminating discrimination against all transgender, gender nonconforming, and nonbinary people—and all people.

IN WITNESS WHEREOF, I have hereunto set my hand this thirtieth day of March, in the year of our Lord two thousand twenty-two, and of the Independence of the United States of America the two hundred and forty-sixth.



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# Presidential Documents

Pl. Trial Ex. 077

**Proclamation 10538 of March 30, 2023**

## Transgender Day of Visibility, 2023

**By the President of the United States of America**

**A Proclamation**

Transgender Day of Visibility celebrates the joy, strength, and absolute courage of some of the bravest people I know—people who have too often had to put their jobs, relationships, and lives on the line just to be their true selves. Today, we show millions of transgender and nonbinary Americans that we see them, they belong, and they should be treated with dignity and respect. Their courage has given countless others strength, but no one should have to be brave just to be themselves. Every American deserves that freedom.

Transgender Americans shape our Nation's soul—proudly serving in the military, curing deadly diseases, holding elected office, running thriving businesses, fighting for justice, raising families, and much more. As kids, they deserve what every child deserves: the chance to learn in safe and supportive schools, to develop meaningful friendships, and to live openly and honestly. As adults, they deserve the same rights enjoyed by every American, including equal access to health care, housing, and jobs and the chance to age with grace as senior citizens. But today, too many transgender Americans are still denied those rights and freedoms. A wave of discriminatory State laws is targeting transgender youth, terrifying families and hurting kids who are not hurting anyone. An epidemic of violence against transgender women and girls, in particular women and girls of color, has taken lives far too soon. Last year's Club Q shooting in Colorado was another painful example of this kind of violence—a stain on the conscience of our Nation.

My Administration has fought to end these injustices from day one, working to ensure that transgender people and the entire LGBTQI+ community can live openly and safely. On my first day as President, I issued an Executive Order directing the Federal Government to root out discrimination against LGBTQI+ people and their families. We have appointed a record number of openly LGBTQI+ leaders, and I was proud to rescind the ban on openly transgender people serving in the military. We are also working to make public spaces and travel more accessible, including with more inclusive gender markers on United States passports. We are improving access to public services and entitlements like Social Security. We are cracking down on discrimination in housing and education. And last December, I signed the Respect for Marriage Act into law, ensuring that every American can marry the person they love and have that marriage accepted, period.

Meanwhile, we are also working to ease the tremendous strain that discrimination, bullying, and harassment can put on transgender children—more than half of whom seriously considered suicide in the last year. The Department of Education is, for example, helping ensure that transgender students have equal opportunities to learn and thrive at school, and the Department of Justice is pushing back against extreme laws that seek to ban evidence-based gender-affirming health care.

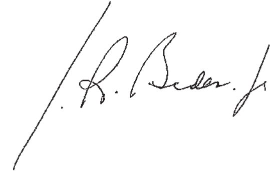
There is much more to do. I continue to call on the Congress to finally pass the Equality Act and extend long-overdue civil rights protections to all LGBTQI+ Americans to ensure they can live with safety and dignity.

Together, we also have to keep challenging the hundreds of hateful State laws that have been introduced across the country, making sure every child knows that they are made in the image of God, that they are loved, and that we are standing up for them.

America is founded on the idea that all people are created equal and deserve to be treated equally throughout their lives. We have never fully lived up to that, but we have never walked away from it either. Today, as we celebrate transgender people, we also celebrate every American's fundamental right to be themselves, bringing us closer to realizing America's full promise.

NOW, THEREFORE, I, JOSEPH R. BIDEN JR., President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim March 31, 2023, as Transgender Day of Visibility. I call upon all Americans to join us in lifting up the lives and voices of transgender people throughout our Nation and to work toward eliminating violence and discrimination against all transgender, gender nonconforming, and nonbinary people.

IN WITNESS WHEREOF, I have hereunto set my hand this thirtieth day of March, in the year of our Lord two thousand twenty-three, and of the Independence of the United States of America the two hundred and forty-seventh.



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# Presidential Documents

Pl. Trial Ex. 078

**Executive Order 13988 of January 20, 2021**

## Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

**Section 1**. *Policy*. Every person should be treated with respect and dignity and should be able to live without fear, no matter who they are or whom they love. Children should be able to learn without worrying about whether they will be denied access to the restroom, the locker room, or school sports. Adults should be able to earn a living and pursue a vocation knowing that they will not be fired, demoted, or mistreated because of whom they go home to or because how they dress does not conform to sex-based stereotypes. People should be able to access healthcare and secure a roof over their heads without being subjected to sex discrimination. All persons should receive equal treatment under the law, no matter their gender identity or sexual orientation.

These principles are reflected in the Constitution, which promises equal protection of the laws. These principles are also enshrined in our Nation's anti-discrimination laws, among them Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. 2000e *et seq.*). In *Bostock* v. *Clayton County*, 590 U.S.__(2020), the Supreme Court held that Title VII's prohibition on discrimination "because of . . . sex" covers discrimination on the basis of gender identity and sexual orientation. Under *Bostock's* reasoning, laws that prohibit sex discrimination—including Title IX of the Education Amendments of 1972, as amended (20 U.S.C. 1681 *et seq.*), the Fair Housing Act, as amended (42 U.S.C. 3601 *et seq.*), and section 412 of the Immigration and Nationality Act, as amended (8 U.S.C. 1522), along with their respective implementing regulations—prohibit discrimination on the basis of gender identity or sexual orientation, so long as the laws do not contain sufficient indications to the contrary.

Discrimination on the basis of gender identity or sexual orientation manifests differently for different individuals, and it often overlaps with other forms of prohibited discrimination, including discrimination on the basis of race or disability. For example, transgender Black Americans face unconscionably high levels of workplace discrimination, homelessness, and violence, including fatal violence.

It is the policy of my Administration to prevent and combat discrimination on the basis of gender identity or sexual orientation, and to fully enforce Title VII and other laws that prohibit discrimination on the basis of gender identity or sexual orientation. It is also the policy of my Administration to address overlapping forms of discrimination.

**Sec. 2**. *Enforcing Prohibitions on Sex Discrimination on the Basis of Gender Identity or Sexual Orientation.* (a) The head of each agency shall, as soon as practicable and in consultation with the Attorney General, as appropriate, review all existing orders, regulations, guidance documents, policies, programs, or other agency actions ("agency actions") that:

(i) were promulgated or are administered by the agency under Title VII or any other statute or regulation that prohibits sex discrimination, including any that relate to the agency's own compliance with such statutes or regulations; and

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(ii) are or may be inconsistent with the policy set forth in section 1 of this order.

(b) The head of each agency shall, as soon as practicable and as appropriate and consistent with applicable law, including the Administrative Procedure Act (5 U.S.C. 551 *et seq.*), consider whether to revise, suspend, or rescind such agency actions, or promulgate new agency actions, as necessary to fully implement statutes that prohibit sex discrimination and the policy set forth in section 1 of this order.

(c) The head of each agency shall, as soon as practicable, also consider whether there are additional actions that the agency should take to ensure that it is fully implementing the policy set forth in section 1 of this order. If an agency takes an action described in this subsection or subsection (b) of this section, it shall seek to ensure that it is accounting for, and taking appropriate steps to combat, overlapping forms of discrimination, such as discrimination on the basis of race or disability.

(d) Within 100 days of the date of this order, the head of each agency shall develop, in consultation with the Attorney General, as appropriate, a plan to carry out actions that the agency has identified pursuant to subsections (b) and (c) of this section, as appropriate and consistent with applicable law.

**Sec. 3**. *Definition.* ''Agency'' means any authority of the United States that is an ''agency'' under 44 U.S.C. 3502(1), other than those considered to be independent regulatory agencies, as defined in 44 U.S.C. 3502(5).

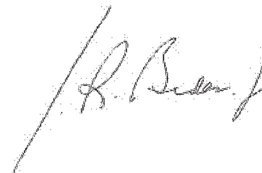
**Sec. 4**. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

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

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

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

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



THE WHITE HOUSE,
*January 20, 2021.*

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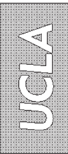


RESEARCH THAT MATTERS

# MEDICAID COVERAGE FOR GENDER-AFFIRMING CARE

DECEMBER 2022

Christy Mallory
Will Tentindo

Pl. Trial Ex. 079

# EXECUTIVE SUMMARY

Medicaid beneficiaries who are transgender face a patchwork of policies across the U.S. that leave many of them without access to coverage for gender-affirming care. Half of the states and D.C. specifically include coverage for gender-affirming care under their Medicaid programs or are in the process of extending coverage, while seven states expressly exclude coverage for such care. Coverage is unclear in 18 states. Gender-affirming care includes a range of services, such as hormone therapy, surgical procedures, and other forms of treatment related to gender transition.

The Williams Institute estimates that

- 1.3 million adults in the U.S. identify as transgender and approximately 276,000 of them are enrolled in Medicaid.
- Sixty percent (164,000) of transgender Medicaid beneficiaries have affirmative access to coverage for gender-affirming care under express policies in state law.
- For 27% (74,000) of transgender Medicaid beneficiaries, coverage is uncertain because they live in states where the laws are silent or unclear on coverage for gender-affirming care.
- Fourteen percent (38,000) of transgender Medicaid beneficiaries live in states with express bans that deny access to covered gender-affirming care.

Despite inconsistent coverage across the U.S., a number of federal and state laws and policies support access to gender-affirming care through Medicaid programs. At the federal level, these laws and policies include statutes, like the Affordable Care Act and the Medicaid Act, as well as the U.S. Constitution. In addition, a number of state-level non-discrimination statutes and constitutional provisions support access to care. Bans have been successfully challenged in court under these laws in several states, resulting in changes to Medicaid policies that have increased care and coverage for transgender beneficiaries.

Additional policy changes in states that still have bans or lack clear language addressing coverage would ensure that transgender Medicaid beneficiaries have access to coverage for gender-affirming medical care no matter where they live. In addition, more transgender people could benefit from Medicaid-covered services if all states adopted Medicaid expansion and if barriers to accessing public benefits, such as requirements pertaining to identity documents, were removed.

# COVERAGE FOR GENDER-AFFIRMING CARE IN STATE MEDICAID PROGRAMS

Medicaid is a federally mandated program, implemented by states, which ensures access to health care for adults and children living in low-income households who qualify.[1] The program is funded with a combination of federal and state funds.[2] States must implement their Medicaid programs consistent with federal law, though they retain some flexibility in the design and administration of their programs, including setting eligibility criteria.[3]

Federal law does not currently expressly direct states to either include or exclude coverage for gender-affirming care under their state Medicaid programs.[4] Some states have chosen to specifically include coverage for gender-affirming care under their Medicaid programs, while other states exclude such care or have not expressly addressed coverage, creating a patchwork of policies affecting transgender Medicaid beneficiaries across the U.S.

## STATES WITH AFFIRMATIVE COVERAGE FOR GENDER-AFFIRMING CARE

Twenty-five states and D.C. expressly include coverage for gender-affirming care under their Medicaid programs, either by statute or administrative policy, or are in the process of extending coverage. More specifically, 23 states already expressly include coverage for gender-affirming care: Alaska, California, Colorado, Connecticut, Delaware, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and Wisconsin. One additional state, Georgia, is obligated to extend coverage for gender-affirming care as a result of a settlement agreement reached in a court case and has removed exclusions on gender-affirming care from its state Medicaid Plan. Similarly, in Iowa, a court recently declared unconstitutional the state's exclusion of gender-affirming care in its Medicaid program, but the state has not yet issued an affirmative policy stating that that care is covered. All of these policies have been adopted within the past decade, with Vermont being the first state to issue this type of policy in 2008. The policies ensure that transgender Medicaid beneficiaries have access to a range of gender-affirming care, including gender-affirming surgery and hormone treatment, though there may be some forms of gender-affirming care that are not included in the policies. For further details on state policies, see Appendix A.

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[1] Ctr. for Medicare & Medicaid Servs., U.S. Dep't. of Health & Human Servs., *Program History*, Medicaid.gov, https://www.medicaid.gov/about-us/program-history/index.html (last visited Oct. 21, 2022).

[2] Ctr. for Medicare & Medicaid Servs., U.S. Dep't. of Health & Human Servs., *Financial Management*, Medicaid.gov, https://www.medicaid.gov/medicaid/financial-management/index.html (last visited Oct. 21, 2022).

[3] *See, e.g.*, Ctr. for Medicare & Medicaid Servs., U.S. Dep't. of Health & Human Servs., *Eligibility*, Medicaid.gov, https://www.medicaid.gov/medicaid/eligibility/index.html (last visited Oct. 21, 2022).

[4] For benefits that states are required to provide under federal law, see Ctr. for Medicare & Medicaid Servs., U.S. Dep't. of Health & Human Servs., *Mandatory & Optional Medicaid Benefits*, Medicaid.gov, https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html (last visited Aug. 15, 2019).

## STATES WHERE THE LAW IS SILENT OR UNCLEAR ON COVERAGE FOR GENDER-AFFIRMING CARE

In 18 states, it is unclear whether transgender Medicaid beneficiaries have access to gender-affirming care either because the law is silent on coverage or because the state maintains a ban, but enforcement of the ban is unclear. Fourteen states have no express statute or administrative policy addressing coverage for gender-affirming care under their Medicaid programs: Alabama, Arkansas,[5] Idaho,[6] Indiana, Kansas, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Dakota, Utah, and Virginia. Three additional states, Hawaii,[7] Ohio,[8] and Wyoming,[9] maintain policies that explicitly exclude coverage for gender-affirming care under their state Medicaid programs, but recent actions by state legislatures or officials indicate that the states may not currently be enforcing these policies. As a result, coverage is uncertain in these three states. Similarly, it is unclear whether West Virginia's exclusion is currently being enforced. West Virginia's Medicaid Provider Manual, last issued by the West Virginia Bureau of Medical Services in 2005, expressly excludes "transsexual surgery" from Medicaid coverage.[10] In August 2022, a federal district court declared the exclusion unconstitutional and a violation of the Affordable Care Act and the Medicaid Act.[11] However, West Virginia filed an appeal in the Fourth Circuit on September 6, 2022.[12] Due to ongoing litigation in the state, coverage for gender-affirming care under the state's Medicaid program is uncertain.

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[5] In 2021, the Arkansas legislature enacted a ban on Medicaid coverage for gender-affirming care for minors. Ark. Code § 20-9-1503 (2022). The law does not address Medicaid coverage for gender-affirming care for adults and no other laws or policies in the state either expressly provide or ban such coverage for adults.

[6] A lawsuit filed in Idaho in 2022 indicates that the state's Medicaid program considers surgery related to gender transition a cosmetic procedure excluded from coverage, though this policy is not clearly stated in any official policies or guidance implementing the state Medicaid program. Complaint, MH & TB v. Jeppesen et al., No. 1:22-CV-409 (D. Idaho Sept. 29, 2022).

[7] The Hawaii Department of Human Services maintains a policy that generally excludes gender-affirming care from coverage under the state Medicaid program, which includes medical treatments, surgical procedures, hormones, and other medications, though it does allow coverage specifically for medication related to gender transition if the beneficiary has a court order affirming his or her gender change. Haw. Admin. R. § 17-1737-84 (2022). However, in 2022, the state legislature passed a bill prohibiting categorical exclusions for gender-affirming care under any "individual or group accident and health or sickness policy, contract, plan, or agreement that provides health care coverage." Haw. Rev. Stat. §§ 431:10A-118.3, 432D-26.3, 432:1-607.3 (2022). Although the bill does not expressly address coverage under the state's Medicaid program, the law is broad in scope and may prohibit Medicaid from denying coverage for gender-affirming care.

[8] Ohio Admin. Code 5160-2-03(A)(2)(e) (2022); Michael Ollove, *States Diverge on Transgender Healthcare*, Stateline by Pew (July 19, 2019) https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/07/17/states-diverge-on-transgender-health-care.

[9] 048-0037-26 Wyo. Code R. § 5(a)(xxiv) (2022); Ollove, *supra* note 8.

[10] *West Virginia Medicaid Provider Manual*, W. Va. Dep't. Health & Hum. Resources, at § 161 (Jan. 1, 2005), https://dhhr.wv.gov/bms/Provider/Documents/Manuals/bms_manuals_Chapter_100.pdf.

[11] Fain v. Crouch, _ F. Supp. 3d _, 2022 WL 3051015 (S.D. W. Va. 2022).

[12] Fain v. Crouch, No. 22-1927 (4th Cir.), Dkt. No. 2, https://files.eqcf.org/wp-content/uploads/2022/09/2-Fain-Docketing-Notice.pdf.

Although these 18 states lack policies clearly stating that gender-affirming care is covered, services may still be approved for coverage. Transgender people in a few of these states have reported being able to access Medicaid coverage for some types of gender-affirming care. But even in these states, transgender beneficiaries report experiencing significant barriers, such as being denied coverage for certain treatments or having different doctors provide different information pertaining to coverage, that likely would not be present if an express policy providing for coverage were in place.[13]

## STATES WITH EXPRESS BANS ON COVERAGE FOR GENDER-AFFIRMING CARE

Seven states have express bans that deny access to coverage for gender-affirming care under their Medicaid programs. These seven states are Arizona, Florida, Missouri, Nebraska, South Carolina, Tennessee, and Texas. Most of these policies specifically exclude coverage for transition-related surgeries. However, some policies are more broadly written and may also exclude hormone treatment and other types of gender-affirming care. For further details on state policies, see Appendix A.

[13] *See, e.g.*, Orion Rummler, *Health Care for Transgender Adults Remains Legal, but States are Quietly Trying to Limit Access*, 19th News (Oct. 3, 2022), https://19thnews.org/2022/10/transgender-healthcare-adults-limit-restrict/l. *See also* Leslie Newell Peacock, *The Real Transgender Crisis in Arkansas: Health Care*, ARK. TIMES (May 11, 2017), https://arktimes.com/news/cover-stories/2017/05/11/the-real-transgender-crisis-in-arkansas-health-care (narrative of difficulties obtaining care prior to Arkansas' gender-affirming care ban for minors).

# IMPACT OF LAWS ADDRESSING MEDICAID COVERAGE

## NUMBER OF TRANSGENDER ADULTS ENROLLED IN MEDICAID

Using the best available data, we estimate that 276,000 transgender adults in the U.S. are enrolled in Medicaid. Sixty percent (164,000) of transgender Medicaid beneficiaries have guaranteed access to coverage for gender-affirming care under express policies in state law. For around 27% (74,000) of transgender Medicaid beneficiaries, coverage is uncertain because they live in states where the laws addressing coverage are silent or unclear on Medicaid coverage for gender-affirming care. Fourteen percent (38,000) of transgender Medicaid beneficiaries live in states with express bans that deny access to covered gender-affirming care.

**Table 1. Medicaid enrollment of transgender adults, by state**

| STATE | NUMBER OF TRANSGENDER ADULTS | TRANSGENDER ADULTS ENROLLED IN MEDICAID BY COVERAGE FOR GENDER-AFFIRMING CARE | | |
|---|---|---|---|---|
| | | GENDER-AFFIRMING CARE COVERED | GENDER-AFFIRMING CARE NOT COVERED | SILENT OR UNCLEAR POLICY ON GENDER-AFFIRMING CARE |
| Alabama | 18,400 | | | 3,000 |
| Alaska | 3,900 | 1,000 | | |
| Arizona | 41,200 | | 7,000 | |
| Arkansas | 16,200 | | | 4,000 |
| California | 150,100 | 36,000 | | |
| Colorado | 27,000 | 6,000 | | |
| Connecticut | 15,300 | 4,000 | | |
| Delaware | 6,300 | 2,000 | | |
| DC | 5,300 | 1,000 | | |
| Florida | 94,900 | | 12,000 | |
| Georgia | 48,700 | 6,000 | | |
| Hawaii | 7,800 | | | 2,000 |
| Idaho | 7,000 | | | 1,000 |
| Illinois | 43,400 | 9,000 | | |
| Indiana | 25,800 | | | 6,000 |
| Iowa | 7,100 | 2,000 | | |
| Kansas | 12,400 | | | 2,000 |
| Kentucky | 17,700 | | | 6,000 |
| Louisiana | 15,700 | | | 5,000 |
| Maine | 5,900 | 1,000 | | |
| Maryland | 24,000 | 6,000 | | |
| Massachusetts | 37,100 | 7,000 | | |
| Michigan | 33,000 | 9,000 | | |
| Minnesota | 26,000 | 5,000 | | |
| Mississippi | 9,600 | | | 1,000 |

| STATE | NUMBER OF TRANSGENDER ADULTS | TRANSGENDER ADULTS ENROLLED IN MEDICAID BY COVERAGE FOR GENDER-AFFIRMING CARE | | |
|---|---|---|---|---|
| | | GENDER-AFFIRMING CARE COVERED | GENDER-AFFIRMING CARE NOT COVERED | SILENT OR UNCLEAR POLICY ON GENDER-AFFIRMING CARE |
| Missouri | 9,500 | | 1,000 | |
| Montana | 3,400 | 1,000 | | |
| Nebraska | 6,600 | | 1,000 | |
| Nevada | 8,100 | 2,000 | | |
| New Hampshire | 6,300 | 1,000 | | |
| New Jersey | 43,100 | 10,000 | | |
| New Mexico | 10,900 | | | 4,000 |
| New York | 81,800 | 24,000 | | |
| North Carolina | 71,300 | | | 13,000 |
| North Dakota | 2,500 | <1,000 | | |
| Ohio | 46,500 | | | 13,000 |
| Oklahoma | 18,900 | | | 4,000 |
| Oregon | 19,900 | 5,000 | | |
| Pennsylvania | 56,000 | 14,000 | | |
| Rhode Island | 5,700 | 1,000 | | |
| South Carolina | 19,000 | | 4,000 | |
| South Dakota | 2,900 | | | <1,000 |
| Tennessee | 27,700 | | 4,000 | |
| Texas | 92,900 | | 9,000 | |
| Utah | 13,700 | | | 1,000 |
| Vermont | 2,700 | 1,000 | | |
| Virginia | 31,400 | | | 6,000 |
| Washington | 33,000 | 7,000 | | |
| West Virginia | 5,700 | | | 2,000 |
| Wisconsin | 15,500 | 3,000 | | |
| Wyoming | 2,100 | | | <1,000 |
| TOTAL | 1,397,250 | 164,000 | 38,000 | 74,000 |

For information about the methodology used to calculate estimates and a supplemental data table, see page 17.

## LIMITATIONS

We used data collected through the Census Bureau's Household Pulse Survey to calculate state-specific percentages for Medicaid enrollment. We relied upon LGBT Medicaid percentages rather than Medicaid percentages for transgender adults alone because they were more stable (e.g., smaller standard errors and narrower confidence intervals due to larger group size) at the state level and were more consistent with estimates of trans-only Medicaid enrollment in other datasets. For example, across the 14 states that collected data on gender identity and Medicaid enrollment through their Behavioral Risk Factor Surveillance System surveys (BRFSS) between 2017 and 2020, average

Medicaid enrollment for transgender adults was 10% (ranging from 1% to 18%).[14] In addition, a recent analysis of data collected through the TransPop survey between 2016 and 2018 found that 22% of transgender adults in the U.S. were enrolled in Medicaid or Medicare.[15] These numbers are consistent with our state-level estimates of Medicaid enrollment for LGBT adults, which ranged from 9% to 37% across states with a national average of 21%.[16]

Our estimates of Medicaid enrollment among transgender adults may be somewhat conservative. It is possible that Medicaid coverage may be higher for transgender adults compared to LGB adults given higher rates of poverty and disability among transgender adults in the U.S.[17] Unfortunately, surveys with samples large enough to support state-level estimation and that collect information about insurance coverage and transgender status (or LGBT status) are rare, and, given these limitations, we used the best available data to produce our estimates.

Our calculations may also underestimate the number of transgender adults who could be impacted by state Medicaid policies because we are unable to calculate the number of transgender adults who are currently eligible for Medicaid but not enrolled or the number of transgender adults who would be newly eligible and enroll if their state adopted Medicaid expansion. Transgender adults who are currently eligible for Medicaid may not be enrolled for various reasons. For example, they may not enroll because gender-affirming services are not covered, because their identity documents do not accurately reflect their name and gender identity, or because of their immigration status, making it difficult to access public benefits.[18] At least some of these adults may be more likely to enroll if their state Medicaid programs reduce barriers to access and affirmatively offer coverage for a range of gender-affirming medical services.

Further adoption of Medicaid expansion by the states would also likely increase enrollment of transgender adults. To date, 38 states have adopted and implemented Medicaid expansion, providing coverage for most adults living at or below 138% of the federal poverty level, and 12 states have not.[19] Medicaid expansion is particularly important for low-income adults without children, who typically

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[14] Analysis on file with authors. Average presented is a weighted average. In addition, analysis of data collected through the California Health Interview Survey between 2020 and 2021 found that 28% of transgender adults in the state were enrolled in Medicaid; similar to our estimate of 25% of LGBT people in California enrolled in Medicaid based on Pulse data.

[15] Ilan H. Meyer, Bianca D.M. Wilson & Kathryn O'Neill, Williams Inst., LGBTQ People in the U.S.: Select Findings from the Generations and TransPop Studies 28 (2021).

[16] The average presented is a weighted national average.

[17] Janelle M. Downing & Julia M. Przedworski, *Health of Transgender Adults in the U.S., 2014–2016*, 55 Am. J. Preventative Med. 336 (2018); M.V. Lee Badgett, Bianca D.M. Wilson & Soon Kyu Choi, Williams Institute, LGBT Poverty in the U.S. (2019).

[18] Kellan E. Baker et al., Ctr. for Am. Progress, The Medicaid Program and LGBT Communities: Overview and Policy Recommendations 10 (2016), https://cdn.americanprogress.org/wp-content/uploads/2016/08/08125221/2LGBTMedicaidExpansion-brief.pdf; *Affordable Care Act Enrollment Assistance for LGBT Communities: A Resource for Behavioral Health Providers*, Substance Abuse & Mental Health Servs. Admin., at 11 (2014), https://store.samhsa.gov/system/files/pep14-lgbtacaenrolla.pdf; *Health Coverage for Immigrants*, Henry J. Kaiser Fam. Found. (Apr. 6, 2022), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.

[19] *Status of State Medicaid Expansion Decisions: Interactive Map*, Henry J. Kaiser Fam. Found. (Aug. 1, 2019), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

are not eligible under traditional Medicaid rules.[20] It is likely that more transgender adults in the non-expansion states would enroll if these states adopted expansion.

Due to these limitations, our calculations likely underestimate the number of transgender adults who are currently or could be impacted by state Medicaid policies. The report also does not consider the number of transgender youth who are enrolled in Medicaid and are impacted by state Medicaid policies.

In addition, these estimates do not consider the number of transgender adults who may have difficulty finding providers who accept Medicaid and are able to provide competent gender-affirming care, even if their state's Medicaid program provides coverage for this care. Health care providers, in general, are less likely to accept Medicaid than other forms of insurance, which may make it difficult for all Medicaid beneficiaries, including transgender people, to find doctors.[21] Additionally, many transgender people report that they have experienced or fear discrimination and other barriers to receiving competent medical care related to their gender transition.[22] For example, the 2015 U.S. Transgender Survey found that 33% of respondents who had seen a health care provider in the past year reported that they had a negative experience with a provider.[23] The estimates consider only access to coverage for gender-affirming care under current state Medicaid policies, and not whether people are actually able to receive competent care.

Finally, the report provides estimates of transgender people who have access to coverage for gender-affirming care under their state Medicaid programs and those who are denied access to coverage under express bans. We are not able to estimate the number of transgender people who would seek such treatment, were coverage for it to be available.

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[20] *See, e.g.*, Baker et al., *supra* note 18.

[21] Medicaid and CHIP Payment and Access Comm., Physician Acceptance of New Medicaid Patients 6 (2019), http://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf.

[22] Jae A. Puckett et al., *Barriers to Gender Affirming Care for Transgender and Gender Nonconforming Individuals*, 15 Sex. Res. Social Policy 48 (2018); Deirdre A. Shires et al., *Primary Care Providers' Willingness to Continue Gender-Affirming Hormone Therapy for Transgender Patients*, 35 Fam. Practice 576 (2018); Gilbert Gonzalez & Carrie Henning-Smith, *Barriers to Care among Transgender and Gender Nonconforming Adults*, 95 Milbank Q. 726 (2017); Sandy James et al., The Report of the 2015 U.S. Transgender Survey 94-95 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[23] James et al., *supra* note 22 at 97.

# STATE AND FEDERAL LAWS THAT SUPPORT ACCESS TO COVERAGE FOR GENDER-AFFIRMING CARE

Medicaid exclusions for gender-affirming care have been challenged in court in several states. Plaintiffs in these cases have asserted that denial of coverage violates federal and state laws and constitutional provisions. In a number of these cases, courts have agreed with the plaintiffs, resulting in increased access to coverage for transgender beneficiaries. Several more cases that raise the same issues are currently being litigated. If these cases are decided in the beneficiaries' favor, more transgender people will have access to coverage for gender-affirming care through Medicaid.

## FEDERAL STATUTES

### Affordable Care Act

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination in health programs and activities based on sex, among other personal characteristics.[24] The U.S. Department of Health and Human Services and several courts have interpreted the ACA's sex non-discrimination provision to prohibit discrimination based on gender identity in state Medicaid programs.

#### Administrative Regulations Issued by HHS

In 2016, the U.S. Department of Health and Human Services (HHS) issued a regulation interpreting Section 1557's sex non-discrimination provisions to prohibit discrimination based on gender identity and sex stereotypes and explicitly barring covered insurers from categorically excluding all types of gender-affirming care from coverage.[25] The 2016 Rule was written broadly to apply to all health programs and activities that receive federal financial assistance, including state Medicaid programs, and all health programs administered by an executive agency or any entity established under the ACA.[26]

In 2020, under a different administration, HHS issued a new rule that removed express protections from discrimination based on gender identity and sex stereotyping in health care and health coverage under Section 1557.[27] The 2020 Rule was met with several successful lawsuits, which resulted in a nationwide injunction preventing the federal government from implementing the 2020 Rule's exclusion of gender identity and sex stereotyping from the definition of sex discrimination.[28]

[24] 42 U.S.C. § 18116(a) (2018).

[25] Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,467 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92) ("2016 Rule").

[26] *Id.*

[27] Nondiscrimination in Health and Health Education Programs or Activities, 85 Fed. Reg. 37160 (June 19, 2020) (to be codified at 45 C.F.R. pt. 92) ("2020 Rule").

[28] *See* Walker v. Azar, 480 F. Supp. 3d 417 (E.D.N.Y 2020); Whitman-Walker v. HHS, 485 F. Supp. 3d (D.C. 2020).

In 2022, HHS issued a proposed rule reinstating the gender identity non-discrimination protections put into place under the 2016 Rule.[29] The proposed rule is consistent with the U.S. Supreme Court's decision in *Bostock v. Clayton County*, holding that discrimination based on gender identity is a form of sex discrimination prohibited under Title VII of the Civil Rights Act of 1964.[30]

### Court Decisions

Several courts have held that the statutory language of Section 1557 prohibits discrimination based on gender identity as a form of sex discrimination. In these cases, the courts have directly interpreted the statutory language and did not rely on any administrative rules or regulations interpreting the law. These decisions are consistent with the Supreme Court's decision in *Bostock* and other case law interpreting analogous sex non-discrimination provisions in other federal laws, as well as HHS' recently proposed rule interpreting Section 1557 to prohibit gender identitvvvvy discrimination.

Some courts have specifically held that Medicaid exclusions for gender-affirming care violate Section 1557. For example, in 2019, a federal district court in Wisconsin held that the state's ban on Medicaid coverage for gender-affirming care violated Section 1557, even before the Court's decision in *Bostock*.[31] The court held in favor of the Medicaid beneficiaries for several reasons. First, the court found that the state discriminated against Medicaid beneficiaries based on sex by covering certain procedures for people whose sex matched their gender identity, but not for those whose sex and gender identity did not match.[32] The court said that this treatment amounts to discrimination based on natal sex—"a straight forward case of sex discrimination."[33] Second, the court held that discrimination against transgender individuals is by its nature discrimination based on sex and sex stereotypes.[34] Similarly, in 2022, a federal district court in West Virginia held that the state's gender-affirming care ban violated the Affordable Care Act, following the reasoning of the Court's analysis in *Bostock*.[35]

In addition, courts have found that other forms of discrimination against transgender people (aside from denials of gender-affirming care under state Medicaid programs) violate Section 1557. For example, in 2018, a district court in Minnesota indicated that an exclusion of gender-affirming care from a private employer's health plan could violate Section 1557.[36] And, in 2017, a federal district court in California found that the parents of a transgender boy who died by suicide after his doctors misgendered him had established a valid claim of sex discrimination under Section 1557 on behalf of

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[29] Nondiscrimination in Health Programs and Activities, 87 FR 47824 (proposed Aug. 4, 2022) (to be codified at 42 C.F.R. 438, 440, 457, 460 & 45 C.F.R. 80, 84, 86, 91, 92, 147, 155, 156). Available at: https://www.federalregister.gov/documents/2022/08/04/2022-16217/nondiscrimination-in-health-programs-and-activities.

[30] Bostock v. Clayton County, 140 S.Ct. 1731 (2020).

[31] Flack v. Wis. Dep't. of Health Servs., 328 F. Supp. 3d 931 (W.D. Wis. 2018).

[32] *Id.* at 947-48.

[33] *Id.* at 948.

[34] *Id.* at 948-51.

[35] Fain v. Crouch, _ F. Supp. 3d _, 2022 WL 3051015 (S.D. W. Va. 2022).

[36] Tovar v. Essentia Health, 342 F. Supp. 3d 947 (D. Minn. 2018).

their son.[37] In all of these cases, the courts were interpreting the statutory language and did not rely on any administrative rules or regulations interpreting the law.[38]

## Medicaid Act

The Medicaid Act, along with administrative regulations interpreting the statute, supports access to coverage for gender-affirming care. The Medicaid Act, part of the more comprehensive Social Security Act, outlines broad parameters for state Medicaid programs. Among these is the requirement that states provide medical assistance to all categorically needy individuals (referred to as the Availability Provision) and that assistance must be provided equally among individuals within beneficiary groups (referred to as the Comparability Provision).[39] The U.S. Supreme Court has implied that the Availability Provision requires state Medicaid programs to provide medically necessary care to all qualified beneficiaries.[40]

Some courts have interpreted these provisions and the Supreme Court precedent to require that states provide gender-affirming care to transgender Medicaid beneficiaries. For example, in 2016, a federal district court in New York held that the state's blanket ban on Medicaid coverage for some surgeries related to gender transition violated the Availability Provision by barring coverage for treatments that could be medically necessary for transgender beneficiaries, and also violated the Comparability Provision of the statute by providing coverage for such treatments for conditions unrelated to gender transition while denying coverage when sought for gender transition purposes.[41] Federal district courts in Wisconsin and West Virginia have also held that those states' bans on gender-affirming care violated the Availability and Comparability provisions for similar reasons.[42]

The federal government has also taken steps to further implement the Medicaid Act to protect transgender beneficiaries. The Medicaid Act authorizes the Secretary of HHS, among other officials, to further define and implement the elements of state Medicaid programs through regulations.[43] In 2016, HHS issued several regulatory provisions that expressly prohibited discrimination based on gender identity in state Medicaid programs pursuant to this grant of power. Two separate provisions require that state Medicaid plans and Managed Care Organizations participating in Medicaid programs "promote access and delivery" of services regardless of sexual orientation and gender identity.[44] A third provision prohibits Managed Care Organizations from using "any policy or practice"

[37] Prescott v. Rady Children's Hosp. San Diego, 265 F. Supp. 3d 1090 (S.D. Cal. 2017).

[38] However, some courts have held the opposite—that discrimination based on gender identity is not a form of sex discrimination prohibited by Section 1557 of the ACA. Franciscan Alliance, Inc. v. Burwell, 227 F. Supp. 3d 660 (N.D. Tex. 2016); Office for Civil Rights, *Fact Sheet: HHS Proposes to Revise ACA Section 1557 Rule*, U.S. Dep't Health & Hum. Servs. (May 24, 2019), https://www.hhs.gov/sites/default/files/factsheet-section-1557.pdf (noting the District Court of North Dakota enjoined the application of the Final Rule to two plaintiffs because the court concluded *Franciscan Alliance* was persuasive).

[39] 42 U.S.C. §§ 1396a(a)(10)(A)–(B) (2018).

[40] *See* Cruz v. Zucker, 195 F. Supp. 3d 554, 570 (S.D.N.Y. 2016) (citing Beal v. Doe, 432 U.S. 438, 444 (1977)).

[41] *Id.* at 570, 576.

[42] Flack v. Wisc. Dept' of Health Servs., No. 18-cv-309-wmc (W.D. Wisc. Aug. 16, 2019); Fain v. Crouch, _ F. Supp. 3d _, 2022 WL 3051015 (S.D. W. Va. 2022).

[43] 42 U.S.C. § 1302(a) (2018).

[44] 42 C.F.R. §§ 440.262, 438.206(c)(2) (2018).

that discriminates based on sexual orientation or gender identity, among other characteristics.[45] Although these protections were removed from the regulations in 2020,[46] HHS's 2022 proposed rule implementing Section 1557 of the ACA reinstates the prohibitions on discrimination based on sexual orientation and gender identity in these provisions.[47]

## STATE STATUTES

Some states' non-discrimination statutes also support transgender Medicaid beneficiaries' access to coverage for gender-affirming care. Non-discrimination statutes in 21 states and D.C. expressly prohibit discrimination based on gender identity in public accommodations.[48] An additional seven states interpret existing sex non-discrimination laws to also prohibit gender identity discrimination consistent with the Supreme Court's decision in *Bostock*.[49] Although the definition of "public accommodation" differs by state, when the term is broadly defined it may include state government programs, such as Medicaid. If Medicaid is considered a public accommodation in states that include protections against gender identity discrimination, courts are likely to find that denial of coverage for gender-affirming care violates the law. Transgender Medicaid beneficiaries in states where Medicaid policies either bar coverage for gender-affirming care or are silent as to coverage can rely on these states' non-discrimination laws to independently support a claim for coverage.

The Iowa Supreme Court addressed this issue in March 2019. In *Good v. Iowa Department of Human Services*, the court held that Iowa's administrative policy barring Medicaid coverage for gender-affirming care violated state law prohibiting gender identity discrimination in public accommodations.[50] The state department had argued that Medicaid was not a public accommodation within the meaning of the statute.[51] The court disagreed, finding that the statute's broad definition of "public accommodation"—which includes "each state and local government unit or tax-supported district of whatever kind, nature, or class that offers services, facilities, benefits, grants, or goods to the public, gratuitously or otherwise"—encompassed the Medicaid program.[52]

State-level non-discrimination laws and policies in other states may be interpreted by courts to similarly prohibit state Medicaid programs from excluding coverage for gender-affirming care. Kansas, New Mexico, Hawaii, and Virginia, which do not address coverage for gender-affirming care under their Medicaid programs, have statutes that expressly prohibit, or have been interpreted to prohibit, discrimination based on gender identity in public accommodations.[53] In addition, Florida and Ohio,

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[45] 42 C.F.R. § 438.3(d)(4) (2018).

[46] Nondiscrimination in Health and Health Education Programs or Activities, 85 Fed. Reg. 37160 (June 19, 2020).

[47] Nondiscrimination in Health Programs and Activities, 87 FR 47824 (proposed Aug. 4, 2022).

[48] *State Non-Discrimination Laws: Public Accommodations*, Movement Advancement Project, https://www.lgbtmap.org/img/maps/citations-nondisc-public-accom.pdf (last visited August 19, 2022).

[49] *Id.* We have included Michigan in this group of states because the state does not have a statutory law that prohibits discrimination based on gender identity. Rather, the state's highest court has interpreted the state's sex non-discrimination law to encompass gender identity discrimination consistent with *Bostock*. Rouch World v. Dep't of Civil Rights, No. 164482 (Mich. July 28, 2022).

[50] Good v. Iowa Dep't. of Human Servs., No. 18-1158, 2019 Iowa Sup. LEXIS 19 (Iowa Mar. 8, 2019).

[51] *Id.* at *14.

[52] *Id.* at *14–16.

[53] Del. Code Ann. tit 6, § 4501 (2018); N.H. Rev. Stat. Ann. § 354-A:1 (2018); N.M. Stat. Ann. § 28-1-7 (2019).

both states with express bans, have interpreted their state's public accommodations laws to prohibit gender identity discrimination. Three of these states' laws—Hawaii, New Mexico, and Virginia—define public accommodations broadly, and Hawaii's statute, like Iowa's law, specifically includes state entities and agencies.[54] If courts in these states interpret the non-discrimination statutes to apply to Medicaid programs, they will likely decide that denials of coverage for gender-affirming care violate the law.

## FEDERAL AND STATE CONSTITUTIONS

The Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution also supports access to gender-affirming care under state Medicaid programs. The Equal Protection Clause requires state governments to provide equal treatment to similarly situated individuals.[55] In cases brought under the Equal Protection Clause, courts review the challenged state action under different standards, depending on the nature of the classification at issue. When a state action that classifies based on sex (a "quasi-suspect" characteristic) is at issue, courts apply a searching level of review, requiring the state action substantially further an important government interest in order to survive.[56] Courts have increasingly applied this heightened standard to laws that discriminate against transgender people and have found that the laws do not pass constitutional muster. Most of these cases have involved discrimination in employment or education, but some have also involved denials of access to gender-affirming care in state health programs.[57] This trend will likely continue following the Supreme Court's holding in *Bostock* that discrimination based on gender identity is a form of sex discrimination.

For example, one case, *Flack v. Wisconsin Dep't of Health Servs.*, specifically addressed a ban on Medicaid coverage for gender-affirming care and held that the policy violated the Equal Protection Clause.[58] The court found that classifications that discriminate against transgender people should be subjected to heightened scrutiny both because gender identity discrimination is a form of sex discrimination and because transgender people should be considered a "suspect" or "quasi-suspect" class independently. The court held that the ban did not pass constitutional muster under that standard.

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[54] Haw. Rev. Stat. § 498-2(2022); N.M. Stat. Ann. § 28-1-2(H) (2022); Va. Code Ann. § 2.2-3904(A). Although the language of Kansas's statute is broad, the state supreme court has limited the term to include "those places of business held open to the general public and where members of the general public are invited to come for business purposes. *Seaborn v. Coronado Area Council*, 257 P.2d 385 (Kan. 1995). In addition, while Ohio's statutory definition of "public accommodations" is broad, it is narrowed to physical "places" through administrative regulations. Ohio Rev. Code § 4112.01(A)(1); Ohio Admin. Code rule No. 4112-5-02 (2022).

[55] U.S. Const. amend. XIV, § 1.

[56] *See* Craig v. Boren, 429 U.S. 190 (1976).

[57] *See e.g.*, Boyden v. Conlin, 341 F. Supp. 3d 979 (W.D. Wis. 2018); Flack v. Wis. Dep't. of Health Servs., 328 F. Supp. 3d 931 (W.D. Wis. 2018); Brown v. Dep't. of Health & Human Servs., No. 8:16CV569, 2017 U.S. Dist. LEXIS 84518 (D. Neb. June 2, 2017)).

[58] 328 F. Supp. 3d at 951.

Other cases currently in litigation have also raised equal protection challenges to state laws that limit access to gender-affirming care. For example, in 2022 transgender Medicaid beneficiaries in Idaho filed a lawsuit against the state Department of Health and Welfare alleging that denial of coverage for surgery related to gender transition violates the Equal Protection Clause.[59] Relatedly, in 2021, the State of Arkansas banned the provision of gender-affirming care to transgender adolescents, prompting a lawsuit challenging the ban. While the case is still working its way through the courts, a federal district court granted a preliminary injunction against the law, finding that the law likely violates the Equal Protection Clause.[60] Similarly, Alabama recently passed a felony ban on the prescription of puberty-blocking medication or hormone treatment for transgender youth, prompting another lawsuit. A federal judge has blocked Alabama's law, stating that there is a substantial likelihood that the law violates the Equal Protection Clause.[61]

Many state constitutions also have equal protection provisions that are interpreted to offer the same protections as the federal Equal Protection Clause.[62] Courts may also find that exclusions of gender-affirming care under state Medicaid programs are unconstitutional under these provisions. For example, a court in Iowa held that a law prohibiting the Medicaid program from covering gender-affirming care, specifically surgical intervention, violated the Iowa Constitution's equal protection clause.[63]

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[59] Complaint, MH & TB v. Jeppesen et al., No. 1:22-CV-409 (D. Idaho Sept. 29, 2022).

[60] Brandt v. Rutledge, 551 F. Supp. 3d 882 (E.D. Ark. 2021).

[61] Eknes-Tucker et al. v. Marshall, 2022 WL 1521889 (M.D. Ala. May 13, 2022).

[62] Daniel Polonsky, *Equal Protection & State Constitutional Amendment*, 56 Harv. L. Rev. 414 (2021).

[63] Covington v. Reynolds ex rel. State, 949 N.W.2d 663 (Iowa Ct. App. 2020).

## CONCLUSION

An estimated 276,000 transgender adults are enrolled in Medicaid. Transgender Medicaid beneficiaries in the U.S. face a patchwork of policies that make coverage for gender-affirming care uncertain. More than half of transgender Medicaid beneficiaries (164,000) have guaranteed access to coverage for gender-affirming care under express policies in 25 states and D.C. An estimated 74,000 transgender Medicaid beneficiaries live in the 18 states that have not expressly addressed coverage for gender-affirming care in their Medicaid programs. An estimated 38,000 transgender Medicaid beneficiaries live in the seven states with express bans that deny access to covered gender-affirming care. Although many transgender Medicaid beneficiaries are still denied access to gender-affirming care, and many others face additional barriers to accessing such care, recent litigation and administrative policy changes have resulted in the extension of coverage in several states. Additional policy changes in states that still have bans or lack clear language addressing coverage would ensure that transgender Medicaid beneficiaries have access to coverage for gender-affirming medical care no matter where they live.

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### ACKNOWLEDGMENTS

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### ABOUT THE WILLIAMS INSTITUTE

The Williams Institute is dedicated to conducting rigorous, independent research on sexual orientation and gender identity law and public policy. A think tank at UCLA Law, the Williams Institute produces high-quality research with real-world relevance and disseminates it to judges, legislators, policymakers, media, and the public. These studies can be accessed at the Williams Institute website.

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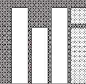

# APPENDIX

## METHODOLOGY

This study analyzed repeated cross-sectional data[64] collected between July 21, 2021 to August 8, 2022 by the U.S. Census Bureau on the Household Pulse Phase 3.5 Survey[65] (weeks 34-48). The Household Pulse Survey was developed to assess the impact of COVID-19 on employment, food and housing security, and the physical and mental well-being of the U.S. population. Households were enumerated via the Census Bureau's Master Address File (MAF); email addresses and cell phone numbers were appended to create a contact sampling frame for the survey.[66] Group quarters such as homeless shelters, nursing homes, and college dormitories were not sampled. Online surveys were conducted in English and Spanish with 971,836 U.S. adults ages 18 and up. The response rate for weeks 34-48 ranged from 4.4% to 7.9%.[67]

Questions about sex assigned at birth (What sex were you assigned at birth, on your original birth certificate?) and current gender identity (Do you currently describe yourself as male, female or transgender?) were added to the Household Pulse Survey starting in week 34 and were used to classify respondents as transgender and cisgender. Respondents who selected transgender as their gender identity were classified as transgender. In the remaining sample that selected male or female gender identity responses and whose sex was not imputed by the Census Bureau (e.g., AGENID_BIRTH=2), those who selected a gender identity (male or female) that differed from their sex assigned at birth (male or female) were classified as transgender. Respondents who selected gender identity options (male or female) that were the same as their sex assigned at birth (male or female) were classified as cisgender. Those who selected "none of these" as their response to the gender identity question were excluded from classification.

Following the rationale and analyses reported *in Food Insufficiency Among Transgender Adults During the COVID-19 Pandemic*, imputed sex was not used to classify transgender and cisgender respondents given concerns about the validity of the imputed sex data. Descriptive analyses conducted by Dr. Bill Jesdale indicate that the demographic characteristics of those classified as transgender based on imputed sex look more similar to those of cisgender respondents than to those of transgender respondents who answered the sex assigned at birth question.[68] In addition, transgender respondents who reported living in households of 10+ members were excluded from the analytic sample for this study based on descriptive analyses conducted by the Williams Institute and reported previously.

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[64] U.S. Census Bureau, *Household Pulse Survey Public Use File (PUF)*, https://www.census.gov/programs-surveys/household-pulse-survey/datasets.html (last visited Oct. 24, 2022).

[65] U.S. Census Bureau, Household Pulse Survey Technical Documentation, https://www.census.gov/programs-surveys/household-pulse-survey/technical-documentation.html#phase3.5 (last visited Oct. 24, 2022).

[66] U.S. Census Bureau, Source of the Data Accuracy or the Estimates for the Household Pulse Survey – Phase 3.5, https://www2.census.gov/programs-surveys/demo/technical-documentation/hhp/Phase3-5_Source_and_Accuracy_Week48.pdf (last visited Oct. 24, 2022).

[67] *Id.*

[68] Bill M. Jesdale, Natn'l LGBT Cancer Network, Counting Gender Minority Populations in the Household Pulse Survey (The AGENID=2 Memo), https://cancer-network.org/wp-content/uploads/2021/10/Counting-GM-People-in-Pulse-Data.pdf (last visited Oct. 24, 2022).

A question about sexual orientation identity (Which of the following best represents how you think of yourself?) was added to the Household Pulse Survey starting in week 34 and was used to classify respondents as lesbian, gay, or bisexual (LGB) and straight based on their selection of these response options (gay or lesbian; straight, that is not gay or lesbian; bisexual). Respondents who selected "something else" as their identity were excluded from classification based on prior research indicating that this group is heterogeneous, and, without a follow-up write-in, cannot be classified as sexual minority or as straight.[69] Respondents who were transgender and/or LGB were classified as LGBT while respondents who were cisgender and straight were classified as non-LGBT—in total, 915,231 respondents were classified as LGBT or as non-LGBT.

Medicaid coverage was determined by response to the question, "Are you currently covered by any of the following types of health insurance or health coverage plans?" Respondents who selected yes for "Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability" were classified as having Medicaid while all others who responded to the health insurance question were classified as not having Medicaid. A fairly large number of the 915,231 LGBT or non-LGBT Pulse respondents had missing responses for all insurance options (n=113,419) and were excluded from the analytic sample. Similar numbers of individuals had missing responses for other survey questions near the health insurance question and were likely missing due to drop-off.

The final analytic sample was limited to 801,812 survey respondents who could be classified as LGBT or non-LGBT based on the criteria described above and who answered the question about insurance coverage. Prevalence proportions were generated using Stata v15.1 statistical software and weighted to represent adults ages 18 and up living in U.S. households using person-level weights provided by the Census Bureau. Confidence intervals (95% CI) were included to communicate the degree of uncertainty around an estimate due to sampling error and are presented in the table below.

To estimate the number of transgender adults enrolled in Medicaid, we multiplied the percentage of Medicaid-insured LGBT adults by estimates of the number of adults living in each state who are transgender, as reported in the Williams Institute's 2022 study, How Many Youth and Adults Identify as Transgender in the United States?, and rounded to the nearest 1,000. We opted to use state-specific LGBT percentages for Medicaid enrollment in calculating our estimates rather than percentages for transgender adults alone because the LGBT Medicaid percentages were more stable (e.g., smaller standard errors and narrower confidence intervals due to larger group size) at the state level. It is possible that Medicaid coverage could be somewhat higher for transgender adults given higher rates of poverty and disability among transgender adults in the U.S., and that our estimates may be somewhat conservative.

[69] U.S. Dep't of Health and Hum. Svcs, Ctrs for Disease Control & Prev., A Brief Quality Assessment of the NHIS Sexual Orientation Data (2014), https://www.cdc.gov/nchs/data/nhis/qualityso2013508.pdf; Michele J. Eliason et al., *The "Something Else" of Sexual Orientation: Measuring Sexual Identities of Older Lesbian and Bisexual Women Using National Health Interview Survey Questions*, 26 Women's Health Issues suppl. 1 S71 (2016).

**Supplemental Table 1. Medicaid enrollment of LGBT people by state, Household Pulse Survey, July 21, 2021 to August 8, 2022**

| STATE | % LGBT ENROLLED IN MEDICAID | 95% CONFIDENCE INTERVALS |
|---|---|---|
| Alabama | 17.6% | 12.6%, 24.1% |
| Alaska | 24.6% | 19.6%, 30.4% |
| Arizona | 18.1% | 14.9%, 22.0% |
| Arkansas | 26.1% | 21.3%, 31.7% |
| California | 24.0% | 21.4%, 26.8% |
| Colorado | 21.1% | 17.9%, 24.7% |
| Connecticut | 26.9% | 22.3%, 32.1% |
| Delaware | 24.3% | 18.9%, 30.6% |
| DC | 15.7% | 11.6%, 20.8% |
| Florida | 13.1% | 10.3%, 16.5% |
| Georgia | 12.8% | 10.1%, 16.1% |
| Hawaii | 25.3% | 19.9%, 31.5% |
| Idaho | 20.8% | 16.7%, 25.6% |
| Illinois | 21.1% | 17.4%, 25.4% |
| Indiana | 22.9% | 19.0%, 27.3% |
| Iowa | 31.8% | 27.0%, 37.1% |
| Kansas | 15.3% | 11.8%, 19.7% |
| Kentucky | 31.5% | 26.3%, 37.3% |
| Louisiana | 30.6% | 25.1%, 36.6% |
| Maine | 21.8% | 17.1%, 27.3% |
| Maryland | 26.6% | 21.8%, 32.0% |
| Massachusetts | 18.9% | 16.2%, 21.9% |
| Michigan | 28.1% | 24.2%, 32.4% |
| Minnesota | 20.0% | 16.9%, 23.7% |
| Mississippi | 13.5% | 9.0%, 19.8% |
| Missouri | 13.2% | 10.4%, 16.7% |
| Montana | 28.5% | 22.8%, 35.0% |
| Nebraska | 18.3% | 14.9%, 22.3% |
| Nevada | 20.9% | 17.2%, 25.1% |
| New Hampshire | 20.7% | 16.3%, 25.9% |
| New Jersey | 22.2% | 18.1%, 27.0% |
| New Mexico | 36.8% | 32.2%, 41.6% |
| New York | 29.4% | 25.4%, 33.9% |
| North Carolina | 18.6% | 14.7%, 23.2% |
| North Dakota | 15.0% | 9.5%, 22.9% |
| Ohio | 27.1% | 22.8%, 31.9% |
| Oklahoma | 20.7% | 16.7%, 25.3% |
| Oregon | 24.8% | 21.8%, 28.1% |

| STATE | % LGBT ENROLLED IN MEDICAID | 95% CONFIDENCE INTERVALS |
|---|---|---|
| Pennsylvania | 25.3% | 21.4%, 29.7% |
| Rhode Island | 23.0% | 18.5%, 28.3% |
| South Carolina | 21.0% | 16.3%, 26.8% |
| South Dakota | 11.3% | 6.7%, 18.6% |
| Tennessee | 15.9% | 12.5%, 20.0% |
| Texas | 9.3% | 7.1%, 12.0% |
| Utah | 9.9% | 7.9%, 12.3% |
| Vermont | 26.6% | 20.9%, 33.3% |
| Virginia | 18.2% | 14.7%, 22.4% |
| Washington | 20.7% | 18.0%, 23.7% |
| West Virginia | 28.6% | 23.0%, 34.8% |
| Wisconsin | 18.7% | 15.2%, 22.7% |
| Wyoming | 16.0% | 10.6%, 23.3% |

## STATE-LEVEL MEDICAID POLICIES

### State policies providing affirmative coverage for gender-affirming care

- **Alaska.** In 2010, the Alaska Department of Health and Human Services issued a regulation expressly excluding "transsexual surgical procedures or secondary consequences" from Medicaid coverage. In 2019, a transgender woman who had been denied care under Alaska's Medicaid program successfully won a settlement challenging the regulation. Alaska now expressly includes coverage for gender-affirming care under the state's Medicaid program.
- **California.** In 2013, the California Department of Health Care Services issued guidance expressly stating that Medicaid covers gender-affirming care.
 The agency re-issued guidance in 2016 reminding Medicaid health plans that they are required to cover gender-affirming care for beneficiaries and explaining that federal regulations implementing the Affordable Care Act prohibit discrimination based on gender identity in health care, including in state Medicaid programs.
- **Colorado.** In 2017, the Colorado Department of Health Care Policy and Financing issued regulations expressly stating that Medicaid covers gender-affirming care. The Department revised the rule twice, most notably in 2019 to reduce the burden placed on transgender beneficiaries seeking treatment for hair removal.
- **Connecticut.** In 2015, the Connecticut Department of Social Services issued guidance expressly stating that Medicaid covers gender-affirming care. The guidance has been updated and expanded several times to reduce barriers or burdens for transgender people seeking care. The guidance was updated most recently in August 2022 to reduce barriers to certain procedures and align the policy with current standards of care.
- **Delaware.** In 2018, the Delaware Department of Health and Social Services amended its state Medicaid plan to include coverage for gender-affirming care.

- **D.C.** In 2015, the D.C. Department of Health Care Finance issued a bulletin expressly stating that Medicaid covers gender-affirming care. The department later issued a policy in line with the bulletin.
- **Georgia.** In 1993, the Georgia Department of Community Health issued a policy expressly excluding "transsexual surgeries" from Medicaid coverage. This policy was challenged in court and in 2022 the Georgia Department of Community Health agreed to remove the exclusion and to adopt benefits and clinical guidelines for care as part of a settlement. Georgia's amendment removing gender-affirming care from the list of non-covered services in its state Medicaid Plan was approved on September 14, 2022, however, the state has not yet issued a policy confirming that care is covered.
- **Illinois.** In 2020, the Illinois Department of Healthcare and Family Services issued a regulation expressly stating that Medicaid covers gender-affirming care.
- **Iowa.** In 1994, the Iowa Department of Human Services issued a regulation expressly excluding gender-affirming care from Medicaid coverage. In 2019, the Iowa Supreme Court held that the exclusion violated the state's non-discrimination law, which prohibits discrimination based on gender identity in public accommodations, and as such, could not be enforced. The state responded by passing an appropriations bill that included a provision stating that Iowa's non-discrimination law does not require Medicaid to cover gender-affirming surgeries or procedures, which the governor signed into law in May 2019. In 2021, a state court in Iowa held that the exclusion of coverage for gender-affirming care under the state's Medicaid program violated the equal protection clause of the Iowa Constitution. The Department of Human Resources has not yet updated its manual or policies to reflect coverage for gender-affirming care.
- **Maine.** In 2019, the Maine Department of Health and Human Services issued a regulation expressly stating that Medicaid covers gender-affirming care.
- **Maryland.** In 2015, the Maryland Department of Health issued a regulation expressly stating that Medicaid covers gender-affirming care.
- **Massachusetts.** In 2015, MassHealth issued guidance expressly stating that Medicaid covers gender-affirming care. The policy was most recently updated in 2021.
- **Michigan.** In 2019, the Michigan Department of Health and Human Services issues a bulletin clarifying that gender-affirming care is covered under the state's Medicaid program. This change is also reflected in Michigan's Medicaid Provider Manual.
- **Minnesota.** In 2016, a state court in Minnesota held that the ban on coverage for gender-affirming surgical care under the state's Medicaid program violated Minnesota's constitution. A few months later, the Minnesota Department of Human Services implemented the court's decision by issuing guidance expressly stating that Medicaid covers gender-affirming care.
- **Montana.** In 2017, the Montana Department of Health and Human Services issued guidance expressly stating that Medicaid covers gender-affirming care. The agency explained that federal regulations implementing the Affordable Care Act prohibit discrimination based on gender identity in health care, including in state Medicaid programs. Although the guidance is no longer available on the website, a 2021 survey of state health departments conducted by Kaiser Family Foundation confirmed that coverage has not changed. In addition, the

Department of Health and Human Services recently issued a policy expressly stating that Medicaid covers mental health services for adults diagnosed with gender dysphoria.

- **Nevada.** In 2018, the Nevada Department of Health and Human Services announced that Medicaid covers gender-affirming care.
- **New Hampshire.** In 2017, New Hampshire removed an exclusion on coverage for gender-affirming care in the state's Medicaid program. New Hampshire's Member Handbook now expressly states that gender-affirming care is covered.
- **New Jersey.** In 2017, the legislature of New Jersey enacted a statute requiring Medicaid coverage for gender-affirming care.
- **New York.** In 2015, the New York State Department of Health issued regulations expressly stating that Medicaid covers gender-affirming care. Several transgender Medicaid beneficiaries challenged the rule in federal district court, arguing that its denial of coverage for minors and its exclusion for surgeries deemed "cosmetic" violated their rights under the federal Medicaid statute. The court agreed that the categorical ban on cosmetic surgeries violated federal Medicaid laws by foreclosing the availability of treatments that may be medically necessary for some individuals. The court declined to hold that the age restriction violated federal Medicaid laws. In response to the decision, the Department of Health amended its regulations to remove the exclusion for cosmetic surgery. Because many states exclude coverage for treatment deemed "cosmetic" even if they cover other aspects of gender-affirming care, New York's policy is among the most expansive.
- **North Dakota.** In 2022, the North Dakota Department of Human Services updated the state's Provider Manual to expressly include coverage for gender-affirming care.
- **Oregon.** In 2015, the Oregon Health Authority issued a policy expressly stating that Medicaid covers gender-affirming care.
- **Pennsylvania.** In 2016, the Pennsylvania Department of Human Services issued a bulletin expressly stating that Medicaid covers gender-affirming care. The agency explained that federal regulations implementing the Affordable Care Act prohibit discrimination based on gender identity in health care, including in state Medicaid programs. A policy addressing gender-affirming hormone treatments was updated in 2020.
- **Rhode Island.** In 2015, the Rhode Island Executive Office of Health and Human Services issued guidance expressly stating that Medicaid covers gender-affirming care.
- **Vermont.** In 2008, the Vermont Agency of Human Services issued guidance expressly stating that Medicaid covers gender-affirming care. The guidance has been updated and expanded several times to reduce barriers or burdens for transgender people seeking care. In November 2019, the agency adopted a new regulation addressing coverage for gender-affirming care. The rule further expands Medicaid coverage, including providing coverage for gender affirmation surgery to emancipated minors and other minors with parental consent.
- **Washington.** In 2015, the Washington State Health Care Authority issued a regulation expressly stating that Medicaid covers gender-affirming care.

- **Wisconsin.** In 1996, the Wisconsin Department of Health Services issued a regulation expressly excluding gender-affirming care from Medicaid coverage. In 2019, a federal district court in Wisconsin ruled that the ban violated the Affordable Care Act, the Medicaid provisions of the Medicaid Act, and the federal constitution. The Department has updated its policies to reflect that gender-affirming care is covered under the state's Medicaid program as a result of the decision.

## State policies that expressly exclude coverage for gender-affirming care

- **Arizona.** Since at least 2004, the Arizona Health Care Cost Containment System has had a policy expressly excluding "treatment of gender dysphoria including gender reassignment surgeries" from Medicaid coverage. A challenge to the exclusion is currently making its way through the courts. In March 2022, the Ninth Circuit affirmed a lower court's denial of an injunction against the policy, allowing for its continued enforcement as the case is litigated.
- **Florida.** In 2022, the Florida Agency for Health Care Administration issued a regulation expressly barring coverage for gender-affirming care under the state's Medicaid program
- **Missouri.** Missouri's Physician Manual for Medicaid providers expressly excludes "surgical procedures for gender change" from Medicaid coverage.
- **Nebraska.** In 1990, the Nebraska Department of Health and Human Services issued a regulation expressly excluding "sex change procedures" from Medicaid coverage.
- **South Carolina.** South Carolina's Physicians Services Provider Manual for Medicaid providers expressly excludes "services and procedures related to gender transition" from Medicaid coverage.
- **Tennessee.** In 2006, the Tennessee Department of Finance and Administration issued a regulation expressly excluding "transsexual surgery" from Medicaid coverage.
- **Texas.** Texas's Medicaid Providers Manual, last issued in 2019, expressly excludes "sex change operations" from Medicaid coverage.

1 IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
2 CENTRAL DIVISION

3 DYLAN BRANDT, et al.,

4 Plaintiffs,
v. No. 4:21CV00450 JM
5
November 28, 2022
6 Little Rock, Arkansas
8:57 AM
7 LESLIE RUTLEDGE, et al.,

8 Defendants.

9 **TRANSCRIPT OF BENCH TRIAL - VOLUME 5**
BEFORE THE HONORABLE JAMES M. MOODY, JR.,
10 UNITED STATES DISTRICT JUDGE

11
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12
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24 Appearances continuing...

25

Pl. Trial Ex. 080

1
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23 *Proceedings reported by machine stenography. Transcript prepared utilizing computer-aided transcription.*
24
25

1
2 **INDEX - VOLUME 5 (11/28/22)**
3



| WITNESSES FOR THE DEFENDANTS: | Direct | Cross | Redirect | Recross |
|---|---|---|---|---|
| STEPHEN LEVINE | 781 | 885 | 955 | 959 |



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1 (Proceedings continuing in open court at 8:57 AM.)
2 THE COURT: Are y'all ready?
3 MR. JACOBS: Your Honor, Defendants are ready to
4 call, I guess, our next witness, not our first witness. One
5 thing I wanted to check in on. So Dr. Regnerus is prepared to
6 testify remotely tomorrow, and I wanted to ask at what time the
7 Court could begin tomorrow with the hope that it could begin I
8 guess as early as we can make it happen. Because Dr. Regnerus
9 is testifying late in the evening from where he's located, so
10 just to avoid him having to run into testifying in the wee
11 hours of the early morning, if we could start as early as we
12 can. I recognize that --
13 THE COURT: I expect this will likely make everybody
14 cringe, but courthouse opens at 7:30.
15 MR. JACOBS: Could we -- I think he'd be available
16 to start at like 8:00.
17 THE COURT: That's fine. That would give everybody
18 time to get in the building and get settled and we could make
19 sure stuff is up.
20 MR. JACOBS: Okay. That's all the preliminary
21 matters that we have.
22 THE COURT: So with an asterisk, you've got my
23 entire week. What are your thoughts on how long you're going
24 to take?
25 MR. JACOBS: Our witnesses will be done Thursday and

1 we'll rest on Thursday.
2 THE COURT: I've got two sentencings, one at 1:00
3 and one at 2:00 on Wednesday. Those usually last 30 minutes,
4 so we're probably going to work a little later into lunch on
5 Wednesday.
6 MR. JACOBS: That won't be a problem, Your Honor.
7 THE COURT: And then it looks like I've got a lunch
8 hearing on the 1st. Okay. That's what is on my schedule other
9 than you guys. So are we ready to jump back in?
10 MR. JACOBS: We're ready, Your Honor. Defendants
11 will call Dr. Stephen Levine.
12 THE COURT: Sir, if you could come on the far side
13 of that silver rail. Good morning.
14 **STEPHEN LEVINE, DEFENDANTS' WITNESS, DULY SWORN**
15 DIRECT EXAMINATION
16 BY MR. CANTRELL:
17 Q Good morning, Dr. Levine.
18 A Good morning.
19 Q Can you state your name and spell it for the record.
20 A Stephen, S-t-e-p-h-e-n, Barrett, B-a-r-r-e-t-t, Levine,
21 L-e-v-i-n-e.
22 Q Thank you. Dr. Levine, can you tell us what academic and
23 clinical positions that you currently hold?
24 A I am clinical professor of psychiatry at Case Western
25 Reserve University. I'm a staff psychiatrist in a group

1 dictating a trans identity. As many people have come to
2 realize that teenagers and now especially during COVID when
3 teenagers were at home have spent a great deal of time on the
4 internet and we believe that the internet has many
5 opportunities to learn about trans life, and we think this has
6 been an influence on the rising incidence of transgender
7 identities.
8 But I can say that while I could go on and speculate
9 about why there has been this increase, I don't really think
10 that science can tell you why. We can speculate and various
11 people have various speculations. Some people think it's a
12 social contagion from the internet, other people think it's a
13 social contagion from friends, close relationships, especially
14 among girls who have a friend who's trans. Some people think
15 that it's a retreat from adverse life experiences and family
16 disruptions and inability to like both parents or love both
17 parents, but these are all speculations, and I doubt since
18 there are so many people involved with this that we would find
19 one explanation that would explain everything.
20 We need to understand that in mental health work and
21 trying to grasp what happens to people who become who they
22 become and why, that we can't ever find one explanation for
23 things. Things are multifactorial, so I think this phenomenon
24 must be multifactorial as well, but it is a dramatic worldwide
25 change in how young people are identifying. And they're not

1 A. Yes.
2 Q. Have you reviewed any transcripts of the first week
3 of trial?
4 A. No.
5 Q. Has anyone spoken to you about the testimony that was
6 given during the first week of trial?
7 A. No.
8 Q. You've been a psychiatrist seeing patients, I believe
9 you said, since 1973. Is that correct?
10 A. I started my residency three years before and I saw
11 patients then, so officially as credentialed psychiatrist,
12 yes, 1973.
13 Q. And the overwhelming majority of your patients have
14 been adults.
15 A. Over the years, yes.
16 Q. Is that right, that the overwhelming majority have
17 been adults?
18 A. Yes.
19 Q. Is that a yes?
20 And you've estimated that you've seen about 50
21 minors, patients under 18, in your nearly 50-year career.
22 Is that correct?
23 A. Yeah. In a previous testimony, give can you give me
24 that number?
25 Q. I can show you.

1 THE COURT: Let's short cut. Is that true?
2 THE WITNESS: It's approximately true.
3 MS. COOPER: Thank you, Your Honor.
4 BY MS. COOPER:
5 Q. And you've testified that you've seen about six
6 prepubertal children in your career over 50-plus years.
7 A. Yes. That's probably approximately true, personally
8 seen.
9 THE COURT: What was the last part? I couldn't
10 hear you?
11 THE WITNESS: I'm sorry?
12 THE COURT: I didn't hear the last couple of
13 words. Did you say something --
14 THE WITNESS: That I personally have been
15 involved.
16 THE COURT: Thank you. You faded off. I
17 couldn't hear.
18 BY MS. COOPER:
19 Q. I believe you testified on direct that there are
20 about 70 gender clinics in the United States. Is that
21 right?
22 A. Yes.
23 Q. And you don't know how different practitioners or
24 clinics provide care, correct?
25 A. There are many, many practitioners. How would I

1 possibly know how they all provide care? I've been aware
2 of some instances of care, yes.
3 Q. So there are many practitioners and clinics about
4 which you don't know protocols --
5 A. Many.
6 Q. And you don't know how common it is for clinicians to
7 provide hormone therapy to minors without a careful
8 assessment of the child and their comorbidities. Is that
9 correct?
10 A. Well, I've been in touch with many parents from all
11 over the country who have indicated that to me. But in a
12 numerical sense with a denominator, I'm not aware. I
13 certainly have had many experience where I heard
14 complaints of -- about that.
15 Q. You don't know if it's a small minority, a majority,
16 or something in between?
17 A. I don't know that 38 percent do and 42 percent don't
18 or -- I don't have that kind of information.
19 Q. You wouldn't say whether it's a majority or a
20 minority.
21 A. Couldn't say.
22 Q. You don't have any knowledge about how gender
23 affirming medical care is provided to minors in Arkansas.
24 Is that correct?
25 A. That's correct.

1 of rapid onset gender dysphoria versus lifelong gender
2 dysphoria, the parents -- the parents' view is vital, you
3 see.
4 But, you know, today most of the onset of the gender
5 dysphoria presents itself at first in adolescence, not at
6 age four. In that sense, you and I are talking past each
7 other.
8 Q. All right. If we can look at -- just to wrap this
9 question up for clarity, on page 41 -- can you see the
10 screen in front of you --
11 A. Yes.
12 Q. -- beginning on line 22. Question: Does your -- you
13 mentioned that you meet with the parents too. Does that
14 contribute to your assessment whether someone meets the
15 criteria for gender dysphoria, what's reported by the
16 parents.
17 Answer: Of course.
18 That was your testimony?
19 A. I thought I just explained what I meant by that.
20 Q. When you diagnosis patients for other conditions like
21 depression or bipolar disorder, do you rely on self-report
22 of patients?
23 A. And reports from the parents.
24 Q. Reliance on self-report from the patients and
25 information from parents is not unique to the diagnosis of

1 gender dysphoria, is it?
2 A. That's right. It's not unique.
3 Q. Diagnosing patients based on self-report and
4 information from families who know the -- people who know
5 the patient, that's how psychiatry works, isn't it?
6 A. Ideally.
7 Q. You were deposed this past March in a case called BPJ
8 in West Virginia. Do you remember that case involving
9 athletics?
10 A. Yes.
11 Q. I'd like to show you a passage from -- well, a
12 passage from your deposition in that case. Can we look at
13 paragraph 6, please?
14 Do you see that in front of you in paragraph 6? It
15 says, if you'll read along with me: In the course of my
16 five decades of practice treating patients -- I'm sorry.
17 This is not your deposition. Let me back up. I misspoke.
18 You remember giving a report in the BPJ case. Is
19 that right?
20 A. I vaguely remember.
21 Q. And is this your expert report?
22 A. I don't know. You just --
23 Q. Can we scroll through this front page just to show?
24 A. It's my signature, yes.
25 Q. So if we can turn back to paragraph 6. And I would

1 like you to read along with me. In the course of my five
2 decades of practice treating patients who suffer from
3 gender dysphoria, I have at one time or another
4 recommended or prescribed or supported social transition,
5 cross-sex hormones, and surgery for particular patients,
6 but only after extensive diagnostic and psychotherapeutic
7 work.
8 So you wrote this passage, correct?
9 A. Yes.
10 Q. And you have supported patients' social transition.
11 Is that correct?
12 A. This -- this paragraph or sentence doesn't give an
13 age group.
14 Q. Understood. But I'm just asking generally, you have
15 supported --
16 A. Many four-year-olds.
17 Q. Yes. Okay. You have counseled some parents to
18 support the transgender identification of their child,
19 haven't you?
20 A. I'm not sure that's true. Depending on what you mean
21 by child. Child -- a could be 25. That is a child of a
22 parent can be 25.
23 Q. You've counseled some parents to support their minor
24 child's social transition, haven't you?
25 A. I have on rare occasion, yes.

1 Q. And switching back to adults, you've written letters
2 of authorization for adults seeking gender-affirming
3 surgeries. Is that correct?
4 A. I have.
5 Q. And you've done that as recently as the past two
6 years.
7 A. I have.
8 Q. And you've also written letters authorizing hormone
9 therapy for adult patients with gender dysphoria.
10 A. I have.
11 Q. And these are letters they can take to the
12 endocrinologist. Is that right?
13 A. Yes.
14 Q. And you have written such letters approving hormone
15 therapy for minors under 18 in a few cases within the past
16 five years, haven't you?
17 A. I don't think in the past five years.
18 Q. Okay. Can we turn to Dr. Levine's deposition, page
19 78?
20 I would like you to read along with me starting on
21 line 3. So between you and Mrs. Novak, there have been a
22 handful of cases in the past, say, five years where you
23 have approved hormone therapy for minor. Is that right?
24 These are particularly fraught difficult
25 circumstances, yes.

1 A. Yes.
2 Q. Mrs. Novak is someone who works in your medical
3 practice -- or your psychiatry practice?
4 A. She's a younger colleague of mine.
5 Q. That was your testimony.
6 A. I'm sorry?
7 Q. That was your testimony that I read correctly.
8 A. Yes. I'm just not sure today whether it's five years
9 or six years now. And in generally, there have been a few
10 very fraught cases where we felt that this is a very
11 reasonable thing given the severity, the complexity of the
12 case, and that we would -- we, along with parents, would
13 hold our breath that this would be of help.
14 Q. And you have cosigned letters for hormone therapy for
15 minors written by Mrs. Novak, again, approving some minors
16 for hormone therapy. Is that right?
17 A. Yes, but this has not occurred very recently, Ms.
18 Cooper.
19 Q. You would not write a letter supporting hormone
20 therapy for a minor if you did not believe the patient had
21 gender dysphoria, correct?
22 A. Correct.
23 Q. And you would not write a letter approving a minor
24 for hormone therapy without first determining that they
25 had a longstanding, stable gender identity. Is that

1 much more cautious. We will give adolescents hormones,
2 but not as quickly as the Standards of Care would like.
3 That was your testimony in Keohane.
4 A. I have to say yes.
5 Q. And just to clarify, the Standards of Care you're
6 referring to in the 7th Edition, is that the WPATH's
7 Standards of Care 7th Edition?
8 A. Yes.
9 Q. When you were deposed in May of this year in this
10 case, the Brandt case, you testified, did you not, that
11 going forward you have not made a decision to no longer
12 write letters approving hormone therapy for patients under
13 18 years of age.
14 A. Indulge me a minute. In the previous thing you put
15 up, my deposition of adolescents was not the definition I
16 gave to the Judge earlier this morning. It was my
17 definition of an adolescent is somebody 19 years of age.
18 And so if you reread that, it would include 18-year-olds
19 and 19-year-olds.
20 So would you repeat the last question you asked me?
21 Q. Sure. When you were deposed this past May in this
22 case in Arkansas, you testified that, going forward, you
23 have not made a decision to categorically not write
24 letters approving hormone therapy for patients under 18,
25 correct?

1 A. I don't remember saying that, but if you have that, I
2 trust you.
3 Q. Yeah. I think we want to put that in the record.
4 Can we look at deposition page 227?
5 And if you go to line 3, part way through beginning
6 with the words, "Have you made a decision." Are you with
7 me? It's highlight.
8 Have you made a decision to no longer consider
9 hormone therapy for anybody who has not reached their 18th
10 birthday since you provided those letters?
11 Answer: I've made a decision to be very cautious and
12 to put a period of time in therapy between me and the
13 letter.
14 You go on to say more, which you're welcome to read
15 if you would like, but I want to continue on to another
16 passage that picks up rather than taking the Court's time
17 reading a lot of discussion in between.
18 If we could turn to page 228, line 3. Let me know if
19 you want to review there.
20 MR. CANTRELL: Your Honor, I would like to just,
21 if we could, take a look at the intervening testimony,
22 glance at that.
23 MS. COOPER: Sure. We can post that.
24 Absolutely.
25 THE COURT: I thought you were in the

1 deposition, Mr. Cantrell, but go ahead.
2 BY MS. COOPER:
3 Q. Do you have that in front of you now, Doctor? If you
4 look at line 3 and read along with me.
5 So I'm not sure if that answers my question. Have
6 you made a decision to no longer provide letters?
7 Answer: Oh, I'm sorry. No, I haven't made that
8 decision.
9 Question: So would it be a case-by-case basis if
10 there were a patient that you felt it was appropriate for
11 you -- appropriate for, you would consider doing it, say,
12 a 17-year-old or a 16-year-old?
13 Mr. Cantrell: Object to form.
14 Answer: I don't have a -- yes. The answer to your
15 question is yes.
16 I'm not going to ask you if that was your testimony
17 again --
18 A. Thank you.
19 Q. -- since I see how you love those questions.
20 Now, today you testified that you would not recommend
21 hormone therapy for patients under 18. Do you mean you
22 would not generally recommend hormone therapy as a general
23 matter?
24 A. Yes.
25 Q. So there may be exceptional cases where you would

1 still consider it appropriate.
2 A. Yes. These are very fraught circumstances. I think
3 all of us all over the world recognize that we are under
4 very difficult circumstances sometimes. We don't know
5 what to do and we eventually go along with the patient's
6 sincere desire to try hormones.
7 Q. Now, you talked on direct about an article you wrote
8 called, *Reconsidering Informed Consent for*
9 *Trans-identified Children, Adolescents, and Young Adults.*
10 And I just want to ask you a couple of questions
11 about that article.
12 In this article, you recommend informed content
13 process that you think providers should undertake before
14 authorizing medical or surgical transition for minors,
15 correct?
16 A. Yes.
17 Q. I'd like to pull up a passage from that article to
18 show you. If we can look at page 2. And I have some
19 material highlighted. Actually, I would like you to skip
20 to -- sorry. I wasn't in front of the mic. I would like
21 to skip to the second highlighted paragraph.
22 A. I know what you're you talking about.
23 Q. We over highlighted. If you'll read along with me in
24 the second paragraph there.
25 Social transition, hormonal interventions, and

1 that is immutable, that it cures suicidal ideation, and
2 that it makes everyone live happily ever after, you see.
3 So in order to understand that last -- the
4 second-last sentence there, it does not preclude
5 transition. It presumes that the doctor is knowledgeable.
6 And what it I have been saying is that all the doctors are
7 not equally knowledgeable about the state of science.
8 Q. But you're not saying that no doctors are
9 knowledgeable.
10 A. Of course I'm not saying that, Ms. Cooper.
11 Q. In that article that we're looking at here, you don't
12 say that gender-affirming medical care, specifically
13 hormone therapy or blockers or surgeries, should be
14 categorically prohibited for minors, do you?
15 A. No, I don't. This is -- that was not the topic of
16 this article.
17 Q. You testified that you would like to see an
18 international committee -- this was today. You testified
19 that you'd like to see an international committee
20 developed standards for informed consent to provide
21 gender-affirming medical care to adolescents. Is that
22 right?
23 A. Yes.
24 Q. So, you're not seeking to prohibit care, but to
25 ensure that patients have been thoroughly provided

1 information and take the time and patience to understand
2 it before making this monumental decision.
3 A. Ms. Cooper, when you say "patients," you need to ask
4 -- for me to agree to that, you have to add parents and
5 patients.
6 Q. Thank you. Let me ask it differently.
7 So you're not looking to prohibit care, but to ensure
8 that patients, and particularly their parents when they're
9 minors, have thorough information in order to be able to
10 adequately make that decision. Is that correct?
11 A. I am not motivated to prohibit care. I am motivated
12 to clarify the scientific basis upon which the care is
13 provided, and if the basis is inadequate, to let doctors
14 be cautious about this.
15 Q. And to inform families of this information as well.
16 A. And to inform -- to use their own ethical unease
17 about the wisdom of this in their informing patients and
18 parents about the state of science here and what is not
19 known, the uncertainties, and the risks of harms.
20 Q. And your view is that, if families are -- by
21 "families," I'm specifically focusing on parents -- are
22 fully informed about the risks and the state of the
23 science, the decision about whether to pursue hormone
24 therapy for adolescents -- minor adolescents should be
25 made by the parents, patient, and doctors. Is that

1 Q. I'm sorry. Yes?
2 A. Yes.
3 Q. You believe that for youth who are currently
4 receiving hormone therapy, requiring them to discontinue
5 treatment could create a psychological -- could create
6 psychological and physiological problems, correct?
7 A. Most certainly, I think it would be a psychological
8 challenge for those folks, whether physiologically or
9 cause a significant problem is not clear because,
10 depending on their age and depending on the original
11 maturation of their ovaries and testes, stopping estrogen
12 or stopping testosterone abruptly may cause brief periods
13 of thermo-regulatory -- what we call hot flashes.
14 But I think if a person's just had hormones, say,
15 starting at age 15 or 16, their gonads had matured enough,
16 that they would begin the secretion of progesterone and
17 estrogen for biologic girls and testosterone for boys.
18 But I think psychologically, it would be a shocking and
19 devastating thing for them.
20 There are lots of negative things that happen to all
21 of us in life that are shocking and devastating, and we
22 learn to cope with it. And what I said at the deposition
23 is that doctors are compassionate people generally and
24 they would find a way to be of help. And my concern with
25 the law as ti was originally written is that it seems to

1 (Proceedings continuing at 3:00 p.m.)
2 BY MS. COOPER:
3 Q. Dr. Levine, you submitted a report in opposition to our
4 plaintiffs' motion for preliminary injunction. Do you remember
5 doing that in this case?
6 A. In this case?
7 Q. In this case, yeah.
8 A. That's too legalese for me.
9 Q. Okay. Let's show you -- if you can put up the report or
10 the rebuttal.
11 If you can look at the document on the screen dated
12 July 9th, '21, or filed. On the top, it says, "July 9th, '21,
13 declaration of Stephen Levine." Is this a report that you
14 prepared in this case?
15 A. That was my original report.
16 Q. Okay. If you can look at page -- excuse me -- paragraph
17 35, and read along, the highlighted material.
18 "To my knowledge, there is no credible scientific evidence
19 beyond anecdotal reports that psychotherapy can enable a return
20 to male identification for genetically male boys, adolescents,
21 and men, or return to female identification for genetically
22 female girls, adolescents and women."
23 That's what you said in your report?
24 A. That's what I did say, yes.
25 Q. Okay. Now, you talked on direct about your clinical

1 experience, and you mentioned that most of your patients were
2 adult patients. It's correct that you've had only two patients
3 who have detransitioned after medically transitioning. Is that
4 correct?
5 A. That I'm aware of at the moment, yeah.
6 Q. Okay. And in your report in this case, you cited a paper
7 by Exposito-Campos about detransition. Correct?
8 A. Yes.
9 Q. And you noted that the Exposito-Campos review of
10 detransitioning claimed to have identified 16,000 entries in a
11 search of proliferating websites devoted to this topic. Is that
12 correct?
13 A. Detransitioning, yes.
14 Q. And, to be clear, this did not represent 16,000
15 detransitioners. Right?
16 A. It's not possible to know what percentage of them are
17 individual people who have detransitioned.
18 Q. That was a reference of the number of people participating
19 in these online groups. Is that right?
20 A. Right.
21 Q. Uh-huh. Okay. Now, you talked some during direct
22 testimony about detransition and studies looking at rates of
23 detransition. I just had a couple of questions about that. You
24 mentioned that there was a study that said that there was a rate
25 of about 30 percent of patients detransitioned.

1 A. Yes.
2 Q. Right? How was detransition defined in that study?
3 A. I think as stopping hormones.
4 Q. People may stop hormones without going back to reverting to
5 their biological sex. Correct?
6 A. Yeah. The study is about the rate, you see. It's not
7 about the details, right?
8 Q. Okay. And I would like to pull up a passage in your
9 rebuttal report in this case. Do you have that, paragraph 17?
10 If you can look at page 1, is this your rebuttal?
11 Oh, is this the same document? I'm sorry. It is the same
12 document.
13 This is your report you wrote in this case?
14 A. I trust you.
15 Q. It has your name on it. Right? Did you look at it? I
16 want to make sure we're on the same page.
17 A. A rebuttal declaration of Dr. Stephen Levine, M.D.
18 Q. Let's look at paragraph 17, please. I would like to have
19 you go down sort of towards the bottom, second-to-last line in
20 that paragraph, beginning with the word "according." And read
21 along with me.
22 It says, "According to a recent study from a UK adult
23 gender clinic, 6.9 percent of those treated with
24 gender-affirmative interventions detransitioned within 16 months
25 of starting treatment, and 3.4 percent had a pattern of care

1 detransition occurs in various forms to various degrees should
2 not be denied any longer. The incidence of using this 1 or
3 2 percent of regret for the whole phenomenon of maybe a mistake
4 has been made somewhere along the line no longer is acceptable.
5 What we need to think is that with the rising number of people
6 getting hormones and the rising number of people saying they are
7 transgender and then the rising number of people getting access
8 to hormones, we should expect that some of those people, given
9 the ordinary ambivalence of the human soul, will change their
10 mind as they get older and detransition to various degrees.
11 These studies are just the first early reports.
12 Q. Understood. But my question has to do with the 30 percent
13 figure you gave. These studies don't show that 30 percent of
14 patients who were on treatment detransitioned. Isn't that
15 right?
16 A. I think -- yes, that's right. They are showing that
17 30 percent dropped out of treatment or were lost to the original
18 treatment plan.
19 Q. So, to be clear, they showed that 6.9 percent, what you
20 described here, 6.9 percent detransitioned, and another
21 3.4 percent had a pattern of care suggestive of detransition.
22 But separately, to get to the remainder, to get to that
23 30 percent are 21.7 percent who are just people who dropped out
24 of the program. Right?
25 A. And that's study No. 1. That's Hall.

1 Q. Just to clarify, we don't know if 21 percent of those
2 people detransitioned.
3 A. No. They may have gotten their care at a different
4 country.
5 Q. In fact, your own description says some of them reengaged
6 in the clinics in those 21 percent.
7 A. That was a quote.
8 Q. That was a quote. Okay. Tell me, so there's another study
9 that showed 30 percent detransitioned? Which one is that?
10 A. If you look down further to No. 9, reference No. 9 to Boyd,
11 that's a study of older people detransitioning.
12 Q. Okay.
13 A. My point, Ms. Cooper, is that people detransition. And we
14 shouldn't be surprised, and we shouldn't sell the public that
15 once a trans always a trans.
16 Q. I want to switch gears for now and ask you about a
17 presentation you gave at the American Psychiatric Association
18 this past May. Correct?
19 A. Correct.
20 Q. Yeah. You presented at an annual conference of the
21 American Psychiatric Association in a symposium on reexamining
22 the best practices for transgender youth. Is that correct?
23 A. That is very correct.
24 Q. And among your co-presenters were Ken Zucker. Correct?
25 A. Yes.

1 Q. And others were Lisa Marchiano and Sasha Ayad? Correct?
2 A. Yes.
3 THE COURT: Ms. Cooper, can you spell that last name?
4 MS. COOPER: I can. Ayad is A-y-a-d.
5 BY MS. COOPER:
6 Q. And all four of you who were on that panel are people who
7 have dissenting views from APA policies on trans healthcare.
8 Correct?
9 A. That's right.
10 Q. Okay. And the APA was aware that the four of you were
11 presenting ideas that were not in keeping with official policies
12 of the APA. Correct?
13 A. Yes. They made an announcement of that before we were
14 allowed to present. And they sent a special person to moderate
15 it. They didn't allow me, the chairman, to moderate it, but
16 they didn't tell me they were going to do that. They just
17 showed up three minutes before the symposium, yes.
18 Q. And while you were talking, the group in the audience was
19 polite, and no one interrupted. Is that correct?
20 A. While I --
21 Q. While you were presenting on the panel.
22 A. Yes. They were very polite until the presentation was --
23 the presentations were finished.
24 Q. Excuse me? Until the presentations were --
25 A. Finished.

1 THE COURT: Dr. Levine, as a psychiatrist, how did
2 that make you feel? No. I'm kidding.
3 THE WITNESS: I can answer that, Your Honor.
4 THE COURT: You don't have to answer it. I'm just
5 trying to shake things up a bit. Keep going.
6 THE WITNESS: You succeeded.
7 BY MS. COOPER:
8 Q. No one interrupted. Correct?
9 A. I'm sorry?
10 Q. No one interrupted the presentations. Correct?
11 A. The only interruption in the presentation was when I began
12 to speak to introduce the symposium, this woman appeared and
13 told me to wait a minute, she was going to make the first
14 comment.
15 Q. But there wasn't a disruption of the content of the
16 presentations?
17 A. That's right.
18 Q. We just mentioned Ken Zucker, who was on the panel with
19 you. Is it correct that he is called -- excuse me -- he is a
20 proponent of what some call watchful waiting for prepubertal
21 children?
22 A. That's not what he presented about.
23 Q. But your understanding is he's a proponent. I'm sorry if
24 that wasn't clear. Putting aside his presentation at the panel,
25 he is a person who supports watchful waiting for prepubertal

1 for off-label use."
2 That was your testimony. Correct?
3 A. Oh, yes, yes. That was my testimony.
4 Q. Okay. Off-label drug use is very common in probably every
5 field of medicine. Correct?
6 A. Yes.
7 Q. Uh-huh. And the fact that a drug is being used off label
8 does not make the use experimental. Correct?
9 A. In some sense it is experimental. It's not approved.
10 There hasn't been evidence other than in a clinical fashion to
11 do it. It's not experimental in the same serious way we're
12 talking about using the various drugs for gender dysphoria off
13 label and perhaps experimental.
14 Q. You would agree, though, that the fact that a drug is being
15 used off label does not alone mean that it's experimental.
16 Correct?
17 A. I would agree with that.
18 Q. People in your field know the difference between articles
19 that are peer reviewed in a scientific journal and different
20 kinds of publications. Right?
21 A. Yes.
22 Q. Speaking generally about psychiatric conditions, you would
23 agree that because of the complexity of the human psyche and the
24 difficulty of running controlled experiments in this area,
25 substantial disagreements among professionals about the causes

1 WPATH's principles.
2 Q. But, again, you don't know how most practitioners around
3 the country, how credentialed they are and how they provide
4 care.
5 A. Who in the world knows?
6 Q. But you don't.
7 A. I don't and you don't.
8 Q. Okay. Now, I want to switch gears and talk about some of
9 the European reports that you talked about. Let's start with
10 Finland. You talked about a report from Finland. Do you
11 remember talking about that? Okay. And you mentioned that a
12 committee of, I believe you said, blue ribbon experts put
13 together these international reports. Which were the experts
14 who were the blue ribbon experts who put together the Finnish
15 report?
16 A. Their names?
17 Q. Anything about them.
18 A. I don't know their names.
19 Q. Do you know anything about them?
20 A. Well, I know the head of this national program. I know
21 her, but I don't know her colleagues.
22 Q. And do you know what organization put that report out?
23 A. Well, it's called COHERE. Please don't ask me what the
24 COHERE stands for.
25 Q. How many experts were on that blue ribbon committee that

1 THE COURT: Is that true, Doctor?
2 THE WITNESS: It is true.
3 BY MS. COOPER:
4 Q. Okay. Now, the French report, the French document that you
5 talk about, that's not a review of the literature. Right?
6 A. I'm sorry. Which one?
7 Q. The French application.
8 A. The French, I don't think -- I don't want to testify it's
9 based on a review.
10 Q. So you don't know if that was done by a blue ribbon
11 committee of experts?
12 A. I don't know who did it, just there was a national body in
13 France.
14 Q. Okay. Thank you. That helped clarify that. I want to go
15 back to some of these individual reports and just a few
16 questions. The Finnish report did not recommend banning
17 gender-affirming medical care for minors, did it?
18 A. I think in special cases they thought it could be
19 continued.
20 Q. In fact, it allowed puberty blockers on a case-by-case
21 basis after careful consideration. Isn't that what it says?
22 A. I think so.
23 Q. And it says in the Finnish report that hormone therapy
24 could be provided to minors based on a thorough case-by-case
25 consideration if it can be ascertained that the identity as the

1 other sex is of a permanent nature and causes severe dysphoria.
2 Is that correct?
3 A. Yes.
4 Q. Now --
5 A. Ms. Cooper, then how could a bunch of doctors know that a
6 nine year-old's gender identity is permanent? It only could be
7 based on the fact it has existed for three years.
8 Q. Is anybody providing hormone therapy -- cross-sex hormone
9 therapy to nine year-olds?
10 A. Yes, yes, yes.
11 Q. Cross-sex hormone therapy?
12 A. No, no.
13 Q. That's what we're talking about.
14 A. Puberty blocking hormones.
15 Q. This was about cross-sex hormone therapy.
16 A. Oh, I'm sorry.
17 Q. Yeah.
18 A. Even so, if somebody has consistent cross-gender
19 identification from 12 to 16, there's no guarantee that that
20 person will be cross-gender identified at 25.
21 Q. But that's what the Finnish report said, what I described.
22 A. Right. You see the limitations inherent even in policy.
23 Q. So, turning to the French report, just to be clear, they
24 did not recommend prohibiting gender-affirming medical care for
25 minors, did they?

1 A. I don't know.
2 Q. You don't know?
3 A. At this moment.
4 Q. Uh-huh. So you don't know if in France minors can receive
5 gender-affirming medical care to treat gender dysphoria?
6 A. I think this was a general recommendation rather than a
7 prohibition. And the recommendation was psychotherapy and
8 psychiatric evaluation first.
9 Q. Okay.
10 A. I think what we have in common here in all of these
11 countries we're talking about is the recommendation, the prudent
12 recommendation that psychiatric evaluation and attention to
13 associate a psychopathology and worry about both detransition
14 and the rapid rise in the number of people calling themselves
15 transgender calls for a different approach, not the preclusion
16 of individual cases getting a particular treatment, but, in
17 general, doctors of our country think psychotherapy first, not
18 hormones first, not transition first. That's what these things
19 have in common, whether I remember one phrase or another from
20 the report.
21 Q. And your assumption is in the U.S. doctors are doing
22 medical transition before psychotherapy?
23 A. Oh, yes.
24 Q. But you don't actually know how many doctors do that.
25 Right?

1 get these drugs.
2 Q. And you mentioned a report from Canada. Hormone therapy
3 and puberty blockers are not prohibited for minors in Canada,
4 are they?
5 A. No. This was done for the State of Florida. It was not
6 done by the Canadian National Service. But what it did was
7 reiterate the low quality of evidence for puberty blockers being
8 beneficial and for cross-gender hormones being beneficial or
9 them in sequence being beneficial. Based on international
10 standards, blue ribbon people, sophisticated people, every
11 review says that the scientific objective review of the evidence
12 supporting these treatments is of very low quality.
13 Q. I'm not asking about the quality of evidence. I'm asking
14 about the recommendations in the reports. That's what my
15 questions were focused on. And going back to the Canadian
16 report, do I understand from what you said earlier that that's a
17 report that was prepared to be used in litigation to support a
18 ban on treatment in Florida?
19 A. I don't know exactly why it was done. What I was trying to
20 help you not make a mistake in thinking, that it was part of
21 Canadian national policy. It was an academic center. That
22 place does reviews, does all kind of reviews. And somebody I
23 think from the State of Florida commissioned and paid for the
24 review. And the review said, and it was objectively done, the
25 same thing that the other reviews have said, low quality and

1 taking that into consideration in comorbidities, but in Europe
2 they are focusing on that. But when I pointed out that the
3 standards of care here actually require that, you said, well,
4 they don't really follow the standards.
5 A. Ms. Cooper, what I was trying to say to you, you can read
6 these wonderful words in the standards of care, but it turns out
7 the devil is in the details. The devil is how it's translated,
8 who is doing the psychiatric assessments, what mindset do they
9 have, what knowledge do they have, and how long do they have to
10 do it. Every clinic can say we do comprehensive care. Every
11 clinic will say we do these evaluations. But from the parents'
12 point of view or the educated parents' point of view, that is
13 not what is happening to their child frequently.
14 Q. For some families you've talked to.
15 A. Frequently.
16 Q. For some families you've talked to. Correct?
17 A. I'm sorry?
18 Q. For some families you've talked to.
19 A. Almost for all the families I've talked to.
20 Q. Which is a tiny amount, representing a very tiny amount of
21 the clinics around the country. Correct?
22 A. And I don't know what percentage of the clinics, but they
23 are from many states.
24 Q. I just have a few more questions. I want to go back to the
25 second study on detransition that you mentioned showing the

1 30 percent detransition rate.
2 A. The Boyd study?
3 Q. That was the one by Boyd. Thank you. We're going to put
4 that up so we can get clarity on that. Looking at a study
5 called "Care of Transgender Patients: A General Practice
6 Quality Improvement Approach" by Isabel Boyd, et al., that's the
7 study you are talking about?
8 A. That was I think a primary care study.
9 Q. Okay. You have the highlighted portion in front of you?
10 A. Yes.
11 Q. "3.2.4. Undesired Treatment Outcomes (stopping hormones,
12 abnormal blood test results, side effects and complications)."
13 It says here, "Nine patients had stopped hormone therapy, one
14 related to practice policy because they had not attended any GIC
15 follow-up (the patient has restarted since the audit). Thus,
16 eight patients had stopped hormones voluntarily (20 percent
17 stopping rate; six trans men, two trans women). These patients
18 had been on treatment for a mean of five years (range 17 months
19 to 10 years). Four trans men had comments in the record that
20 related to a change in gender identity or detransitioning (4 out
21 of 41, 9.8 percent) quote: Would like to gradually
22 detransition. No longer wish to live your life as a male. Has
23 decided to detransition. Feels comfortable having decided to
24 dress and appear more feminine. Feels it was a mistake
25 identifying as non-binary now, close quotes.

1 None of these patients had undergone any gender-related
2 surgery. They had presented at a mean of 18 years of age, taken
3 testosterone for a mean of 18 months and currently presented as
4 female (three) or non-binary (one). The other four patients who
5 had stopped hormones continued to present as trans (two women,
6 two men): One, who had experienced orchidectomy, had a record
7 of regret (no hormonal treatment currently, regrets gender
8 reassignment); one had a medical reason noted for stopping,
9 quote, problems with PV bleeding despite androgen; two had no
10 specific reason for stopping in their record, but it was
11 documented that they had stopped."
12 So I see a 20 percent stopping rate, but I don't see a
13 30 percent detransition rate anywhere in there. Is this the
14 study you are talking about?
15 A. Yes. But, you know, I haven't read this study since it
16 came out. And you've picked out one paragraph. And perhaps we
17 could sit down and read it together and figure out whether I'm
18 right or wrong. And if I'm wrong, I'm wrong by 10 percent. The
19 point is, Ms. Cooper, the detransition for various reasons
20 happens. If it happens in this clinic, we should assume it
21 happens in Arkansas and in Missouri and everywhere else. And
22 the idea that people think it's a mistake is one of the things
23 I've tried to talk about this morning. We can't be sure that a
24 14 or 15 or 17 year-old knows what his or her future is going to
25 be. And if they cannot be prudent, we have to be prudent. And

1 if the medical profession isn't prudent about this, isn't
2 careful, isn't aware of the limitations, I guess legislatures
3 make a decision.
4 So I'm just asking the medical profession to be prudent and
5 to know about the evolution of gender identity. Even after it's
6 been solid during adolescence for three years or four years, it
7 doesn't mean that when you are 23 you don't think differently.
8 We must be prudent, and we must protect people sometimes against
9 things that we have reason to believe that a majority of people
10 may come to regret. Now, you see the real question here is not
11 the Boyd study.
12 Q. Well, I do want to stay on the Boyd study for a minute. I
13 understand your point that detransition happens. And that is
14 not the question I want to -- I'm not arguing about that.
15 A. Good.
16 Q. I'm asking about this 30 percent number that you testified.
17 I understand now you may be not standing by that 30 percent
18 figure?
19 A. Yeah. Maybe I'm going back to 20 percent.
20 Q. Then, even the 20 percent you would agree is not a
21 representation of detransition, but it represents the number of
22 people who stop medical transition for various reasons, some
23 medical reasons and unknown reasons. Correct?
24 A. I don't think you are going to make compelling points in my
25 view by picking out one paragraph and not looking at the whole

1 thing.
2 Q. You used the number 30 percent, and this appears to be
3 where it came from, so I need to pick it apart.
4 A. I do not represent myself as infallible. And my
5 statements, I can't imagine every statement is verifiable that I
6 ever make in my life. I'm doing the best I can with my memory.
7 Q. Fair enough. It's not a memory test. Looking at it here
8 now, though, you would agree that this study does not even say
9 20 percent detransitioned. It says 20 percent stopped the
10 medical transition for various reasons.
11 A. Well, can you tell what the denominator here is?
12 Q. Well, 20 percent. Twenty is a percentage.
13 A. That requires a denominator. What number of people are we
14 talking about?
15 THE COURT: Twenty out of a hundred.
16 THE WITNESS: That's not --
17 BY MS. COOPER:
18 Q. 41 is the N. If you want to know the number, it's 41 I
19 think it says. Four out of 41 were the ones who --
20 A. Is 41 the denominator?
21 Q. 4 out of 41 detransitioned.
22 A. So nine of 41 people stopped their hormones. Is that what
23 you are saying? So we do that math. 9 of 41.
24 Q. Twenty percent stopped.
25 A. It's over 20 percent.

1 Q. Stopped hormones?
2 A. Yeah.
3 Q. I just want to be clear, though, that doesn't represent
4 detransition. It represents stopping hormones for a variety of
5 different reasons.
6 A. And I want to be clear. I want to be clear that you don't
7 know it doesn't represent detransition. It means stopping
8 hormones. Why does a person stop hormones?
9 Q. Well, it says right here problems with bleeding despite
10 androgen, and two had no specific reasons. You don't understand
11 people stopping hormones besides detransition?
12 A. What are you quizzically asking?
13 Q. Do you think the only reason somebody who is on hormone
14 therapy for gender dysphoria would stop treatment, that the only
15 reason would be because they detransitioned?
16 A. No. Some stop because they get hypertension. Some stop
17 because they get obese. Some stop because they get blood clots.
18 Some stop because their hemoglobin levels go way up and they are
19 threatened with stroke.
20 Q. But they may still maintain their trans identity. Correct?
21 A. And, of course, if that would happen to a person, that
22 would make them rethink everything.
23 Q. I think we can put this study aside, and just a couple of
24 questions. Prior to this case, you had never heard of Mark
25 Regnerus. Correct?

1 Q. I understand you are speculating about the connection
2 there. But the national review board of Sweden did not ban
3 blockers. Correct? We talked about that before.
4 A. If Karolinska blocked blockers and if Karolinska is the
5 primary site for the Swedish people to get gender-affirming
6 care --
7 Q. Is it your understanding that's the only place you could
8 get gender-affirming medical care if you are a minor in Sweden?
9 A. I'm not sure. Sweden is a small country compared to the
10 United States. Those countries tend to create clinics like the
11 Portman Clinic in the UK that funnel these patients to the
12 centers of excellence, the centers of study.
13 Q. But you don't know how it's done in Sweden?
14 A. I don't know for sure how it's done in Sweden. I do know
15 Sweden, we're very concerned about the suicide rates of their
16 transgender population. The last report I had, it was
17 3.5 percent higher than the general population.
18 Q. I lied. I have a second question, if that's okay, related
19 to the same topic. I would like to put up another document, the
20 Swedish national report that we have discussed. This is, for
21 reference, DX17. This is the Swedish report you were discussing
22 earlier. Correct?
23 A. The translation of it?
24 Q. The English translation. If we can scroll, if you can look
25 at the first highlighted paragraph with me. "To minimize the

1 risk that a young person with gender incongruence later will
2 regret a gender-affirming treatment, the NBHW deems that the
3 criteria for offering GnRH analog and gender-affirming hormones
4 should link more closely to those used in the Dutch protocol,
5 where the duration of gender incongruence over time is
6 emphasized. Accordingly, an early childhood onset of gender
7 incongruence, persistence of gender incongruence until puberty
8 and a marked psychological strain in response to a pubertal
9 development is among the recommended criteria."
10 I'm sorry. I'm reading the wrong paragraph.
11 Apologies. I'm going to read the highlighted second
12 paragraph. "To ensure that new knowledge is gathered, the NBHW
13 further deems that treatment with GnRH analogs and sex hormones
14 for young people should be provided within a research context,
15 which does not necessarily imply the use of randomized
16 controlled trials, RCTs. As in other healthcare areas where it
17 is difficult to conduct RCTs while retaining sufficient internal
18 validity, it is also important that other prospective study
19 designs are considered for ethical review and that register
20 studies are made possible. Until a research study is in place,
21 the NBHW deems that treatment with GnRH analogs and sex hormones
22 may be given in exceptional cases, in accordance with the
23 updated recommendations and criteria described in the
24 guidelines." This is the requirement or provision in the
25 Swedish national report. Correct?

1 eight o'clock tomorrow.
2 MR. JACOBS: Yes, Your Honor.
3 (Overnight recess at 4:19 p.m.)
4 REPORTER'S CERTIFICATE
5 I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.
6
7 /s/Elaine Hinson, RMR, CRR, CCR Date: December 4, 2022.
United States Court Reporter
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